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EUROPEAN SOCIAL CHARTER

30th National Report on the implementation
of the European Social Charter

submitted by

THE GOVERNMENT OF ICELAND

Articles 3, 11, 12, 13 and 14
for the period 01/01/2012 - 31/12/2015

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CYCLE XXI-2 (2017)

EUROPEAN SOCIAL CHARTER

30th report on the
implementation of the
European Social Charter

Submitted by
THE GOVERNMENT OF ICELAND
Ministry of Welfare
(for the period 1st January 2012 to 31st December 2015)

REPORT

on the application of Articles 3, 11, 12, 13, 14 for the period 1st January 2012 to 31st December 2015 made by the Government of ICELAND in accordance with Article 21 of the European Social Charter and the decision of the Committee of the Ministers, taken at the 573rd meeting of Deputies concerning the system of submission of reports on the application of the European Social Charter.

Article 3
The right to safe and healthy working conditions

Article 3, para 1. – Issue of safety and health regulations.

Amendments to the Occupational Health and Safety Act and related regulations during the period 1 January 2012 to 31 December 2015.

I. On land.

Legislative amendments.

The Occupational Health and Safety Act, No. 46/1980[1]

1. *Act No. 46/1980 was amended by Act No. 59/2013.*
   The amendment did not make substantive changes to the Act. The amendments involved provisions of various statutes to bring them into line with the acts on the Icelandic Transport Authority and the Icelandic Road and Coastal Administration, which were passed in 2012.

2. *Act No. 46/1980 was amended by Act No. 80/2015.*
   The aim of these amendments was to establish a basis in law for a new regulation on measures against ostracism and exclusion (bullying), sexual harassment, gender-based harassment and violence in the workplace, to enhance safety at work through more efficient monitoring by the Occupational Safety and Health Administration and to grant temporary exemptions from provisions of the Act regarding rest periods and night work in the case of workers who deliver client-controlled individual assistance to disabled persons. The Act requires employers to send formal notifications to the administration when improvements have been made in the working environment in accordance with instructions from the administration. Regarding client-controlled individual assistance, it was clear that the earlier provisions of the Act constituted obstructions when it came to implementing this service. Consequently, it was proposed, on the basis of a consensus of the organisations of the social partners, that it

[1] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-No-46-1980-with-subsequent-amendments.pdf

be permitted to deviate from certain legal provisions regarding rest periods and night work applying to workers who delivered these services under the collaborative agreement between the state, the municipalities and the national associations of disabled persons regarding client-controlled individual assistance. Thus, if deviations are made from the provisions of Article 53 of the Act with the result that rest periods applying to the workers in question are shorter than those provided for in the article, then steps are to be taken to ensure that the workers in question will receive at least the rest time prescribed in the article as soon as possible. When this amendment was under preparation, the rules in force elsewhere in the Nordic countries were taken into account.

Amendments to regulations.

1. *Regulation on aerosol dispensers, No. 260/2012.*[2]
   The aim of this regulation was to respond to the technical advances that have been made in the design of aerosol dispensers, at the same time guaranteeing the current safety levels. It was issued to give effect to EU Commission Directive 2008/47/EC amending Council Directive 75/324/EEC on the approximation of the laws of the Member States relating to aerosol dispensers in order to adapt it to take account of technical advances.

2. *Regulation on service-providers and specialists who provide services to employers in connection with schedules on occupational safety and health, No. 730/2012.*[3]
   The provisions of this regulation require approved service-providers and recognised specialists to have the skills necessary to carry out their work under the Occupational Health and Safety Act, with subsequent amendments, in order to ensure as far as possible the quality of the services they provide to employers.

3. *Regulation on transportable pressure equipment, No. 218/2013.*[4]
   The aim of the regulation is to enhance safety regarding transportable pressure equipment for the transport of dangerous goods by road and to ensure the free movement of such equipment within the EEA, including its marketing and repeated use. The regulation was issued to give effect to Council Directive 2010/35/EC, on transportable pressure equipment and repealing Council Directives 76/767/EEC, 84/525/EEC, 84/526/EEC, 84/527/EEC and 1999/36/EC.

4. *Regulation on the protection of workers against injuries caused by sharp implements when providing healthcare services, including services provided in hospitals, No. 980/2014.*[5]
   The aim of this regulation is to enhance safety in the workplace and prevent healthcare workers, including those in hospitals, from being in danger or potential danger of injury from sharp implements. The regulation was issued in order to give effect to Council Directive 2010/32/EU, implementing the Framework Agreement on prevention of injuries from sharp implements in the hospital and healthcare sector,

[2] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/260_2012-Reglugerd-um-udabrusa.pdf
[3] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/730_2012_vidurkenning_thjonustuadila.pdf
[4] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/218_2013_reglur_um_faeranlegan_thrystibunad.pdf
[5] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/980_2014.pdf

which was concluded between the European Hospital and Healthcare Employers' Association, HOSPEEM, and the European Federation of Public Services Unions (EPSU).

5. *Regulation on motor-powered amusement park equipment, No. 151/2015.*[6]
The aim of this regulation is to promote safety in connection with the use of motor-powered amusement park equipment, and of workers who operate them, their passengers and others who may be situated in their vicinity, in order to prevent injuries. The main amendments as compared with the older regulation concern markings and instructions for users of the equipment, in addition to which the text now contains more detailed provisions on the obligations of importers and operators, risk assessment, staff training and procedures involved in the running of the equipment. There are also provisions on monitoring of operators and external monitoring, which falls to the Occupational Safety and Health Administration.

6. *Regulation on measures against ostracism and exclusion (bullying), sexual harassment, gender-based harassment and violence in the workplace, No. 1009/2015.*[7]
The aim of this regulation is to prevent bullying, sexual harassment, gender-based harassment and violence in the workplace, by means including preventive measures, and to promote mutual respect in the workplace, e.g. by enhancing awareness and a realisation that ostracism and exclusion (bullying), sexual harassment, gender-based harassment and violence constitute behaviour that is prohibited in the workplace. Provision is made for measures to be taken in accordance with a written programme on safety and health in the workplace (these are detailed in Section II) if a complaint or tip-off is received or if there is reason to suspect that ostracism and exclusion (bullying), sexual harassment, gender-based harassment and violence has taken place in the workplace or if there is friction between workers that is likely to result in behaviour of this type unless measures are taken.

7. *Regulation on maximum levels of radiation to which workers and the public may be exposed and which emanate from activities which employ radiation, No. 1290/2015.*[8]
This regulation applies regarding maximum levels of radiation to which workers and the public may be exposed and which emanate from activities which employ ionizing radiation. Under the regulation, the Icelandic Radiation Safety Authority may issue guidelines on the classification of workers and working areas for certain types of activity. Thus, the areas within workplaces where ionizing radiation is employed are classified as general areas, areas under monitoring and closed areas.

8. *Regulation on radiation safety measures for the use of closed radiation sources, No. 1298/2015.*[9]
This regulation applies to safety measures applying to the use of closed radiation sources. The Icelandic Radiation Safety Authority issues guidelines on safety measures and radiation prevention for use in connection with closed radiation sources. Under it, requirements are made stating that employees who work with closed radiation sources are to hold appropriate qualifications and shall have undergone

[6] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/151_2015.pdf
[7] http://www.vinnueftirlit.is/media/sem-heyra-undir-vinnuvernd/B_nr_1009_2015.pdf
[8] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/velferdarraduneyti/nr/19948
[9] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/velferdarraduneyti/nr/19948

appropriate vocational training and received information on radiation prevention measures.

9. *Regulation on protective measures against radiation in connection with the use of equipment that emits ionizing radiation, No. 1299/2015.*[10]
This regulation applies to protective measures in connection with the use of radiation equipment for which licences are required. The Icelandic Radiation Safety Authority may issue further instructions on protective measures to be taken when using equipment covered by the regulation. All importation of radiation equipment must be reported under the regulation unless radiation from it is under levels set by the authority. Licences from the authority are required for the use of radiation equipment. It should also be noted that care is taken to ensure that all radiation to which people are exposed is within the limits stated in the regulation as the maximum levels that workers and the public may be exposed and which emanates from activities in which ionizing radiation is employed.

II. At sea and in the air.

Legislative amendments.

1. *Act on the Icelandic Transport Authority (ICETRA), the administrative institution for transport, No. 119/2012.*[11]
The Icelandic Transport Authority is the administrative institution dealing with transport, and it was established under Act No. 119/2012. The authority deals with administrative and supervisory functions covering aviation, harbours and breakwaters, shipping, traffic and roads. Through its activities, it is required to promote safe, sustainable, smooth and economically viable transport and work towards having transport develop in conformity with aims that take account of the needs of society and the environment. All functions previously handled by the Icelandic Aviation Authority and the Icelandic Maritime Authority were transferred to ICETRA. The principal aim of this restructuring was to achieve the professional advantages, clearer divisions of responsibilities and economic streamlining that resulted. A common plan of action covering all types of transport has resulted in an integrated future vision with a common aim.

2. *Transport Accident Investigation Act, No.18/2013.*[12]
The aim of this act is to promote transport safety by developing and improving the investigation of accidents. This involved the combination in a single act of law of provisions in earlier separate statutes on the investigation of accidents at sea, aviation accidents and traffic accidents. The aim of merging the separate investigative committees dealing with accidents in the different modes of transport was to pool their expertise in single committee. Its investigations are to be focussed solely on establishing the causes of transport accidents and incidents, and not to determine guilt or responsibility. The Act lays the basis for the introduction of Council Regulation 996/2010 on the investigation and prevention of accidents and incidents in civil aviation and the introduction of Council Directive 2009/18/EC establishing the

[10] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/velferdarraduneyti/nr/19950
[11] http://www.icetra.is/about/legislation/
[12] http://www.althingi.is/lagas/nuna/2013018.html

fundamental principles governing the investigation of accidents in the maritime transport sector, with authorisation for the issue of regulations.

Amendments to regulations.

1. *Regulation amending Regulation No.80/2013, on a shipping monitoring centre and monitoring of maritime traffic, No. 1179/2015.*[13]
   The aim of this regulation is to ensure safe shipping in Iceland's economic zone and the safety of vessel passengers and crews and to enhance preventive measures against marine pollution resulting from vessels. In order to achieve this aim, the regulation specifies that a shipping monitoring centre be established to attend to tasks assigned to it under the Shipping Monitoring Centre Act. The following EU directives were given effect in Icelandic law by the regulation.
   a. Council Directive 2002/59/EC of 27 June 2002 establishing a Community vessel traffic monitoring and information system and repealing Council Directive 93/75/EEC.
   b. Council Directive 2009/17/EC of 23 April 2009, amending Council Directive 2002/59/EB establishing a Community vessel traffic monitoring and information system.
   c. Council Directive 2009/18/EC of 23 April 2009 establishing the fundamental principles governing the investigation of accidents in the maritime transport sector and amending Council Directive 1999/35/EC and Directive 2002/59/EC of the European Parliament and of the Council.
   d. Commission Directive 2011/15/EU of 23 February 2011 amending Directive 2002/59/EC of the European Parliament and of the Council establishing a Community vessel traffic monitoring and information.

2. *Regulation on the work of the transport accident investigation committee, No. 763/2013.*[14]
   The aim of this regulation is to promote greater transport safety by laying down more detailed provisions on how transport accidents and incidents are to be investigated. The regulation gave effect to the following EU acts.
   a. Directive 2009/18/EC of the European Parliament and of the Council of 23 April 2009 establishing the fundamental principles governing the investigation of accidents in the maritime transport sector and amending Council Directive 1999/35/EC and Directive 2002/59/EC of the European Parliament and of the Council.
   b. Commission Implementing Regulation (EU) No 651/2011 of 5 July 2011 adopting the rules of procedure of the permanent cooperation framework established by Member States in cooperation with the Commission pursuant to Article 10 of Directive 2009/18/EC of the European Parliament and of the Council.
   c. Commission Regulation (EU) No 1286/2011 of 9 December 2011 adopting a common methodology for investigating marine casualties and incidents developed pursuant to Article 5(4) of Directive 2009/18/EC of the European Parliament and of the Council.

[13] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/innanrikisraduneyti/nr/1179-2015
[14] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/innanrikisraduneyti/nr/18794

3. *Regulation amending Regulation No. 666/2001, on safety on board passenger ships in domestic shipping, No. 260/2013.*[15]
   The aim of this regulation is to establish harmonised safety standards to prevent loss of life and damage to property on new and old passenger ships and high-speed passenger craft when these are in use in domestic shipping. The amendment gave effect to Directive 2009/45/EC of the European Parliament and of the Council of 6 May 2009 on safety rules and standards for passenger ships (recast), and Commission Directive 2010/36/EU of 1 June 2010 amending Directive 2009/45/EC of the European Parliament and of the Council on safety rules and standards for passenger ships (recast).

4. *Regulation on the education, training and professional rights of seafarers, No. 676/2015.*[16]
   The aim of this regulation is to ensure the safety of crews, passengers and Icelandic passenger and commercial vessels and to increase the effectiveness of measures to prevent pollution of the sea. These aims are to be achieved by making certain requirements concerning the education and training, age, seagoing service, health, sight and hearing of those who work on board ship, so ensuring the professional competence of crews relative to the size of their ships, the projects on which they are employed and the region in which they sail. The regulation was issued to give effect to Directive 2008/106/EC of the European Parliament and the Council of 19 November 2008 on the minimum level of training of seafarers (recast), together with the amendments made by Directive 2012/35/EU of the European Parliament and of the Council of 21 November 2012 amending Directive 2008/106/EC on the minimum level of training of seafarers.

5. *Regulation amending Regulation No.680/2004, on the working hours and rest period of seamen on passenger and cargo vessels, with subsequent amendments, No. 735/2015.*[17]
   The aim of this regulation is to improve safety at sea and the working environment of seamen on Icelandic passenger and cargo vessels, and of sailors on foreign passenger and cargo vessels which pass through Icelandic ports. The amending regulation of 2015 increased the rights of seamen aged under 18, prohibiting night work by them and making various other minor changes. The regulation transposed into Icelandic law the provisions of Council Directive 2009/13/EC of 16 February 2009 implementing the Agreement concluded by the European Community Shipowners' Associations (ECSA) and the European Transport Workers' Federation (ETF) on the Maritime Labour Convention, 2006, and amending Directive 1999/63/EC.

6. *Regulation on the continuing airworthiness of aircraft and aeronautical products, parts and appliances, and on the approval of personnel and organisations involved in these tasks, No. 926/2015.*[18]
   The aim of this regulation is to enhance flight safety by laying down common technical standards applying to enterprises and staff and providing for harmonised procedures in order to ensure the continuing airworthiness of aircraft, including their

[15] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/samgonguraduneyti/nr/18569
[16] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/innanrikisraduneyti/nr/0676-2015
[17] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/innanrikisraduneyti/nr/19721
[18] http://www.reglugerd.is/reglugerdir/eftir-raduneytum/innanrikisraduneyti/nr/0926-2015

components. This regulation gave effect to the following EU regulations: Commission Regulation (EU) No. 1321/2014 of 26 November 2014 on the continuing airworthiness of aircraft and aeronautical products, parts and appliances, and on the approval of personnel and organisations involved in these tasks and Commission Regulation (EU) 2015/1088 of 3 July 2015, amending Commission Regulation (EU) 1321/2014 and containing alleviations for maintenance procedures for general aviation aircraft.

Protection against dangerous agents and substances
Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee previously concluded (Conclusions XVIII-2 (2007) and XIX-2 (2009)) that the situation in Iceland with respect to the legal framework relating to the protection of workers against asbestos and ionising radiation was in conformity with Article 3§1 of the 1961 Charter. The report does not contain information on the matter. The Committee asks that the next report provides full and updated information on these points.

Regulation No. 430/2007, prohibiting the use of asbestos in workplaces, was issued in 2007 and is still in force without amendment. It applies to all activities covered by the Occupational Health and Safety Act, No. 46/1980, with subsequent amendments, where asbestos and products containing asbestos are used, manufactured or treated in any way. The regulation applies to products containing asbestos and asbestos impurities amounting to 1% or more. Its aim is to prevent occupational diseases that may result from the inhalation of asbestos dust. It should be noted that special instruction courses are held by the Occupational Health and Safety Administration for those who intend to work on demolition projects involving asbestos which are subject to a reporting requirement. Completion of these courses grants the right to work on projects involving low-contaminant quantities of asbestos.

The Radiation Safety Act, No. 44/2002, is intended to ensure that sufficient measures are taken against radiation from radioactive materials and radiation equipment in order to reduce its injurious or damaging impact. The Icelandic Radiation Safety Authority is the agency charged with seeing to safety precautions against radiation from radioactive substances and radiation devices. Chapter VI of Act No. 44/2002 covers radiation safety measures taken in workplaces; all radiation to which workers and the public are exposed as a result of activities and circumstances covered by the Act is to be kept to a minimum. The Act also provides for the issue of regulations; in 2015 the regulation on ionizing radiation discussed above was issued. It specifies maximum levels of radiation to which workers and the public may be exposed in the course of activities that employ ionizing radiation, and also the maximum radiation levels to which the public may be exposed by activities which employ non-ionizing radiation. It also covers the categorisation of employees and working areas with respect to ionizing radiation, and monitoring of the exposure of employees to radiation. The Icelandic Radiation Safety Authority makes regular assessments of the total exposure of the public to radiation by all activities covered by Radiation Safety Act, No. 44/2002, with subsequent amendments. Those involved in such activities are obliged to furnish the authority with the information necessary for its assessment to be as realistic as possible. Furthermore, the Icelandic Radiation Safety Authority may issue guidelines on the categorisation of workers and working areas for particular types of operations.

Other types of workers

The report provides no specific information on possible developments with respect to the legal framework relating to the protection of self-employed and domestic workers. The Committee asks that the next report provides specific information on this point.

Under Article 2 of the Occupational Health and Safety Act, No. 46/1980, the Act applies to all activities at which one or more persons work, irrespective of whether they are the owners of the enterprises or their employees. Thus, the Act also applies to work done by domestic workers and self-employed persons. The Occupational Health and Safety Administration is empowered to make inspection visits to enterprises and homes. Employers are also responsible for having special risk assessments carried out in which the risks involved in the work are assessed as regards the health and safety of the employees and the hazards in the working environment. The provision allows for the issue of regulations in which the Minister is empowered to set further rules regarding risk assessments. Regulation No. 920/2006, on the structure and execution of protective measures in workplaces, provides that in undertakings where there are between one and nine workers, or in independently operating working units, the employer and/or foreman shall take measures to promote good working facilities, hygienic practices and safety in the workplace, in close collaboration with the undertaking's workers. The employer is responsible for establishing safety and health procedures applying to the undertaking and for having a written plan drawn up covering safety and health in the workplace. This plan is to ensure that deliberate measures are taken to promote safety and health in the undertaking. Amongst other things, it is to include a special risk assessment. The risk assessment is to be in writing and cover the facilities and conditions under which the workers are employed. The assessment shall evaluate the risks involved in the work regarding the workers' health and safety and the hazards in the working environment.

Furthermore, individuals who suffer injuries in the home are covered by accident insurance under Article 5 of the Accident Cover under Social Insurance Act, No. 45/2015, providing they have secured themselves the right to compensation for accidents suffered in this work by registering a wish to this effect on their tax returns at the beginning of each year (*cf.* Article 8 of the Act). Work in the home that is covered by accident insurance includes the following.

- Traditional housework, such as cooking and cleaning.
- Care of sick persons, the elderly and children.
- Maintenance and repairs.
- Traditional gardening work.

Article 3, para 2 – Provision for the enforcement of safety and health regulations by measures of supervision.

The Occupational Safety and Health Administration is responsible for the enforcement of safety and health regulations on land, with the exception of measures against radiation, which are the responsibility of the Icelandic Radiation Safety Authority. The Iceland Transport Authority is responsible for implementing the rules on safety and health at work as regards shipping and aviation. Reference is made to the material on the Iceland Transport Authority above.

Establishment inspections.

According to Statistics Iceland, 62,961 enterprises were registered in Iceland in 2012. By the year 2013 the number had risen to 64,625; it rose again in the following year to 66,504 and to 68,893 in 2015. It should be noted that these figures cover all enterprises registered with an ID number, irrespective of whether or not they pursued any active business activity.

The following table shows the number and classification of establishments in adapted and regular inspections. The number of establishments increased between 2012-2015.

Table 1. Registered establishments according to risk categories in 2012–2015.

	2012	2013	2014	2015
Adapted inspections – establishments employing 30 employees or more	**508**	**566**	**610**	**614**
Category 1, inspection every six years	158	193	261	217
Category 2, inspection every four years	127	125	131	129
Category 3, inspection every two years	223	248	218	268
Total adapted inspections	**508**	**566**	**610**	**614**
Regular inspections – establishments employing fewer than 30 employees:				
Category 0, inspection every year			1	1
Category 1, inspection every two years	2,986	2,859	2,753	2,796
Category 2, inspection every four years	3,000	3,242	3,438	3,634
Category 3, inspection every six years	3,639	3,866	4,105	4,317
Category 4 irregular inspections	1,885	1,892	1,939	1,901
Total regular inspections	**11,510**	**11,859**	**12,236**	**12,649**
Total of inspected establishments	**12,018**	**12,425**	**12,846**	**13,263**

Source: Occupational Safety and Health Administration.

As Table 1 shows, the Occupational Safety and Health Administration ranks its inspections into categories according to the method employed and the risk involved. Further information on this categorisation is given below. It should also be pointed out that factors such as complaints by workers, serious and minor accidents, targeted campaigns within occupational sectors and follow-up measures to monitor the application of new regulations also influence the choice of establishments that are visited.

Adapted inspections – establishments employing 30 employees or more.
Under the procedure adopted by the Occupational Health and Safety Administration, establishments employing 30 employees or more are subject to what is known as 'adapted inspections'; in certain cases, those with fewer than 30 employees have been monitored by this method too. The table below shows how establishments falling into this category have been grouped up to now. The grouping depends partially on the way safety and health matters are dealt with within the establishment in question and partly on an assessment of working conditions there as they affect workers' health and safety. The grouping determines how often inspectors will call at the establishments. Those in the first and second categories are to be inspected every four to six years; those in the third, which do not have adequate safety and health precautions in place, are to be visited every second year.

A total of 614 enterprises or branches are registered as being subject to 'adapted inspections', and this number has grown slightly from year to year. The administration's goal is to have all enterprises employing 30 or more workers inspected according to this system. The number of first-time visits for the purpose of adapted inspections declined in 2015 as compared with the preceding years, the main reason for this being that priority was given to other projects and methods of inspection, including a special campaign in the fishing industry, additional

monitoring of the construction industry and joint inspections involving other monitoring authorities.

Regular inspections – establishments employing fewer than 30 employees.
Most establishments with fewer than 30 employees are under regular inspection, the frequency of which depends on the degree of risk involved in their operation. The aim is to visit them every two to six years.

Inspection visits to establishments by the administration.
There was a drop in the total number of inspection visits made to enterprises between 1 January 2012 and 31 December 2015. In 2015 the number was about 17% lower than in 2012.

Table 2. Inspection visits to establishments in 2012–2015.

Establishment inspections- number and type	**2012**	**2013**	**2014**	**2015**
Regular inspections-comprehensive inspection	1092	1196	1010	945
Regular re-inspections	22	11	12	27
Adapted inspection	78	80	71	27
Adapted inspection re-inspection	0	1	0	0
Partial inspections	735	684	676	602
Re-inspections following on from partial inspections	0	1	17	6
Inspections, total	**1,927**	**1,973**	**1,786**	**1,607**
Other visits to establishments	206	267	218	148
Visits to establishments, total	**2,133**	**2,240**	**2,004**	**1,755**
Measurements and tests performed	176	167	111	221
Call-outs due to accidents	112	112	123	136

Source: Occupational Safety and Health Administration.

The number of first-time visits for the purpose of adapted inspections fell substantially compared with previous years; as noted above, this was due to other priorities and a different approach to inspection, involving other supervisory authorities.

The number of inspectors was as seen in the following table.

Table 3. Number of inspectors in 2012–2015.

	2012	**2013**	**2014**	**2015**
In Reykjavík	14	13	13	14
Outside Reykjavík	16	15	16	15

Source: Occupational Safety and Health Administration.

Table 4. Measures taken by the Occupational Safety and Health Administration due to non-compliance in establishments in 2012–2015.

	2012	**2013**	**2014**	**2015**
Instructions on improved health standards	689	626	493	557
Instructions on improved safety standards	1111	1085	918	1188
Instructions on improvements to facilities	174	186	133	129
Instructions on health and safety efforts	951	962	806	782
Other instructions	6	6	8	22
Instructions issued, total	*2,931*	*2,865*	*2,358*	*2678*
Recommendations on improved health standards	165	129	168	95
Recommendations on improved safety measures	175	178	142	116
Recommendations on improved facilities	19	29	22	12
Recommendations on improved facilities	138	122	152	105
Other recommendations	7	14	8	6
Recommendations, total	*504*	*472*	*492*	*334*
Instructions and recommendations, total	**3,435**	**3,337**	**2,850**	**3012**
Per diem fine threats	36	48	54	46
Per diem fines decisions	11	7	7	7
Use/work prohibited	64	80	65	132
Measures to achieve compliance, total	**75**	**87**	**72**	**139**

Source: Occupational Safety and Health Administration.

The table above presents data on the types of instructions and recommendations given by the administration, ranked according to whether they concerned facilities, health precautions, safety considerations or other matters. It also shows the coercive measures taken, ranging from prohibitions on certain types of work or practice, closures, work bans or *per diem* fines.

As can be seen from the table, the total number of instructions issued dropped by 8% from 2012 to 2015, while there was a drop of 34% in the number of recommendations. In most (89%) cases, inspectors gave instructions on improvements which were systematically followed up. The most common type (44%) of instruction concerned safety measures.

Coercive measures, i.e. prohibitions on work or the use of particular pieces of equipment, were taken in 132 cases in 2015, almost twice as many as in 2012. The increase in numbers was mainly due to the tightening of inspections of the construction industry and monitoring of machinery and other equipment.

The following table shows a breakdown of health and safety inspection issues.

Table 5. Safety and health categorized according to inspection issues in 2012–2015.

	Number of instructions				Number of recommendations			
Health and safety inspection issues	**2012**	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Chemicals and chemical effects	290	305	234	245	62	55	65	49
Psychosocial working environment	17	23	25	20	5	2	3	0
Noise	27	15	14	21	14	11	9	3
Air quality indoors	110	88	91	74	17	17	17	13
Carcinogenic substances	0	0	0	7	0	0	2	0
Biological risk agents	1	6	4	2	0	0	2	0
Lighting	45	18	20	19	6	3	11	3
Vibration	0	0	0	0	0	0	1	0
Workstations- physical strain /ergonomics	100	74	46	74	20	8	12	5
Work space	99	97	59	95	41	33	46	22
Total	**689**	**626**	**493**	**557**	**165**	**129**	**168**	**95**

Source: Occupational Safety and Health Administration.

The above table shows the various health issues addressed; criticisms in this area amounted to 22% of all instructions and recommendations given. Most (45%) concerned chemical substances and their effects; 18% concerned workspaces; 13% concerned indoor air quality and 12% concerned physical strain and ergonomic problems.

Psychosocial working environment.

Table 6. Complaints concerning bullying (ostracism and exclusion) in the workplace.

Year	Complaints concerning bullying (ostracism and exclusion) in the workplace
2012	31
2013	21
2014	23
2015	37

Source: Occupational Safety and Health Administration.

The administration receives a large number of questions each year concerning alleged bullying (exclusion and ostracism) in the workplace. In some cases several complaints are received from the same workplace; thus the number of workplaces involved has not increased in step with the number of complaints.

When complaints of this type are received, the administration holds meetings with the management and security committee of the workplace in order to ensure that preventive measures designed to promote good psychosocial circumstances are in place, i.e. that the

workplace has carried out a risk assessment regarding the social environment and that it has response plan prepared to deal with cases of bullying. Since the issue of the Regulation on measures against ostracism and exclusion (bullying), sexual harassment, gender-based harassment and violence in the workplace, No. 1009/2015, an examination is also made to check whether preventive measures and a response plan exist covering all the matters addressed in the regulation: bullying, harassment and violence.

During 2015 the administration issued 20 instructions regarding the social environment in workplaces; in ten cases, this was done either because there was no risk assessment in place on psychosocial circumstances or because assessments were inadequate, and ten concerned matters involving communication, bullying, harassment in the workplace, the flow of information and the structure of work.

Machinery and equipment inspections.
One of the important aspects of the administration's operations is the inspection of working machinery and equipment. Such inspections involve checks on safety equipment of various types: brakes, steering equipment, controls, lights, load-bearing frames, etc. The following tables show the number of machines and pieces of equipment registered and inspected by the Occupational Safety and Health Administration in the period 2012-2015.

Table 7. Total number of items of registered machinery and equipment in 2012–2015.

	2012	**2013**	**2014**	**2015**
Machinery (67 categories of variable machines)	18,358	18,612	19,142	20,077
Ski lifts (3 categories)	58	57	54	53
Passenger and goods lifts (5 categories)	2,961	3,034	3,156	3,292
Car lifts (2 categories)	1,500	1,557	1,653	1,727
Boilers and compressed air containers	638	640	644	665
Total	**23,515**	**23,900**	**24,649**	**25,814**

Source: Occupational Safety and Health Administration.

Table 8. Inspections of machinery and equipment in 2012–2015.

	2012	**2013**	**2014**	**2015**
Major inspections	119	73	64	80
Regular inspections	12,168	14,332	14,092	14,416
Re- inspections	117	248	94	273
Other inspections	1,527	1,467	702	515
Total	**13,812**	**12,914**	**12,206**	**15,284**

Source: Occupational Safety and Health Administration.

As can be seen from the table, the numbers of major inspections, regular inspections and re-inspections of machinery and equipment rose between 2014 and 2015. The fall in the numbers in other categories is because, with the introduction of a new computer system, inspection reports made no longer have to be recorded when machinery is first registered and again when it is removed from the register.

Table 9. Measures taken due to non-compliance involving working machinery and equipment in 2012–2015.

	2012	2013	2014	2015
Full approval - without remarks	10,920	13,182	11,220	11,178
Inspection, instruction/requirement	0	10	1,784	2,024
Half approval, review	305	300	236	367
Half approval, notice of improvements	903	1,531	1,411	1,483
Use prohibited/machinery sealed	0	907	303	232
Total	**12,128**	**15,930**	**14,954**	**15,284**

Source: Occupational Safety and Health Administration.

"Half approval" in Table 9 refers to cases in which either instructions were issued, with a re-inspection requirement, or it was recommended that improvements be made and reported to the Administration.

Educational and publicity work.

The Occupational Health and Safety Administration does a lot of educational and publicity work. Principally, this takes the form of publications, courses, workplace meetings, lectures, the publication of articles in professional journals and trade union newsletters and contact with the media. Tables 10-13 show the number of courses held by the administration and the number of participants attending them.

Occupational safety courses for workplace safety representatives and safety managers.

The administration holds two-day occupational safety courses for workplace safety representatives and safety managers and others who are interested in these matters and in improving the working environment. These courses are held at the employer's expense in accordance with Articles 8 and 9 of the Occupational Health and Safety Act, No. 46/1980. They lead to greatly enhanced awareness of safety issues and provide an opportunity to improve the working environment, reduce the number of accidents and absenteeism due to illness and injury and generally improve workers' well-being and morale.

Altogether, 25 occupational safety courses for workplace safety representatives and safety managers were held during the year 2015, 17 of them in Reykjavík. These courses are offered all over the country and are held in response to demand.

Table 10. Number of courses and participants in courses on workers' safety representatives and safety managers in 2012–2015.

Year	Courses	Participants
2012	20	367
2013	21	401
2014	20	312
2015	25	622

Source: Occupational Safety and Health Administration.

Job risk assessment courses.

Courses on assessing the risks and hazards associated with particular jobs are among the administration's educational and awareness-raising activities. Great emphasis has been placed on risk assessments in establishments recently. Under the Regulations on occupational health

and safety in the workplace, No. 920/2006, enterprises are obliged to carry out, or have carried out for them, risk assessments covering the jobs done by their employees.

The number of risk assessment courses, and those attending them, fell slightly in 2015 compared with the previous year. Most of those who attended the courses were managers; workplace safety representatives, safety managers, human resource managers and ordinary employees were also among their number.

Table 11. Risk assessment courses and numbers of participants in 2012–2015.

Year	Number of courses	Number of participants
2012	14	210
2013	6	55
2014	7	68
2015	5	44

Source: Occupational Safety and Health Administration.

Certification courses.
Regular courses are held by the Occupational Safety and Health Administration which lead to certification (licences) for machine operators. Following theoretical studies, students take an examination which grants them licences to enter into practical training by instructors who are qualified to teach them. The numbers of courses held, and participants attending them, have risen since 2012. The table below shows the figures for the years 2012-2015.

Table 12. Certification courses in 2012–2015.

Year	**2012**		**2013**		**2014**		**2015**	
Machine operation courses	**Cou-rse**	**Particip.**	**Cou-rse**	**Par-ticip.**	**Cou-rse**	**Par-ticip.**	**Cou-rse**	**Par-ticip.**
Machine operation	35	683	35	696	35	732	34	734
Construction crane operation	6	43	4	28	4	40	4	43
Other courses	56	751	51	612	34	444	59	796
Total	**97**	**1,434**	**90**	**1,336**	**73**	**1,216**	**97**	**1,573**

Source: Occupational Safety and Health Administration.

ADR courses: Certification courses for the transport of hazardous materials by road.
The ADR Treaty (the European Agreement concerning the International Carriage of Dangerous Goods by Road – ADR) applies in the European Economic Area, including Iceland. Drivers are required to attend special courses which grant them the right to transport hazardous material by road in Iceland and elsewhere in the EEA. They must attend a three-day basic course which grants the right to transport merchandise other than explosives and radioactive materials. In addition, three types of further courses are offered: a two-day course which confers the right to transport dangerous goods in tanker vehicles, a one-day course which confers the right to transport explosives, flammable and combustible substances and a one-day course leading to a licence to transport radioactive materials.

The main aim of these courses is to make vehicle drivers aware of the hazards involved in transporting goods of this type and teaching them the necessary basic techniques for reducing the danger of accidents to the extent possible. They are also aimed at teaching drivers response procedures in the event of an accident, to protect both themselves and to reduce the

impact on the environment. The courses cover what constitutes dangerous goods, exemptions, definitions, categorisation of cargoes by risk, rules on packaging, accompanying documents, equipment, markings (transport pictograms) and general provisions on transport. Attention is also given to each and every category of dangerous goods, the hazards involved in transportation and what special provisions apply to each category.

Table 13. ADR courses in 2012-2015

ADR courses	**2012**		**2013**		**2014**		**2015**	
Basic course	8	98	8	98	8	113	9	116
Cont. Education	10	73	12	62	10	108	5	35
Advanced course	15	87	13	115	13	47	15	112
Cont. Edu. for advanced course	19	80	19	76	17	58	9	29
Total	**52**	**338**	**52**	**351**	**48**	**326**	**38**	**292**

Source: Occupational Safety and Health Administration.

Projects run by the Occupational Safety and Health Administration.

2012.
The slogan under which the European Safety and Health Weeks were held in Iceland in 2012 and 2013 was *Vinnuvernd – allir vinna* (which exploits the two meanings of the verb *vinna* in Icelandic, translating as either *Safety at work – everyone wins* or *Safety at work – everyone works*) and the main emphasis was on the joint responsibility of managers and employees in safety at work. The campaign addressed two main points. Managers were urged to take the lead in safety issues by involving their employees in planning and adopting the best possible measures in risk assessment and prevention. Secondly, employees and their representatives were urged to share ideas and to play an active part, with their managers, in working on safety improvements for the benefit of all.

Four companies of different sizes received awards at an occupational safety conference in recognition of their work in this area, showing managerial leadership and active participation by the employees, in 2012. The recipients were the Fljótsdalsstöð Power Plant (operated by Landsvirkjun), a fish-processing plant, Reykjafiskur, in Húsavík, the National Museum of Iceland and the engineering consultancy Mannvit. Among the points influencing the choice of companies were danger warnings in the workplace, training of new staff, preventive measures, emergency plans and risk assessments.

The annual conference held by the insurance company VÍS and the Occupational Health and Safety Administration on 2 February 2012 had the theme *Priority on prevention*. This focussed, in particular, on safety measures in establishments, from design to final implementation, in matters large and small. Amongst other things, attention was turned to a zero-tolerance attitude towards hazards, according to which all accidents can be prevented; other topics included establishments' own investigations of occupational accidents and their own fire-prevention inspections, safety in goods transport, the inculcation of a culture of

safety and first steps in environmental protection. The conference's award for preventive work was made to the bus company Strætó.

2013.
A nation-wide campaign was held in the fish-processing industry which began in spring 2013.A special check-list was prepared for the campaign. The ergonomic environmental indicators used in the industry were updated, meetings were held with industry players, letters were sent to companies in the sector, the campaign was publicised in the media, awareness-raising activities were launched after the campaign and a final report was written; this is accessible on the administration's website.

A campaign featuring Napo, a character familiar from video materials on health and safety in the workplace in many parts of Europe, was launched. The European Agency for Safety and Health at Work (EUOSHA) had materials on the subject prepared for use by teachers. This was intended to teach junior school children about health and safety issues in an attractive, informative and varied manner, including the use of Napo as the main character. The materials consist of educational packages containing reasonably detailed information and ideas on topics proposed for highlighting. Various solutions are proposed, together with a sample teaching programme that could be used in an ordinary 40-minute teaching session. The materials are designed for use in teaching children aged 7-11, and are divided into two parts. They contain guidelines, proposals for assignments and background materials that can be found on the internet to give teachers and others guidance on integrating health and safety issues into teaching within the current school syllabus.

To mark the European Safety and Health Week, *Vinnuvernd – allir vinna*, which was held from 21 to 25 October 2013, inspectors visited companies and presented materials and information about the week and its theme; 109 companies were visited.

Also in connection with European Safety and Health Week, a conference on policy on occupational health and safety for the period 2014-2020 was held on 24 October. It was attended by about 180 participants from all occupational sectors. The aim was to establish priorities regarding safety at work as identified by the largest possible number of participants in the labour market; broad participation by the social partners, service providers in the field of safety and health, institutions and undertakings had been sought in order to guarantee that all relevant points of view would be aired. A large number of suggestions and wishes were received at the various working-group tables to be used in formulating policy for the period 2014-2020 and in prioritising projects and developmental work at the administration.

The annual conference on preventive measures and safety, held by the insurance company VÍS and the Occupational Health and Safety Administration, took place on Friday, 22 February under the title *An accident-free future – our responsibility*. The conference discussed the responsibilities and obligations of company managers/owners regarding safety issues from many interesting perspectives. Also discussed were the manifold advantages to be gained by putting safety first, in both small and large undertakings, and why this should be a priority for everyone.

2014.
The theme of European Safety and Health Week in 2014 was stress. A task force consisting of representatives of the administration saw to the execution of the project in Iceland. Stress is found in all types of workplaces, but can be reduced significantly by simple measures.

Guidelines for workers and managers, designed to reduce work-related stress, were published as part of the project. Personnel were encouraged to use simple, user-friendly checklists to help reduce stress. The main aim of the project was to raise awareness of work-related stress and the psychosocial risks entailed, improve management of the risks, give guidance and support to workers and employers and encourage them to use the available means to improve the psychosocial environment in the workplace.

The annual conference on preventive measures and safety organised by the insurance company VÍS and the Occupational Health and Safety Administration was held for the fifth time on 6 February 2014, this time with the title *Safety measures – structure and administration*. It was the best-attended conference ever held in Iceland dealing with occupational safety and preventive measures.

Priority on Prevention was the title of a conference held by VÍS and the Occupational Health and Safety Administration in Akureyri, the largest town in the north of the country. It was attended by people from all over the northern and eastern parts of the country, representing all sorts of occupations. This was the first time such a conference had been held outside the metropolitan area. Representatives of the administration discussed occupational accidents from various angles. Amongst other things, it was revealed that in the past 6 years, 32 people had become unfit for work as a result of falls on level surfaces. This is the only type of occupational accident in which women are more prone to risk than men. Attention was also given to establishments' own fire-prevention monitoring, occupational health and safety, administration in the field of occupational health and safety at the local-government level and safety measures and accident prevention at sea.

A trade fair was held in Sauðárkrókur on 26-27 April; this is a bi-annual event and was being held for the third time. There were 61 exhibition stalls and about five thousand guests attended the fair. The Occupational Health and Safety Administration had a stall, in which it gave a special promotion in connection with the campaign *A good health and safety policy reduces stress*, with photographs, videos and other materials; some of these featured the cartoon character Napo, which aroused special interest among younger guests. Many people spent time at the stall, finding out about the work of the administration.

2015.
The campaign on the theme of Stress in the Workplace was continued during 2015.

The sixth conference organised jointly by the insurance company VÍS and the Occupational Health and Safety Administration was held on 12 February 2015 under the title *No excuses regarding safety measures*. The power utility HS Orka received VÍS's Prevention Award for the year. The engineering consultancy Verkís hf. and the harbour association Faxaflóahafnar sf. received awards from the company for good results in their preventive programmes and safety precautions.

The Occupational Health and Safety Administration, the University of Akureyri and the Icelandic Teachers' Association held a joint conference on 30 September 2015. It was decided to hold this conference, which was part of the Occupational Health and Safety Week, outside the metropolitan area, so making two separate conferences, and this policy is to be followed in future. At this first conference of the week, held outside the metropolitan area, the theme was *Stress and noise in the workplace*. Attention was given to damaging noise levels in workplaces, how noise affects individual's health, e.g. by causing stress, the regulations in

this field, what measurements can be used as a frame of reference and how damaging noise levels can be prevented in the workplace. It was decided to hold this conference in Akureyri.

Accidents at work.
The total number of work accidents on land rose over the period, from 1,352 in 2012 to 1,496 in 2013, to 1,742 in 2014 and to 1981 in 2015. Accidents again became more frequent in the construction industry, presumably reflecting the rising level of activity in that sector of the economy.

One of the important goals in the Occupational Health and Safety Administration's policy and work is the reduction of accidents at work and occupation-related diseases and injuries, and deliberate efforts are directed towards achieving this. The administration's new policy and plan of action for 2015-2018 identifies special emphases which will be given greater priority than previously. Greater attention is to be given to hazardous occupations with the aim of reducing the number of accidents and the incidence of injuries and health problems and encouraging the greatest possible level of preventive measures in these occupations.

Table 14. Number of work accidents on land in 2012–2015.

	Total	Men	Women
2012	1,352	871	481
2013	1,496	998	498
2014	1,742	1,112	630
2015	1,981	1,256	725

Source: Occupational Safety and Health Administration.

The number of occupational accidents rose over the period 2012-2015. In particular, accidents in the construction industry became more frequent in the last two years of the period, presumably reflecting the rise in activity. Nevertheless, the increase has not been on anything like the scale seen in 2009. The number of reported accidents in the fishing industry has fallen slightly.

Table 15. Number of persons injured in 2012–2015, by occupation.

	2012		2013		2014		2015	
Occupation	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Aluminium and ferro-silicon production	34	6	36	5	34	4	31	6
Automobile trades	11	0	27	0	15	0	29	3
Construction and maintenance	77	2	85	1	123	0	131	2
Construction and maintenance, other	0	0	1	0	2	0	3	0
Chemical industry	15	6	14	5	8	4	9	9
Operation of real estate and business	34	22	27	16	31	17	29	16

services								
Fish-processing and freezing	94	59	126	71	117	81	100	84
Fishing	15	3	22	2	6	9	10	6
Transport, etc.	100	8	91	21	102	26	136	21
Public works	18	5	21	12	15	1	19	5
Primary schools	6	24	1	34	4	29	6	22
Road sweeping and rubbish collection	20	2	20	3	21	2	24	1
Wholesaling	42	13	41	9	50	20	39	20
Agriculture	13	7	15	8	6	4	16	4
Food industry (processing of agric. products)	50	13	60	23	59	17	46	15
Food industry (other)	23	3	42	11	43	19	31	14
Metalworking, machine work, shipbuilding and ship repairs	103	1	109	1	127	2	105	2
Cultural activities	15	15	18	19	8	18	17	15
Public administration	161	126	224	122	236	209	225	210
Public services, etc.	39	126	34	129	34	108	30	119
Activities of an unclear nature	30	23	37	20	65	24	61	26
Paper industry	9	1	5	1	1	0	3	2
Financial institutions	2	5	1	5	1	4	4	12
Personal services other than car services	8	1	8	3	5	6	4	4
Electricity, heating and water utilities	19	3	19	0	11	5	10	1

Post and telecommunications operations	33	51	23	34	37	37	37	41
Herring salting and fish meal factories	3	1	0	1	3	0	4	2
Retail trading	18	19	21	18	28	18	32	23
Mineral production and processing	13	0	13	0	17	0	16	0
Woodworking industries	8	0	8	0	8	0	9	0
Insurance	1	7	0	4	0	3	3	3
US Iceland Defence Force and foreign embassy staff	1	1	0	0	0	0	0	0
Textile industry	4	0	2	0	0	0	5	1
Hotel and catering trades	31	32	29	30	25	38	26	36
Other industries and construction	4	1	8	2	4	3	6	0
Total	**1,054**	**586**	**1,188**	**610**	**1,246**	**708**	**1,256**	**725**

Source: Occupational Safety and Health Administration, Icelandic Marine Accidents Investigation Committee.

Fatal accidents

Table 16 shows the number of fatal accidents at work in Iceland in 2012 to 2015.

Table 16. Number of fatal work accidents on land in 2012–2015.

2012	1
2013	0
2014	1
2015	2

Source: Occupational Safety and Health Administration.

Fatal accidents in the workplace continued to fall in number in 2009-2011; the average over the period 2012-2015 was one per year, and there were none at all in 2013. Nevertheless, the Occupational Health and Safety Administration intends to continue its work in the hope of influencing on that development with the aim to reduce the number of fatal work accidents and work accidents in general.

In 2012, one fatality occurred in an occupational accident on land, on 26 March 2012, on the road in Ólafsfjörður by the farm Krossá, when a van was blown by a violent gust of wind and collided with an approaching lorry. The driver of the van, a 24-year-old man, was killed.

In 2014, one fatality occurred in an occupational accident on land. This was on 17 March, when a man fell off the platform of a lorry; he died on 28 March 2014 from the injuries he sustained in the accident.

In 2015, two fatalities occurred in work accidents on land. One was when an employee was killed in a traffic accident on his way to work. The other was the sudden death of a worker at his place of work; it was not work-related.

Accidents involving seafarers.

Table 17. Total number of registered accidents involving seafarers in 2012–2015.

2012	48
2013	53
2014	42
2015	51

Source: Icelandic Marine Accidents Investigation Committee, Icelandic Transportation Safety Committee.

Table 18. Number of inspected accidents involving seafarers in 2012 -2015.

Cases recorded by the Marine Accidents Investigation Committee	**2012**	**2013**	**2014**	**2015**
Fatal accidents	4	2	0	1
Injuries to personnel	48	53	42	51

Source: Icelandic Marine Accidents Investigation Committee, Icelandic Transportation Safety Committee.

There were 51 accidents involving injuries to personnel in 2015; the figures for the previous two years were 53 and 42. Most of these (18) occurred on trawlers; 13 were on freight ships and 11 on line-fishing vessels. The largest group (25) of these accidents involved falls of various types; others could be attributed to winches, fish-processing equipment, conveyor belts, or involved cuts of various types (about 50% were in this category). Other common types of accident involved employees being jammed in hatches, doors, etc. when discharging catches or cargoes, or being struck or trapped by hawsers or other pieces of equipment. One employee was struck by trawl equipment and was knocked over board, but did not suffer injury as a result.

Table 19. Accidents regarding seafarers in 2012-2015.

Vessel type	2013	2014	2015
Fishing boats under 20 BT	6	1	1
Cargo vessels	10	9	13
Net-boats, shellfish boats and line-fishing boats.	11	11	13
Seiners	5	2	3
Tugboats			1
Trawlers		18	18
Dredgers			1
Marine research vessels	2		1
Pleasure craft	1	1	
Passenger vessels	4		

Source: Icelandic Transportation Safety Committee. Figures for 2012 are not available; the committee was established in 2013.

Table 20. Fatal accidents within the Icelandic continental shelf in 2012–2015.

2012	4
2013	2
2014	0
2015	1

Source: Icelandic Marine Accidents Investigation Committee.

There was one fatal accident on an Icelandic ship in 2015, and none in 2014, which was the third year on record in which no seamen were involved in fatal accidents; the others were 2008 and 2011. This could be due to various factors, such as continuing education and awareness-raising about hazards and security issues, greater working experience, conditions of work, etc.

Occupational diseases.

Table 21. Notifications of occupational diseases in 2012–2015.

2012	6
2013	24
2014	9
2015	7

Source: Occupational Safety and Health Administration.

In 2012 the Occupational Safety and Health Administrationn received 6 notifications of occupational diseases or alleged occupational diseases. These were attributed to various causes: dust pollution, mould, handling of drugs and incautious handling of nickel.

In 2013 the administration received 24 notifications of occupational diseases or alleged occupational diseases. Fifteen of these were related to leakages or damp, with concomitant mould or fungus formation. Other cases included illness caused by silicon dust, general chemical pollution and allergies to shellfish and wheat.

In 2014 the administration received 9 notifications of occupational diseases or alleged occupational diseases. Six of these involved allergies or intolerance reactions to chemicals, foods or substances. Two cases involved complaints about general aspects of the workplace premises and one concerned musculoskeletal disorders.

In 2015 the administration received 7 notifications of occupational diseases or alleged occupational diseases. These involved air pollution resulting from industrial activities, damage caused by damp and mental disorder following exposure to a difficult psychosocial working environment.

Article 3, para 3 – Right to safe and healthy working conditions

Consultation with employers' and workers' organization on safety and health issues.
Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee takes note of the information contained in the report submitted by Iceland.

It previously concluded (Conclusions XIX-2 (2009)) that the situation was in conformity with Article 3§3 of the 1961 Charter. It asked that any changes of the consultation with employers' and workers' organisations on occupational safety and health issues occurred during the reference period be indicated in the next report. The report states that the situation on this matter has not been subject to change. The Committee asks that the next report provide full and updated information on this point.

No changes have occurred in the process of consultation and collaboration between the government and the organisations of the social partners regarding occupational safety and health. The general rule is that when new legislative bills, or legislative amendments, are drawn up and these are to apply to the labour market, the Minister responsible for social affairs appoints a committee in which the social partners have representatives who guard their interests.

According to Act No. 46/1980 on Working Environment, Health and Safety in Workplaces (the Occupational Safety and Health Act), the Minister responsible for social affairs appoints the nine-member board of the Occupational Safety and Health Administration for a term of four years. The Minister appoints the chairman without nomination, two members are nominated by the Icelandic Confederation of Labour, one by the Association of Academics, one by the Confederation of State and Municipal Employees, one by the Ministry of Finance, one by the Association of Local Authorities in Iceland and two are nominated by SA-Business Iceland. The same Act assumes that the Minister will seek comments from the board when preparing to issue legislation, regulations and other rules on matters covered by the Act. The Minister is therefore at all times under an obligation to submit draft bills or regulations to the board for comment. Furthermore, as a general rule, attempts are always done in order to have consensus on the substance of individual bills before they are submitted to the Althingi or regulations before they are passed.

The principal social partners on the Icelandic labour market have representatives on the board of the Occupational Safety and Health Administration and, as result, seeking further collaboration has not been the norm. When regulations apply to specific sectors, it is assumed that it is the role of the appropriate association to guard the interests of individual unions or employers, and in such cases, as appropriate, further collaboration may be requested.

Mention should also be made of particular consultative projects; for example, in the latter part of 2015 a collaborative programme was launched by public supervisory authorities (the Occupational Safety and Health Administration, the Directorate of Labour, the Directorate of Taxes and the police) to combat social dumping and under-bidding on the labour market. The trade unions were also involved in this project. The administration's role is to ensure that the provisions of the Occupational Safety and Health Act are applied. Consultation and collaboration in this field is still being developed and refined, but it is safe to say that it has already yielded considerable results.

Article 11
The right to protection of health

Article 11, para 1- Removal of the causes of diseases.
All people in Iceland shall have access to the most efficient health care services that can be provided irrespective of their gender, religion, political views, age, national origin, colour, economic circumstances, origin and position. In order to meet the aims of the services, all inhabitants in Iceland must be ensured equal access to efficient healthcare services.

The following tables show public and private expenditure on health in 2012-2015.

Table 22. Public expenditure on health in 2012-2015, % of GDP.

2012	2013	2014	2015
6.98	7.02	7.12	7.02

Source: Statistics Iceland.

Table 23. Private expenditure on health in 2012-2015, % of GDP.

2012	2013	2014	2015
1.69	1.68	1.66	1.60

Source: Statistics Iceland.

Life expectancy at birth continued to increase in the reference period. Ten-year averages (2005-2014), based on information from the Eurostat database, show that the highest life expectancies of men in Europe are found in Iceland and Switzerland, at 80.2 and 80 years respectively.

Table 24. Life expectancy at birth during the reference period.

	2012	2013	2014	2015
Men	80.8	80.8	80.6	81.0
Women	83.9	83.7	83.6	83.6

Source: Statistics Iceland.

According to data from Eurostat, the ten-year average infant mortality rate in Iceland for the period 2005–2014 was 1.8 per 1,000 live births. This was the lowest rate in Europe. The following table shows figures for the reference period.

Table 25. Infant mortality per 1,000 live births in the reference period.

2012	2013	2014	2015
2.2	0.9	2.5	1.9

Source: Statistics Iceland.

The following table shows figures covering deaths per 1,000 inhabitants in the reference period.

Table 26. Deaths per 1,000 inhabitants in the reference period.

2012	2013	2014	2015
6.1	6.7	6.3	6.6

Source: Statistics Iceland.

The following table shows information on causes of death (European Shortlist).

Table 27. Number of deaths by causes of death (European Shortlist) in 2012-2015.

Disease or external cause	ICD-10 greiningar *ICD-10 code*	20-12	20-13	20-14	20-15
All causes of death	**A00-Y89**	**1955**	**2158**	**2048**	**2183**
Infectious and parasitic diseases	**A00-B99**	**20**	**19**	**29**	**25**
Tuberculosis	A15-A19, B90	1	0	0	2
Meningococcal infection	A39	0	0	1	0
AIDS (HIV-disease)	B20-B24	0	1	1	0
Viral hepatitis	B15-B19	0	0	1	3
Neoplasms	**C00-D48**	**593**	**598**	**628**	**609**
Malignant neoplasms	C00-C97	583	586	620	600
of which Malignant neoplasm of lip, oral cavity, pharynx	C00-C14	9	4	10	8
of which Malignant neoplasm of oesophagus	C15	15	20	13	14
of which Malignant neoplasm of stomach	C16	19	19	19	23
of which Malignant neoplasm of colon	C18	31	43	62	59
of which Malignant neoplasm of rectum and anus	C19-C21	10	15	14	10
of which Malignant neoplasm liver and the intrahepatic bile ducts	C22	16	21	24	19
of which Malignant neoplasm of pancreas	C25	41	34	50	53
of which Malignant neoplasm of larynx and trachea/bronchus/lung	C32-C34	143	134	135	117
of which Malignant melanoma of skin	C43	10	3	9	7
of which Malignant neoplasm of breast	C50	40	53	52	55
of which Malignant neoplasm of cervix uteri	C53	3	5	3	4
of which Malignant neoplasm of other parts of uterus	C54-55	7	2	3	3
of which Malignant neoplasm of ovary	C56	18	7	13	14
of which Malignant neoplasm of prostate	C61	43	63	53	56
of which Malignant neoplasm of kidney	C64	19	22	18	23
of which Malignant neoplasm of bladder	C67	23	24	14	15
of which Malignant neoplasm of lymph./haematopoietic tissue	C81-C96	47	41	40	49
Diseases of the blood(-forming organs), immunol.disorders	**D50-D89**	**7**	**6**	**4**	**5**
Endocrine, nutritional and metabolic diseases	**E00-E90**	**33**	**44**	**31**	**35**
Diabetes mellitus	E10-E14	23	33	27	23
Mental and behavioural disorders	**F00-F99**	**57**	**72**	**79**	**79**
Chronic alcohol abuse (including alcoholic psychosis)	F10	6	8	1	8
Drug dependence, toxicomania	F11-F16, F18-F19	0	2	0	1
Diseases of the nervous system and the sense organs	**G00-H95**	**189**	**218**	**183**	**214**
Meningitis (other than 03)	G00-G03	1	2	1	0
Diseases of the circulatory system	**I00-I99**	**656**	**712**	**674**	**746**
Ischaemic heart diseases	I20-I25	324	344	316	314
Other heart diseases (except rheumatic, hypertensive, valvular and pulmonary heart disease)	I30-I33, I39-I52	116	143	134	175
Cerebrovascular diseases	I60-I69	134	134	130	155
Diseases of the respiratory system	**J00-J99**	**152**	**174**	**159**	**166**
Influenza	J10-J11	6	3	1	4
Pneumonia	J12-J18	41	63	61	56

Chronic lower respiratory diseases	J40-J47	79	94	77	87
of which asthma	J45-J46	1	2	3	1
Diseases of the digestive system	**K00-K93**	**61**	**72**	**56**	**79**
Ulcer of stomach, duodenum and jejunum	K25-K28	2	8	3	4
Chronic liver disease	K70, K73-K74	7	9	7	12
Diseases of the skin and subcutaneous tissue	**L00-L99**	**3**	**4**	**4**	**4**
Diseases of the musculoskeletal system/connective tissue	**M00-M99**	**11**	**10**	**14**	**13**
Rheumatoid arthritis and osteoarthrosis	M05-M06, M15-M19	0	4	6	1
Diseases of the genitourinary system	**N00-N99**	**28**	**39**	**32**	**32**
Diseases of kidney and ureter	N00-N29	20	29	24	25
Complications of pregnancy, childbirth and puerperium	**O00-O99**	**0**	**0**	**0**	**0**
Certain conditions originating in the perinatal period	**P00-P96**	**2**	**5**	**3**	**6**
Congenital malformations and chromosomal abnormalities	**Q00-Q99**	**6**	**12**	**8**	**7**
Congenital malformations of the nervous system	Q00-Q07	1	3	2	2
Congenital malformations of the circulatory system	Q20-Q28	1	5	2	2
Symptoms, signs, abnormal findings, ill-defined causes	**R00-R99**	**16**	**27**	**22**	**26**
Sudden infant death syndrome	R95	1	1	2	1
Unknown and unspecified causes	R96-R99	9	21	14	16
External causes of injury and poisoning	**V01-Y89**	**121**	**146**	**122**	**137**
Accidents	V01-X59	75	81	72	80
of which Transport accidents	V01-V99	16	20	7	16
of which Accidental falls	W00-W19	15	22	16	15
of which Accidental poisoning	X40-X49	15	12	20	16
Suicide and intentional self-harm	X60-X84	37	49	44	41
Homicide, assault	X85-Y09	1	3	1	3
Events of undetermined intent	Y10-Y34	1	9	2	10

Source: The Directorate of Health.

Table 28. Healthcare professionals – number of inhabitants per number of physicians and nurses

	2012	2013	2014	2015
Inhabitants per physicians	282	279	276	266
Inhabitants per nurse	111	108	109	108

Source: Statistics Iceland.

Legislative amendments in the field of healthcare services.

Dental Care Act, No. 38/1985.

The Dental Care Act was repealed and replaced by the Healthcare Practitioners Act, No 34/2012. The new act consolidated provisions on healthcare service employees in a single framework statute instead of the 14 separate items of legislation previously covering their professional designations, rights and obligations.

The Patients' Rights Act, No. 74/1997.[19]

The Act on the Rights of the Patient was amended twice in the reference period:

1. *By Act No. 34/2012.* The amendment did not make substantive changes to the Act.

2. *By Act No. 44/2014.* Amendments were made in connection with the adoption of Act No 44/2014 on Scientific Research in the Health Sector. A new provision was added covering patients' rights in connection with scientific research. Certain provisions on patients' rights were dropped from the Act on the Rights of the Patient and their substance was included in the Act on Scientific Research in the Health Sector

Patient Insurance Act, No. 111/2000.[20]

The Patient Insurance Act was amended once during the reference period:

1. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.

The Healthcare Services Act, No. 40/2007.[21]

The Healthcare Services Act was amended twice in the reference period:

1. *By Act No. 28/2012.* The amendment provided for a single placement needs assessment committee, instead of two committees, to assess the need to placement in institutions (nursing or residential homes).

2. *By Act No. 106/2014.* The amendment authorised the Minister to transpose the provisions of Directive 2010/53/EU of the European Parliament and of the Council of 7 July 2010 on standards of quality and safety of human organs intended for transplantation, which was incorporated in the EEA Agreement by Decision 164/2013 of 8 October 2013 by the EEA Joint Committee.

The Medical Director of Health and Public Health Act, No. 41/2007.[22]

The Act was amended twice in the reference period:

1. *By Act No. 44/2014.* The amendment authorised the Minister to issue regulations entrusting the Directorate of Health with organising and maintaining specific registers covering the treatment of particular diseases or other matters relating to health and the health services, and to enter personal data in them without patients' consent.

[19] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Patients-Rights-Act-No-74-1997.pdf

[20] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-Patient-Insurance-as-amended.pdf

[21] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Health-Service-Act-No-40-2007-as-amended-2016.pdf

[22] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act_on_the_Medical_Director_of_Health_and_Public_Health_as_amended.pdf

2. *By Act No. 45/2014.* The amendment added a provision to Article 4 of the Act, which lays down the role of the Directorate of Health, stating that the Directorate is responsible for monitoring the activities of biobanks and medical databases in conformity with the Biobanks and Medical Database Act.

Health Insurance Act, No. 112/2008.[23]

The Act was amended 7 times in the reference period:

1. *By Act No. 45/2012.* Under the amendment, a new cost-sharing system was established for the purchase of new drugs. The system is based on a three-step arrangement by which the individual patient pays progressively less in proportion as his or her total drug costs rise over a twelve-month period. Provision is also made for a centralised drug-cost payment database. The main aim of the amendment is to put individuals on a more equal footing as regards the cost of medical drugs, irrespective of the conditions from which they are suffering, and to reduce the cost of drugs.

2. *By Act No. 105/2012.* The amendment deferred the adoption of the new cost-sharing system and the drug-cost payment database of Iceland Health Insurance until 1 January 2013. Other provisions of the Act were nevertheless to take effect on 1 October 2012.

3. *By Act No. 130/2012.* The amendment deferred the adoption of the new cost-sharing system and the drug-cost payment database of Iceland Health Insurance until 4 May 2013.

4. *By Act No. 131/2012.* The amendment authorised the Minister to issue regulations on the implementation, in further detail, of the provisions of the Health Insurance Act regarding the authority to enter into health service contracts. Also, the commencement of the provision on contracts with the local authorities (municipalities) and other parties operating nursing homes was postponed in view of the proposed transfer of responsibility for the affairs of the elderly to the municipalities, and at the same time the interim provision granting the Minister temporary authority to issue regulations laying down *per diem* charges for health services delivered to persons placed in nursing homes was extended.

5. *By Act No. 125/2014.* Under this amendment, expenditure on 'S'-marked drugs and prescription drugs was brought into the same ordinary cost-sharing system as applies to other drugs prescribed for use outside health-care institutions.

6. *By Act No. 11/2015.* This amendment ensures all those whom the Icelandic authorities have assigned the status of refugees in Iceland an equal standing and harmonised entitlements to general health insurance, i.e. that the provisions of Article 16 of the Health Insurance Act, with subsequent amendments, will cover not only "quota refugees" but also those who have acquired the status of refugees following the hearing of their applications for asylum or following family reunification.

7. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.

[23] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-Health-Insurance-No-112-2008-16.pdf

Act on the Right of Live Organ Donors to Temporary Financial Assistance, No. 40/2009.
The Act was amended once in the reference period:

1. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.

Health Records Act No 55/2009.[24]
The Act was amended three times in the reference period:

1. *By Act No. 6/2014.* This amendment was made to clarify in further detail the provisions of Articles 7, 14 and 15 of the Act in view of the role of the Directorate of Health and the Ministry when decisions are taken regarding access to medical records. The aim was to remove all doubt regarding citizens' right to refer denial of access to medical records, either in the case of their own records or those of a deceased family member, to the Directorate of Health for appeal. Also, the provision for appealing to the Minister against such denials, and against decisions on the correction or deletion of medical records, was repealed. A provision was added which allows patients to request information from the supervisor of the medical records registry regarding who has accessed its medical records.

2. *By Act No. 44/2014.* The amendment added a provision to the effect that access to medical records for the purpose of medical research was subject to the Act on Scientific Research in the Health Sector. Patients, or their representatives, may prohibit that their health data are stored as identifiable in a health databank for use in scientific research and that shall be noted in his/her record.

3. *By Act No. 77/2014.* The amendment made it compulsory to pass medical records over to public archives, preserve them and grant access to them in accordance with the Public Archives Act, No. 77/2014.

Healthcare Practitioners Act No. 34/2012.[25]
The main changes and innovations introduced by this Act were as follows:

1. It created a single framework statute, replacing 14 items of separate legislation and the Act on Healthcare Practitioners' Professional Designations and Rights of Employment.
2. The scope of responsibilities of healthcare workers was determined on the basis of their education and competence with regard to patients' interests, and outdated restrictions on their professional rights were repealed.
3. A provision was introduced by which healthcare practitioners are required to take account of their professional limitations and refer patients to other healthcare practitioners when appropriate.
4. It is emphatically stated that working while under the influence of alcohol or other intoxicants is prohibited, and healthcare institutions are empowered to set a prohibition on the consumption of alcohol or other intoxicants during a certain period before work begins.

[24] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Health-Records-Act-No-55-2009-as-amended-2016.pdf
[25] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Healthcare_Practitioners_Act_No34_2012-as-amended.pdf

5. Healthcare practitioners are responsible for ensuring that assistants and student working under their direction have sufficient competence and knowledge, and receive the necessary guidance, to attend to the tasks they entrust to them.
6. It is stipulated that healthcare practitioners are to ensure that patients, the health insurance system or other parties do not incur unnecessary expense or inconvenience.
7. Older provisions on advertisements were replaced by provisions on the demands made regarding the publicising of healthcare services and advertisements, and an authorisation to issue regulations setting restrictions.
8. The Minister is authorised to issue regulations stating that certain types of treatment may only be administered by healthcare practitioners, specified categories of healthcare workers or persons who have received the appropriate licences from the Directorate of Health. Provision is also made for the prohibition of specific types of treatment. Regulations on these points are to be issued after the proposals of the Directorate of Health and the comments of the relevant professional associations have been received.

The Act was amended once in the reference period:

1. *By Act No. 43/2014.* Under this amendment, healthcare professionals are permitted to provide healthcare services in their own places of practice until they reach the age of 75 years, with the possibility of extension. A change was also made in the provision authorising the Directorate of Health to charge fees for processing applications for operating licences and specialists' licences. This authorisation concerns the collection of fees from citizens of states within the EEA, the aim being to clarify and simplify the previous rules.

Act on the Legal Status of Individuals with Gender Identity Disorder, No. 57/2012.[26]
The aim of the Act is to ensure persons with gender identity disorder an equal standing in law as compared with other persons in conformity with human rights and human integrity. 'Individuals with gender identity disorder' refers to an individual's perception from a young age that he or she has been born into the wrong gender, and a desire to belong to the other gender. The Act covers the procedure applying in the case of such individuals regarding healthcare services and administration as regards gender re-assignment procedures and changes of name in the National Register.

The Act was not amended in the reference period.

Right to the highest possible standard of health.

Comment by the European Committee of Social Rights
Conclusions XX-2(2013)
The death rate (deaths/ 1,000 population) was low, at 6.27 in 2009. The Committee asks the next report to provide updated information on the main causes of death.

The death rate (deaths/1,000 population) was 6.1 in 2012, 6.7 in 2013, 6.3 in 2014 and 6.6 in 2015 (source: Statistics Iceland).

[26] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-the-legal-status-of-individuals-with-gender-identity-disorder-No-57-2012_220413.pdf

On the main causes of death, reference is made to Table 27 on the number of deaths by causes of death (European Shortlist) in 2012-2015.

Right of access to health care

In its last examination of this provision, the Committee adopted a general question addressed to all States on the availability of rehabilitation facilities for drug addicts, and the range of facilities and treatments. The Committee requests that information be included on this issue in the next report.

The Directorate of Health

The Directorate provides professional guidance on policymaking, research and other matters regarding preventive measures against alcohol and drug abuse. It also promotes collaboration and coordination between those who work at anti-abuse activities. The Directorate produces educational and awaren ess-raising material on alcohol and other intoxicants for professionals and the general public.

The main aim of this work is to reduce, or prevent, the damaging impact that consumption of intoxicants has on individuals, families and the community. Particular emphasis is placed on preventing young people from starting to consume intoxicants (both legal and illegal), or on having them postpone doing so until they are older. The Directorate makes regular surveys of the consumption of legal and illegal intoxicants in Iceland.

The directorate collaborates with institutions in Iceland and abroad, universities and counterpart institutions on research and preventive measures aimed at tackling the alcohol and drug-abuse problem.

The Directorate operates a professional council dealing with measures against alcohol and drug abuse, and also smoking. The council consists of experts and representatives of institutions and NGOs in this field. The professional council acts in an advisory capacity to the Directorate.

Services provided by SÁÁ (Samtök áhugafólks um áfengis- og vímuefnavandann – Alcohol Concern).

The services provided by SÁÁ (Alcohol Concern) for patients suffering from alcohol or drug abuse are supported by the Ministry of Welfare and are under the supervision of the Directorate of Health. Broadly, they fall into two types.

Firstly, there are services of a general nature for patients suffering from alcohol or drug abuse which address the psychological and physical effects of the abuse. They are aimed primarily at dealing with these consequences, and not at changing the individual's behaviour with regard to consumption. These services are delivered within the healthcare clinics and emergency and general wards of the hospitals. These general services are intended primarily as a means of reducing damage and mitigating the consequences of the abuse. They are vital for those who suffer from alcoholism and addiction, and access to them constitutes part of their social rights.

Secondly, Alcohol Concern provides specialised health services for the same persons which are aimed at two goals, as follows.

a) Detoxification and the restoration of balance to the patient's physical and mental condition.
b) Treatment intended to end or reduce consumption of alcohol or drugs.

SÁÁ runs a detoxification clinic, Vogur, that specialises in the detoxification of alcoholics and drug abusers. About 2,000 people are admitted to Vogur each year. Both women and men are admitted to Vogur, and the average period they spend there is about 10 days. Vogur has places for 60 patients, including 11 in a special patients' ward and 11 in a ward for patients aged 16-20. At any given time there are four or five physicians, eight nurses, eight medical orderlies and about 20 counsellors working full-time at Vogur.
In addition to its detoxification programmes and initial steps in treatment, Vogur has an outpatients department for those undergoing continuing treatment and receiving medication for opioid addiction. About 100 persons are in such treatment at any given time, many of them on a life-long basis.

About 7 out of every 10 patients at Vogur proceed to further treatment with SÁÁ, either in the outpatients department or in the treatment centres Staðarfell (for men) and Vík in Kjalarnes (for women and for men aged 55 and older). The treatment remedies employed and assistance given are of various types. Broadly, five main treatment channels are available to patients after they leave Vogur.

Firstly, they can return home after a short stay at Vogur and then receive unstructured help from the outpatients department according to their needs.

Secondly, those who live in the metropolitan area, are above the age of 25 and have sufficiently solid social circumstances and physical health can receive treatment as outpatients, beginning with four days a week for the first four weeks and then once a week for the next three months.

The third possibility is to go to Staðarfell (for men under the age of 55) or Vík (for women and men over 55) for a four-week rehabilitation course, after which the patient receives support from the outpatients department for 2-3 months.

The fourth possibility, for men, is that of a return for repeated rehab treatment, consisting of four weeks' special treatment at Staðarfell followed by a year's outpatient support.

The fifth possibility, for women, after being discharged from Vogur, is a special 30-day rehab course at Vík, followed by a year's outpatient support.

There is a special ward with 11 places for older teenagers at Vogur. The situation at Vogur provides a good opportunity for diagnosing their problems and assessing their treatment requirements. On the other hand, Vogur differs from other child welfare treatment institutions in that patients are not without the freedom of choice and the staff therefore do not prevent those who wish to leave from doing so. SÁÁ regards it as a priority to have teenagers take the initiative in ending or reducing their consumption. When this happens, the focus is then on individually-tailored psychiatric and cognitive treatment which lasts a short period, after which social rehabilitation and education is the responsibility of the family and the support systems available within the school system.

The following table presents a survey of alcohol and drug-abuse treatment in 2015.

Table 29. Treatment for alcohol and drug abuse, 2015.

Institution/ organisation.	Cost to state, ISK m.	Type of service	No. of places	Treatm., consult. or patient nos.	Type, age	Ideology or professional basis of service
Akureyri Hospital, in-patient ward. Psychiatric ward.	35	42 of 284 (15%) of in-patients in psychiatric ward. First diagnosis of alcohol or drug abuse problems.	1.5	42 pat.	Patients whose alch. or drug abuse is one of several diagnosed problems.	Medical
LSH Reception ward for addiction treatment	394	Treatment; hospitalisation	15	4.400	Pat. with addiction in addition to other serious psych. problems.	Medical approach.
LSH Day and Outpatient wards for drug addiction treatment	91	Outpatient service/daytime treatment at Teigur		9.800	Pat. with addiction in addition to other serious psych. problems.	Medical approach.
SÁÁ -Vogur general ward	330	Treatment; hospitalisation	59	14000	Adults	Minnesota model/Physicians
SÁÁ -Vogur, teenage ward	135	Treatment; hospitalisation	11	2800	Teenagers	Minnesota model/Physicians
SÁÁ -Vogur, outpatients	46	Outpatient service		7200		
SÁÁ – Outpatients at Von	43	Consultation, group therapy.				
SÁÁ – Outpatients in Akureyri		Consultation, group therapy.				
SÁÁ - Vík	86	Daytime service	34	299 pat.	Women and older men.	
SÁÁ - Staðarfell	86	Daytime service	30	329 pat.	Men	

Treatment homes under supervision of child welfare authorities

Under Article 79 of the Child Protection Act, the Ministry of Welfare is responsible for ensuring that homes and institutions are available to provide children with appropriate specialised services in the event of substance abuse. Under the second paragraph of Article 79, the Child Protection Agency is to see to the development and operation of these homes and institutions; the agency may entrust the running of these bodies to other parties under a service contract.

The rehabilitation centre Stuðlar is divided into two departments: a treatment department and a closed ward (generally referred to as a compulsory inpatient ward). Stuðlar is intended to serve children aged 12-18. Diagnoses, and treatment lasting normally 6-8 weeks, take place in the treatment department. Staff of the child protection committees (child welfare committees), or the police, in consultation with the child protection authorities, may commit children to the closed ward. There, they are under monitoring and assessments of their condition are made. The maximum committal period is 14 days at a time, and the capacity is a maximum of five children at a time.

There are three treatment centres administered by the Child Protection Agency. All are located outside the metropolitan area: there is Háholt in Skagafjörður (in the north of the country), Laugaland in Eyjafjarðarsveit (also in the north) and Lækjarbakki (in the south). They have places for a total of 17-20 children aged 13-18. The treatment normally lasts 6-9 months. The basis for admission is that the children have been diagnosed and treated at Stuðlar beforehand.

General Introduction to Conclusions XX-2 (2013)

The Committee asks States Parties whether legal gender recognition for transgender persons requires (in law or in practice) that they undergo sterilisation or any other invasive medical treatment which could impair their health or physical integrity.

The Act on the Legal Status of Individuals with Gender Identity Disorder, No**.** 57/2012, took effect in 2012. This improved the legal status of transgender persons, primarily as regards administration of transgender persons' affairs and the conduct of gender re-assignment procedures and changes of name in the National Register. It should be stated immediately that the term 'transgender individuals' is used to refer collectively to those who suffer from various disorders in connection with their gender identity. It was decided to use a more exact term in legislation, i.e. 'individuals with gender identity disorder', i.e. persons who, from a young age, have been aware that they have been born in the wrong gender and who wish to belong to the other gender.

The requirements for individuals to receive a correction of their gender registration in law are enumerated in Article 6 of the Act. As is stated there, in the second sentence of the third paragraph, a gender re-assignment operation (which is defined as a correction of biological gender by means of a surgical operation, see item 2 of Article 3 of the Act) is not a pre-requisite for an individual's receiving a correction of his or her gender registration in law.

Article 6 of the Act reads as follows.

Article 6. *Functions of the specialist committee on gender identity disorder.*
A person who has received a diagnosis and undergone approved treatment by Landspítali's team dealing with gender identity disorder may apply for confirmation by the specialist committee on gender identity disorder that he or she belongs to the opposite gender. Applications shall be accompanied by a report by the team. The report shall state, amongst other things, that the individual has been under supervision by the team for at least 18 months and has been functioning in the role of a person of the opposite gender for at least one year.
Further conditions for confirmation are that the person in question be legally competent, be domiciled and have lived continuously and legally in Iceland for the two years preceding the date of application and be covered by health insurance under the Health Insurance Act.
If the individual meets the conditions of the first and second paragraphs, the specialist committee shall confirm that he or she is a member of the opposite gender. If appropriate, the specialist committee shall also confirm that the individual is a suitable candidate for a gender re-assignment operation.
The specialist committee shall inform the applicant of the decision taken under the third paragraph. The specialist committee shall also inform the National Registry that the applicant's gender registration has been corrected under this Act.
The decision by the specialist committee under the third paragraph is final and may not be referred to a higher authority.

As is stated in Article 7 of the Act, individuals who have received confirmation under the third paragraph of Article 6 of the Act acquire all the rights and entitlements in law which accompany their registered gender.

Article 11, para 2 - Advisory and educational facilities.

Reference is made to previous reports.

A comprehensive policy on preventive measures against alcohol and drug (intoxicant) abuse up to the year 2020 was issued in December 2013.[27] It covered preventive measures, treatment options, follow-up measures after treatment, rehabilitation and the legal environment. The policy also reflects contemporary international emphases and international obligations regarding policy in this area, and is based on the legislative framework covering alcohol and other intoxicants.

Government policy statements over the past decade have repeatedly named priorities regarding the importance of preventive measures, with a particular emphasis on the problem of substance (intoxicant) abuse. Also, proposals and recommendations to the government may be found in many reports, calling for a clear and deliberate policy on alcohol and its related problems. It is necessary that the government have a clear policy in this area, providing guidelines and points of connection between the various parties involved. In that way, better results could be achieved in prevention; efficiency and quality of services could be raised through better coordination and integration regarding those individuals who are in need of assistance, and the available expertise, human resources and funding could be utilised better.

[27] https://www.velferdarraduneyti.is/media/rit-og-skyrslur-2014/Stefna-i-afengis--og-vimuvornum-desember-2013.pdf

This policy, with a plan of action intended to accompany it, gives a clear message to the community on the course to be taken and how, through deliberate efforts, it is possible to reduce the psychological, social and physical damage and cost to individuals, families, enterprises and the community at large caused by the consumption of intoxicants.

The principal goals of the policy are as follows:

- To restrict access to alcohol and other intoxicants.
- To protect groups that are at particular risk from the damaging effects of alcohol and other intoxicants.
- To prevent young persons from starting to consume alcohol or other intoxicants.
- To reduce the number of individuals who go on to develop dangerous consumption patterns with regard to alcohol or other intoxicants.
- To ensure that those who have problems related to abuse or addiction have access to continuous and integrated services based on the best available knowledge and quality standards.
- To reduce damage and untimely deaths resulting from individuals' consumption, or that of others, of alcohol or other intoxicants.

Health Insurance.
Under Article 1 of the Health Insurance Act, the purpose of the Act is to ensure assistance for health-insured individuals, protection of health and equal access to healthcare services irrespective of an individual's economic circumstances. All have access to Primary Health Care Clinics (*heilsugæslan*) as well as to hospital emergency wards and services. In addition the health insurance system is meant to equalise access to other medical services.

Health-insured persons are charged ISK 1,200 for visits to Primary Health Care Clinics or to a GP during normal working hours, but old age pensioners and disability pensioners are charged ISK 960[28] or ISK 600[29] for visits to health services or to a GP. Children under the age of 18, and children with 'care cards' are exempt from these charges. Health-insured persons are charged ISK 6,200 for visits to accident or emergency wards, but old age pensioners and disability pensioners are charged ISK 5,200[30] or ISK 3,400[31]. Children under 18 years of age are not charged for first visits to emergency and accident wards. The charge for general and specialised healthcare services at an outpatient ward, a day ward, an accident ward and an emergency ward in a hospital without hospitalisation is lower for the elderly, persons with disabilities and children. The charge covers, amongst other things, the cost of registration, medical services and the services of other healthcare workers.

Article 14 of the Regulation on the proportional share of health-insured individuals in the cost of healthcare services, No. 1144/2015, with subsequent amendments, lays down the right of health-insured individuals between 18 and 70 years of age to discount cards when the

[28] Elderly person, category I: Persons aged 67-69 who have no old-age pension, or reduced pension.
[29] Elderly person, category II: Disabled persons aged 70 and older; persons aged 67-69 who received disability pensions until the age of 67, persons aged 60-69 who receive full old-age pension and those who have been unemployed for more than six months.
[30] Elderly persons, category I: Persons aged 67-69 who have no old-age pension, or reduced pension.
[31] Elderly person, category II: Disabled persons aged 70 and older; persons aged 67-69 who received disability pensions until the age of 67, persons aged 60-69 who receive full old-age pension and those who have been unemployed for more than six months.

individuals have paid ISK 35,200 during the same calendar year for visits to Primary Health Care Clinics or to a GP, for doctors' visits, hospitalisations, visits to the accident ward, the hospital outpatient ward, the day ward and to the hospital emergency rooms, visits to medical specialists outside the hospitals, laboratory tests, radiodiagnosis, imaging and measurement of bone density.

Children under 18 years of age having the same family registration code number according to the definition of the National Registry shall be considered as one person. The custodians of children are entitled to a discount card when payments of ISK 10,700 have been made on behalf of these children during the same calendar year with regard to children under the age of 18 in the same family to medical specialists outside hospitals, doctors' visits, laboratory tests, radiodiagnosis, imaging and measurement of bone density.

Old-age pensioners, 70 years and older, disability pensioners and old age pensioners, 67–70 years of age who received disability pension until the age of 67, and old age pensioners, 60–70 years of age who receive full old age pension, shall be entitled to hold a discount card when they have paid ISK 8,900 during the same calendar year because of visits to a Primary Health Care Clinic or to a GP, doctors' visits, hospitalisations, visits to the accident ward, the hospital outpatient ward, the day ward and to the hospital emergency room, visits to specialists outside the hospitals, laboratory tests, radiodiagnosis, imaging and measurement of bone density.

The holders of discount cards shall pay as follows for healthcare services for the remainder of the calendar year:

1. For visits to primary healthcare clinics or GPs, under Article 4, during daytime working hours:
    a. Those covered by general health insurance: ISK 700.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 600 kr.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 480 kr.
2. For visits to primary healthcare clinics or GPs, under Article 5, outside daytime working hours:
    a. Those covered by general health insurance: ISK 1,800.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 1,200.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 840.
3. For visits to a physician under the first paragraph of Article 6, during daytime working hours:
    a. Those covered by general health insurance: ISK 2,000.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 1.200.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 840 kr.
    d. Children under 18 and children holding 'care cards' under Regulation No. 504/1997, on financial assistance to those who support disabled or chronically ill children, are not charged a fee.

4. For home visits by a physician under the second paragraph of Article 6 outside daytime working hours:
    a. Those covered by general health insurance: ISK 2,800.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 2,100.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 1,080.
    d. Children under 18 and children holding 'care cards' under Regulation No. 504/1997, on financial assistance to those who support disabled or chronically ill children, are not charged a fee.
5. For visits to hospital emergency and accident wards under the first paragraph of Article 9:
    a. Those covered by general health insurance: ISK 3.400 kr.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 2.700 kr.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 1.200 kr.
6. For visits to hospital outpatients' departments for services other than physicians' services under paragraph 2 of Article 9:
    a. Those covered by general health insurance: ISK 2.000 kr.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 1,600.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 960.
7. For visits to specialist outside hospitals and to specialists in hospital outpatients' departments under Article 12.:
    a. Those covered by health insurance: ISK 2,300 plus 1/3 of 40% of the agreed or predetermined total cost at the time of the visit which is in excess of this sum, though with a maximum ceiling of ISK 35,200.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 1,900 plus 1/3 of 40% of the agreed or predetermined total cost which is in excess of this sum, though with a maximum ceiling of ISK 35,200.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: 1/9 of the fee under indent 1 of the first paragraph of Article 12, though not less than ISK 1,010 and up to a maximum of ISK 35,200 kr.
    d. Children under the age of 18: 1/9 of the fee under indent 1 of the first paragraph of Article 12, though not less than ISK 1,010 and up to a maximum of ISK 35,200; no charge is made for visits to specialists at hospital outpatients' departments.
8. For laboratory tests under the first paragraph of Article 13:
    a. Those covered by general health insurance: ISK 1,200.
    b. Elderly persons aged 67-69 (see, however, indent c): 730 kr.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: 440 kr.
    d. Children under 18 do not pay a fee.
9. For radiodiagnosis, imaging and bone-density measurements under the second paragraph of Article 13:

a. Those covered by general health insurance: ISK 1,100 plus 1/3 of 40% of the agreed or predetermined total cost at the time of the visit which is in excess of this sum, though with a maximum ceiling of ISK 35,200.
b. Elderly persons aged 67-69 (see, however, indent c): ISK 880, plus 1/3 of 40% of the agreed or predetermined total cost which is in excess of this sum, though with a maximum ceiling of ISK 35,200.
c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: 1/9 of the fee under indent 1 of the second paragraph of Article 13, though with a minimum of ISK 570 and a maximum ceiling of ISK 35,200.
d. Children under 18 do not pay a fee.

10. For conisation under the sixth paragraph of Article 9:
    a. Those covered by general health insurance: 3.500 kr.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 2,300.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 1,400.
11. For coronary and cardiac catheterization under the seventh paragraph of Article 9:
    a. Those covered by general health insurance: ISK 3,500.
    b. Elderly persons aged 67-69 (see, however, indent c): ISK 300.
    c. Elderly persons aged 70 and older, disabled persons elderly persons aged 67-69 who received disability pensions up to the age of 67 and those aged 60-69 who receive full old-age pensions: ISK 1,400.

For visits under indent 7 of the second paragraph, in which an anaesthetist administers a general or local anaesthetic so that a surgeon can perform an operation, a person covered by health insurance shall pay a maximum total fee of ISK 35,200.

Education and awareness raising

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013).

The Committee asks the next report to include examples of concrete activities and campaigns undertaken by the Directorate of Health, or other bodies, to promote health and prevent diseases.

The principal role of the Directorate of Health is defined in Article 4 of the Director of Health and Public Health Act. This enumerates the Directorate's roles. The Director of Health himself has defined his role in a single sentence: to promote better public health in Iceland.

This is done by:

- Setting the healthcare services standards and monitoring them.
- Providing advice on, and encouraging, healthy life-styles.
- Promoting preventive measures against infectious diseases and risk factors that pose a hazard to health.
- Providing government authorities with advice regarding matters relating to health.

The website of the Directorate of Health contains a large amount of information designed to promote public health.[32] Topics covered include preventive measures against alcohol and drug

[32] http://www.landlaeknir.is/english/

abuse, mental health, public health campaigns, exercise, sexual health, nutrition, measures against violence and injury due to accidents, dental health and anti-smoking material. There is also advice on health for various age-groups: pregnancy and infancy, children at pre-school age, children aged 6-12, young people, adults and the elderly. Material can also be found there about infection risks and infection precautions, including a database on the principal infectious diseases in Iceland.

The following special campaigns have been waged by the Directorate of Health.

- **Health in All Policies.** This is an intersectoral approach to health. It is a strategy to enable people to have greater control of their health and to improve it. It is a comprehensive approach based on the view that all sectors have a part to play when it comes to creating circumstances that promote health and well-being. The main aim of the project is to enable communities to create conditions that will promote healthy life-styles, health and well-being for all. Active involvement of the entire community, including stakeholders from all sectors, is necessary for its success. In the first phase, seven municipalities are involved. The Directorate of Health supports the project by means of:
    - Support and counselling for taskforces
    - Checklists for priority topics
    - Defining and publishing public health indicators
    - Publicising the name of the communities involved on the Directorate's website.
    - Advice, educational materials and other support materials
    - Health workshops in all the administrative quarters of the country
    - Courses for health clinic workers covering healthy conduct
    - Educational and awareness-raising materials, a button on the website and a flag.
- **Senior Schools for Health.** This project is based on a policy of approaching preventive measures from a broad and positive perspective with the aim of promoting well-being and enhanced results among all those involved in senior school: pupils, teachers and other staff. The project provides opportunities to strengthen the school's bonds with the immediately surrounding community, so achieving better support and opportunities for pupils and staff to develop a positive and healthy life-style. It offers a comprehensive policy on preventive and health-promotional measures which enable the senior schools to adopt a clear policy, refine their action plans and preventive measures and also take practical steps to adopt a clear framework for matters in this category. The project has been developed in consultation with the Ministry of Education, Culture and Science, the Ministry of Welfare and the Association of Icelandic Secondary School Pupils (SÍF), as part of the HoFF collaborative programme. The main points of focus in the project are nourishment, exercise, mental health and life-style; after a preparatory year, each of these is made the object of attention for a whole school year; thus, they are covered during the time most pupils spend in senior school (4 years). Each year's theme is introduced with an opening ceremony and the unveiling of a sign; when the school has completed the checklist for Health in Senior School, showing that it has fulfilled the basic requirements, it receives a bronze award; silver or gold awards are available for those schools that fulfil more of the check-list requirements. The check-lists were developed by taskforces, taking account of professional standards set in the project, and the lists are prepared to some extent in collaboration with the schools to take account of their

environments, circumstances and priorities. Currently, 31 schools are participating in the project and are at different stages of it.

- **Junior Schools for Health.** This is the product of developmental work carried out in collaboration between many players. The idea is based on the Ottawa Charter for Health Protection from the World Health Organization. The programme was formulated using materials from the SHE network (Schools for Health in Europe). Egilsstaðir Junior School took the lead in this work. The aim is to support schools in promoting health in their work. The Directorate of Health compiled a manual with a professional introduction and check-lists for each of the eight priorities embraced by the project. These are: diet/dental health; exercise/safety, mental health, the home, life skills (preventive measures against alcohol and drugs), pupils, the immediate community and staff.
- **Nursery Schools for Health.** The Directorate of Health launched this project, which is designed to promote health issues and make them a part of the daily functioning of nursery schools (pre-schools). The General Syllabus for Nursery Schools of 2011 define health and welfare as one of the six basic elements of education that are to be among the guiding principles in nursery schools and to be included in all aspects of their work. Nursery schools in the programme will make a priority of attending to eight points of emphasis in their work. These are: exercise, diet, mental health, safety, dental health, the family, the immediate community and staff. It is envisaged that they will set themselves a comprehensive policy on health-conscious work in the schools, with a scheduled plan of action, and that the syllabus will take the policy into account. The policy must be developed in close consultation between school principals, teachers, other staff, parents, the children and the immediate community; this is the premiss for achieving the best support for the project and mutual understanding. After that, the results of the policy must be assessed regularly in collaboration with representatives of all those involved in creating it.
- The health-issue website 6H.is is run by the Directorate of Health in collaboration with the Metropolitan Area Primary Health Clinics and the Hringur Children's Hospital. The aim is to make available reliable information from healthcare professionals on health issues for children and teenagers, and their parents.
- The health-issue website heilsuhegdun.is is designed to give everyone who wants to the chance to pursue a healthier life-style without cost. It can be used as an aid to stop smoking, and also as a source of advice on alcohol consumption, exercise, nutrition, well-being and dental health.
- The health-issue website sykurmagn.is is designed to make children and their parents more aware of food choices. Foods marketed for children are often not really what is most desirable for them. With the aid of this website, parents can help their children to choose better alternatives which contain less added sugar than some of the major and most advertised brands.

Counselling and screening.

Comment by the European Committee of Social Rights

Conclusions XX-2(2013)

The Committee has previously noted that infant healthcare services and health services in school are available (Conclusions XIX-2 (2009)). The present report provides information on the counselling and screening services for pregnant women. Clinical guidelines on antenatal care recommend that a primiparous healthy pregnant woman in a normal pregnancy has 10, and a multiparous woman 7, antenatal care appointments during pregnancy. In general, the

antenatal care follows a midwife and GP led model of care, with the opportunity to seek counsel from an obstetrician. A midwife follow up is offered 6–8 weeks after birth in association with the 6-week examination of the child.

As regards counselling and screening for the population at large, every patient has the right to information regarding his or her state of health, including medical information on his or her condition and prognosis, the proposed treatment, as well as information on its course, risks and benefits. Health care centres are open for everyone, thus playing a role in prevention and counselling in individual cases and in general.

Cancer screenings take place across the country. Nation-wide screening programs for cervical cancer since 1964 have resulted in a marked decrease in incidence and death from the disease. Women between the ages 40−69 are sent a letter every two years inviting them to come in for breast cancer screening via mammography. Although the incidence of breast cancer continues rising, the death rate is going down, with >90% survival after 5 years. The Committee asks if other counselling and screenings are available.

In addition to screening for breast and cervical cancer, scans for colon cancer are also offered. Persons in the 50-75 year age range are encouraged to discuss colon cancer scans with their doctors. Each year an average of 134 cases of colon or rectal cancer are detected, 74 among men and 60 among women. Colon cancer is the third most common type of cancer for both sexes. The average age at detection is 70. Identification of colon cancer begins among patients in their thirties, but most diagnoses (80%) are made in people aged 60 and older. Each year about 50 people die from these forms of cancer in Iceland. The incidence of colon cancer among men has risen over the past half-century, while little change has been observed in the incidence among women over the same period. Smaller changes have taken place in the death rate from this disease. Screening for colon and rectal cancer is believed to reduce the incidence of the diseases and the resulting death rates.

The aim of the public screening programme is to reduce incidence and the death rates associated with the disease and so reduce the cost for the community in the least disruptive way. Screening is defined as a public preventive measure in which all symptom-free individuals in a particular group are invited to undergo a test to detect colon or rectal cancer in its prodromal phase. Screening must result in an advantage for the individuals involved, rather than cause them loss or injury, this also applying if further diagnostic measures or treatment follow. Screening is based on a medical procedure that is classified as second-degree prevention.

On 10 June 2015 the Ministry of Welfare formally requested the Icelandic Cancer Society to submit proposals on the preparation of screening for colon and rectal cancer, with a cost analysis, a system for contacting and summoning participants, the registration of screening records and identified cases of cancer in the Cancer Register and the structure of measures to ensure satisfactory participation rates and educational materials for the public. The Ministry also entrusted the Directorate of Health with defining the target group and the methods to be employed in screening; the proposals of the Icelandic Cancer Society were to take these into account. This revealed that screening based on a search for blood in faeces was feasible and cost-effective. The dDirectorate stated that there were not sufficient numbers of specialised staff available to be able to base the screening on properly-conducted endoscopic examinations alone. On 21 October 2015 the Director of Health informed the Minister in writing of his proposals for screening for colon cancer. In these, he recommended that the

opinion submitted in 2008 by a committee appointed by the Minister to advise on screening for colon and rectal cancer be followed, taking account of the recommendations of the Icelandic Cancer Society of 1 September 2015. These were as follows:

- That screening for colon and rectal cancer be begun among the 60-69 year age group by means of the faecal immunochemical test (FIT) every second year, followed by endoscopic examinations of those found to be passing blood in the stool. If the results are good, the target group should be expanded (to cover the age range 50-74 years).
- That a central control unit be established. A database is to be maintained by the Cancer Register with data on colon and rectal cancer and cases of the disease in its prodromal phase. This register is to cover all endoscopic examinations, including those made outside the screening schedule, so that the results of screening can be assessed.
- Quality is to be ensured in endoscopic examinations, and it must be a simple matter for those who are called in for examination to have access to the service.
- The Director of Health shall appoint a consultative council (screening council) to serve the healthcare authorities in Iceland.
- The costs paid by participants shall be determined.
- Clinical instructions issued by the Directorate of Health shall apply to those who are not included in the screening schedule.

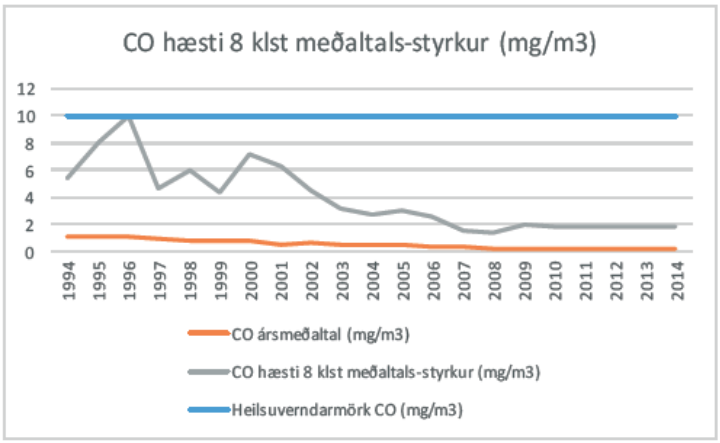
Article 11, para 3 – Prevention of diseases.
Reference is made to previous reports.

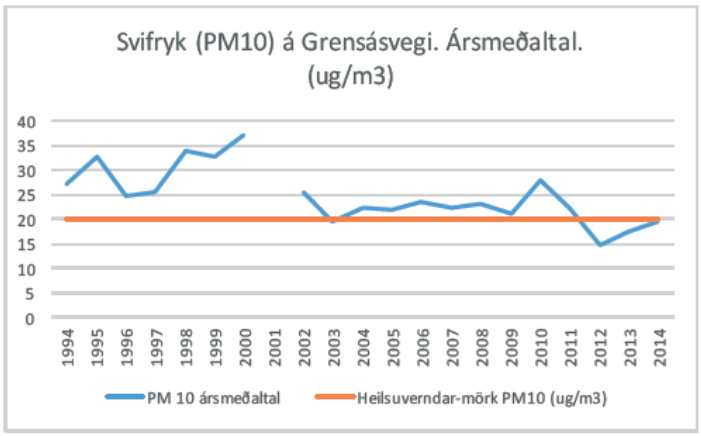
Policies on the prevention of avoidable risks - Reduction of environmental risks.
Comment by the European Committee of Social Rights
Conclusions XX-2(2013)
The Committee asks the next report to provide updated information on the levels of air pollution, contamination of drinking water and food intoxication during the reference period, namely whether the latter have increased or declined.

Levels of air pollution
One of the major events in Iceland in 2014 from the point of view of air quality was the Holuhraun volcanic eruption, which began at the end of August that year and lasted five months until the end of February 2015. It soon became clear that the eruption released gases that could have a substantial impact on the human population and the natural environment: measurements showed that these gases had an impact on air quality in Reykjavík and in Ísafjörður and even outside Iceland. Principally, the compound sulphur dioxide (SO_2) was involved. In high concentrations this is visible as a bluish haze. Pollution by this gas was detected clearly in the East Fjords of Iceland where high levels were recorded by meters operated by the Environmental Agency. In collaboration with the Chief Epidemiologist at the Directorate of Health and the Civil Defence Division of the office of the National Commissioner of Police, issued guidelines on response to sulphur dioxide pollution, and figures on pollution levels were published as soon as they became available on the agency's website (www.ust.is/einstaklingar/loftgaedi/maelingar). The Icelandic Meteorological Office also issued forecasts of areas likely to be affected by gas from the eruption.

The Environmental Agency monitors the release of pollutants into the atmosphere, e.g. from industry, transport, agriculture and recycling activities. In order to monitor these developments, the agency has selected certain environmental indicators and result assessment

indicators which show what developments are taking place. Total emissions of greenhouse gases (not including land use, changes in land use and forestry) have increased over the period 1990-2014. The figure for 1990 was 3,633 thousand tonnes of CO_2 equivalents; in 2014 it had risen to 4,597 thousand tonnes, an increase of more than 26%.[33]





Source: Environmental Agency, Annual Report 2015.

[Legends on graphs: CO hæsti... : Maximum average levels of CO (mg/m^3) in an 8 hour period.
CO ársmeðaltal: CO, annual average
Heilsuverndarmörk: Health hazard limit

Svifryk .. á Grensásvegi. Ársmeðaltal: Airborne particulates at the Grensásvegur monitoring sensor (in Reykjavík). Annual average]

Levels of contamination of drinking water

The chemical condition of drinking water in Iceland is generally very good and it is rare that undesirable substances are found in it in concentrations above the permitted maximum. Most of the chemical analyses that have been made are of water which is piped in utility systems serving 500 people or more, and 99.7% of these samples have met the standards set in the regulation on drinking water quality.

[33] Ársskýrslur Umhverfisstofnunar fyrir árin 2014 og 2015.

Regarding contamination by bacteria, the condition of drinking water supplied by the larger utilities in Iceland is generally good. In regular monitoring carried out in 2010-2012, *E.coli* was found in fewer than 1% of samples taken from utilities serving more than 500 persons.

The Icelandic Food and Veterinary Authority (MAST) has not compiled or published data on the quality of drinking water since 2012, but has confirmed that no significant change has taken place in this area since 2012.

Table 30. Results of regular surveys of water quality in utilities serving more than 500 persons, 2010-2012. Categories 1-12.

Testing topic	Response category	Maximum value	No. of tests	No. of tests above limit	% of tests passing drinking water regulation standards
Total bact. count at 22℃	C	100/ml	8,923	852	90.5%
Coliform bacteria	C	0/100 ml	8,931	611	93.2%
E.coli	A	0/100 ml	8,931	532	94.0%
Clostridium perfringens **(only measured in the case of surface water)**	C	0/100 ml	72	0	100.0%
Ammonium	C	0,50 mg/l	5,840	1	100.0%
Conductivity	C	2500 µS cm-1 at 20℃	1,145	0	100.0%
Acidity (pH)	C	≥ 6,5 and ≤ 9,5	929	18	98.1%
Total			8134	120	98.5%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Table 31. Results of regular surveys of water quality in utilities serving 500 persons or fewer, 2010-2012.
Categories 13-15.

Testing topic	Response category	Maximum value	No. of tests	No. of tests above limit	% of tests passing drinking water regulation standards
Total bact. count at 22℃	C	100/ml	1,111	104	90.6%

Coliform bacteria	C	0/100 ml	1,113	94	91.6%
E.coli	A	0/100 ml	1,113	72	9.5%
Clostridium perfringens **(only measured in the case of surface water)**	C	0/100 ml	0		
Ammonium	C	0,50 mg/l	878	0	100.0%
Conductivity	C	2500 µS cm-1 at 20°C	891	0	100.0%
Acidity (pH)	C	≥ 6,5 og ≤ 9,5	889	48	94.6%
Total			6893	367	94.7%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Levels of food toxification

Salmonella

Table 32. Incidence of salmonella infection in humans, by origin, 2012-2015

	2012	2013	2014	2015
Domestic origin	18	14	14	10
Foreign origin	17	32	26	34
Origin unknown	5	3	1	0

Source: Icelandic Food and Veterinary Authority, Report, 2015

Salmonella in foods.

Imported foodstuffs: The sampling programme for monitoring imports of animal products originating outside the EEA allows for sampling for salmonella testing of 20% of consignments of meat and pet food to Iceland. In recent years very few consignments of these products have come from the regions in question and therefore samples (five in number) were taken from only one batch of each type of product in 2015. All samples proved to be negative.

Table 33. Batches of chickens slaughtered and results of salmonella testing.

Year	No. of batches	Batches testing positive	Proportion
2012	715	2	0.3%
2013	715	2	0.3%
2014	712	1	0.1%
2015	749	7	0.9%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Table 34. Swab tests from pig carcasses and results of salmonella testing

Year	No. of samples	Samples testing positive	Proportion
2012	2,171	7	0.3%
2013	2,878	26	0.9%
2014	4,921	23	0.5%
2015	2,541	17	0.7%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Salmonella in animal feeds and fishmeal

Table 35. Samples of animal feeds: sampling by government authorities and sampling taken in internal monitoring. Results testing positive for salmonella.

Year	No. of samples	Samples testing positive	Proportion
Samples taken by government authorities			
2012	0	0	0.0%
2013	29	1	3.4%
2014	36	3	8.3%
2015	237	1	0.4%
Samples taken in undertakings' internal monitoring audits			
2012	230	0	0.0%
2013	570	18	3.2%
2014	473	8	1.7%
2015	237	1	0.4%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Table 36. Samples of fishmeal production taken by government authorities and in internal monitoring for salmonella testing.

Year	No. of samples	Samples testing positive	Proportion
Samples taken by government authorities			
2012	3	0	0.0%
2013	0	0	0.0%
2014	1	0	0.0%
2015	0	0	0.0%
Samples taken in undertakings' internal monitoring audits			
2012	899	7	0.8%
2013	814	0	0.0%
2014	589	1	0.2%
2015	933	1	0.1%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Campylobacter

Table 37. Incidence of campylobacter infections in humans, by origin, 2012-2015

	2012	2013	2014	2015
Domestic origin	24	50	69	47
Foreign origin	34	43	61	59
Unknown origin	8	8	11	13

Source: Icelandic Food and Veterinary Authority, Report, 2015

Table 38. Batches of chickens slaughtered and results of campylobacter testing

Year	No. of batches	Batches testing positive	Proportion
2012	229	7	3.1%
2013	429	8	1.9%
2014	405	14	3.5%
2015	367	8	2.2%

Source: Icelandic Food and Veterinary Authority, Report, 2015

E.coli

Table 39. Incidence of E. coli 0157 infections in humans, by origin, 2012-2015

	2012	2013	2014	2015
Domestic origin	1	3	2	2
Foreign origin	0	0	1	0
Unknown origin	0	0	0	0

Source: Icelandic Food and Veterinary Authority, Report, 2015

E. coli (VTEC) in animals and foodstuffs

The sampling programme for monitoring imports of animal products originating outside the EEA allows for sampling for E. coli testing of meat, ready-for-consumption shrimps and pet foods. Allowance is made for sampling of 20% of consignments of these products. In recent years very few consignments of these products have come from the regions in question and therefore samples (five in number) were taken from only one batch of each type of product in 2015. All samples proved to be negative.

Listeria

Table 40. Number of incidences of Listeria monocytogenes in humans in 2012-2015. All cases of domestic origin.

	2012	2013	2014	2015
Number of incidences	4	1	4	0

Icelandic Food and Veterinary Authority, Report, 2015

Listeria in foodstuffs

The sampling schedule for monitoring the importation of animal products from non-EEA countries allows for sampling and testing for Listeria monocytogenes in ready-for-consumption fish products. Imported ready-for-consumption animal products from non-EEA countries have consisted mainly of boiled shrimp and fish roes. Allowance is made for sampling of 20% of consignments of such products. In the past few years few such consignments have been transported to Iceland, and only one batch was sampled in 2015 (five samples taken) for Listeria monocytogenes, among other things; all five samples proved negative. The Food and Veterinary Authority carried out a survey of ready-for-consumption food products in 2015, checking for Listeria among other things. Samples were taken of marinated fish and cold cut meats in vacuum-sealed packages or modified atmosphere packaging (MAP) from 19 producers, covering a total of 31 production batches; the bacterium was not found in any of them.

Q fever

Table 41. Numbers of cases of antigens against the Q fever bacterium (Coxiella burnetii) in milk samples, 2012-2015.

Year	No. of farms sampled	Proportion testing positive
2012	80	0.0%
2013	70	0.0%
2014	78	0.0%
2015	63	0.0%

Source: Icelandic Food and Veterinary Authority, Report, 2015

Table 42. Primary Causes of Air Pollution, Indoors and Outdoors, in Iceland.

POLLUTANT	SOURCE
Tobacco smoke	*Smoking.*
Airborne particles	*Erosion of roads, exhaust emissions from vehicles, construction work, soil erosion, salinity, sandstorms, volcanic eruptions, indoor conditions and insufficient sanitation.*
Allergens	*Vegetation, animals, use of chemicals.*
Mould spores and bacterial remains	*Mould and bacterial growth in moisture in buildings.*
Nitric oxide and nitrogen dioxide *NOx*	*Exhaust emissions from automobiles, vessels and other means of transport.*
Carbon monoxide *CO*	*Exhaust emissions from automobiles, fuel- run ovens and lamps, such as gas lamps.*
Carbon dioxide CO_2	*Human exhalation, insufficient air ventilation.*
Sulfur dioxide SO_2	*Industrial activities, automobiles and vessels.*
Hydrogen sulfide H_2S	*Geothermal power plants, natural transpiration from geysers and hot springs.*
Dioxins etc.	*Waste incineration, industrial activities, fisheries, fires.*
Formaldehyde	*Industrial activities, scientific laboratories, construction products.*
Odors	*Various sources, such as industrial activities, geothermal heat, animal keeping, chemical products, insufficient sanitation.*

Source: Report of the Committee on Improved Air Quality and Public Health.

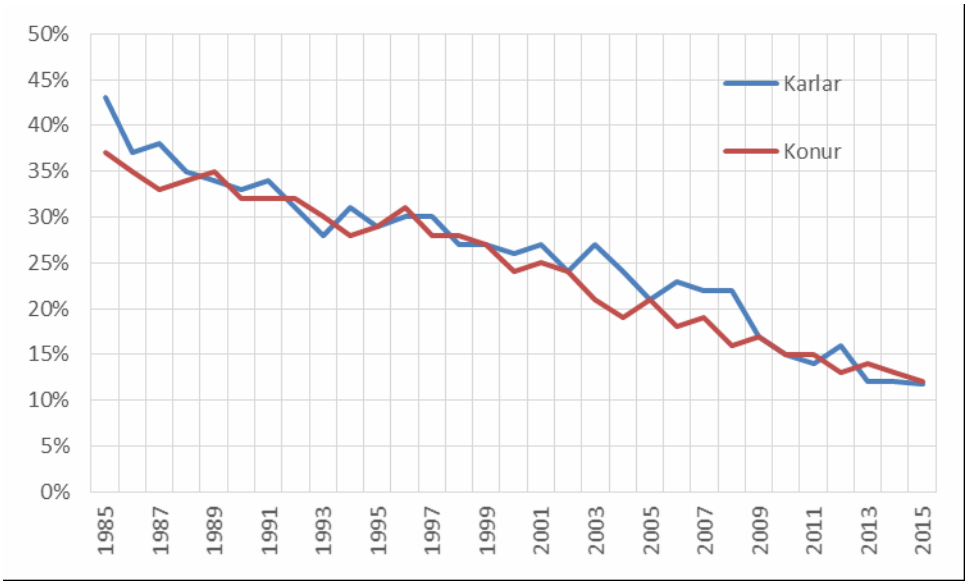
Tobacco smoke.
In 1991, almost 30% of the population aged 15-89 smoked tobacco on a daily basis as compared to 13.8% in 2012. The proportion of smokers has fallen in step with rising levels of education and higher household income. Findings of a European survey of smoking by teenagers aged 15-16 published in 2012 showed that Icelandic teenagers were the least likely to have smoked; 9% of boys and 10% of girls had smoked cigarettes in the 30 days before they took the survey questionnaire. Between 2012 and 2015, rates of daily smoking by Icelanders aged 18 and over declined from 14.2% to 11.3%. The rates of daily smoking among men fell further in the period, from 16.1% to 11.3%; the number of women who smoke on a daily basis fell over the same period from 12.4% to 11.3%.

The frequency of smoking varies depending on the age of the smoker and is highest among individuals in the age range 30-59, in which 16-18% of both men and women smoke tobacco on a daily basis. The frequency of daily smokers aged 15 and older in Iceland is the sixth-lowest among the OECD member states and since 1999, Iceland been one of the five states in which smoking has decreased the most in the world, along with Denmark, Norway, Canada and New Zealand. In Iceland, most smokers begin smoking between the ages of 15 and 19. There has been a steady decline in the percentage of teenage smokers.

As is described in this report, a considerable amount of time was spent in 2012 on developing overall policy on measures to combat substance abuse and addiction. The project manager dealing with measures to combat alcohol and substance abuse was one of the members of a task force appointed by the Minister of Welfare to draft a comprehensive policy on alcohol and substance abuse. Work began in 2012 on an interactive website, www.heilsuhegdun.is, which is intended for the public. There, individuals are able to assess where they stand in terms of alcohol and tobacco consumption, and can also receive feedback and support to help them reduce alcohol or tobacco consumption. Work on policy formulation on anti-smoking measures began in 2012 in collaboration with the Ministry of Welfare.

Measures to combat smoking in Iceland have produced good results. This can be seen best from the fact that about half of all adults smoked on a daily basis in 1970; in 1991 the figure was just under 30% and in 2015 it was 11.5%. Over the past 20 years there has been little difference in the frequency of smoking among men and women, and it has fallen in all age groups. Surveys made by the Reykjavík City Medical Officer in the mid-1970s showed that about half of school pupils in Grades 9 and 10 smoked in some quantity. Smoking among schoolchildren has been monitored regularly since then. In 1998, 23% of pupils in Grade 10 smoked on a daily basis; by 2014 this figure had fallen to 2%.

Table 43. Percentage of those aged 18-69 who smoked on a daily basis in the period 1985-2015.



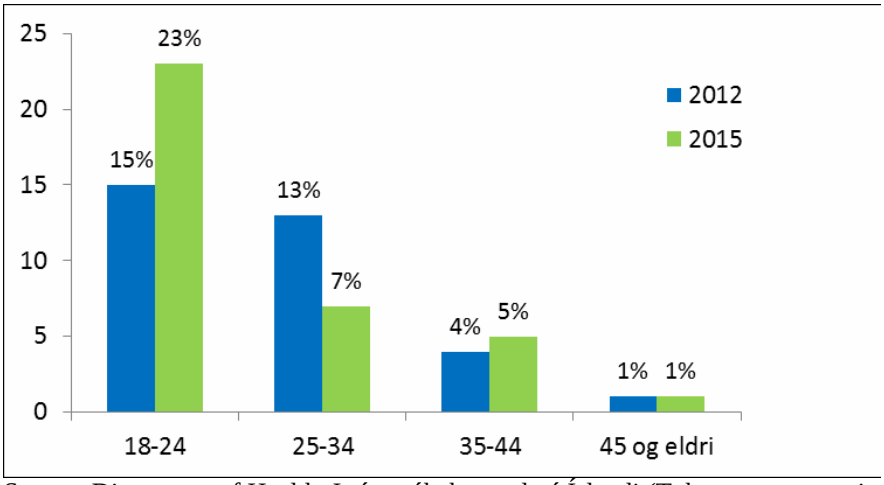
The blue line shows the percentage of men who are daily smokers in Iceland and the red line shows the percentage of women, aged 18 and older, between 1985 and 2015. Source: Directorate of Health: Þróun tóbaksneyslu á Íslandi (Tobacco consumption in Iceland).

The survey *Heilsa og líðan Íslendinga* (Health and well-being in Iceland), which was last taken in 2012, showed that just over 12% of both sexes smoked on a daily basis. This had fallen since 2007, when it was 17.7% among women and 18.7% among men; this trend was independent of subjects' place of residence. Smoking on a daily basis is now most common among people aged 40-54.

A special survey was made by the Directorate of Health of the use of non-smoking tobacco in 2012. Consumption of chewing tobacco was very common in the youngest age-groups among men, while snuff was the most common form used by middle-aged men. It was also found that non-smoking tobacco consumption was very rare among women.

The Directorate of Health's survey of non-smoking tobacco was repeated in 2015. The proportion of young men (aged 18-24) using chewing tobacco on a daily basis had risen from 15% to 23%, whereas it had fallen significantly among those aged 25-34. The overall rate of snuff consumption on a daily basis had risen slightly, from 1.9% in 2012 to 3.4% in 2015. This increase took place fairly evenly throughout the youngest age-groups, 10% of men aged 18-44 reporting that they took snuff on a daily basis.

Table 44. Percentages of men using chewing tobacco on a daily basis, by age group, 2012-2015.

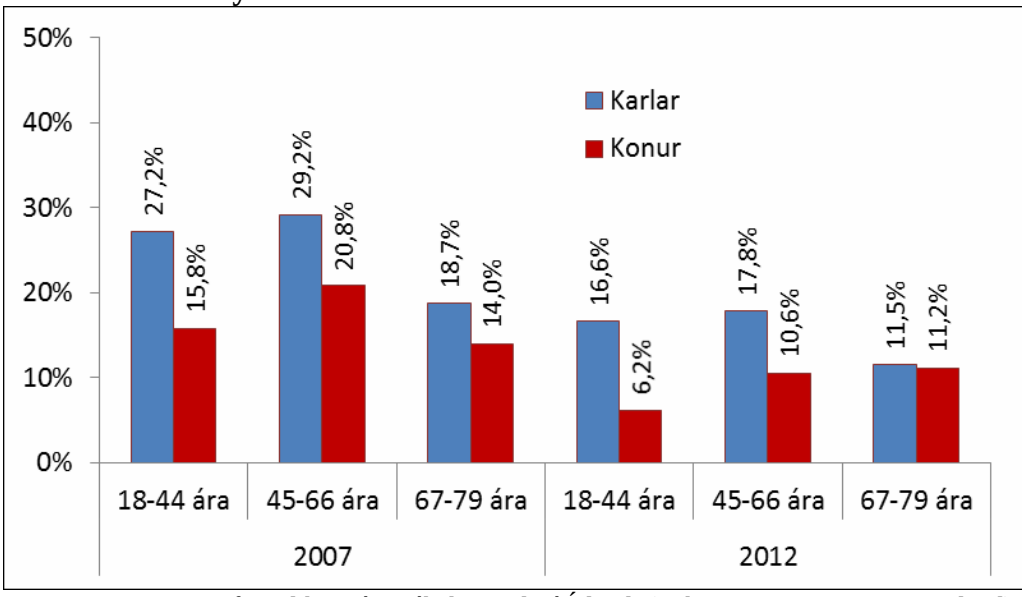


Source: Directorate of Health: Þróun tóbaksneyslu á Íslandi (Tobacco consumption in Iceland).

The first surveys made in Iceland to assess the frequency of use of e-cigarettes were made in 2015. They revealed that 2.5% of adults (aged 18-69) reported using e-cigarettes, 0.7% on a daily basis and 1.8% less often than every day (about 2% of men and 3% of women were users). Just under 95% had never used e-cigarettes, and 2.9% had used them, but stopped. When asked about the types of substance or fluid they most often used, 76% reported using a fluid containing nicotine. A private market research company, *Rannsóknir og greining*, made a survey of intoxicant use by teenagers in Iceland in 2015 in which it asked whether subjects had ever tried e-cigarettes. This showed that 9.9% of children in Grade 10 of school (i.e. aged 15-16) had tried them on 1-5 occasions; 4.2% reported having tried them 20 times or more often and 82.9% said they had never tried them.

As awareness of the dangers of indirect smoking has increased, attitudes towards indoor smoking, particularly where children are present, have undergone a great change in Iceland. An Icelandic survey of indirect smoking by adults, made in 1994, revealed that 23% of adults were exposed to indirect smoking in their homes; taking into account all places in which they were exposed to indirect smoking, the figure was 53%. The proportion of people who were exposed to indirect smoking indoors in 2012 had declined still further as compared with the situation in 2007, according to the results of the survey *Heilsa og líðan Íslendinga* (‘Health and well-being in Iceland).

Table 45. Percentages of people in Iceland who were exposed to indirect smoking indoors on a daily basis or several times a week in 2007 and 2012.



Source: Directorate of Health: Þróun tóbaksneyslu á Íslandi (Tobacco consumption in Iceland). (Karlar = men, konur =women).

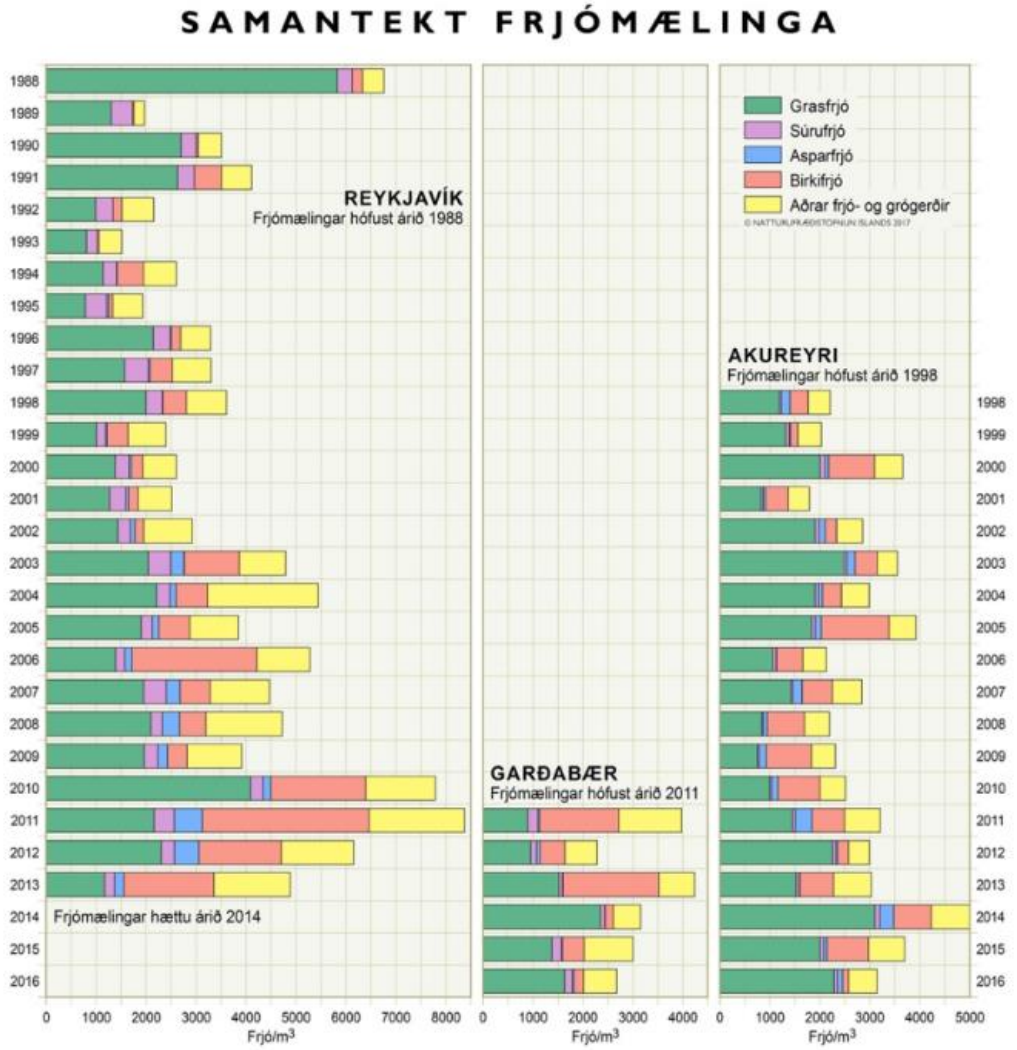
Indirect smoking by children has declined significantly; from 1995 to 2006, the proportion of children aged 3 who lived in homes where people smoked dropped from 43% to 8%. Five per cent of children whose homes were smoke-free were exposed to indirect smoking, while parents smoked in the homes of 28% of children. In step with these developments, the attitudes of parents of young children towards respecting the children's right to a smoke-free indoor environment have changed radically. In 1995, 17% of parents who smoked considered that their children had a right to a smoke-free environment, by 2005 this figure had risen to 41%.[34]

Allergens.

The table below displays the comprehensive pollen count measurements in *Reykjavík* and *Akureyri* from the time when such measurements began (1988 in *Reykjavík* and 1998 in *Akureyri*) to 2015.

[34] Directorate of Public Health: Þróun tóbaksneyslu á Íslandi (Tobacco consumption in Iceland), 2016.

Table 46. Pollen count measurements in *Reykjavík* and in *Akureyri*.

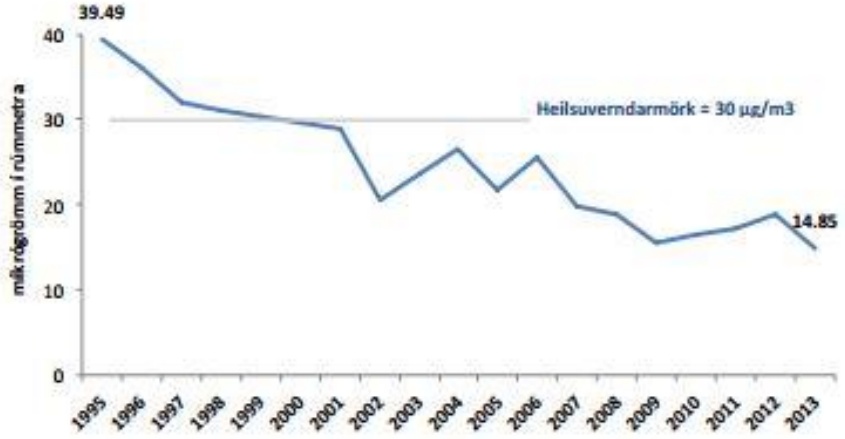


Green refers to grass pollen, purple to rumex pollen, blue to aspen pollen, red to birch pollen and yellow to other types of pollens. Pollen counts in Reykjavík were discontinued in 2014.

Nitric oxide and nitrogen dioxide (NOx).

As can be seen from the table below, NO_x pollution from automobiles has decreased in Iceland since 1995, mostly due to an increase in the use of catalytic converters.

Table 47. Annual average NO_x pollution at *Grensásvegur* in 1995-2013.

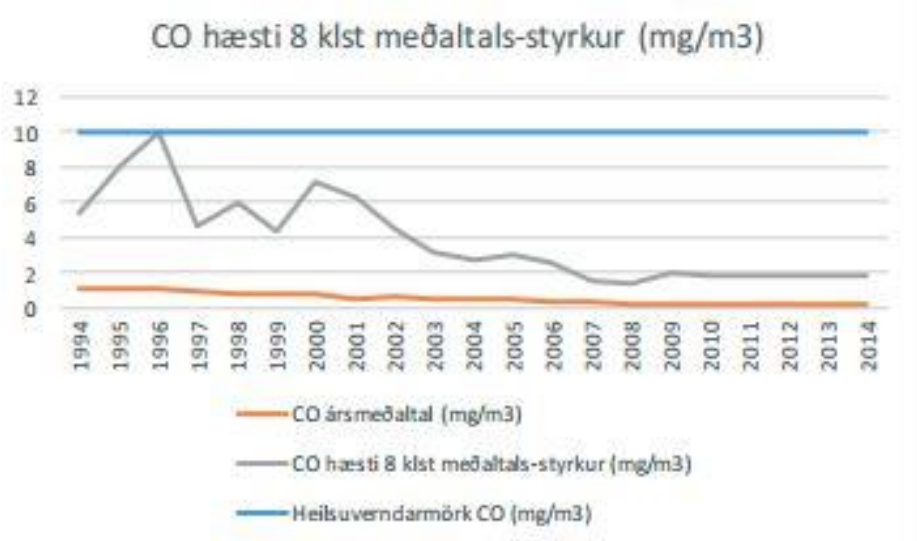


Sources: Environmental Agency, Annual Report 2014.

Carbon monoxide (CO).

Following the emergence of catalytic converters in automobiles, much progress has been made with regard to a reduction of the emission of carbon monoxide from vehicles. The levels of carbon monoxide have therefore been significantly lower than they were two decades ago and well below the health protection levels applicable to average measurements for 8 hour periods of time.

Table 48. Annual average CO pollution from 1994-2014.



[Legends on graph: CO hæsti... : Maximum average levels of CO (mg/m^3) in an 8 hour period.
CO ársmeðaltal: CO, annual average
Heilsuverndarmörk: Health hazard limit]

Measures taken to combat smoking, alcoholism and drug addiction
Reference is made to previous reports.

Smoking.
Reference is made to statistics and tables in the discussion on Art. 11, para 2, concerning air pollution and tobacco smoke. The Directorate of Health routinely processes surveys on the extent of tobacco consumption in the country. It also collects other statistics that indicate the status of these affairs in the country and the harmful consequences of tobacco consumption and shares this information with the public, professionals and health authorities.

The following table shows the percentage of adult smokers and smoking habits in three surveys each year, made by Capacent Gallup for the Directorate of Health.

Table 49. Percentage of adult smokers in 2012–2015.

	2012	**2013**	**2014**	**2015**
Have never smoked	49.5	45.3	46.0	49.0
Stopped more than a year ago	30.4	34.4	37.9	35.7
Stopped less than a year ago	2.7	3.2		
Smoke occasionally	3.2	5.3	3.6	3.7
Smoke daily	14.2	11.8	12.6	11.5
Total	**100**	**100**	**100**	**100**

Source: Directorate of Health.

These figures show a slow decline in the group of daily adult smokers.

The following table shows the pattern of smoking or abstention among the 20 – 29 age group.

Table 50. Tobacco smoking among the 20 – 29 age group, 2012–2015.

	2012	2013	2014	2015
Have never smoked	63.9	62.4	65.0	68,8
Stopped more than a year ago	9.7	11.6	19.9	20,7
Stopped less than a year ago	4.3	6.5		
Smoke occasionally	5.0	8.9	3.4	3,0
Smoke daily	17.2	10.6	11.7	7,5
Total	**100**	**100**	**100**	**100**

Source: Statistics Iceland

This table shows a steady rise in the group of non-smokers and a clear decline in the group of those who smoke daily in this age group.

Tobacco.
Reference is made to the discussion above and the last report.

Alcohol
The table below shows the sales figures in the reference period.

Table 51. Sold litres of pure alcohol per capita in 2012–2015, 15 years and older.

Year	Total sales	Sales in governmental stores
2012	6.97	5.32
2013	7.06	5.29
2014	7.18	5.34
2015	7.35	5.39

Source: Directorate of Health

ESPAD -The European School survey Project on Alcohol and other Drugs - published a report in 2015 on substance use among 15-16 year-old European school pupils in 2015.[35] ESPAD's aim is to collect comparable data on substance use among 15–16 year-old European schoolchildren in order to monitor trends both within and between countries. The 2015 ESPAD Report showed a clear decline in Iceland in the criteria alcohol use:

- Lifetime: In all ESPAD countries except Iceland (35%), over half of the pupils had drunk alcohol at some time during their lives.
- Last 30 days: Overall, 48% of the pupils in the ESPAD countries had consumed alcohol during the 30 days prior to the survey. A particularly low prevalence rate was reported from Iceland (9%).
- Intoxication: An average of 13% of students reported having been intoxicated during the last 30 days. The incidence in Iceland was the lowest in the survey: 3% of pupils reported having been intoxicated.

Iceland had by far the lowest rate of drinking in the sample in the ESPAD survey (8%), followed by Norway (19%).

Prophylactic measures
Epidemiological monitoring
Reference is made to previous reports.

The present arrangement of the national Childhood Vaccination Programme can be seen in the table below.

[35] http://www.espad.org/Uploads/ESPAD_reports/2011/The_2011_ESPAD_Report_FULL_2012_10_29.pdf

Table 52. Childhood Vaccination Programme.
General vaccination of children in Iceland, September 2015

Age:	Vaccination (immunization) against:
3 months	Whooping cough, diphtheria, tetanus, Haemophilus influenzae type b (Hib) and poliomyelitis in a single injection (Pentavac). Pneumococcal vaccines in a separate injection (Synflorix).
5 months	Whooping cough, diphtheria, tetanus, Haemophilus influenzae type b (Hib) and poliomyelitis in a single injection (Pentavac). Pneumococcal vaccines in a separate injection (Synflorix).
6 months	Meningitis C (NeisVac-C).
8 months	Meningitis C (NeisVac-C).
12 months	Whooping cough, diphtheria, tetanus, Haemophilus influenzae type b (Hib) and poliomyelitis in a single injection (Pentavac). Pneumococcal vaccines in a separate injection (Synflorix).
18 months	Measles, mumps and rubella in a single injection (M-M-RVAXPRO).
4 years	Diphtheria, tetanus and whooping cough in a single injection (Boostrix).
12 years	Measles, mumps and rubella in a single injection (M-M-RVAXPRO). Cervical cancer (HPV), for girls only; two injections given about 6 months apart. (Cervarix).
14 years	Diphtheria, tetanus and whooping cough, together with poliomyelitis in a single injection (Boostrix Polio).

Under Regulation No. 221/2001, all inoculations/vaccinations carried out in Iceland are to be recorded in a central database operated by the Chief Epidemiologist at the Directorate of Health. The database contains information on all vaccinations carried out in Iceland since 2004/2005; data for earlier periods is only available where the vaccinations were administered, i.e. at the primary health clinics. Material in the database is drawn from the electronic records of the primary health clinics, hospitals and schools. The name, ID No., date

of birth, place of residence, date and place of vaccination, and finally the specific name and code number of the vaccine are recorded. The aim of this vaccination database is to monitor participation in vaccination programmes and assess the danger of an epidemic outbreak of the diseases against which vaccines are administered. In addition, this makes it possible to contact individuals who have not been vaccinated and offer them vaccination. The vaccination database is unique in that few countries have databases showing the vaccination status of an entire nation in real time. It is planned to publish annual statistics on vaccinations in Iceland.

Participation rates in vaccination programmes in Iceland stand at about, or just over, 90%, which is slightly higher than in 2013. For the most part, participation is satisfactory, except in the case of 4-year-olds: participation by that age group is only 84% for the country as a whole, which is similar to what it was in 2013. The participation rate is fairly similar from one region to another, though there are variations when it comes to particular types of vaccination.

Reference is made to the last report regarding notifications of certain communicable diseases to the health authorities.[36]

Table 53. Notifiable diseases 2012-2015

	2012	2013	2014	2015
Upper respiratory infections				
Acute laryngitis, tracheitis, epiglottitis	2,113	2,525	1,872	2,143
Acute upper respiratory infections, unspecified	9,856	9,766	8,242	8,853
Acute nasopharyngitis	11,653	10,983	10,260	11,067
Otitis media	17,699	17,490	15,065	14,964
Acute pharyngitis, tonsillitis	19,002	17,682	18,662	16,005
Lower respiratory infections				
Bacterial pneumonia, streptococcus/unspecified	393	613	698	650
Acute bronchitis	20,609	19,889	19,467	19,825
Pneumonia, unspecified	6,339	6,632	7,055	7,234
Unspecified acute lower respiratory infection	2,586	2,602	2,745	3,087
Viral pneumonia, unspecified	21	25	31	35
Other notifiable diseases				
Anogenital (veneral) warts	529	438	414	368
Varicella (chickenpox)	487	945	551	466
Influenza like illness	2,551	3,186	1,477	3,465
Scabies	272	294	254	243
Intestinal infectious diseases	5,289	4,773	4,563	4,587
Enterobius vermicularis	1,584	1,933	2,135	2,476
Herpes zoster	1,112	1,141	1,130	1,120
Scarlat fever	459	394	529	409
Acute sinusitis	13,950	14,527	13,331	15,459

[36] Report by the Directorate of Health, 2016: *Þátttaka í almennum bólusetningum barna á Íslandi 2015*.(Participation in general child vaccination programmes in Iceland, 2015).

Viral infection, unspecified	24,689	25,478	22,524	24,164
Viral and other specified intestinal infections	595	616	544	605

Source: Directorate of Health.

Information on trends in domestic and leisure-time accidents.
The following tables show the trends in accidents in the country in the reference period.

Table 54. Number of accidents by type in 2012

Tegund slyss *Type of accident*	2012 Fjöldi - *Number*
Umferðarslys - *Traffic accidents**	7.443
Vinnuslys - *Occupational accidents*	5.301
Heima- og frítímaslys - *Domestic and leisure accidents*	16.577
Íþróttaslys - *Sports accidents*	3.808
Skólaslys - *School accidents*	2.266
Önnur slys - *Other accidents***	2.194
Samtals - *Total*	**41.993**

**This also includes incidents where no one was injured (i.e. also damaged cars).*
Source: Directorate of Health

Table 55. Number of accidents by type in 2013.

Tegund slyss *Type of accident*	2013 Fjöldi - *Number*
Umferðarslys - *Traffic accidents**	6.956
Vinnuslys - *Occupational accidents*	5.256
Heima- og frítímaslys - *Domestic and leisure accidents*	13.918
Íþróttaslys - *Sports accidents*	3.707
Skólaslys - *School accidents*	2.142
Önnur slys - *Other accidents***	3.475
Samtals - *Total*	**35.454**

**This also includes incidents where no one was injured (i.e. also damaged cars).*
Source: Directorate of Health

Table 56. Number of accidents by type in 2014.

Tegund slyss *Type of accident*	2014 Fjöldi - *Number*
Umferðarslys - *Traffic accidents**	7.932
Vinnuslys - *Occupational accidents*	5.794
Heima- og fritimaslys - *Domestic and leisure accidents*	14.499
Íþróttaslys - *Sports accidents*	3.849
Skólaslys - *School accidents*	2.203
Önnur slys - *Other accidents***	4.051
Samtals - *Total*	**38.328**

Source: Directorate of Health
*This also includes incidents where no one was injured.

Table 57. Number of accidents by type in 2015.

Tegund slyss *Type of accident*	2015 Fjöldi - *Number*
Umferðarslys - *Traffic accidents**	8.391
Vinnuslys - *Occupational accidents*	5.245
Heima- og fritimaslys - *Domestic and leisure accidents*	13.060
Íþróttaslys - *Sports accidents*	3.843
Skólaslys - *School accidents*	2.096
Önnur slys - *Other accidents***	5.764
Samtals - *Total*	**38.399**

Source: Directorate of Health
**This also includes incidents where no one was injured*
**The category 'other accidents' includes accidents at sea, aircraft accidents and other types excluding automobile accidents, occupational accidents, accidents in the home and in leisure activities, sporting accidents and accidents at school.*

At 16,577, the number of domestic and leisure-time accidents in 2012 was higher than it had been in the previous years. In 2015 the number was 13,060.

The following tables show the number of injured in domestic and leisure time accidents in the reference period:

Table 58. Number of injured in domestic and leisure time accidents in 2012-2015.

	2012	**2013**	**2014**	**2015**
Type of accident	Fjöldi - *Number*	Fjöldi - *Number*	Fjöldi - *Number*	Fjöldi - *Number*
Heima- og frítímaslys - *Domestic and leisure accidents*	16.577	13.918	14.499	13.060

Source: Directorate of Health

Article 12

The right to social security

Article 12, para 1. – Existence of a system of social security.

Social Security System

Reference is made to the last report regarding a description of the social security system in Iceland. Details of reforms and legislative changes in the system are given below.

Legislative amendments concerning social security made in 2012-2015

Maternity, Paternity and Parental Leave Act, No. 95/2000[37]
The Act was amended four times in the reference period:

1. *By Act No. 143/2012*. The principal changes were as follows.
    a) The right to take maternity/paternity leave ('parental leave') and to receive financial grants in connection with childbirth expires when the child reaches the age of 24 months or 24 months after the child is adopted or taken into permanent foster-care.
    b) Single mothers who undergo assisted fertilisation or single parents who adopt children or take them into permanent foster-care have the right to parental leave or financial grants for up to nine months.
    c) Monthly payments from the Parental Leave Fund to parents during parental leave were set at 80% of their average aggregate earnings over a reference period, though with a ceiling of ISK 350,000.
    d) Maximum payments were raised from ISK 300,000 to ISK 350,000 per month.
    e) The provision under which parents' joint entitlement to parental leave and grants can be extended due to the child's illness was amended. In the event of serious illness or disability of the child which calls for additional parental care, the entitlement may be extended by up to seven months. It is no longer a condition that the child be hospitalised for more than seven days immediately following the birth; this was the requirement for extension under the old provision.

2. *By Act No. 140/2013.* The amendment did not make substantive changes to the Act.
3. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.
4. *By Act No. 88/2015.* The amendment did not make substantive changes to the Act.

Act on Patient Insurance, No. 111/2000.[38]
The Act on Patient Insurance was amended once during the reference period:

2. *By No. 85/2015.* The amendment did not make substantive changes to the Act.

[37] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-maternity-paternity-leave-95-2000-with-subsequent-amendments.pdf
[38] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-Patient-Insurance-as-amended.pdf

Act on Payments to the Parents of Chronically Ill Children, No. 22/2006.[39]
The Act on Payments to the Parents of Chronically Ill Children was amended twice during the reference period:

1. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.
2. *By Act No. 88/2015.* The amendment did not make substantive changes to the Act.

The Social Security Act, No. 100/2007[40]

The Act was amended 11 times during the reference period:

1. *By Act No. 178/2011.* A new item was added to the interim provisions of the Act, stating that benefits and payments under Article 63 were to rise by 3.5% in 2012. The income threshold applying to these payments, on the other hand, was not to rise during 2012.
2. *By Act No. 28/2012*. The amendment did not make substantive changes to the Act.
3. *By Act No. 134/2012*. Under this amendment, the income threshold for the purpose of calculating income supplement for disability pensioners, ISK 1,315,200, was extended until 31 December 2013.[41]
4. *By Act No. 86/2013*. Under this amendment, income from pension funds no longer resulted in a reduction of basic old-age pensions and disability pensions. Furthermore, the period of validity of the interim provision laying down an annual income threshold of ISK 1,315,200 for earnings by recipients of disability pension was extended to 31 December 2014.[42]
5. *By Act No. 107/2013.* The amendment did not make substantive changes to the Act.
6. *By Act No. 140/2013.* Under this amendment, the provisions on car-drivers' accident insurance made insurance cover subject to the condition that the driver be covered by the vehicle's insurance policy. Certain limits were also imposed on the payment of medical costs resulting from accidents.
7. *By Act No. 8/2014.* The amendment clarified citizens' rights and obligations in their dealings with the Social Insurance Administration, and clearer provisions were laid down on the SIA's supervisory role. The new provisions defined the SIA's obligations regarding guidance, information, non-disclosure obligations and investigation obligations. The amendment also set provisions defining the obligations of applicants, beneficiaries and others to provide information, the authorisations made to the SIA to conduct its monitoring, non-disclosure obligations, protection of personal data and applications for benefits.[43]
8. *By Act No. 125/2014.* This amendment extended the period during which disability pensioners' earnings threshold of ISK 1,315,200 per year was extended until 31 December 2015.[44]
9. *By Act No. 137/2014.* Interim provisions took effect on the comparative calculation of income supplement and household supplement applying to rehabilitation pensioners who receive payments from obligatory employment-related pension funds for the

[39] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-payments-to-parents-of-chronically-ill-or-severely-disabled-children-No-22-2006-with-subsequent-amendments.pdf
[40] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Social-Security-Act-100-2007-with-subsequent-amendments.pdf
[41] http://www.althingi.is/altext/stjt/2012.134.html
[42] http://www.althingi.is/altext/stjt/2013.086.html
[43] http://www.althingi.is/altext/143/s/0533.html
[44] http://www.althingi.is/altext/144/s/0780.html

period 1 January 2014 to 31 December 2014, inclusive, under the rules pertaining to 2014 on the one hand and those that were in force in 2013, on the other, in addition to a 3.6% increase, taking account of the income limits which came into being due to the application of the interim provision on the influence of general increases in disability pension payments made by ordinary pension funds. The procedure that resulted in higher payments was to be applied.[45]

10. *By Act No. 88/2015.* The comprehensive revision of the Social Security Act was continued: considerable changes were made. New rules were set regarding general provisions, the form of the Act and its administration. The aim of these amendments was to make the Act clearer, correct some minor flaws and make certain provisions clearer, e.g. those pertaining to how several types of benefits have an effect on each other. Provisions covering accident insurance were repealed, being enacted in a separate statute (see the discussion later in this report).

    Changes were made regarding the objectives of the Act, definitions, the scope of the Act, changes regarding administrative appeals in the light of the establishment of a new Welfare Appeals Committee and establishing who is entitled to insurance cover under the Act. Provisions were also made changing the payment of benefits, the legal standing of cohabiting couples and payments to third parties; the validity of the Administrative Procedure Act was reaffirmed, and rules on incompatible rights and duplication of benefits were clarified. Changes were also made providing clearer explanations of the status of provisions in international insurance agreements and the introduction of regulations applying in the EEA region. Provisions were also set regarding the application of Chapters V and VI of the Social Security Act when the Social Assistance Act is applied.[46]

11. *By Act No. 125/2015.* The interim provisions of the Act were extended so as to avoid a repetition of the mutual disruption between the disability benefit payments from the SIA and disability pension payments from the pension funds. The interim provision on the raising of the income threshold applying to disability pensioners when income supplement is calculated was also extended to the end of 2016.[47]

The Social Assistance Act, No. 99/2007[48]

This Act was amended four times during the reference period:

1. *By Act No. 8/2014.* The amendment did not make substantive changes to the Act.
2. *By Act No. 137/2014.* A new paragraph was added to the interim provision of the Act stating that when household supplement payments are calculated for those recipients of invalidity and rehabilitation pensions who receive payments from obligatory employment-related pension funds, a comparison was to be made, regarding the period 1 January-31 December 2014 of the calculated household supplement according to the rules applying during 2014, on the one hand, and according to those applying in 2013, on the other, raised by 3.6% and taking account of the income threshold resulting from the application of item 16 in the interim provision of the Social Security Act. The procedure resulting in higher payments amount was to be applied.

[45] http://www.althingi.is/altext/stjt/2014.137.html
[46] http://www.althingi.is/altext/144/s/0393.html
[47] http://www.althingi.is/altext/145/s/0708.html
[48] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Social-Assistance-Act-No-99-2007-as-amended.pdf

3. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.
4. *By Act No. 88/2015.* This amendment provided that where payments based on applicants' or benefit recipients' income, they were to be determined in accordance with both Article 16 of the Social Security Act and Chapters V and VI of the same Act. This amendment was passed in 2015 and took effect on 1 January 2016.

Act on the Right of Living Organ Donors to Temporary Financial Assistance, No. 40/2009.
The Act was amended once in the reference period:

1. *By Act No. 85/2015.* The amendment did not make substantive changes to the Act.

Social Security (Accident Insurance) Act, No. 45/2015
Provisions in the Social Security Act regarding accident insurance were deleted from the Social Security Act and a separate statute, the Social Security (Accident Insurance) was enacted. No material amendments were made to the relevant provisions when this was done. The aim of the new act is to ensure that those covered by accident insurance will receive benefits from the SIA in view of occupational accidents, or other specified types of accidents, irrespective of their income. Benefits take the form of monetary payments or assistance.

Welfare Appeals Committee Act, No. 85/2015[49]
The aim of this act was to increase efficiency and improve administration by combining seven different appeals and review committees into one. The new committee consists of nine members; normally, three deal with each case. The Act repealed provisions in separate statutes on the appointment of the various earlier committees and rules applying to their functions. The Act was passed in 2015 and took effect on 1 January 2016.

Supreme Court judgments relevant to social security during the period 2012-2015
The following Supreme Court judgment was delivered during the period regarding social security issues.

> *Supreme Court Judgment in Case 61/2013 of 13 June 2013 (Sara Rafaelsdóttir v. the Social Security Institute and Iceland).* S moved to Iceland in 1998, aged 38. Following serious illness in 2000, her degree of disability was assessed both by a Disability Assessment Committee and by SSI (the Social Security Institute), who gave her a rating of 75% up to the age of 67 as from March 2007. Under the fourth paragraph of Article 18 (*cf.* the first paragraph of Article 17) of the Social Security Act, No. 100/2007, payments to S were reduced, with the result that she received 71.45% of full disability (invalidity) pension, age-related invalidity supplement and income supplement according to S's acquired entitlement based on the time during which she had been domiciled in Iceland. The dispute between the parties concerned whether the aforementioned reduction of payments to S was lawful. The Supreme Court confirmed that the aforementioned provisions of Act No. 100/2007 constituted a clear basis in law for SSI's determination of S's disability pension, and also that Article 21 of the Act, on age-related invalidity supplement, and Article 22, on linking to income, referred clearly to Articles 17 and 18 of the Act on basing payments on the length of domicile in Iceland. The Court referred to the fact that the provisions of the Act regarding length of domicile were of a general nature and applied to all, irrespective of their citizenship, gender, national origin or status in other respects. Consequently, the

[49] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Welfare-Appeals-Committee-Act-No-85-2015.pdf

Court did not concur with the view that the rules constituted unlawful discrimination against S of such a nature as to violate Article 65 of the Constitution, on equality, or that they constituted an infringement of the principle of proportionality. Nor did it accept S's argument that the reduction was unlawful under the first paragraph of Article 76 of the Constitution. Finally, the Supreme Court stated that the rules did not constitute an encroachment on S's right of property in the sense of the first paragraph of Article 72 of the Constitution, or that her pension rights should be based on the length of domicile in Iceland of her spouse or that the rules constituted indirect reduction of her daughter's entitlements or rights. The Supreme Court therefore upheld the district court judgment acquitting SSI and I.

Government expenditure.
The following table shows the total expenditure on social protection in Iceland in the reference period.

Table 59. Social Protection Expenditure in 2012 –2015, ISK millions.*

	2012	2013	2014	2015
Expenditure on social protection	**422,331**	**444,356**	**478,173**	**510,074**
Total allocations	222,405	235,168	252,492	269,398
Total spent on services	179,502	194,410	225,681	240,677
1. Accidents and illness	**144,962**	**155,413**	**167,649**	**183,261**
Allocations relating to accidents and illness	25,324	27,527	29,455	32,905
Services – health care	119,638	127,886	138,193	150,356
2. Invalidity and disability	**63,905**	**70,703**	**76,996**	**80,913**
Allocations relating to invalidity and disability	48,219	52,336	56,916	59,638
Services relating to invalidity and disability	15,686	18,367	20,080	21,275
3. Elderly persons	**100,872**	**108,702**	**121,820**	**133,199**
Allocations to the elderly	92,476	100,127	112,965	123,896
Services relating to elderly persons	8,397	8,575	8,855	9,303
4. Widows/widowers	**10,248**	**10,237**	**11,525**	**12,015**
Allocations to widows/widowers	10,248	10,237	11,525	12,015
Services relating to widows/widowers	0	0	0	0
5. Families and children	**46,071**	**51,399**	54,343	56,012
Allocations to families and children	19,044	22,456	21,844	22,754
Services relating to families and children	27,027	28,943	32,499	33,267
6. Unemployment	**22,983**	**17,874**	14,738	12,282
Allocations relating to unemployment	21,640	16,681	13,709	11,216
Services relating to unemployment	1,343	1,193	1,029	1,066
7. Housing assistance	**19,099**	**13,414**	13,969	12,648
Allocations relating to housing assistance	19,099	13,414	13,969	12,648
8. Other social assistance	10,413	12,544	13,391	15,719
Allocations relating to other social assistance	5,453	5,805	6,078	6,974
Other social assistance in the form of services	4,959	6,740	7,313	8,745
9. Other expenditure on social protection, unspecified, not counted elsewhere	**3,777**	**4,069**	3,741	4,015
Other services relating to soc. protection, unspecified not counted elsewhere.	3,777	4,069	3,741	4,015

Source: Statistics Iceland.
*According to the ESSPROS classification system.

Total social protection expenditure in 2012 as defined in table 49 came to 23.75% of GDP, 23.50% of GDP in 2013 and 23.84% of GDP in 2014. In 2015 it came to 23.04% of GDP.

The table below shows benefits by function, in percentage of total social benefits 2015.

Table 60. Benefits by function, in percentage (%) of total social benefits in 2015.

Old age & widows/widowers	Sickness/ healthcare & disability	Family & children	Unemployment	Housing & social exclusion
26.6	30.3	22.6	5.9	10.3

Source: Statistics Iceland and Eurostat

Number of benefit recipients.
The table below shows the number of recipients in social security pension schemes in 2012-2015.

Table 61. Number of old age pensioners and persons receiving invalidity pension in 2012-2015.

	2012	2013	2014	2015
Old age pensioners	27,023	30,201	31,342	32,415
Invalidity pensioners	15,526	16,146	16,323	16,765

Source: Statistics Iceland

The largest groups of recipients consist of old-age and invalidity pensioners, as is shown in the table above.

Social Security Benefits. Amounts and numbers of recipients in different sectors.
The following tables show the benefit sums to which individuals may be entitled under the Social Security Act, No. 100/2007, the Social Assistance Act, No. 99/2007, the Maternity/Paternity Leave and Parental Leave Act, No. 95/2000, and the Unemployment Insurance Act, No. 54/2006.

Table 62. Number of recipients in social security pension schemes and population in 2012-2015.

Year	*Number of recipients*	*Population*	*Ratio*
2012	64,959	321,857	20.2%
2013	68,491	325,671	21.0%
2014	70,040	329,100	21.3%
2015	71,124	332,529	21.4%

Source: Social Insurance Administration

In 2012, 64,959 individuals, or 20.2% of the population, received payments of some type from the Social Insurance Administration. The ratio was 21.0% and 21.3% the following year. In 2015, 71,124 individuals, or 21.4% of the population, received payments of some type from the Social Insurance Administration.

Table 63. Full monthly benefits according to the Social Security Act and the Social Assistance Act in 2012–2015, in ISK.

Benefits under the Social Security Act, No. 100/2007	**2012**	**2013**	**2014**	**2015**
Pension benefits				
Old age benefits (basic pension)	32,775	34,053	35,279	36,337
Pension supplement on old age pension	103,427	107,461	111,330	114,670
Invalidity pension (basic pension)	32,775	34,053	35,279	36,337
Pension supplement on invalidity pension	104,957	109,050	112,967	116,365
Child pension for each maintained child under age 18	24,230	25,175	26,081	26,863
Personal allowance, hospital and nursing home residents	46,873	50,000	51,800	53,354
Occupational injury benefits				
Per diem occupational injury benefits, individual	1,558	1,619	1,677	1,727
Per diem occupational injury benefits, for each maintained child	349	363	376	387
Widow/widower benefits (occupational injuries, 8 years)	36,174	37,585	38,938	40,106
Other				
Child maintenance for one child	24,230	25,175	26,081	26,863
Benefits under the Social Assistance Act, No. 99/2007				
Household supplement (only those who live alone)	30,480	31,669	32,809	33,793
Supplement for the operating costs of an automobile	12,115	12,587	13,04	13,431
Single parent allowance for two children	7,014	7,288	7,55	7,777
Single parent allowance for three or more children	18,237	18,948	19,630	20,219
Death allowance six months	36,090	37,498	38,848	40,013
Death allowance 12-48 months	27,036	28,09	29,101	29,974
Rehabilitation Benefits	32,775	34,053	35,279	36,337

Source: Social Insurance Administration and Icelandic Health Insurance

Invalidity benefits.
Invalidity benefits are paid under the Social Security Act, No. 100/2007, with subsequent amendments. The following table shows the monthly amount of full flat-rate invalidity benefits.

Table 64. Full monthly invalidity benefits, single person, 2012–2015.

	2012	2013	2014	2015
Basic pension	26,642	34,053	35,279	36,337
Pension supplement and lump sum payments	109,306	113,560	117,651	121,185
Basic pension and supplement with lump sum payments	142,081	147,613	152,930	157,522
Household supplement	30,480	31,669	32,809	33,793
Special monthly supplement on pension	2,018	2,097	2,172	2,238
Total	**310,527**	**328,992**	**340,841**	**351,075**

Source: Social Insurance Administration

Rehabilitation benefits
Rehabilitation benefits are paid under the Social Assistance Act, No. 99/2007. The following table shows the number of rehabilitation benefits recipients and expenditure in 2012-2015.

Table 65. Number of recipients and expenditure 2012-2015.

Year	Number of recipients	Expenditure, ISK millions
2012	1,247	2,653
2013	1,414	2,973
2014	1,599	3,586
2015	1,448	3,980

Source: Social Insurance Administration

Old-age benefits.
Old-age benefits are paid under the Social Security Act, No. 100/2007, with subsequent amendments. The following table shows monthly full flat-rate old-age pensions.

Table 66. Full monthly retirement pension benefits, single person, in 2012–2015.

	2012	2013	2014	2015
Old-age pension (basic pension)	32,775	34,053	35,279	36,337
Pension supplement, lump sum payments	107,712	111,905	115,937	119,420
Basic pension and supplement with lump sum payments	140,487	145,958	151,216	155,757
Household supplement/additional household supplement	30,480	31,669	32,809	33,793
Special monthly supplement on pension	36,323	37,739	39,097	40,270
Total	**144,733**	**184,987**	**184,987**	**202,554**

Source: Social Insurance Administration

Number of individuals receiving old-age-, rehabilitation- or invalidity pensions.
The next three tables show the number of individuals receiving full pensions in the reference period.

Table 67. Number of recipients of full pensions and allowances in 2012.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	22,104	1,075	311
Invalidity pensioners	12,732	6,713	2,357
Rehabilitation pensioners	1,055	842	263
Total number of recipients with full pensions and allowances	35,891	8,630	2,931
Total number of pensioners in each category	43,784	42,261	12,940

Source: Social Insurance Administration

Table 68. Number of recipients of full pensions and allowances in 2013.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	28,430	1,625	478
Invalidity pensioners	13,848	6,991	2,409
Rehabilitation pensioners	1,252	982	300
Total number of recipients with full pensions and allowances	43,530	9,598	3,187
Total number of pensioners in each category	47,761	42,205	13,185

Source: Social Insurance Administration

Table 69. Number of recipients of full pensions and allowances in 2014.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	29,407	1,822	530
Invalidity pensioners	13,907	6,768	2,344
Rehabilitation pensioners	1,460	1,077	322
Total number of recipients with full pensions and allowances	44,774	9,677	3,196
Total number of pensioners in each category	49,264	44,789	13,739

Source: Social Insurance Administration

Table 70. Number of recipients of full pensions and allowances in 2015.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	30,292	1,985	601
Invalidity pensioners	14,174	6,680	2,300
Rehabilitation pensioners	1,309	974	303
Total number of recipients with full pensions and allowances	45,775	9,639	3,204
Total number of pensioners in each category	50,628	45,653	13,934

Source: Social Insurance Administration

Sickness benefits.

Comment by the European Committee of Social Rights.
Conclusions XX-2 (2013).
What is the minimum amount of the overall sickness benefit?
Reference is made to the previous reports regarding sickness benefits; however the figures have been updated.

Table 71. Per diem benefits under the Health Insurance Act, No. 112/2008, ISK.

Sickness benefits	2012	2013	2014	2015
Per diem sickness benefits, individual	1,558	1,619	1,677	1,727
Per diem sickness benefits, for each maintained child	349	363	376	387

Source: Icelandic Health Insurance

Comment by the European Committee of Social Rights.
General introduction to conclusions XX-2 (2013).
If the minimum level of income-replacement benefits under the social security system falls below a minimum guaranteed income threshold established by national law, will it be topped up with social assistance? If so, please provide details of any such threshold and the social assistance benefits that may be available in such a case.

Supplements for invalidity and old-age pensioners
Special support supplements may be paid in addition to the old-age and invalidity pensions in the social security system. Assessments on which such payments are based take account of other income, based on the following reference thresholds:

- Pensioners receiving household supplement whose aggregate monthly income is under ISK 225,070. [50]
- Pensioners who do not receive household supplement whose aggregate monthly income is under ISK 193,962.[51]

All taxable income, including payments from the social insurance system, has an effect on the calculation of this supplement.

Comment by the European Committee of Social Rights.
Conclusions XX-2 (2013).
The Committee recalls that in order to assess whether the personal coverage is adequate it requires the following information: as regards healthcare, the report should provide the number of insured persons out of the total population. As regards income-replacement benefits (unemployed, pension, sickness), information should be provided on the number of insured persons out of the total active population.

[50] Reference amount for 2015.
[51] Reference amount for 2015.

All legal residents are covered by the social security pension scheme and are considered as covered by illness insurance after 6 months' lawful residence in Iceland (including periods during which a person has a temporary residence permit).

Table 72. Number of individuals domiciled in Iceland in 2012-2015.

1 January 2012	319,575
1 January 2013	321,857
1 January 2014	325,671
1 January 2015	329,100

Source: Statistics Iceland

According to information from Statistics Iceland, 329,100 individuals were domiciled in Iceland on 1 January 2015. The age spread was as follows: 66,868 were 15 or younger, 220,754 were aged between 16 and 66 and 38,956 were over 67.

Reference is made to previous reports regarding the review of income-replacement benefits regarding unemployment and pensions.

Payments to Parents of Chronically Ill or Severely Disabled Children.
Reference is made to the previous reports regarding payments to parents of chronically ill or severely disabled children; the figures have since been updated.

Table 73. Payments to Parents of Chronically Ill or Severely Disabled Children, cf. Act No. 22/2006.

	2012	**2013**	**2014**	**2015**
Maximum amount in income-linked benefits	587,127	610,025	631,986	650,946
Monthly basic benefits	164,685	171,108	177,268	182,586
Additional payments for each child	24,230	25,175	26,081	26,863
Special child support payments to single parents -two children	7,014	7,288	7,550	7,777
Special child support payments to single parents -three or more children	18,237	18,948	19,630	20,219
Number of recipients/parents	95	92	99	102
Total expenditure, ISK million	70,883	75,894	84,050	88,704

Source: Social Insurance Administration

Maternity/Paternity Leave and Parental Leave.
Reference is made to the discussion earlier in this report regarding amendments.

Table 74. The Maternity/Paternity Benefits and Parental Grants.

	2012	2013	2014	2015
The maximum monthly income-linked payments from the Parental Leave Fund* to parents who have been active on the labour market	300,000	350,000	370,000	370,000
The minimum monthly payments from the Parental Leave Fund* to parents who have been active on the labour market in 25-49% jobs.	91,950	94,938	97,786	100,720
The minimum monthly payments from the Parental Leave Fund* to parents who have been active on the labour market in 50-100% jobs	127,437	131,578	135,525	139,591
Parental grants for parents outside the labour market or in less than 25% positions**	55,608	57,415	59,137	60,911
Parental grants for students (75-100%)	127,437	131,578	135,525	139,591

*Employees who have been working at least six months on the labour market are entitled to 80% of their average wages with certain minimum and maximum payments.
**Childbirth benefits for those who are not active on the labour market and students.
Source: Directorate of Labour

Table 75. Total number of parents receiving maternity/paternity benefits and parental grants in 2012–2015.

	2012	2013	2014	2015
Fathers	5,797	5,650	5,738	6,463
Mothers	6,993	6,867	6,760	7,056
Total	12,790	12,517	12,498	13,519

Source: Directorate of Labour

Table 76. Total expenditure on Maternity/paternity leave/grants in 2012–2015, ISK millions.

	2012	2013	2014	2015
Total expenditure	7,845	8,311	8,830	9,282

Source: Directorate of Labour

Unemployment insurance.
At the end of 2012, registered unemployment stood at 5.8% and an average of 9,505 individuals had been registered as unemployed. These figures declined in 2013-2014 and in 2015 the average monthly unemployment rate was 2.9%. The unemployment rate can be seen in the following table.

Table 77. The average monthly registered unemployment in 2012–2015.

	2012	2013	2014	2015
Percentage				
Monthly average	5.8%	4.4%	3.6%	2.9%
Men	5.5%	4.0%	3.2%	2.5%
Women	6.1%	5.0%	4.2%	3.5%
Numbers, average				
Monthly registered unemployment	9,505	7,303	6,053	4,955
Men	4,997	3,536	2,858	2,296
Women	4,508	3,768	2,659	2,159

Source: Directorate of Labour

In December 2014, the maximum period for which a person may be entitled to receive unemployment benefits payments was lowered from 36 to 30 continuous months.

Table 78. The Unemployment Benefits in 2012-2015.

	2012	2013	2014	2015
The maximum monthly income-linked payments from the Unemployment Insurance Fund for the first three months	263,548	272,113	281,909	290,366
The basic unemployment benefits to the unemployed which had been in full employment last twelve months	167,176	172,609	187,823	184,188

Source: Directorate of Labour

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013).
The Committee understands that after the expiry of the initial period the job offers are not distinguished by nature, but a job refusal can be justifiable on grounds of individual circumstances. It asks under what circumstances a job refusal may be justified, other than distance from home and reduced physical capacity.

Decisions on the part of insured persons to reject an offer of employment may be justifiable in terms of their age, social circumstances relating to diminished working capacity or care-giving commitments relating to young children or other close family members. Furthermore, the Directorate of Labour is authorised to take insured persons' domestic circumstances into account when they turn down offers of employment at places far from their homes, and may also make allowance in the case of engagements in permanent employment that are due to begin within a specified period. Circumstances in which the person concerned is unable to undertake specific types of work due to diminished working capacity as confirmed by a medical specialist may also be taken into account.

Child benefit.
Persons subject to full tax liability in Iceland who are supporting children under the age of 18 at the end of the financial year are entitled to receive child benefit. Those who are subject to full tax liability include all those who are normally resident or domiciled in Iceland, and those who reside in Iceland for more than 183 days, in total, during each 12-month period. In addition to child benefit, in accordance with the foregoing, special income-related child benefit payments are made in respect of children aged under 7 during the financial year.

Child benefits are paid in respect of every child under the age of 18 years who is domiciled in Iceland and dependent on a person or persons who have an unlimited tax liability in Iceland. Child benefit is paid to the child's supporter, i.e. the person that the child is living with and was dependent upon at the end of the previous income year. The person that pays child support is not regarded the child's supporter in this context.

Married couples who file joint tax returns are both regarded as supporters and child benefits are split equally between them. The same applies to cohabiting parents who, at the end of the year, meet the conditions for joint taxation, even if they have asked to be taxed separately.

Persons who share a household with their child are both considered the child's supporters even if they have not registered their cohabitation.

Child benefits in Iceland are income-related and calculations are based on both parents' / supporters' total income for the previous year. In the case of a single parent, only the income of that parent is used in the calculations.

Full benefit is paid for the year of birth of a child, but none is paid for the year in which a child reaches 18 years of age. The amount of child benefits is calculated in the tax assessment at the end of June each year and the calculated amount is split into two payments, the first on 1 July and the second on 1 October. It is possible to apply for advance payments which are then paid on 1 February and 1 May.

A special supplement, which also is income-related, is paid in respect of children under 7 years of age.

The table below shows the number of parents who received child benefit in 2012 to 2015.

Table 79. Number of parents receiving child benefit in 2012 – 2015.

	2012	2013	2014	2015
Number of parents receiving child benefit	58,182	54,770	49,594	45,882

Source: Directorate of Internal Revenue.

Measures taken against poverty.

In Iceland there is no official national definition of an absolute and/or relative poverty line. However, Statistics Iceland *(Hagstofa Íslands)* participates in the European Union Statistics on Income and Living Conditions (EU-SILC) and has done so since 2004. According to the EU-SILC standard[52] Iceland has one of the lowest at-risk-of-poverty rates in Europe: 2.4% in 2015 were at persistent risk of poverty.

Table 80. At-risk-of-poverty rate by age and gender 2012-2014.

	Rate			2014	
	2012	2013	2014	CI	Estimated number
All ages					
Total	7.9	9.3	7.9	+/- 1.1	24,500
Males	8.4	9.6	8.1	+/- 1.3	12,600
Females	7.5	8.9	7.7	+/- 1.3	11,900
18 and over					
Total	8.4	10.0	8.0	+/- 1.3	27,900
Males	8.4	9.6	8.1	+/- 1.3	14,400
Females	7.5	8.9	7.7	+/- 1.2	13,600
18-64 years					
Total	7.7	9.2	7.2	+/- 1.1	17,900
Males	8.6	9.5	9.5	+/- 1.2	9,400
Females	6.9	8.8	6.8	+/- 1.1	8,500
65 and over					
Total	4.5	4.0	7.0	+/- 1.7	1,800
Males	4.6	3.9	6.5	+/- 1.6	500
Females	4.5	4.0	7.4	+/- 2.1	1,300

Source: Statistics Iceland.

Table 81. At-risk-of poverty threshold (illustrative values) in 2012–2014.

ISK per month	2012	2013	2014	CI 2014
One person household	156,300	170,600	182,600	+/- 3,200
Two adults and two children	328,200	358,400	383,400	+/- 6,700

Source: Statistics Iceland.

Statistical data for 2015 was not available.

[52] This indicator is defined here as the percentage of persons with an equalized disposable income below 60% of the national median equalized disposable income

Reference is made to the last report regarding an Icelandic standard budget.

Table 82. Icelandic budget standards for a single person excluding housing and transportation cost.

Expenditure	Typical standard	Basic standard
Consumer products	ISK 59,728	ISK 45,009
Services	ISK 43,794	ISK 28,493
Hobbies	ISK 34,381	ISK 11,667
Total, excl. transportation and housing cost	**ISK 137,903**	**ISK 85,169**

Source: Ministry of Welfare

Table 83. Icelandic budget standards for a couple with two children excluding housing and transportation cost.

Expenditure	Typical standard	Basic standard
Consumer products	ISK 112,838	ISK 85,448
Services	ISK 65,918	ISK 42,509
Hobbies	ISK 57,254	ISK 21,522
Total, excl. transportation and housing cost	**ISK 236,010**	**ISK 149,480**

Source: Ministry of Welfare.

It has already been clearly stated by the Minister responsible for social affairs that the budget standards will not be a determining factor in decisions affecting, e.g., cost of pensions, disability benefits and unemployment benefits; nor are wages on the labour market. They are nevertheless thought useful for individual and family financial planning and in financial consultation by, e.g., banks to individuals and families. The Office of the Ombudsman for Debtors bases its standard for the cost of living on the published Standard Budget, as it is obliged to publish and update such standards regularly.

Table 84. Numbers of recipients of unemployment benefit in 2012-2015, in absolute terms and as a proportion of the population.

	2012	2013	2014	2015
Average population over the year*	320,716	323,764	327,386	330,815
Number drawing unemployment benefit**	22,828	19,310	16,862	15,135
Proportion of population drawing unemployment benefit	7.1%	6.0%	5.2%	4.6%

*Average 1 Jan. and following year.

**Accumulated over year

Source: Directorate of Labour

Table 85. The average monthly registered unemployment in 2012–2015.

	2012	2013	2014	2015
Percentage				
Monthly average	5.8%	4.4%	3.6%	2.9%
Men	5.5%	4%	3.2%	2.5%
Women	6.1%	5%	4.2%	3.5%
Numbers, average				
Monthly registered unemployment	9,505	7,303	6,053	4,955
Men	4,997	3,536	2,858	2,296
Women	4,508	3,768	2,659	2,159

Source: Directorate of Labour

The situation on the labour market improved gradually in 2012, with unemployment falling from 7.4%, the level in 2011, to 5.8% for the year 2012. According to a labour-market survey by Statistics Iceland, the number of jobs on the market rose by nearly 2,000 over the year, during which the average number of persons in employment stood at about 169,000, against about 167,000 in 2011. The increase was largely accounted for by young people in unskilled jobs, the burgeoning of the tourist industry being the main reason for these. There was also some increase numbers of managers and specialists, while there was a considerable drop in the numbers of employed craftsmen.

The number of people receiving financial assistance from the local authorities rose considerably in the years after the financial collapse of 2008. The local authorities (municipalities) sought to work with the Directorate of Labour to assist people in this group to look for work; the first step in this collaboration was the Job Forum scheme (Atvinnutorg), which was established in 2012 in the towns Hafnarfjörður, Kópavogur, Reykjavík and Reykjanesbær, the aim of which was to help young people aged 18-29 who were not eligible for unemployment benefit to enter employment or study courses. There was nevertheless also an urgent need for people in the older age-groups by the end of 2013 and the Stígur scheme was set up to address it. The scheme covered the whole country. Preparatory work began late in 2013, with meetings between social affairs directors and the heads of the social service departments all over the country. On 19 November 2013 an agreement was signed between the Directorate of Labour and the Association of Local Authorities, acting on behalf of the municipalities, on collaboration on services for job-seekers who receive financial assistance. The aim was that all job-seekers referred to Stígur would be engaged in employment within three months. The success of the project outstripped expectations.

The Job Forum scheme in Reykjavík was a three-year experimental project which came to an end when the Directorate of Labour took over the entire service under a contract dated 1 January 2015. The Job Forum served job-seekers of all ages who were not entitled to unemployment benefit or were about to lose their benefit entitlements with the Directorate of Labour from the outset, the main focus was on young job-seekers, though the service was open to all age groups during 2014.

The demand for manpower rose considerably in 2015 and the number of persons in employment rose by nearly 6,000 as compared with the previous year, according to a survey

by Statistics Iceland. Between 2012 and 2015, the unemployment rate fell from 5.8% to 2.9%. A needs analysis was carried out among job-seekers in 2015 regarding their wishes for education-related labour-market measures. After this, and an assessment of the composition of the group of job-seekers, tenders were invited to supply remedial measures. Nearly one hundred tenders were received; following analysis and prioritisation, about 50 courses were set up for job-seekers.

The Directorate of Labour set itself the target of expanding its services and increasing the number of vocation-related labour-market measures available for women in 2015. Vocation-related labour-market measures, consisting of vocational training programmes in workplaces, are a very successful measure because the majority of participants remain on the labour market after training ends, either with the same employers or else in new places of work. In 2015, 676 job-seekers received employment on the basis of vocation-related labour-market measures: 346 men and 330 women.

Job-seekers of foreign origin were another group that was the object of a special focus in 2015. This was done in the light of the fact that unemployment among their number had fallen rather more slowly than among Icelandic citizens. Collaboration was sought with course-providers on Icelandic language teaching, with an emphasis on training in the workplace, in addition to which some vocation-related courses were offered, e.g. an 'office-workers' school' for Poles. A large number of job-seekers of foreign origin attended these courses in 2015.

Emphasis was also placed on services for university graduates in 2015, in the light of the fact that this group, as a fraction of all unemployed persons, had grown; i.e. their numbers had not declined in step with those of other groups. At the end of 2014, graduates accounted for about 25% of all unemployed persons.

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee considers that the minimum level of unemployment benefit is adequate. It asks however that the next report indicate the minimum level of income-linked unemployment benefit.

Income-linked unemployment benefit is provided for in the Unemployment Insurance Act. This states that wage-earners and self-employed individuals who are insured have the right to income-linked unemployment benefit for up to three months after the period in which basic unemployment benefit is paid for a total of two weeks, unless other provisions are made in the Act.

Income-linked unemployment benefit for wage-earners is to be 70% of their average aggregate wages, based on the six-month period ending two months before the individual became unemployed. Income-linked unemployment benefit for self-employed individuals is to be 70% of their average aggregate wages, based on the financial year preceding the one in which the individual became unemployed.

However, maximum income-linked unemployment benefit paid each month is related to the insurance proportion applying to the insured person in such a way that it cannot at any time be

more than a certain figure per month, based on full unemployment insurance. This maximum figure was as follows during the period covered by this report.

Table 86. Maximum income-linked unemployment benefit, per month, 2012-2015 (ISK).

2012	2013	2014	2015
263,548	272,113	281,909	290,366

The Unemployment Insurance Act contains no provisions on minimum levels of income-related unemployment benefit, though there is a guarantee that payments are not to go below the level of basic unemployment benefit, taking the insurance proportion of the individual into account. Thus, the seventh paragraph of Article 32 of the Unemployment Insurance Act provides that persons exercising their entitlement to unemployment benefit under the Act, but who have not worked on the domestic labour market during the reference periods prescribed under the second or third paragraphs of Article 32 of the Act acquire the right to basic unemployment benefit in accordance with their insurance proportion. The same applies when income-related unemployment benefit proves to be lower than basic unemployment benefit to which the insured person is entitled under Article 33.

Basic unemployment benefit was as follows over the report period.

Table 87. Basic unemployment benefit payments, ISK per month, 2012-2015.

2012	2013	2014	2015
167,176	172,609	178,823	184,188

Article 12, para 2. – Maintenance of social security system at a satisfactory level at least equal to that required for ratification of International Labour Convention No. 102.

On 6 November 2013 the Minister of Social Affairs and Housing appointed a committee to revise Iceland's social security legislation, i.e. to carry out a complete revision of the Social Security Act, No. 100/2007, and the Social Assistance Act, No. 99/2007. Broadly, the committee's task was two-fold: to examine the work capacity assessment which was to replace the previous disability assessment and to examine flexible end-of-employment dates, on the one hand, and on the other to examine the monetary amounts of pension payments made to elderly people and disabled persons, in which it was to base its work largely on the work already done in connection with the comprehensive review of the social security system. There has been a general consensus on the need to revise the Social Security system and also the structure of pensions under the social security system. Many task forces and committees have been occupied on the revision of the social security system and the structure of the pension system since 2005; a report on the revision of the social security system, together with dissenting opinions and special comments, was published in February 2016; this will be discussed in further detail in Iceland's next report.[53]

[53] https://www.velferdarraduneyti.is/media/skyrslur2016/Skyrsla_nefndar_um_endurskodun_laga_um_almannatryggingar_01032016.pdf

International Labour Convention No. 102 defines nine branches of social security:

1) Access to medical care.

The Icelandic medical care system is based on a solid foundation and it has been one of the Government's top priorities to maintain a good, universal healthcare system covering all residents and include all morbid conditions even though the country has been through serious financial difficulties in recent years.

Figures on access to medical care can be seen in other parts of the report; in particular, reference is made to material in connection with Article 12, para 1 and to Article 13.

2) Sickness benefit.

Table 88. Benefit payments under the Health Insurance Act, 2012–2015; (ISK)

Sickness benefits	2012	2013	2014	2015
Per diem sickness benefits, individual	1,275	1,325	1,373	1,414
Per diem sickness benefits, for each maintained child	349	363	376	387

Source: Icelandic Health Insurance.

Reference is made to the material on Article 12, para 1 in this report.

The right to sickness benefit is decided by law and collective bargaining. Employees who are unable to work due to illness or the consequences of an accident are entitled to wages from their employers for a certain time. All employees who are unable to work as a result of accidents at work, or on their way directly to or from work, or due to occupational diseases caused by their work, are to be paid wages for daytime work for up to three months at the rates at which they were engaged, providing that they were working for an employer in the occupational sector in question. After the entitlement to sick pay has ceased, the employee is entitled to *per diem* sickness benefits from his or her union's sickness benefit fund according to the fund's rules. These funds are operated by all trade unions which make collective agreements. Payments amount to 80-100% of the employee's average wage over the previous year, and can be paid for 120-300 days. Funds of the constituent unions of the Icelandic Confederation of Labour are obliged to guarantee members who have paid their 1% premiums for six months or more minimum *per diem* benefits for 120 days if they are absent from work as a result of accidents or illness, these payments following on after payments under the provisions of collective agreements regarding accident and sickness benefit have ceased. These *per diem* payments, together with social insurance benefits, payments under employees' accident insurance and other insurance prescribed in law, shall not amount to less than 80% of the average aggregate wages on which premiums have been based during the previous six months. *Per diem* benefits according to the foregoing arrangement are not paid in respect of accidents and occupational diseases covered by compensatory liability; this includes accidents involving power-driven vehicles. A large majority of individuals on the labour marked are members of a union and are therefore entitled to payments from the sickness funds. There is a statutory continuation of payment of salaries for at least 1 month after 12 months of consecutive employment. Collective agreements also provide for the continued payment of wages and salaries for a certain period during sickness. The length of the period with sick pay depends on the collective agreements.

3) Unemployment benefit.

Unemployment insurance.

A change in the position of students took place at the beginning of 2010 under which students were no longer entitled to unemployment benefit over the summer holidays. Instead, an employment campaign was launched in collaboration with central government institutions and the municipalities. In 2012, over 900 summer jobs of various types, lasting up to two months, were advertised for job-seekers and students who were in mid-course vacations. As in 2011, the Government of Iceland approved the payment of a special December supplement to job-seekers in 2012. Individuals who were covered by the unemployment insurance system received lump-sum payments that were proportional to their benefit entitlements. Those who had been completely without employment for 10 months or longer and were fully insured received a lump-sum payment of ISK 50,152. Those who had been unemployed for shorter periods or were only partially covered received lower payments in accordance with their degree of cover. Altogether, 12,538 individuals received December supplement payments.

Unemployment benefit was paid for a maximum of three years in 2014. They are income-related for the first three months of the unemployment period, based on a certain proportion of the recipient's previous earnings and subject to a certain ceiling. Nevertheless, job-seekers receive only basic benefit for the first ten days. As of the beginning of 2015, the benefit payment period was reduced from 3 years to two and a half.

The unemployment insurance fund was involved in financing the summer job scheme for students in 2014 and 2015, as in previous years.

Table 89. Unemployment benefit in 2012-2015. (ISK)

	2012	2013	2014	2015
Maximum monthly income-linked payments from the Unemployment Insurance Fund for the first three months	263,548	272,113	281,909	290,366
Basic unemployment benefits to recipients who had been in full employment during previous twelve months	167,176	172,609	187,823	184,188

Source: Directorate of Labour

Reference is made to the discussion of Article 12, para 1 in this report.

4) Old-age benefit

Table 90. Monthly full retirement pension benefits, single person, in 2012–2015. (ISK)

	2012	2013	2014	2015
Old-age pension (basic pension)	32,775	34,053	35,279	36,337
Pension supplement, lump-sum payments	107,712	111,905	115,937	119,420
Basic pension and supplement with lump-sum payments	140,487	145,958	151,216	155,757
Household supplement/additional household supplement	30,480	31,669	32,809	33,793
Special monthly supplement on pension	36,323	37,739	39,097	40,270
Total	**144,733**	**184,987**	**184,987**	**202,554**

Source: Social Insurance Administration

Reference is made to the discussion of Article 12, para 1 in this report.

5) Employment injury benefit

Table 91. Occupational injury benefit in 2012-2015. (ISK)

Occupational injury benefits	2012	2013	2014	2015
Per diem occupational injury benefits, individual	1,558	1,619	1,677	1,727
Per diem occupational injury benefits, for each maintained child	349	363	376	387

Source: Social Insurance Administration.

Reference is made to Article 12, para 1 of this report.

Occupational accidents which are not traced to the employer's fault provide the same benefit right as sickness; in addition, recipients are paid three months of their wages at day-time rates. Employers are obliged to purchase occupational accident insurance for their employees in accordance with collective agreements. This insurance applies to accidents at work and on a direct route to or from work. Invalidity benefits are paid in proportion to recipients' reduction of working capacity. *Per diem* benefits are paid in respect of temporary disability and widow(er) benefits are paid when a breadwinner has died.

6) Maternity benefit

Table 92. Maternity/Paternity Benefits and Parental Grants in 2012-2015.

	2012	2013	2014	2015
The maximum monthly income-linked payments from the Parental Leave Fund* to parents who have been active on the labour market	300,000	350,000	370,000	370,000
The minimum monthly payments from the Parental Leave Fund* to parents who have been active on the labour market in 25-49% jobs	91,950	94,938	97,786	100,720
The minimum monthly payments from the Parental Leave Fund* to parents who have been active on the labour market in 50-100% jobs	127,437	131,578	135,525	139,591
Parental grants for parents outside the labour market or in less than 25% jobs**	55,608	57,415	59,137	60,911
Parental grants for students (75-100%)	127,437	131,578	135,525	139,591

*Employees who have been at least six months on the labour market are entitled to 80% of their average wages, with certain minimum and maximum payments.
**Parental benefits for those who are not active on the labour market and students.
Source: Parental Leave Fund

Reference is made to the discussion of Article 12, para 1 in this report.

7) Family benefits.

Persons receiving invalidity benefits are entitled to special payments with every child under 18 years old. The following table shows the amounts per month.

Table 93. Pension supplement per month for each maintained child under age 18 in 2012-2015.

	2012	2013	2014	2015
Amounts	24,230	25,175	26,081	26,863

Source: Social Insurance Administration.

As described above, those who support children receive child benefits until the child reaches the age of eighteen. These benefits are paid through the tax system by tax cuts or direct payments. The benefits are income-tested and calculated on the basis of taxable income according to the tax-return in August each year. Advance payments that are made in February and May each year are deducted and the remaining part of benefits is paid in July and October. Over-payments are recovered together with taxes.

Table 94. Full child benefits per year in 2012 – 2015.

	2012		2013		2014		2015	
	Cohabiting parents	**Single parents**	**Cohabiting parents**	**Single parents**	**Cohabiting parents**	**Single parents**	**Co-habiting**	**Single Parents**
One child	152,331	253,716	167,564	279,087	167,564	279,087	194,081	323,253
Each additional child	181,323	260,262	199,455	286,288	199,455	268,288	231,019	331,593
Supplement for each child under 7 years	61,191	61,191	100,000	100,000	100,000	100,000	115,825	115,825

Source: Directorate of Internal Revenue.

The child benefit amount remained unchanged in 2013-2014. Reference is made to the discussion of Article 12, para 1 of this report.

8) Disability benefit

Disability benefit is paid under the Social Security Act, No. 100/2007, with subsequent amendments. The following table shows full monthly invalidity benefit amounts.

Table 95. Full monthly disability benefit, single person, 2012–2015.

	2012	**2013**	**2014**	**2015**
Basic pension	26,642	34,053	35,279	36,337
Pension supplement and lump -sum payments	109,306	113,560	117,651	121,185
Basic pension and supplement with lump-sum payments	142,081	147,613	152,930	157,522
Household supplement	30,480	31,669	32,809	33,793
Special monthly supplement on pension	2,018	2,097	2,172	2,238
Total	**310,527**	**328,992**	**340,841**	**351,075**

Source: Social Insurance Administration

Reference is made to the discussion of Article 12, para 1 in this report.

9) Widow's / widower's benefit

Table 96. Full monthly widow's/widower's benefit, single person, 2012-2015.

Widow's/ widower's benefit per month	**2012**	**2013**	**2014**	**2015**
Widow's/widower's benefits (occupational injuries, 8 years)	36,090	37,585	38,938	40,106

Source: Social Insurance Administration.

Reference is made to the discussion of Article 12, para 1 in this report.

Reference is also made to the Icelandic reports to the ILO on Convention No. 102.

Article 12, para 3 –Development of the social security system
Comment by the European Committee of Social Rights.
Conclusions XX-2(2013).
The Committee asks what measures were taken to minimise the negative effects of the financial crisis on other branches of social security, such as health care, unemployment and sickness.

Reference is made to the last report.

Article 12, para 4 – Social security of persons moving between States

Equality of treatment and retention of accrued benefits

Act ratifying the Nordic Convention on Social Security, No. 119/2013
A new Nordic Convention on Social Security between Iceland, Norway, Sweden, Denmark and Finland was concluded during the reference period. The convention, which entered into force on 1 May 2014, was implemented by this Act. Greenland and the Faroe Islands are also bound by the agreement as from 1 May 2015. The Nordic Convention is based on the social security provisions of the EEA Agreement; as that Agreement had been updated and changed as of 1 June 2012 it was necessary to update the Nordic Convention accordingly. In addition to nationals of the member states of the EEA Agreement, the Nordic agreement also covers nationals of other states that fall under the national legislation of the Nordic countries.

a) Right to equal treatment

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013).
The Committee notes from its last conclusion that Iceland did not conclude bilateral agreements guaranteeing equal treatment in matters of social security rights with the following countries: Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, "the Former Yugoslav Republic of Macedonia", Moldova, the Russian Federation, Serbia and Ukraine. The report indicates that no bilateral or multilateral agreements have been concluded in the reference period. Therefore, the Committee concludes that the situation is not in conformity with Article 12§4 of the 1961 Charter on the ground that equal treatment with regard to social security rights is not guaranteed to nationals of all other States Parties.

Iceland has concluded bilateral and multilateral agreements on social security with a number of countries. The agreement on the European Economic Area also covers social security rights. The member states of the EU on the one hand and Iceland, Norway and Liechtenstein on the other hand, are party to the EEA agreement. Pursuant to the accession of Croatia to the EU, the EEA Agreement also applies between Iceland and Croatia as of April 2014. Annex VI, Social Security, of the agreement was updated during the reference period and new EU regulations on coordination on social security systems entered into force between Iceland and the other EEA member states on 1 June 2012. The multilateral EFTA Convention, Appendix 2 of Annex K, was also updated to include the new EU regulations on coordination of social security systems, taking effect on 1 January 2016. Iceland, Norway, Liechtenstein and Switzerland are parties to this agreement. Finally, a new Nordic convention on social security between Iceland, Norway, Sweden, Denmark and Finland was concluded during the reference

period. The convention entered into force on 1 May 2014. Greenland and the Faroe Islands are also bound by the agreement as from 1 May 2015.

The social security parts of the EEA Agreement, the EFTA Convention and the Nordic Convention include provisions on equal treatment of benefits, income, facts and events, determination of the legislation applicable, aggregation of insurance periods completed and the export of benefits.

Iceland is not planning to enter into further bilateral agreements in the immediate future.

The Icelandic government has not taken any decision on whether or not it should conclude bilateral agreements with Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, "the Former Yugoslav Republic of Macedonia", Moldova, the Russian Federation, Serbia or Ukraine. In this context it has to be borne in mind that not many exchanges take place between Iceland and these countries. Iceland would, however, like to point out that equal treatment of foreign nationals with regard to social security rights is guaranteed in the relevant national legislation.

Reference is made to 26th, 22nd and 17th Reports by the Icelandic Government.

Right to maintenance of accruing rights (Article 12§4b)

The Committee found in its previous conclusions (Conclusions XVIII-1 (2006) and XIX-2 (2009)) that nationals of States Parties not covered by EU regulations or not bound to Iceland by bilateral agreements did not have the possibility of accumulating insurance or employment periods completed in other countries. Since the situation has not changed, the Committee upholds its finding of non-conformity on this point.

Attention is drawn to the fact that all those who meet the conditions of eligibility for benefits under the law on the relevant field of social security enjoy full rights under the law and receive equal treatment irrespective of their nationality or citizenship status. No distinction is made between Icelandic citizens and citizens of other states regarding entitlement to benefits.

Article 13
The right to social and medical assistance

Article 13, para 1 – Adequate assistance for every person in need.

Legislative amendments.

The Local Authorities' Social Services Act (Municipalities' Social Services Act), No. 40/1991.[54]
The Act was amended twice during the reference period, as follows.

1. *By Act No. 138/2011.*
   The new Local Government Act, No. 138/2011 amended Article 7 of Act No. 40/1991, which now states that collaboration between municipalities on functions that they are obliged to perform under Act No. 40/1991 shall be subject to the Local Government Act.

2. *By Act No. 19/2013.*
   The Act on the UN Convention on the Rights of the Child, No. 19/2013, amended the first paragraph of Article 58 of Act No. 40/1991. This covers collaboration and consultation with clients on procedure and decision-making. Under the amendment, a new sentence was added, reading as follows: Children shall have the right, taking into account their age and maturity, to express their opinions on matters concerning them.

Health Insurance Act, No. 112/2008.[55]
The Health Insurance Act was amended during the period. A list of the amendments can be found in the section on Article 11.

Financial assistance provided by municipalities, cf. Chapter VI of the Municipalities' Social Services Act. Rent benefit provided by municipalities, cf. the Rent Benefit Act, No. 138/1997.
As can be seen from the tables below, there was a reduction in the number of households receiving financial assistance from the municipalities in the last two years of the period, by 1,046 (about 13%). Prior to that, the number rose each year, by an average of about 627 per year, from 2007 onwards. The number of persons receiving financial assistance has changed in step with the improvement in the employment situation in the country.

Among the household types receiving municipal financial support in 2015, the same groups as before constituted the largest shares: single men without children (44.3%) and single women with children (24.7%). Thirty-eight per cent of recipients in 2015 were unemployed, 5/6 of them (2,172 individuals) lacking entitlement to unemployment benefit.

Municipal financial assistance was paid to households were 11,371 people (3.4% of the population) lived in 2015, including 3,736 children (aged 17 or younger), i.e. 4.7% of

[54] An English translation of the Act can be found on the Ministry of Welfare's website: https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/The-Municipalities-Social-Services-Act-No-40-1991-with-subsequent-amendments-16.pdf
[55] An English translation of the Act can be found on the Ministry of Welfare's website: https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act-on-Health-Insurance-No-112-2008-16.pdf

children. In 2014, the corresponding figures were 12,625 people (3.8% of the population) and 4,203 children (5.3%).

Table 97. Number of households receiving financial assistance, average payment per month and average number of monthly payments in 2012–2015.

Year	Total households	Average payment per month in ISK	Average number of monthly payments
2012	7,736	109,912	4.8
2013	8,042	121,251	4.7
2014	7,749	126,638	4.8
2015	6,996	131,977	4.9

Source: Statistics Iceland

Table 98. Households receiving financial assistance, by family type of recipients in 2012–2015.

	2012	2013	2014	2015
Total	7,736	8,042	7,749	6,996
Single men with children	161	148	136	131
Single men without children	3,326	3,582	3,472	3,098
Single women with children	2,098	2,094	1,930	1,727
Single women without children	1,540	1,587	1,560	1,458
Married/cohabiting with children	429	450	456	415
Married/cohabiting without children	182	181	195	166

Source: Statistics Iceland.

Table 99. Households receiving financial assistance, by age and place of residents by recipients 2012-2015.

		*Capital area**			
	Total	*Total*	*Reykjavík*	*Other municipalities*	*Municipalities outside the metropolitan area with over 300 inhabitants*
2012					
Households, total	**7,736**	**5,690**	**4,182**	**1,508**	**2,046**
Age of recipients					
24 and under	2,353	1,679	1,202	477	674
25-39 years	3,301	2,466	1,792	674	833
40-54 years	1,450	1,069	812	257	381
55-64 years	459	345	271	74	114
65 years and over	173	131	105	26	42
18 years or older, total**	8,347	6,071	4,475	1,596	2,276

2013					
Households, total	**8,042**	**5,907**	**4,274**	**1,633**	**2,135**
Age of recipients					
24 and under	2,280	1,615	1,135	480	665
25-39 years	3,401	2,525	1,819	706	876
40-54 years	1,600	1,208	886	322	392
55-64 years	546	401	311	90	145
65 years and over	215	158	123	35	57
18 years or older, total**	8,673	6,289	4,555	1,734	2,384
2014					
Households, total	**7,749**	**5,624**	**4,184**	**1,440**	**2,125**
Age of recipients					
24 and under	2,081	1,452	1,056	396	629
25-39 years	3,329	2,466	1,814	652	863
40-54 years	1,530	1,132	865	267	398
55-64 years	585	416	323	93	169
65 years and over	224	158	126	32	66
18 years or older, total**	8,400	6,006	4,495	1,511	2,394
2015					
Households, total	**6,996**	**5,131**	**3,820**	**1,311**	**1,865**
Age of recipients					
24 and under	1,673	1,183	889	294	490
25-39 years	3,044	2,251	1,656	595	793
40-54 years	1,496	1,099	821	278	397
55-64 years	526	402	301	101	124
65 years and over	257	196	153	43	61
18 years or older, total**	7577	5,516	4,120	1,396	2,061

Source: Statistics Iceland.

* The municipalities within the metropolitan area are Garðabær, Hafnarfjarðarkaupstaður, Kjósarhreppur, Kópavogsbær, Mosfellsbær, Reykjavík and Seltjarnarneskaupstaður.

**Total number of recipients of financial assistance, 18 years or older, is found by doubling the number of households of married/cohabiting couples.

Financial assistance given by the City of Reykjavík during the period

Financial assistance is given for the support of individuals and families. Those who are domiciled in Reykjavík and whose income is under a certain reference figure qualify for assistance, which takes the form of either grants or loans. It is independent of the number of children, as it is assumed that child benefit, child maintenance payments following divorce

and child pension will cover expenses concerning children. Interest benefit and rent benefit then cover housing costs.

2012
Financial assistance for support in 2012 could amount to ISK 157,493 per month for individuals and ISK 236,240 for married or cohabiting couples. In addition, individuals and families could be granted financial assistance in view of special circumstances, study costs or unforeseen setbacks. Assistance was given in Reykjavík in 4,133 cases; the previous year, 2011, the figure was 4,112; thus, there was an increase of 0.5%. Grants were made for support in 3,295 cases in 2012 and 3,285 in 2011; the increase was 0.3%. Applications for financial assistance were turned down in 648 cases, including 275 in which individuals' applications were completely rejected, an increase of 2.2% of the 269 cases in 2011. Most rejections were of applications for support grants, for study expenses, for advance rent payments, registration fees, book costs, household furnishings and to cover special difficulties.

2013
Financial assistance for support in 2013 could amount to ISK 163,635 per month for individuals and ISK 245,453 for married or cohabiting couples. In addition, individuals and families could be granted financial assistance in view of special circumstances, study costs or unforeseen setbacks. Assistance was given in Reykjavík in 4,218 cases; the previous year, 2012, the figure was 4,133; thus, there was an increase of 2.1%. Grants were made for support in 3,350 cases in 2013 and 3,295 in 2012; the increase was 1.7%. Applications for financial assistance were turned down in 611 cases, including 220 in which individuals' applications were completely rejected, a drop of 20% from the 275 cases in 2012. Most rejections were of applications for support grants, for study expenses, for advance rent payments, registration fees, book costs, household furnishings and to cover special difficulties.

2014
Financial assistance for support in 2014 could amount to ISK 169,199 per month for individuals and ISK 253,799 for married or cohabiting couples. Support grants were made to 3,269 individuals and families, a reduction of 2.4% compared with the figure of 3,350 for 2013. Applications for financial assistance were turned down in 584 cases, including 235 in which individuals' applications were rejected in full, against 220 in 2013, an increase of 7%.
In addition, individuals and families may be granted financial assistance in view of special circumstances, study costs or unforeseen setbacks according to the rules on assistance. Altogether, 4,088 individuals and families were granted assistance in Reykjavík during the year, a reduction of 3.1% as compared with the figure of 4,218 in 2013.

2015
Financial assistance for support in 2015 could amount to ISK 174,952 per month for individuals and ISK 262,482 for married or cohabiting couples. Support grants were made to 2,898 individuals and families, a reduction of 11% compared with the figure of 3,269 for 2014. Applications for financial assistance were turned down in 578 cases, including 206 in which individuals' applications were rejected in full, against 236 in 2014. In addition to grants for support, individuals and families may be given financial assistance in view of special circumstances, study costs or unforeseen setbacks according to the rules on assistance. Altogether, 3,677 individuals and families were granted assistance in Reykjavík during the year, a reduction of 10% as compared with the figure of 4,088 in 2014.

Table 100. Number of households receiving financial assistance in Reykjavík in 2012–2015.

	2012	2013	2014	2015
Number of households	4,133	4,218	4,088	3,677

Source: Reykjavík City´s Welfare Division´s Annual report.

Table 101. Number of households receiving financial assistance in Reykjavík, by type of assistance in 2012–2014.*

Types of financial assistance	2012	2013	2014
Basic financial assistance	3,292	3,350	3,269
Special occupational assistance	492	518	451
Financial assistance for students 18 years and older for fees and books	476	493	442
Financial assistance for students 16 and 17 years for fees and books	0	0	0
Financial assistance for students far from their local community	1	0	2
Special financial assistance for students	442	424	398
Counselling	142	149	125
Assistance to families with children	398	413	462
Assistance because of special difficulties	102	74	92
Grants for housing deposit	143	151	126
Dentist financial assistance	145	155	162
Grants for housing equipment	103	105	105
Financial assistance regarding funerals	69	76	55
Financial assistance to store furniture from the household	12	26	16
Trauma assistance	4	2	2
Other assistance	249	218	233
Special December financial support for families with children	380	405	384
Financial assistance when a child stays outside the home	10	3	4
Total**	**4,040**	**4,127**	**3,996**

* Figures for 2015 not available.

** More than one type of financial assistance is common for recipients.

Source: http://arbok.reykjavik.is/index.php/en/social-welfare/social-assistance.

Financial assistance in Kópavogur and Akureyri

The basic amount of financial assistance given by Kópavogur, a municipality in the metropolitan area with a population of 31,719 in 2013, was ISK 147,700 for an individual and ISK 236,320 for married and cohabiting couples below a certain income figure in 2013. In 2014 these sums were ISK 154,340 and ISK 246,944; in 2015 they were ISK 158,552 and ISK 253,683. Financial assistance available in Akureyri (the largest town outside the metropolitan area, situated in the north of the country) was ISK 150,353 for an individual in 2014; in 2015 the maximum was ISK 151,573. In Akureyri, the basis of support for married and cohabiting couples amounted to 1.6 times the basis of support for individuals aged 18 or older.

Rent benefit.
Reference is made to previous reports.

In 2012, the basic sum for each apartment was ISK 13,500. An additional ISK 14,000 is paid in respect of the first child, ISK 8,500 in respect of the second and ISK 5,500 in respect of the third. These sums were raised in 2013-2015: the basic rate to ISK 17,500, with ISK 14,000 for the first child, ISK 8,500 for the second and ISK 5.500 for the third; children must be legally domiciled in the rented premises. In addition, 15% of the rent lying between ISK 20,000 and ISK 50,000 may be paid as rent benefit (up to ISK 4,500). The maximum monthly amount of rent benefit was ISK 46,000 in 2012 and was raised to ISK 50,000 in January 2013, though with the proviso that it might never exceed 50% of the rent. In 2012, the highest possible rent benefit for a tenant who had no children in her/his care was therefore ISK 18,000. The highest possible rent benefit for a tenant who had one child in his/her care was ISK 32,000; with two children, the highest amount possible was ISK 40,500; and ISK 46,000 in the case of three or more children. Thus, in 2012-2015 full rent benefit, without deductions due to income and assets, could amount to ISK 22,000 per month for individuals or married or cohabiting couples, ISK 36,000 if there was one child in the home, ISK 44,500 if there were two and ISK 50,000 if there were three or more.

Income can reduce the amount of rent benefit. In 2011 the reduction was by 1% of annual income in excess of ISK 2,000,000 (the income reference figure was raised to ISK 2,250,000 in January 2012). 'Income' here refers to the aggregate total earnings of all those who are legally domiciled or resident in the relevant rented premises; the earnings of applicants' children aged 20 and over shall be included unless they are engaged in programmes of school or college (university) study for six months or more during the year. Social security benefit payments from the Social Insurance Administration, rent benefit for the previous year and income payments that are not subject to tax are excluded from these calculations. Assets, aggregated and after deduction of liabilities, can also reduce rent benefit if they exceed a certain threshold. In such cases, 25% of the amount exceeding the threshold is to be added to the income figure used to calculate rent benefit. In 2011, the threshold was ISK 6,063,975 (in 2012, the threshold was ISK 6,383,000 and in 2013 it was ISK 6,651,000). For the period 2012-2015, reductions could be as follows. Income resulted in a 0.67% reduction in each month of annual income above ISK 2,550,000. Thus, monthly rent benefit was reduced by ISK 6,700 for each ISK 1 m of income above this threshold.

Some municipalities grant special rent benefit to those who live under difficult financial and/or social circumstances. The Rent Benefit Act does not require such special rent benefit to be paid so the rules regulating it are stipulated by the municipalities and can vary between one municipality and another.

In 2012, the average amount of rent benefit paid to a tenant renting an apartment on the open rent market was ISK 24,085 and the average amount of special rent benefit was ISK 25,274. The average amount of rent benefit paid to a tenant renting an apartment within the social housing system was ISK 21,294 and the average amount of special rent benefit was ISK 23,850.[56]

[56] This information can also be accessed on the Ministry of Welfare´s website: http://www.velferdarraduneyti.is/media/Rit_2013/Skyrsla-unnin-fyrir-Samradsnefnd-um-framkvaemd-laga--og--reglugerda-um-husaleigubaetur_final.pdf

A new item of legislation, the Act on Housing Benefits, No 75/2016, entered into force on 1 January 2017, repealing and replacing the Act on Rent Benefits. Further information will be provided regarding housing benefits in the next report.

At-risk-of-poverty rate of persons by household type.

The proportion of people in Iceland living under the poverty line was 7-9% during the period. Nearly 8% of Icelanders had income under the poverty line in 2012 and 2014; in both cases, it rose above 9% the following year. Only once before since 2004 have so few people been recorded as living below the poverty line as in 2012 and 2014. According to the Gini coefficient, there was greater income equality in 2014 than at any other time during the period 2004-2015.

When the statistics covering those who are below the poverty line are analysed by gender, it is revealed that the number of women in the group has fallen. The proportion of men remained the same, 9.6%, in 2015 as it was in 2004; the proportion of women fell from 10.5% in 2004 to 9.6% in 2015.

Income distribution was more even in 2015 than at any time since measurements began in 2004. The Gini coefficient in Iceland in 2004 was 24.1; in 2015 it was 23.6.

Table 102. At-risk-of-poverty rate of persons 2012-2015

Year	**2012**	**2013**	**2014**	**2015**
Indices				
Gini coefficient	24	24	22.7	23.6
Poverty line (minimum income)	156.3	170.6	182.6	183.5
Individuals under the poverty line, by sex (%)				
Total	7.9	9.3	7.9	9.6
Men	8.4	9.6	8.1	9.6
Women	7.5	8.9	7.7	9.6
Individuals under the poverty line, by age (%)				
<18	10.6	12.6	10.2	11.3
16-24	9.6	13.7	9	11.4
25-34	11.8	13.5	9.2	14.4
35-44	7.8	9.0	7.9	7.0
45-54	5.1	5.0	6.3	5.7
55-64	3.6	4.1	3.5	7.0
>64	4.5	4.0	6.9	9.0
Individuals under the poverty line, by household type (%)				
Households without children	7.8	8.3	7.8	10.3
Single man	18.6	23.1	23.3	25.4
Single woman	9.0	9.0	14.4	18.3
Household with children	8.0	10.0	8.0	9.2
Single parent	24.5	27.1	22.3	29.5
Two adults with one child	4.9	8.0	6.2	10.7
Two adults with two children	5.6	5.5	4.0	4.7

Two adults with three or more children	6.5	11.5	9.5	7.5
Individuals under the poverty line, by occupancy status of property (%)				
Owner, no debt on property	4.1	6.2	6.7	11.4
Owner, with mortgage	4.4	5.0	4.9	5.5
Tenant on the open market	18	21.9	13.2	16.8
Tenant in social solution	20.8	23.2	19.9	21.3
Individuals under the poverty line, by education, aged 25 and older (%)				
Compulsory schooling	4.9	6.0	4.9	6.5
Upper secondary and vocational education	5.5	5.8	5.9	8.1
Post-secondary (university level) education	3.2	3.7	3.1	4.7
Individuals under the poverty line, by place of residence (%)				
Metropolitan area	8.3	9.4	7.8	10.1
Major population centres	9.4	11.5	9.2	8.9
Rural areas	4.8	6.2	6.4	8.4

Source: Félagsvísar (Social indicators published by Ministry of Welfare and University of Iceland), 2012-2015

The Welfare Watch.
The Welfare Watch, some account of which has been given in previous reports, is still at work.[57] Its role is to be an independent analytical and advisory body which makes proposals to the Government and interest groups and follows up their application. The Welfare Watch includes representatives of NGOs, the social partners, the Ministry, other government bodies and the local authorities. For further information about the Welfare Watch, reference is made to the last report.

Furthermore, Iceland took the initiative on the establishment of the Nordic Welfare Watch, a three-year research programme that lasted from 2014 to 2016 and was aimed at consolidating Nordic welfare projects and promoting their sustainability by initiating studies, increasing collaboration and sharing information and experience between the Nordic countries in this area.

Article 13, para 2 – Non-discrimination in the exercise of social and political rights.
Reference is made to the government of Iceland´s previous reports.

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee takes note of the information contained in the report submitted by Iceland and notes that during the reference period there have been no changes to the situation which it had previously found to be in conformity with the 1961 Charter (Conclusions XIX-2 (2009)). It asks nevertheless that the next report confirm explicitly that, both in law and in practice, beneficiaries of social and medical assistance do not suffer, for that reason, from any restriction to their political and social rights.

[57] The reports of the Welfare Watch may be accessed on the website of the Ministry of Welfare: https://www.velferdarraduneyti.is/velferdarvaktin/

Under Article 65 of the Constitution of the Republic of Iceland, all persons are equal before the law and enjoy human rights irrespective of their gender, religion, beliefs, national origin, race, colour, financial standing, family or status in other respects.

The second paragraph of Article 1 of the Patients' Rights Act moreover states that is prohibited to discriminate against patients on grounds of gender, religion, beliefs, nationality, race, skin colour, financial status, family relationship or status in other respect. In this connection, reference may also be made to the principle of equality as laid down in the Administrative Procedure Act, which states that no distinction may be made between persons when official decisions are taken on the resolution of their cases on grounds of opinions based on their gender, race, colour, nationality or other comparable circumstances.

According to the Directorate of Health, which is the public body that is obliged under law to respond to complaints regarding dealings between the public and those who provide healthcare services, no complaints have been received from patients regarding any restrictions on their political or social rights.

Under Article 12 of the Local Authorities' Social Services Act, No. 40/1991, local authorities are responsible for providing their residents with services and assistance under the Act and ensuring that they are able to provide for themselves and their dependents. On this point, reference is made to the aforementioned provision of the Administrative Procedure Act.

Article 13, para 3 - Prevention, abolition or alleviation of need.
Reference is made to the previous reports; the statistics in previous reports have been updated.

Table 103. Health insurance in comparison with public expenditure on health care in 2012–2015, ISK millions.

	Health Insurance	Public expenditure on Health care	Ratio
2012	30,934	124,179	24,9%
2013	32,178	132,779	24,2%
2014	34,670	142,800	24,2%
2015	36,869	155,303	23,7 %

Source: Icelandic Health Insurance and Statistics Iceland.

Table 104. Total expenditure on social protection in 2012–2013*, ISK millions.

	2012	2013
Total expenditure on social protection	421,006	442,992

* Figures for 2014 and 2015 have not yet been published.
Source: Statistics Iceland.

Table 105. Social Protection Expenditure, by type of benefits in 2012-2013*, ISK millions.

	2012	2013
1. Sickness and health care	144,962	155,412
1.1. Cash benefits, sickness and health care	25,324	27,526
1.1 1 Sickness and injury benefits	2,030	2,377
1.1.1.1 Public *per diem* sickness benefits	676	747
1.1.1.2 Employers *per diem* sickness benefits	1,353	1,630

1.1.2 Other sickness and injury benefits	23,293	253149
1.1.2.1 Patient benefits	171	260
1.1.2.2 Wages and salaries during sickness	23,121	24,889
1.2. Health care services	119,638	127,886
1.2.1 Hospital care	83,228	89,600
1.2.2 Outpatient services	23,634	26,001
1.2.3 Pharmaceutical products	8,911	8,218
1.2.4 Other medical products	3,340	3,497
1.2.5 Health n.e.c.	524	568
2. Disability	62,968	69,722
2.1. Cash benefits due to disability	48,219	52,336
2.1.1 Disability pension	48,219	52,336
2.1.1.1 Social security cash benefits to disabled persons	33,642	36,139
2.1.1.1.1 Disability pension	24,639	26,504
2.1.1.1.2 Disability allowances	241	246
2.1.1.1.3 Child pension for parents with disabilities	2,775	2,917
2.1.1.1.4 Rehabilitation pension to disabled persons	2,049	2,300
2.1.1.1.5 Household supplement to disabled persons	2,955	3,118
2.1.1.1.6 Other disability benefits	980	1,051
2.1.1.2 Private pension funds. benefits to disabled persons	14,577	16,196
2.2 Services for disabled persons	14,749	17,386
2.2.1 Homes for disabled persons	12,065	13,767
2.2.1.1 Public homes for disabled persons	12,065	13,767
2.2.1.1.1 Central gov. homes for disabled persons	0	0
2.2.1.1.2 Local gov. homes for disabled persons	11,946	13,664
2.2.1.1.3 Investment on homes for disabled persons	119	103
2.2.2 Home care for disabled persons	2,514	2,597
2.2.2.1 Public home care for disabled persons	2,514	2,597
2.2.2.1.1 Local home care for disabled persons	2,514	2,597
2.2.3 Other services to disabled persons	169	1,021
2.2.3.1 Other services by central gov. for disabled persons	169	1,021
3. Old age	100,882	108,702
3.1 Cash benefits to elderly persons	92,475	100,126
3.1.1 Old-age pensions	92,475	100,126
3.1.1.1 Social security old age pensions	35,782	37,897
3.1.1.1.1 Old age pensions	30,045	32,345
3.1.1.1.2 Household supplement to elderly persons	3,375	3,309
3.1.1.1.3 Other benefits to elderly persons	2,361	2,241
3.1.1.2 Private pension funds. benefits to elderly persons	56,693	62,229
3.2 Services to elderly persons	8,406	8,575
3.2.1 Retirement homes for elderly persons	4,574	4,663
3.2.1.1.1 Public retirement homes for elderly persons	4,574	4,663
3.2.1.1.1 Central gov. retirement homes for elderly	2,923	3,231

persons		
3.2.1.1.2 Local gov. retirement homes for elderly persons	1,650	1,432
3.2.2 Home care of elderly persons	1,711	1,771
3.2.2.1 Public home care for elderly persons	1,711	1,771
3.2.2.1.1 Local gov. home care for elderly persons	1,711	1,771
3.2.3 Other services to elderly persons	2,119	2,139
3.2.3.1 Other public service to elderly persons	2,119	2,139
3.2.3.1.1 Other local gov. service to elderly persons	2,119	2,139
4. Survivors	10,248	10,237
4.1 Cash benefits to survivors	10,248	10,237
4.1.2 Death grants	159	120
4.1.3 Other death grants	260	259
4.1.4 Private pension funds. benefits to survivors	9,829	9,857
4.2 Services to survivors	0	0
5. Families and children	46,078	50,615
5.1 Cash benefits to families and children	19,044	22,455
5.1.1 Parental leave	7,786	8,295
5.1.3 Family or child allowance	8,241	11,126
5.1.4 Single parent's allowances	319	332
5.1.4 Other family and child allowances	2,696	2,701
5.1.4.1 Spouse and home care payments	1,525	1,546
5.1.4.2 Child pension, incarceration	87	101
5.1.4.3 Child maintenance	1,072	1,035
5.1.4.4 Other cash benefits to families and children	11	17
5.2 Services to families and children	27,034	28,160
5.2.1 Day care for children	16,000	16,981
5.2.3 Home-help services for families with children	483	490
5.2.4 Other services to families and children	10,550	10,688
6. Unemployment	22,983	17,873
6.1 Cash benefits due to unemployment	21,639	16,680
6.1.1 Unemployment benefits	20,563	15,785
6.1.4 Support for training and education	0	0
6.1.6 Other unemployment support expenditure	1,076	894
6.2 Services to unemployed persons	1,343	1,193
6.2.1 Other services to unemployed persons	1,343	1,193
7. Housing	19,098	13,414
7.2 Housing support	19,098	13,414
7.2.1 Rent benefit	3,429	3,801
7.2.2 Subsidized rent	650	639
7.2.3 Alleviating costs of owner-occupiers	15,019	8,974
8. Social exclusion n.e.c.	10,007	12,945
8.1 Cash benefits due to social exclusion n.e.c.	5,453	5,804
8.1.1. Financial assistance provided by municipalities	3,606	4,021
8.1.2. Special financial assistance (social exclusion)	1,846	1,783
8.2 Services related to social exclusion	4,553	7,140

8.2.1 Shelter houses due to social exclusion	0	0
8.2.2 Rehabilitation of alcohol and drug abusers	961	1,019
8.2.3 Other assistance due social exclusion	3,591	6,121
9. Other social expenditure (administration costs)	3,777	4,068
Total expenditure on social protection	**421,005**	**442,992**

* The numbers for 2014 and 2015 have not yet been published.
Source: Statistics Iceland.

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee takes note of this information. It refers to its finding of conformity as regards Article 14§1, where it noted that all social services are provided free of charge and evenly distributed across the country. It recalls that although, in comparison to Article 14§1, Article 13§3 is a special and more precise provision, concerning only advisory services for persons without or liable to be without adequate resources, it does not require specific services separate from the social welfare services of Article 14, so long as persons without adequate resources receive, free of charge, benefits and services adapted to their needs. The Committee understands the information provided in the report as meaning that people without resources or at risk of becoming so can approach the municipal social services as well as the other public institutions involved in the provision of social and medical assistance and obtain there, free of charge, all information and guidance needed to exercise their rights to social and medical assistance. It asks that the next report indicate whether this interpretation is right and what services, if any, address in particular people without resources.

The Government of Iceland confirms the aforesaid interpretation of the European Committee on Social Rights and refers to previous discussions of financial assistance provided by the local authorities and the health insurance system in Iceland. One of the aims of the Health Insurance Act is to ensure equality of access to the healthcare services irrespective of financial standing. Thus, for example, invalids and old-age pensioners pay lower fees for medical attention and medications.

Article 13, para 4 - Specific emergency assistance for non-residents.
Reference is made to the previous reports of the Icelandic Government.

Comment by the European Committee of Social Rights.
Conclusions XX-2(2013)
The Committee recalls that States Parties are required to provide non-resident foreigners without resources – whether legally present or in an irregular situation – emergency social and medical assistance (accommodation, food, emergency care and clothing) to cope with an urgent and serious state of need (without interpreting too narrowly the "urgency" and "seriousness" criteria). It asks that the next report clarify whether emergency medical and social assistance is also provided to nationals of other States Parties who are in an irregular situation.

Under Article 15 of the Local Authorities' Social Services Act, foreign nationals who are not legally domiciled in Iceland may in certain circumstances be given social assistance in Iceland. Assistance is to be given by the authority where the person is residing following consultation with the Ministry of Welfare; a condition is that the foreign national shall have previously sought assistance from his or her home country. This provision is intended first and foremost to cover the cost of the person's return journey to his or her home country, but

may, in exceptional cases, be granted to meet urgent need for a short time. The provision does not apply to citizens of EEA countries: they are covered by special rules in the EEA Agreement.

Under the regulations issued in the period 2012-2015 on healthcare services to persons who are not insured under the Health Insurance Act, and on payments they are required to make for healthcare services (Nos. 1101/2012, 1130/2013, 1188/2014 and 1142/2015), persons who are not insured in Iceland under the Health Insurance Act or international agreements on health insurance are entitled to emergency assistance, i.e. medical assistance and healthcare services, which public bodies are obliged to provide under the Healthcare Act and which are provided by these bodies in the event of sudden illness or accidents.

Article 14

The right to benefit from social welfare services

Article 14, para 1 – Provision or promotion of social welfare services.

Municipalities' Social Services

The local authorities (municipalities) are responsible for a wide range of social services to their inhabitants. In general, as defined in the Local Authorities Social Services Act, No. 40/1991, the role of the social services is to guarantee financial and social services of the inhabitants on the basis of mutual aid. This is to be achieved by means including the improvement of the living standards of the needy, securing a positive environment for children and young persons to grow up in, providing assistance so that people are able to live for as long as possible in their own homes, and also to work and live as normal a life as possible. Measures are also to be taken to prevent social problems. By providing structured social services, the local authorities strive to ensure their inhabitants better living standards through comprehensive social services. The emphasis, in providing structured services, is that people's rights and entitlements should be clear at all times and no one should suffer from discrimination. When services are provided, individuals are to be encouraged to take responsibility for themselves and others; the individual's right to self-determination is to be respected and people are to be helped to help themselves, both through counselling and other appropriate support.

The most important matters dealt with are general social counselling, financial assistance, housing, elderly persons' affairs, disabled persons' affairs and social services in the home, in addition to issues regarding children and young people, including the handling of cases under the child protection legislation. Social counselling, e.g. regarding money matters, housing, the upbringing of children, divorce and adoption, is to be provided in collaboration with other entities that offer similar services, such as the schools and primary health clinics. There is great variety in the services listed in the Act, including, e.g., services in connection with financial difficulty and lack of income, housing problems, difficulties in housekeeping and problems that individuals have with personal cleanliness and hygiene, alcohol abuse and drugs.

With the growing accent in the past few years on individually-tailored services for individuals in their own homes for as long as possible, there has been a gradual shift in emphasis away from diagnostic classification by groups and from institutional services except where no other solutions are available. People's ability to participate in their community, rather than their disabilities and the obstacles to that participation, are the focus of attention. Thus, the local authorities finance various service solutions in order to support individuals and their families and enable them to live in their own homes for as long as possible. These solutions differ in scope according to the financial resources each local authority has to put into the services. In this, population numbers, location in the country and the distances within the service area all play a part.

The state has entered into service contracts with some local authorities on the management and delivery of healthcare and social services. In these cases, the local authorities manage the social and healthcare services within their areas as an integrated unit.

The Local Authorities' Social Services Act, No. 40/1991, was amended by Act No. 19/2013 on the UN Convention on the Rights of the Child. Under the amendment, a provision was included stating that children have the right to express their opinions on matters which have a bearing on them, according to their age and maturity level.

Welfare Watch (Velferðarvaktin)
Reference is made to the last report for further details about the Welfare Watch. As was described there, the committee on the Welfare Watch was appointed by a letter from the Minister of Social Affairs and Social Security on 17 February 2009. A new Welfare Watch was appointed during the period covered by the present report by a letter from the Minister of Social Affairs and Housing dated 18 June 2014, in which its role was described as being to "monitor the social and financial consequences of the economic collapse for families and individuals in Iceland and make proposals on measures to assist households. The Welfare Watch shall attend to the well-being and financial position of low-income families with young children, and in particular single parents and their children, and obtain information on the circumstances of those who live in severe poverty so that this can be reduced.

The Welfare Watch is to act in an advisory capacity to the Minister of Social Affairs and Housing [now the Minister of Social Affairs and Equality] and to other government bodies. It is expected the Welfare Watch will submit regular status reports to the Minister, covering, as appropriate, specific topics and making proposals on improvement measures, on which the government will adopt a position as they arise. In addition, the Welfare Watch shall monitor what is done with its proposals.

The Social Services and Housing Appeals Committee (later the Social Welfare Appeals Committee))
Up until 31 December 2015, appeals could be lodged with the Social Services and Housing Appeals Committee against administrative decisions taken under the Local Authorities' Social Services Act, No. 40/1991, the Housing Act, No. 44/1998, the Rent Benefit Act, No. 138/1997 and the Disabled Persons Act, No. 59/1992. These included decisions taken by social welfare committees and councils, housing committees, the Housing Financing Fund or other government bodies responsible for taking decisions covered by the acts of law listed above. The committee delivered rulings on 99 cases during 2013, 71 cases in 2015, 77 in 2014 and 73 in 2015.

The Welfare Appeals Committee was established under the Welfare Appeals Committee Act, No. 85/2015, which placed appeals dealt with by the following earlier committees under its purview: the Child Protection Appeals Committee; the Payment Adjustments Appeals Committee; the Social Security Appeals Committee; the Unemployment Benefit and Labour-Market Measures Appeals Committee; the Social Services and Housing Appeals Committee and the Maternity/Paternity and Parental Leave Appeals Committee. The committee began functioning on 1 January 2016, on which date the Social Services and Housing Appeals Committee was abolished. The Welfare Appeals Committee took on the role of the former committees. No substantive changes were made otherwise.

Social indicators
Statistics Iceland sees to the updating and publication of the statistics compilation Social Indicators (Félagsvísar) under a contract with the Ministry of Welfare; these indicators have been published every year since 2012. The main aim is to make available, in a single location, a body of statistics that will make it easier for the government and the public to follow

developments in society and understand their impact on the standing of the ordinary consumer. In most cases, the indicators span a 10-year period and therefore clarify the direction of trends in the relevant sphere of welfare. They are broken down by gender, age and household type so as to make it possible to see differences in social circumstances between various groups covered by the figures.

Specialists from the University of Iceland, the market-research company *Rannsóknir og greining*, the Social Insurance Administration, the Child Protection Agency, the Office of the National Commissioner of Police, Statistics Iceland, the Ministries of Welfare, Finance and Economic Affairs and Education, Culture and Science, Reykjavík City's Department of Welfare, the Social Science Institute, the Directorate of Taxes, the Icelandic Confederation of Labour, the Debtors' Ombudsman, the Directorate of Health, the Directorate of Labour and the National Registry participate in the production of the social indicators.

The social indicators are intended to make data on people's welfare, health, well-being and needs more accessible, opening them up to government bodies, the general public, interested parties, the media, experts and researchers. It is envisaged that this data will be of value in connection with policy formulation and decision-making in the field of social welfare. For example, they include information on the composition of the population, educational attainments and economic participation, and also on income distribution, low-income level and material poverty, household assets and liabilities by income group and the situation on the housing market. There are also indicators on life-styles and health, consumption of medical drugs and people's self-perception of their state of health, statistics on children's health, children's participation in sports and leisure activities, how much time parents spend with their children, etc.

The following trends and changes in Iceland society can be identified from the social indicators published in 2015.

- The proportion of economically active women rose from 76.5% in 2004 to 78.5% in 2014; the proportion of economically active men fell slightly over the same period.
- The proportion of elderly people who were economically active rose over the same period from 63.3% to 67.2%.
- The average number of hours worked per week fell, for women and men in all age groups.
- Comparison of statistics on economic activity in Iceland with figures from the other Nordic countries, as is presented by the Nordic Social-Statistical Committee (NOSOSKO) in its recent report, shows that a higher proportion of the population is economically active in Iceland than elsewhere in the Nordic countries, in addition to which Icelanders remain economically active until later ages. For example, it is only in the 65+ age group that the proportion of Icelandic men in work drops below 80%.
- Income equality as measured by the Gini index was greater in 2014 than at any time in the period 2004-2013.
- In 2004, 10% of people were under the poverty line (low income level); the figure was down to 7.9% in both 2012 and 2014. When figures on the numbers under the poverty line are broken down by gender, it is found that the reduction was larger among women than among men, though both groups declined overall. Thus, 9.6% of men were below the line in 2004 and 8.1% in 2014. Among women, the corresponding figures were 10.5% and 7.7%. The figure was recorded lower than the latter figure on one occasion during the period, at 7.5%, in 2012.

- The social indicators demonstrate clearly that children and parents are spending more and more time together. In 2014, sixty-three per cent of children aged 14-15 said they often, or almost always, spent time with their parents at the weekend; in 2006 the figure was 37%. The same trend is seen in replies to questions about parent-child contact out of school time on weekdays. In 2014, half of children aged 14-15 said they were often or nearly always in contact with their parents when out of school on weekdays; in 2006 the figure was under 33%.

Comment by the European Committee of Social Rights.
Conclusions XX-2 (2013).
The report points out that the regulation and inspection of the quality of welfare services is split between health and social services. Within the Ministry of Welfare there is a Working Group that elaborates proposals for the coordination of health and social services' regulating bodies. More specifically, the Directorate of Health is responsible of supervisory procedures and inspection in the health care system. By contrast, the monitoring of the social care system is not centralised, but run mainly by the municipalities. In view of the silence of the report on the criteria public and private providers must fulfil to provide these services, the Committee wishes the next report to provide information on these criteria.

Reference is made to the last report on this point. As was stated in the last report, the local authorities are expected to provide their residents with services and assistance in accordance with the Local Authorities' Social Services Act. Social services at the local government (municipal) level come under the Ministry of Welfare, which monitors to ensure that they deliver the legally-prescribed services. Thus, the Ministry exercises external supervision to ensure that the local authorities provide the services they are required to provide by law. The Ministry furthermore monitors to ensure that the local authorities honour the obligations placed on them under the Act or in accordance with administrative instructions issued under it. The local authorities, on the other hand, exercise internal control over the entities which supply the legally-prescribed services on behalf of the municipal councils, whether these are supplied by public administrative bodies or private entities.

Administrative decisions taken by the local authorities may be referred to the Welfare Appeals Committee (previously, to the Social Services and Housing Appeals Committee). Disputes as to whether the rules applied by a local authority have sufficient basis in law may also be referred to the Minister, since the Minister exercises overall supervision of welfare issues. In such cases, however, all the conditions regarding *locus standi* must be met and the dispute must concern lawful interests of the party requesting a ruling from the Minister under the Act. If these conditions are not met, the Minister may nevertheless state a non-binding opinion on whether the rules applied by the local authority are compatible with law (*cf.* the third paragraph of Article 12 of the Government Ministries Act, No. 115/2011). It should be stated that under Article 78 of the Constitution of the Republic of Iceland, the local authorities are guaranteed the right of self-determination, but the article also states that the local authorities are to determine their own affairs in accordance with the provisions of law.

To take the affairs of disable persons as an example, the Ministry of Welfare exercises supervision to ensure that the services, activities and running of the local authorities achieve the aims of the Disabled Persons Act, No. 59/1992 and that the legally-prescribed rights of disabled persons are respected to the full. Thus, the local authorities are expected to maintain internal supervision of the delivery of the services, including the execution of contracts made

with managerial or service-providing entities dealing with disabled persons (*cf.* Article 6b of the Disabled Persons Act).

The Committee asks whether there is any legislation on personal data protection.
Act No. 77/2000, on the Protection of Privacy as regards the Processing of Personal Data[58] (the Personal Data Act) is the Icelandic statute on personal data protection. The objective of the Act is to promote the practice of personal data processing in accordance with fundamental principles and rules regarding data protection and privacy, and to ensure the reliability and integrity of such data and their free flow within the internal market of the European Economic Area. The Data Protection Authority is responsible for monitoring the application of this Act and those administrative rules that are based on it.

The Data Protection Authority rules on disputes concerning personal data processing in Iceland. It may discuss individual cases on its own initiative or in response to requests from persons who consider that their personal data has not been handled in accordance with the Personal Data Act, regulations issued thereunder or special instructions. Functions entrusted to the authority include processing applications for licences, receiving tip-offs and notifications and issuing instruction regarding technical aspects, security and the organisation of personal data processing. It is also expected to monitor compliance with the rules on personal data processing and on measures taken to rectify mistakes and deficiencies; it is to keep abreast of developments in personal data protection both in Iceland and abroad and maintain an overview of, and acquaint itself with, questions concerning personal data processing; it is to define, and identify the location of, threats to personal data security and provide advice on methods of avoiding them; it is to guide those who propose to process personal data, or develop systems for such processing, on personal data protection. Furthermore, the Data Protection Authority is expected to express a position on points of interpretation and dispute regarding the handling of personal data and make comments in connection with the issue of regulations that are of significance regarding personal data protection. Finally, the authority is required to publish annual reports on its activities.

<u>People with disabilities</u>
Under the Act on the Protection of the Rights of Disabled Persons, No. 88/2011, with subsequent amendments, the Ministry of Welfare is in overall charge of issues relating to disabled persons. The Minister is responsible for the formulation of policy of in this area, and policy is to be developed in collaboration with the Association of Local Authorities. National federations of disabled people, and their constituent associations, are to be consulted. The aim of the Act is to guarantee disabled persons equality and a quality of life comparable with that of other citizens and to create conditions in which they are able to live normal lives. In the application of the Act, international obligations that Iceland has undertaken, and in particular the UN Convention on the Rights of Persons with Disabilities, are to be taken into account. In addition, the authorities are to ensure that national federations of disabled people, and their constituent associations, will have an influence on policy-making and decisions taken regarding disabled persons' affairs.

[58] https://www.personuvernd.is/information-in-english/greinar/nr/438

Rights protection officers
Under the Act on the Protection of the Rights of Disabled Persons, No. 88/2011, with subsequent amendments, rights protection officers operate in all the administrative areas in Iceland. Their function is to monitor conditions under which disabled persons are living and assist them in any way in securing their rights. Disabled persons are able to turn to the rights protection officers with any questions concerning their rights, finances and other personal matters. The rights protection officers are to given them support and assist them in securing their rights as appropriate. The idea is also that any person who considers that a disabled person's rights are being violated should be able to notify the rights protection officer, in addition to which the officers are able to take matters up at their own initiative. Rights protection officers are expected to be 'visible' and to organise educational and awareness-raising presentations for disabled persons and others who work with them.

Rights monitoring unit
The rights monitoring unit operates under the Act on the Protection of the Rights of Disabled Persons and is located in the Ministry of Welfare. It monitors the work of the rights protection officers and provides them with advice and guidance when necessary.

Specialist team on measures to reduce the use of coercion against disabled persons
Under the Act, coercion may not be used in services to disabled persons except to prevent individuals from injuring themselves or others or causing serious damage to property, or else to meet the individual's basic needs. When a service-provider, director or other party responsible for services to a disabled individual has to respond to a situation in such a way that it may become necessary to use coercion against the individual in question, he or she shall refer the matter to a specialist team on measures to reduce the use of coercion against disabled persons. If it is necessary to employ coercion in an emergency situation, this must be reported to the specialist team, as it must if coercion has been employed in accordance with a temporary exemption granted by the exemptions committee appointed under Article 15 of Act on the Protection of the Rights of Disabled Persons, No. 88/2011 (see the discussion below).

Exemptions committee – Committee on exemptions from the prohibition against the use of coercion against disabled persons
The committee on exemptions from the prohibition against the use of coercion against disabled persons operates under Article 15 of Act on the Protection of the Rights of Disabled Persons, No. 88/2011. The Act specifies that coercion may not be used in services to disabled persons except to prevent individuals from injuring themselves or others or causing serious damage to property, or else to meet the individual's basic needs. When a service-provider, director or other party responsible for services to a disabled individual considers it unavoidable to use coercion, he or she may apply for an exemption from the prohibition against coercion or telemonitoring, providing he or she has received comments from specialist team on measures to reduce the use of coercion against disabled persons.

Client-controlled personal assistance
A collaborative project on client-controlled personal assistance has been under way since 2011. This form of assistance is based on the idea of maximizing the degree to which disabled persons are able to live an independent life: they determine *how* assistance is to be structured, *when* it is delivered, *where* it takes place and *who* provides it. The aim of the policy is that disabled persons should be able to live fulfilling lives and have the same opportunities as people who do not have disabilities, and also that they should have the maximum degree of control over how they create their own life-style. This is, of course, subject to the financial

resources available and the time available, which in turn depends on the assessment of each person's needs.

This policy places a clear demand on the service recipient to decide how it is to be applied. It therefore calls for a change in many aspects regarding how these services are structured and delivered within the welfare system, and makes demands of recipients, assistants and those who administer the service.

Plan of action on issues regarding the disabled
On 11 June 2012 the Althingi approved a parliamentary resolution on policy and a plan of action on disabled persons' affairs; this had been presented by the Minister in January that year.[59] It set out 43 projects in eight fields, covering access, employment, social protection, independence in life, health, image and awareness, human rights, education and participation. In summer 2012 the Althingi approved a two-year plan of action laying down a policy and schedule of measures; this was done partly in connection with the incorporation in Icelandic law of the UN Convention on the Rights of Persons with Disabilities; also included were issues regarding access for the disabled, waiting lists for services, employment issues and other matters. When the plan of action had run its course, the Minister decided to extend it and at the same time to begin work on a new plan to replace it. The existing policy and plan of action were used as a basis for developing the new plan. Policy is based on the UN Convention and on current trends in the Nordic countries and elsewhere. The task force includes representatives of the National Association of People with Intellectual Disabilities (Þroskahjálp), the Association of Local Authorities, the Ministry of Welfare, the City of Reykjavík's Welfare Department and the Organisation of Disabled in Iceland. The intention from the beginning was that other players and specialists in the field should be involved in consultation.

Public spending on social security and welfare
Public spending in all areas of welfare rose during the report period, with the exception of allocations to housing and services for job-seekers.

Table 106. Total public spending on Social Protection 2012-2015 (ISK in millions)

	2012	2013	2014	2015
Sickness	933	1,093	1,162	1,505
Disability	49,894	54,184	59,125	62,025
Old age	44,194	46,255	51,624	55,296
Widows/widowers	321	321	336	331
Family and children	39,883	44,520	46,726	47,382
Unemployment	22,983	17,874	14,738	12,282
Housing	19,099	13,414	13,969	12,648
Social exclusion n.e.c.	7,411	7,888	8,719	9,005
Social protection n.e.c.	3,908	6,748	7,400	9,264
Social protection Total	**188,624**	**192,297**	**203,799**	**209,738**

Source: Statistics Iceland.

[59] https://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Parliamentary_Resolution_on_a_Plan_of_Action_on-Disabled_Persons_Affairs_until_2014.pdf

The classification of the expenditure in the table above is based on the COFOG standard. Total spending on social protection came to 24.5% of the total government expenditure in 2012; in 2013 it came to 23.0%. The figures for 2014 and 2015 were 21.7% and 21.4% respectively.

Local authorities' rules on financial assistance and social services in the home.
Under the Local Authorities' Social Services Act, the local authorities are required to set themselves rules on financial assistance and on social services in the home. The Ministry of Welfare has provided guidelines for the determination of the minimum. For example, the local authorities' social service departments provide financial assistance to all persons who cannot support themselves or their children by other means, such as with salaries or income from the social security system.

The Municipal Equalization Fund
The Municipal Equalization Fund operates under the Municipal Income Base Act, No. 4/1995, with subsequent amendments. During the reference period a new article was added to the Act under the Act of amendment, No. 139/2012, describing the role of the fund as follows: "The role of the Municipal Equalization Fund is to equalize the municipalities' various expenditure requirements and tax revenues by means of allocations from the fund on the basis of the provisions of this Act and of regulations and procedural rules set on the fund's activities. Furthermore, the fund shall pay contributions to the local authorities' national association and to their agencies and other parties in accordance with legal provisions."

Thus, the Equalization Fund has a twofold role: to make payments to the local authorities so as to put them on an equal footing regarding the options they have for raising revenues and meeting their expense requirements in accordance with regulations, and also to pay a share of rent benefit paid by all local authorities and legally-prescribed contributions to their agencies and associations. About 10% of the total income of the local authorities is from the Equalization Fund.

Table 107. Special contributions from the Municipal Equalisation Fund to municipalities (ISK millions).

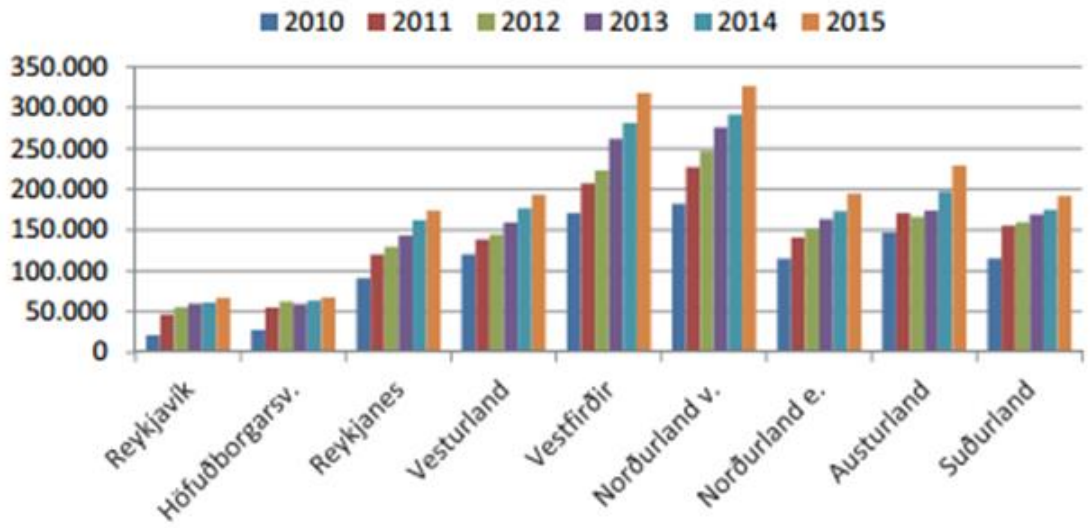
	2012	**2013**	**2014**	**2015**
Contributions for rent benefit	2,777	3,832	4,072	4,455
Contributions in respect of financial difficulties	27	85	11	15

Source: Municipal Equalisation Fund.

Income equalization contributions are allocated to equalize municipality income. The contributions are used to meet various municipal payment needs based on economies of scale and income, taking into account the factors affecting the municipalities´ expenditure needs.

The following table shows contributions per inhabitant from the Municipal Equalisation Fund divided into regions 2010-2015 (ISK per capita).

Table 108. Contribution per inhabitant from the Municipal Equalisation Fund by regions in 2010-2015 (ISK per capita).



Source: Municipal Equalisation Fund.[60]

The above figure shows total payments made by the Equalization Fund in the period 2010 to 2015. Contributions from the fund to the local authorities rose substantially in 2011, mainly because of the transfer from central to local government of responsibility for disabled persons' affairs on 1 January 2011 and also because of payments made by the fund to support music teaching and to put pupils on a more equal footing as regards the opportunity to study. Allocations to the local authorities from the Equalisation Fund came to ISK 38.85 billion in 2015, this figure including contributions to service areas and municipalities in connection with the transfer of responsibility for disabled persons to the local authorities.

Financial assistance provided by the local authorities

As was previously discussed in this report, the local authorities provide financial support to individuals and families. Those who are legally domiciled in a local government area and whose income is below a certain figure are entitled to receive financial support. Reykjavík, which is by far the largest local authority in the country, will be examined in the following discussion as an example. In 2015 it had a population of 121,822. Financial assistance for the support of an individual could amount to a maximum of ISK 174,952 per month; for a married or cohabiting couple, the figure was ISK 262,282. This assistance is independent of the number of children the recipients may have, since it is assumed that child benefit, child maintenance payments and pensions would meet the costs involved. Interest benefit and rent benefit would cover housing expenses.

In 2015, financial assistance for support was given to 2,892 individuals and families in Reykjavík; in 2014 the figure had been 3,296; thus, there had been a reduction of about 11%. Applications for support in Reykjavík were rejected in 578 cases that same year; applications from 206 individuals were rejected completely (in 2014 the figure had been 236). In addition to financial assistance for support, individuals and families may be granted assistance to cover particular circumstances, education costs and unexpected setbacks. Altogether, assistance was

[60] Höfuðborgarsvæðið: the Metropolitan Area; Reykjanes: South Western Iceland; Vesturland: Western Iceland, Vestfirðir: West Fjords, Norðurland vestra: North-west Iceland, Norðurland eystra: North-east Iceland, Austurland: East Iceland and Suðurland: South-Iceland.

given to 3,677 individuals and families in 2015, a reduction of 10% from the figure of 4,088 in 2014.

Table 109. Number of households receiving services of the Reykjavik social services, by type of service in 2012 to 2015.

	2012	2013	2014	2015
Type of service	**Total**	**Total**	**Total**	**Total**
Rent benefit	8,221	8,314	8,846	8,548
Special rent benefit – council housing	2,192	2,200	2,233	2,265
Special rent benefit – private market	1,244	1,275	1,313	1,291
Financial assistance	4,133	4,218	4,088	3,677
Service in the home	3,805	3,808	3,725	3,745
Reykjavík Child Welfare Committee	2,474	2,69	2,818	2,610
Nursing in the home	2,291	2,456	2,348	2,387
Specialist services in the schools - referrals	1,611	1,589	1,573	1,568
Arrangements for social counselling	983	1,403	1,662	1,734
Home delivered food	934	894	920	960
Transport service for disabled persons	903	908	929	930
Driving service for elderly people	884	724	632	587
Personal assistance/supervision	422	413	436	458
Support service for disabled children	232	230	220	210
Care needs assessment/disabled children	210	253	274	179
Personal supervision and counselling	199	200	222	295
Financial assistance – loans	166	157	167	207
Allocations of housing – socially assisted apartments	163	135	128	
Short-term placements for disabled persons	156	166	160	161
Support in the home – parental counselling	147	211	136	143
Support families	131	115	89	91
Extra personal assistance/disabled persons	110	133	158	182
Allocations of housing – service apartments	65	55	83	83
Grants for purchase of equipment, fees for schools and courses/disabled persons	62	69	75	60
Activity workshops for teenagers	57	57	63	58
Client-controlled personal assistance		14	14	13
Total number of service clients/recipients*	**19,757**	**20,265**	**20,414**	**19,857**
Number of meals	114,072	104,465	104,323	108,551

Source: Annual report of the Reykjavik Social Services for 2015

*Number of clients, taking overlapping services into account. In 2014, 33% of clients received more than one type of service.

Table 110. Financial assistance from the City of Reykjavík – Itemisation for 2012-2015.

	2012	2013	2014	2015
Rent benefit	8,221	8,314	8,846	8,548
Special rent benefit – council housing	2,192	2,200	2,233	2,265
Special rent benefits – private market	1,244	1,275	1,313	1,291
Personal assistance				
Number of people receiving personal assistance or supervision	609	608	654	747
Number of children receiving assistance from support families	131	115	89	191
Reykjavík Child Welfare Department				
Number of notifications	3,464	3,891	4,003	3,948
Number of children in child welfare cases	2,474	2,690	2,818	2,610
Number of families	1,983	2,157	2,153	2,046
Rent apartments				
Number of rent apartments	1,790	1,777	1,817	1,901
Number of housing allocations	163	135	128	126
Number of people on the waiting list at the end of the year	782	843	827	723
Service apartments for the elderly				
Number of service apartments	375	374	374	375
Number of housing allocations	65	55	83	83
Number of people on the waiting list at the end of each year	283	252	221	190
Home delivered food to the elderly or patients				
Number of people	934	894	920	960
Number of meals	114,072	104,465	104,323	108,551

Source: Annual report of the Reykjavik Social Services for 2015.

Social home assistance.

Under the Elderly Persons Act and the Local Authorities' Social Services Act, those who live in their own homes but are unable to do housekeeping work or other tasks without help have the right to social assistance at home. This service may be provided on a temporary basis or for the long term, according to needs.

Table 111. Numbers of households receiving social home assistance.

	The Elderly	Persons with Disabilities	Other	Total
2012	6,800	1,244	423	8,467
2013	6,893	1,199	295	8,387
2014	6,943	1,355	319	8,617
2015	7,283	1,308	484	9,075

Source: Statistics Iceland

Financial assistance for elderly and people with disabilities.
Senior citizens may be entitled to financial assistance from the local authorities just like other age groups, and are all entitled to a retirement (old-age) pension under the Social Security Act, No. 100/2007. Furthermore, they may be entitled to payments from an occupational pension scheme and supplementary pension scheme if they have paid premiums to such schemes while working. Under the Pension Funds (Compulsory Insurance) Act, No. 129/1997, all employees and employers or self-employed persons were obliged to ensure themselves pension entitlements by being members of a pension fund from the age of 16 to 70.

Persons with disabilities may qualify for financial assistance under the municipalities' social service structures in the same way as other people, but they are also entitled to benefit payments under the Social Security Act, No. 100/2007. Persons with disabilities are not itemised as a separate group in the statistics on financial assistance given by the local authorities. The following table shows the numbers of elderly people and people with disabilities who receive payments from the Social Security Institute.

Table 112. The numbers of elderly people and persons with disabilities who receive pensions under the Social Security Act, No. 100/2007.

Numbers	**Expenditure (ISK millions)**
Retirement pension	**Retirement pension**
2012 – 27,023	2012 - 33,304, including basic pension 9,971
2013 – 30,201	2013 - 35,545, including basic pension 11,177
2014 – 31,342	2014 - 40,523, including basic pension 13,091
2015 – 32,415	2015 – 43,424, including basic pension 14,007
Disability pension	**Disability pension**
2012 – 15,526	2012 – 22,065, including basic pension 5,667
2013 – 16,146	2013 – 23,709, including basic pension 6,151
2014 – 16,323	2014 – 25,776, including basic pension 6,633
2015 – 16,765	2015 – 26,648, including basic pension 6,997

Source: Statistics Iceland/Social Security Institute

Allowances under the Social Assistance Act.
The social assistance benefits enumerated in the Social Assistance Act, No. 99/2007, consist of single parent's allowance, child pension in connection with schooling or vocational training of young people aged 18–20, home-care allowance, spouse's benefit, home-care benefit, death grants, rehabilitation pensions, household supplement, additional supplements, automobile purchase grants, automobile purchase supplements, automobile operation supplements and reimbursements of substantial outlay related to medical assistance and medications.

Single parent's allowance may be paid to single parents who have dependent children under the age of 18 and are domiciled in Iceland. Annual single parent's allowance for two children in 2015 came to ISK 63,900; in the case of a single parent supporting three or more children, it was ISK 166,152. In addition, single parent's allowance may be paid to the spouse of a disability pensioner when payments from the Social Insurance Administration are discontinued because the individual is placed in an institution. Also, the spouse of an individual who is held in custody or serving prison sentence may be paid single parent's allowance if the incarceration has lasted three months or more.

Home-care allowance is a form of financial support to parents of disabled or seriously ill children; it is granted when the amount of care they need places great demands on them and when the costs related to health services, treatment and therapy is substantial and puts strain on the parents. Home-care allowance for the parents or supporters of disabled and chronically ill children who live at home or in a hospital amounted during the report period to a maximum of ISK 96,978 per month. The system also plays an additional role in the payment of healthcare expenses if the child's mental or physical handicap results in substantial expense and calls for special care or supervision. In special circumstances, caregiving allowances may be raised by up to 25%. General nursery-school and other school services do not result in a reduction of care allowances; other special services provided may, on the other hand, result in reductions.

In special circumstances, spouse's benefit may be paid to the spouse of a recipient of an old-age, disability or rehabilitation pension. Also, under the same circumstances, other persons who run households together with the pensioner may be paid home-care benefit. Spouse's benefit is primarily intended to make up for loss of income due to the reduction in the working capacity of the caregiver when the pensioner requires help with the tasks of ordinary life, and these payments amount to up to 80% of full disability pension and income supplement.

The table below shows the number of persons supporting children who were entitled to single parent's allowance and care-givers' allowance under the Social Assistance Act, No. 99/2007.

Table 113. Number of persons supporting others who received allowances under the Social Assistance Act, No. 99/2007, during the period 2012-2015.

	Number	Expenditure, ISK millions.
Single parent's allowances		
2012	2,637	319
2013	2,560	332
2014	2,453	335
2015	2,358	338
Home care payments		
2012	2,204	1,526
2013	2,149	1,546
2014	2,151	1,591
2015	2,241	1,710
Spouse benefits/home care payments		
2012	80	106
2013	91	127
2014	92	137
2015	103	146

Source: Statistics Iceland

In 2012, 5,976 children were supported by single parent's allowances paid to their parents, 5,845 children were supported in 2013, 5,587 children were supported in 2014 and 5,347 children were supported in 2015.[61]

In 2012, 2,764 sick and/or children with disabilities were supported by home care payments, 2,736 children were supported in 2013, 2,713 children were supported in 2014 and 2,796 children were supported in 2015.[62]

Services related to alcohol and drug abuse

Reference is made to the previous discussion on services related to alcohol and drug abuse in this report, inter alia information on the National Centre for Addiction Medicine (SÁÁ).

In 2015 there was a 13.9% likelihood that a person born in Iceland would have to seek treatment at some point in life: 18.3% for men and 9.4% for women. These figures have declined: in 2002 they were 23.3% for men and 11.7% for women.

The following table shows the number of people registered for treatment at the National Centre of Addiction Medicine (SÁÁ) 2012-2015.

Table 114. Number of people registered for treatment at the National Centre of Addiction Medicine in 2012–2015.

Year	Number
2012	2,248
2013	2,214
2014	1,997
2015	2,144

Source: National Centre of Addiction Medicine (SÁÁ)

The state contributions to the National Centre of Addiction Medicine (SÁÁ) in the reference period were as can be seen in the following table:

Table 115. State Contributions to the National Centre of Addiction Medicine (SÁÁ).

Year	ISK millions
2012	658
2013	706
2014	752
2015	816

Source: State Treasury

Of the 1,689 initial diagnoses made at the detoxification hospital Vogur in 2015, 38% were abusing alcohol, 15% alcohol and other substances, 21% were using cannabis, 14% amphetamines, 4% barbiturates, 4% cocaine and 4% opioids. A quarter were diagnosed as using three or more substances and 50.4% as using a single substance. Of those who used a single substance, alcohol was the problem in 75% of cases and cannabis in 13%.

Of patients admitted to Vogur in 2015, 548 were addicted to drugs. These included 301 with problems arising from consumption of barbiturates, 150 using opioids and 364 taking Ritalin.

[61] Annual report of the Social Security Institute, 2014

[62] Annual report of the Social Security Institute 2014

Ritalin abuse has become a much more common problem since 2010 when, of the 565 patients treated for drug problems, 268 were on Ritalin, 168 on opioids and 386 on barbiturates.

One hundred and thirty patients aged 19 and younger were admitted to Vogur in 2015. The main drug involved in 59% of cases was cannabis. Alcohol was the main substance in 8% of cases, alcohol in combination with other substances was the problem in 5% of cases and amphetamines were the main intoxicant used by 25% of the patients in this group.

Gender-based abuse and violence, prostitution and human trafficking

During the report period, the authorities gave increased priority to the importance of supporting treatment and prevention against sexual abuse and gender-based violence. For this purpose, the Ministry of Welfare gave support to the work of the Women's Refuge and Stígamót (the Educational and Counselling Centre for Victims of Sexual Abuse and Violence).

Women's Refuge (Kvennaathvarfið) and Kristínarhús.

As was stated in the last report the main aim of the organization running the Women's Refuge (*Kvennaathvarfið*) is to provide refuge facilities both for women and their children when the situation in the home makes it impossible for them to go on living there because of domestic violence, whether in the form of physical assaults or mental cruelty, practiced by the husband or cohabiting partner or other persons in the home, and also for women victims of rape.

The organization also provides advice and information and supports awareness-raising measures and discussion of sexual abuse and violence with the aim of increasing understanding in the community of the nature and seriousness of the problem, and its consequences, and it also seeks to have society, legislation and public institutions protect and assist the victims of domestic violence.

Towards the end of 2011 a special refuge, Kristínarhús, was opened for women who have been trafficked, have engaged in prostitution or been abused sexually and who want to escape from such circumstances. It was closed at the end of 2013 as operation proved more expensive than had been envisaged at the outset and the cases it dealt with were more complex than expected. In December 2014 the Women's Refuge and the Ministry of Welfare entered into an agreement on extending the role of the shelter to include an emergency reception shelter for female victims of human trafficking; thus the operation of Kristinarhús was relocated in the Women's Refuge.

Table 116. Admissions and interviews at the *Women´s Refuge (Kvennaathvarfið)* 2012-2015.

	2012	2013	2014	2015
Total admissions	739	708	706	846
Interviews*	626	583	606	720
Stay periods	113	125	100	126
Number women without children	56	61	51	76
Number of women with children	57	64	49	50
Number of children	87	97	84	74
Total number of clients	324	351	388	396

Source: Women's Refuge's Annual reports for 2012-2015.
*Interviews during stay are not included in this figure.

The total number of women who sought assistance from the Women's Refuge in 2012 was 324. There was a rapid increase in the number of women staying at the shelter from 2014 to 2015, but numbers decreased considerably, from 125 in 2013 to 100 in 2014. The number of children who stayed at the shelter dropped from 97 to 84.

Many women go to the shelter more than once, particularly when they return for counselling sessions. Three hundred and ninety-six women went to the shelter in 2015, and 74 children went to stay there with their mothers. These figures do not include the interviews/counselling sessions with the women staying in the shelter; they had such sessions at least once each week.

Seventy-four children spent time ranging from one day to 149 days in the Women's Shelter. The average length of women's stays in the shelter in 2015 was 19 days, four days longer than the average stay during the previous year. On average, women with children stay for longer than those without children, and women of foreign origin stay for longer than Icelandic women. During the same year, children stayed for an average of 20 days in the shelter. Thus, on average, there were seven women and four children in the shelter every day, though of course the figures were spread unevenly over the year. In 2015, 73% of women using the services of the Women's Shelter were Icelandic, 7% were from other countries in the EEA and 19% were from outside the EEA.

The Women's Shelter runs a help line which is open 24 hours a day giving advice and support. Users include not only women victims of violence but also men who are victims of violence, members of the families of victims and professionals.

The Education and Counselling Centre for Survivors of Sexual Abuse and Violence (Stígamót).
There are many reasons why individuals turn to the Education and Counselling Centre for Survivors of Sexual Abuse and Violence: rape, prostitution, incest and their consequences and also sexual harassment. For example 125 individuals contacted the centre in 2015 in connection with incest and its consequences and 155 in connection with rape. 5 contacted the organization in connection with prostitution and 99 in connection with sexual harassment.

Altogether, 288 individuals approached Stígamót in 2012, 358 in 2013, 306 in 2014 and 330 in 2015. These figures include those who had approached the organisation before, possibly on more than one occasion. The table below presents a breakdown of those who approached it for the first time during the years covered by the report.

Table 117. Persons received by Stigamót for the first time, by gender

	2012		2013		2014		2015	
	Number	**Proportion**	**Number**	**Proportion**	**Number**	**Proportion**	**Number**	**Proportion**
Women	241	91.3%	265	82.0%	244	88.1%	257	85.1%
Men	23	8.7%	58	18.0%	33	11.9%	45	14.9%
Total	264	100%	323	100%	277	100%	302	100%

Source: Education and Counselling Centre for Victims of Sexual Abuse and Violence Annual report for 2015.

Altogether, 677 people attended interviews at Stígamót in 2015, an increase of 9.7% over the figure of 617 for the previous year. Of these 677 people, 302 came in connection with their own cases for the first time. The total number of interviews at the centre in 2015 amounted to 2,209, a 2.9% increase over the corresponding figure of 2,146 for 2014; thus, there was an increase from 2014 to 2015 both in terms of numbers of people and interviews held, though both numbers were lower than those in 2013. It should also be mentioned that 2013 was a record year since the opening of the centre.

Table 118. Reasons for seeking assistance at Stígamót, 2014 and 2015.

	2014		2015	
	Number	**Proportion**	**Number**	**Proportion**
Incest	107	23.7%	125	26.9%
Rape	157	34.8%	155	33.4%
Attempted rape	28	6.2%	39	8.4%
Porn	21	4.7%	19	4.1%
Prostitution	8	1.8%	5	1.1%
Sexual Harassment	95	21.1%	99	21.3%
Other	24	5.3%	20	4.3%
Uncertain	11	2.4%	2	0.4%
Total	**451**	**100%**	**464**	**100%**

Source: Education and Counselling Centre for Survivors of Sexual Abuse and Violence Annual report for 2015.

The table above shows the number and proportion of alleged victims who arrived for the first time at the Education and Counselling Centre for Survivors of Sexual Abuse and Violence in 2014 and 2015 as well as the reasons for their visit. The people who use the centre's services often seek assistance to work their way through old traumas (often more than one trauma); this is why the total number of reasons for visits is higher than the number of individuals arriving.

Rape, attempted rape and incest account for 64.7% of the reasons given for arrivals at Stígamót during 2015. It should be noted that 21.1% applied to the centre in connection with sexual harassment.

Table 119. Age of people when seeking assistance at Stígamót, 2014 and 2015.

	2014		2015	
	Number	**Proportion**	**Number**	**Proportion**
17 years and younger	5	1.8%	5	1.7%
18 - 29 years	142	51.3%	149	51.2%
30 - 39 years	61	22.0%	67	23.0%
40 - 49 years	33	11.9%	35	12.0%
50 - 59 years	17	6.1%	19	6.5%
60 years and older	3	1.1%	12	4.1%
Information missing	16	5.8%	4	1.4%
Total	**277**	**100%**	**291**	**100%**

Source: Education and Counselling Centre for Victims of Sexual Abuse and Violence Annual report for 2015.

The table above shows the age of people who sought assistance in 2014 and 2015. More than half of the people who used the service of the centre for the first time were under the age of 30.

Work continued during 2015 on developing Stígamót's services for men; a male counsellor had been engaged in 2014. In all the centre's educational and awareness-raising work, great emphasis was placed on men's responsibility in connection with sexual violence against women and the importance of making perpetrators visible when these problems are tackled. In particular, priority was given to expanding the centre's services for male victims, making it generally known that men and boys may be the victims of sexual violence and encouraging men to seek assistance and feel welcome to apply to Stígamót with their problems. In 2015, men accounted for 14.9% of those who approached the centre for the first time; the previous year they had been 11.9%. The rise in the figure is an indication that the campaign was successful.

Two new booklets were published during the year. The first was "Stígamót for everyone," the purpose of which was to put across the message that everyone was welcome at Stígamót, irrespective of how they classified themselves, i.e. people of all gender designations, people of foreign origin, men and boys, disabled persons and all other groups. The second booklet was "Stígamót for men," which was aimed at stressing that males were welcome to apply to the centre with their problems.

Aflið in Akureyri

A similar shelter against sexual and domestic violence is run in Akureyri, in the north of the country, named Aflið. In 2012, the number of private interviews there, including those conducted by phone, came to 748; the figure for 2013 was 803; in 2014 it was 980 and in 2015 it was 1,309. The number of new individuals approaching the service was 198 in 2012, 222 in 2013, 189 in 2014 and 209 in 2015. (Source: Aflið Annual report for 2015)

Sexual Offences – Procedure in cases involving sexual offences

Legislation on a new future structure of the prosecution, No. 47/2015, was passed by the Althingi on 30 June 2015, providing for a new agency, the National Prosecuting Authority, to

handle prosecutions at the first-instance level (see Articles 23, 146 and 147 of the Code of Criminal Procedure, No. 88/2008). Under the previous structure, the Directorate of Public Prosecutions handled the prosecution of the most serious offences against the General Penal Code, including sexual offences; under that arrangement, it was not possible to appeal to a higher prosecuting authority against a decision to drop a case or abandon investigation of a criminal case. Under the new arrangement, the prosecution of sexual offences is transferred to the National Prosecuting Authority and so an appeal channel within the prosecution system is guaranteed in all cases of sexual offences. This arrangement should increase security under the law, which was one of the main reasons for the establishment of the National Prosecuting Authority.

Sixty-four cases were referred to the Department of Public Prosecutions in 2011 involving violations of Articles 194-199 of the General Penal Code (No. 19/1940, with subsequent amendments), covering rape and other offences against the sexual freedom of the individual. In 2012 it was decided to have more categories of sexual offence in statistical analysis, and the following discussion takes account of this.

The Directorate of Public Prosecutions received 53 cases in 2012 that were grouped under Article 194 of the General Penal Code, which covers rape. Of these, 33 were dropped. Indictments were issued in 19 cases. One case was sent abroad for processing. Twelve of the indictments led to convictions at the district court level and five to acquittals. Nine cases were referred to the Supreme Court; in two cases the Supreme Court upheld convictions.

In 2013, 64 cases involving violations of Article 194 of the General Penal Code were referred to the Directorate of Public Prosecutions, of which 24 resulted in indictments. 17 of these cases led to convictions at the district court level. Nineteen appeals were lodged with the Supreme Court and it rendered acquittals in three of them.

In 2014, 64 cases involving violations of Article 194 of the General Penal Code were referred to the Directorate of Public Prosecutions. Twenty-two indictments were issued; 40 cases were dropped; investigations were abandoned in one and the determination of punishment was deferred in another. Nine of the indictments led to convictions at the district court level and five to acquittals. Nine cases were referred to the Supreme Court; in two cases the Supreme Court upheld convictions. No judgment had been rendered in 7 cases when the statistics used here were compiled.

In 2015, 46 cases involving violations of Article 194 of the General Penal Code were referred to the Directorate of Public Prosecutions. Four indictments were issued and eight cases were dropped. At the end of 2015, 34 cases still had not been concluded.

Reference is made to the last report regarding prostitution: a discussion was presented there of the amendment to the General Penal Code, No. 19/1940, with subsequent amendments, under which purchasing the services of a prostitute was made a criminal offence.

In 2012 the Directorate of Public Prosecutions received only one case falling under Article 206 of the General Penal Code on the purchase of the service of prostitutes. An indictment was issued and the defendant was convicted in the district court; an appeal was brought but the Supreme Court upheld the conviction.

In 2013, 68 charges were sent to the directorate regarding cases under the provision on the purchase of prostitutes' services. Thirty-five of them were dropped and indictments were issued in 33 cases.

In 2014, 74 charges were sent to the directorate under the aforementioned provision. Of these, 26 were dropped and indictments were issued in 45, all of which led to convictions.

In 2015, four charges were sent to the directorate under this provision; two were dropped and an indictment was issued in one, leading to a conviction in the district court. At the end of 2015, one case had still not been processed.

Domestic violence – Preventive measures; other measures
Saman gegn ofbeldi ('United against Violence') is a collaborative project by the City of Reykjavík, the Metropolitan Police and the Women's Refuge and was launched in January 2015. The aim is to raise awareness and make information available and to improve working procedures in tackling cases of domestic violence that arise so as to ensure citizens' safety in the home, provide better services to both victims and perpetrators of domestic violence and improve the position of children who are exposed to it.

At the end of 2014 the Gender Equality Agency, together with the Ministry of Welfare's collaborative team on domestic violence, held a workshop on preventive measures and other measures to deal with the problem. This was held in Akureyri and was intended for social service workers, healthcare workers, the police, schools, child welfare committees and others who work to combat domestic violence and deal with its consequences.

Act No. 140/2012, amending the Restraining and Exclusion Orders Act, No. 85/2011, added a provision to that act under which appeals may be lodged with higher authorities against orders made by a judge under the Act; procedure in such appeal cases is to be subject to the Code of Criminal Procedure.

The motivation for this amendment may be traced to Supreme Court Judgment of 14 October 2011 in Case No. 557/2011. This judgment mentioned that there was no special appeal provision in Act No. 85/2011. It went on to say that even though the Code of Criminal Procedure, No. 88/2008, was to apply, as appropriate (*cf.* Article 18 of that Act), the order against which the appeal had been brought did not fall under any of the appeal authorisations listed in Article 192 of Act No. 88/2008, and that no such authorisation was to be found in any other statute. Thus, the Supreme Court's conclusion was that there was no basis in law for the appeal against the order, and consequently the case was automatically dismissed by the Court.

Human Trafficking
In April 2013 the Government of the time approved a plan of action against human trafficking to cover the years 2013-2016. Overall supervision of its application was entrusted to the Ministry of the Interior. A steering committee was established under the leadership of the Ministry of the Interior. It includes representatives of other agencies and ministries which have responsibilities in this field according to law; these are: the Ministry of Welfare, the Directorate of Immigration, the Office of the National Commissioner of Police, the Suðurnes Police Commissioner, the Metropolitan Police, the Federation of General and Special Workers in Iceland, the Icelandic Human Rights Centre and Reykjavík City's Human Rights Office. The steering committee exercises overall supervision of the implementation of the

plan of action, secures consultation, prioritises projects to be worked at, passes on information and expertise and maintains statistical records.

Priority was also given to raising awareness about human trafficking. An information team consisting of members of the steering committee has held publicity meetings all over the country in order to stimulate awareness of the issue in local communities. At these meetings the team has gone over the main characteristics of human trafficking and the options and remedies open to victims. Emphasis has been placed on the legal aspects of the problem and the identification of victims. It is hoped that with coordinated guidelines and means of identification, a basis will be developed for a response team which can be notified and approached if a suspicion of human trafficking arises in any part of the country. Also, a clear and informative site has been set up on the website of the Ministry of Interior.

The Ministry of Welfare is responsible for the implementation of three of the measures in the plan of action, and two teams have been appointed to ensure that they will go ahead. One is a consultative and coordinating team; the other is a team of specialists. The aim of both is to ensure that victims of human trafficking will receive the appropriate welfare services. The consultative and coordinating team has an overview of the solutions and forms of assistance that can be offered to victims or presumed victims of human trafficking. It develops procedures for the provision of services to victims and examines ways of developing solutions to improve their social competence and mental well-being. The consultative team also functions as a support background for the team of specialists, which works at securing the necessary services in particular cases. The team's responsibilities are, on the one hand, to support the procedure followed in individual cases, and on the other to ensure as far as possible the provision of the assistance and services needed by the victims. The specialist team deals with individual cases, operating in part under an agreement between the Ministry of Welfare and the Women's Refuge on providing services to victims of human trafficking.

Support for a project in Belarus in which the Icelandic Red Cross was involved was continued until 2015. In this the Icelandic Red Cross supports its sister organisation in Belarus in a campaign against human trafficking. It was initiated by a declaration by the Ministry for Foreign Affairs and the Icelandic Red Cross in 2010 on support for 'forgotten areas'. It involves raising awareness among young people of the dangers of human trafficking and giving trafficking victims support and assistance after they return to the country, in some cases after many years in other countries. Funding of ISK 9.1 m each year was devoted to the project over the five-year period, and it is regarded as having been successful.

Men's Responsibilities

Reference is made to the last report regarding the 'Men's Responsibilities' project (*Karlar til ábyrgðar*), a set of treatment measures for male perpetrators of sexual violence. In 2012, fifty-five perpetrators attended treatment under the scheme, 37 of them being new to it. During the same year, 27 spouses underwent treatment. In 2013, 78 perpetrators, including 53 new ones, and 30 spouses attended treatment; in 2014 the figures were 95 perpetrators (54 of them new) and 28 spouses (it was in 2014 that treatment was offered for female perpetrators; two attended that year).

A review of the project was made in 2014. The conclusion was that considerable results had been achieved. For example, in a survey which was part of the review, it was revealed that 86% of respondents were pleased or very pleased with the treatment. Following the treatment, 94% of the men reported finding it easier to restrain their tempers and remain calm in

challenging situations. A survey of their spouses revealed, amongst other things, that the incidence of violence of various types, and the level of intensity, had been reduced from as much as 60% prior to treatment to as little as 4%, or had even stopped completely, after the treatment.

The Emergency Reception Centre

The Emergency Reception Centre for Victims of Rape and Sexual Violence has been in operation at the Accident and Emergency Ward of Landspítali (the National Hospital) in Fossvogur (a suburb of Reykjavík) since 1993. Nurses, psychologists and doctors provide services at the centre, the aim of which is to ensure the welfare of victims of rape, attempted rape or other sexual violence by mitigating or preventing the mental and physical consequences which often result from sexual violence.

The centre received 139 people in 2012, 142 the following year and 123 in 2014.

Table 120. Numbers of men and women seeking help at the Emergency Reception Centre 2012-2014.

	2012	2013	2014
Women	117	134	120
Men	10	8	3
Total	127	144	123

Source: Report by the Minister of Social Affairs and Housing on the status and trends in gender equality issues, 2013-2015. Figures for 2015 were not available at the time of the report.

Since the centre opened in 1993, it has provided services to 2,452 people. In the period 2013-2015 it was approached by 265 people: 254 women and 11 men.

Table 121. Age and numbers of rape victims who sought help at the Emergency Centre, 1993-2014.

Age	Number
10-15	300
16-17	381
19-25	1,010
26-35	384
36-45	256
46-55	85
>55	34

Source: Report by the Minister of Social Affairs and Housing on the status and trends in gender equality issues, 2013-2015.

Services provided at the centre consist primarily of emergency treatment; most victims (61%) seek assistance from the centre within 24 hours of the occurrence of the incidents involving sexual violence; about 74% do so within 2-3 days. About 70% of the offences are classified as rape. The vast majority of these cases (78%) occur at the weekend and generally in the context of 'entertainment' in night-clubs or public gatherings. Most victims were attacked at night-time; most came to the Emergency Reception Centre in the afternoon or evening. The background circumstances leading to most of the incidents are that the victim and perpetrator

are only newly acquainted or that the perpetrator has no previous acquaintanceship with the victim. About 44-47% of these incidents lead to the pressing of charges each year; a team of lawyers at the centre provide victims with assistance and defend their legal interests in dealings with the police and the courts. In 2013-2014, charges were pressed in 106 cases out of a total of 371.

Article 14, para. 2 – Public participation in the establishment and maintenance of social welfare services.

The state has continued to support institutions that are active in the sphere of social services. In 2015 it was decided to make allocations to 46 non-governmental organisations active in the sphere of social services to cover particular projects or general operations; these came to a total of ISK 167 m. They include seven grants to NGOs that have been on contracts for 1-2 years amounting to ISK 82 m in total; all other grants came to a total of ISK 85 m. In addition to the funding to cover projects and operations, grants are made to NGOs which work at preventive measures, education and awareness raising activities and rehabilitation.

Table 122. State grants to institutions active in the sphere of social services 2015 (ISK thousands).

Name	
1. ADHD-association	5,660
2. Aflið – against domestic and sexual violence	3,000
3. Átak (developmental disabilties)	1,000
4. Women's Association in Reykjavík	250
5. Drekaslóð (charity)	5,000
6. Dyngjan (half-way house)	2,000
7. EAPN in Iceland	750
8. Einhverfusamtökin (Autism association)	1,500
9. Senior citizens' association	500
10. Dyslexic Association	500
11. Félag stjúpfölskyldna (Association of families with step-parents/children)	13500
12. Fjóla – (Association of deaf-blindness sufferers)	1,500
13. Fjölskylduhjálp Íslands með fjórar starfsstöðvar (Family support)	4,000
14. Fræðslufélagið	500
15. Geðverndarfélag Akureyrar (Mental health)	2,00
16. Hagsmunasamtök heimilanna (Consumer lobbying group)	4,450
17. Hjálparstarf kirkjunnar (Charity operated by the National Church)	5,000
18. Hugarfar (Association of people with brain damage)	1,000
19. YMCA, YWCA	2,000
20. Krossgötur (half-way house)	10,000
21. Kvennaráðgjöfin (counselling service to women)	1,500
22. Ljósið (Rehabiltation and support for cancer sufferers)	3,000

23. MND Society in Íslandi (Motor-neurone disorder)..... 3,500
24. Ný dögun (Bereavement response and counselling) 600
25. Samtök leigjenda á Íslandi (Renters' association)..... 1,000
26.Samtök meðlagsgreiðanda (Payers of child maintenance after divorce)..... 1,000
27. Sjálfbjörg (association of the handicapped)..... 1,500
28. Specialisterne á Íslandi 3,000
29. Stelpur rokka..... 1,000
30. Styrktarfélag lamaðra og fatlaðra (Disabled persons' charity association)..... 5,000
31. Systkinasmiðjan ..... …… 500
32. UNICEF in Iceland 500
33. Vímulaus æska – Foreldrahús (Drug-abuse reponse –support for parents).... 8,000
34. Þjónustusetur líknarfélag - ÞSL (Charity)…… 2,000
35. Æskulýðsvettvangurinn (Youth activities)..... 500

Total..... …… 84,710

NGOs that have had 1-2 year contracts

36. Blindrafélagið (Association of the Blind)..... 8,000
37. Félag heyrnalausra (Association of the Deaf) .....…… 10,000
38. Geðhjálp (Mental health)…….. 17,500
39. Heyrnarhjálp-félag heyrnarskertra á Íslandi (Hearing-impaired)……. 8,500
40. Landsamband eldri borgara (Senior citizens' association).....…..... 10,000
41. Landssamtökin Þroskahjálp (Intellectual disabilities)…… 10,500
42. Sjónarhóll – ráðgjafarmiðstöð (Chronically ill/disabled children)…… 17,500
43. MND-society in Iceland …… 800
44. Summer-camp in *Reykjadalur* …….. 5,500
45 *Hver*, rehabilitation centre …….. 4,000

Total 82,000

Article 23

Consultations and communication of copies of the report

In the preparation of this report, consultations were held with the Icelandic Confederation of Labour and SA-Business Iceland, which are, respectively, the main organizations of workers and employers in Iceland.

Copies of this report have been communicated to the following national organizations of employers and trade unions:

The Icelandic Confederation of Labour.
SA-Business Iceland.
The Federation of State and Municipal Employees.
The Alliance of Graduate Civil Servants.