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EUROPEAN SOCIAL CHARTER

26th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF ICELAND

(Articles 3, 11, 12, 13 and 14 and for the period 01/01/2008 – 31/12/2011)

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CYCLE 2013

EUROPEAN SOCIAL CHARTER

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THE GOVERNMENT OF ICELAND

Ministry of Welfare
(for the period 1st January 2008 to 31st December 2011)

REPORT

on the application of Articles 3, 11, 12, 13, 14 for the period 1st January 2008 to 31st December 2011 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.
I. On land.
Regulation on machinery and technical equipment, No. 1005/2009.[1]
The objective of the Regulation is to promote safety in use of machines and technical equipment in workplaces according to the Act on Working Environment, Health and Safety in Workplaces, No. 46/1980, with subsequent amendments. The Regulation prohibits use and marketing of machines when the design and structure is not in compliance with essential safety and health requirements of the Regulation. The Regulation was passed to implement the Council Directive 2006/42/EC on machinery, and amending Directive 95/16/EC.

Regulation No. 1003/2009 amending Regulation on lifts, and passengers and goods lifts, No. 341/2003.[2]
The objective of the Regulation is to improve the safety of machinery in workplaces. The Regulation was passed to implement the Directive 2006/42/EC of the European Parliament and of the Council of 17 May 2006 on machinery, and amending Directive 95/16/EC, and it redefines lifts and carries in accordance with that Directive.

Regulation on traffic signs and other safety measures during road construction, No. 492/2009.[3]
The aim of the Regulation is to ensure the safety of workers and road users and prevent physical and health damage, when working on road construction. Furthermore, the aim is to reduce property and environmental damage risks and to reduce traffic disruption.

Regulation on measures against the emission of gaseous and particulate pollutants from internal combustion engines to be installed in non-road mobile machinery, No. 465/2009.[4]
The Regulation aims to approximate the laws of the Member States relating to emission standards and type-approval procedures for engines to be installed in non-road mobile machinery. It will contribute to the smooth functioning of the internal market, while protecting human health and the environment. The Regulation stipulates the obligation for approval by the **Administration of Occupational Safety and Health, or a similar authority, for engines defined in the Regulation.**

The Regulation was passed to implement d**irective 97/68/EC of the European Parliament and of the Council of 16 December 1997 on the approximation of the laws of the Member States relating to measures against the emission of gaseous and particulate pollutants from internal combustion engines to be installed in non-road mobile machinery, with subsequent amendments.**

Regulation on indicative limit values and actions to reduce pollution in workplaces, No.

[1] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/1005-2009.

[2] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/1003-2009.

[3] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/aa0d47377abc977400256a090053ff91/9f4ed21df6bad6c4002575cc0049044a?OpenDocument&Highlight=0,492%2F2009.

[4] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/465-2009.

390/2009.[5]
The objective of the Regulation is to prevent pollution in workplaces and **protect workers from the risks related to exposure to chemical, physical and biological agents at work.** The Regulation stipulates workers' atmosphere limit values in a pollution target file according to an annex to the Regulation. It also requires immediate actions if pollution goes over the indicative limits. In cases of uncertainty as to whether the pollution passes the limits, an investigation must be carried out promptly with regard to it. If the investigation reveals pollution over limits, actions to reduce it shall be taken until it has dropped below these limits.

The Regulation was passed to implement Directive 91/322/EEC of 29 May 1991 on establishing indicative limit values by implementing Council Directive 80/1107/EEC on the protection of workers from the risks related to exposure to chemical, physical and biological agents at work, the Directive 98/24/EC on the protection of the health and safety of workers from the risks related to chemical agents at work, the Directive 2000/39 establishing a first list of indicative occupational exposure limit values in implementation of Council Directive 98/24/EC on the protection of the health and safety of workers from the risks related to chemical agents at work and the Directive 2006/15/EC establishing a second list of indicative occupational exposure limit values in implementation of Council Directive 98/24/EC and amending Directives 91/322/EEC and 2000/39/EC.

Regulation No. 33/2009 amending Regulation on the control of major- accident hazards involving dangerous substances, No. 160/2007.[6]
The Regulation aims to create standardized criteria on derogations in Regulation on the control of major-accident hazards involving dangerous substances. The Regulation was passed to implement the Commission Decision of 26 June 1998 on harmonized criteria for dispensations according to Article 9 of Council Directive 96/82/EC on the control of major-accident hazards involving dangerous substances.

Regulation on protection against the exposure from artificial radiation at a workplace, No. 165/2011.
The objective of the Regulation is to ensure safety at workplaces where workers are or might be at risk to be exposed to artificial radiation. The Regulation was passed to implement the Council Directive 2006/25/EC on the minimum health and safety requirements regarding the exposure of workers to risk arising from physical agents (artificial optical radiation) (19th individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC).

Regulation on notification and registration on occupational diseases, No. 540/2011.
The Regulation lays down requirements for employers and doctors to register all occupational diseases to the Administration of Occupational Safety and Health. The first motion of the Regulation came from the board of the Administration of Occupational Safety and Health and the Ministry has furthermore consulted the social partners and the Directorate of Health.

II. At sea.
Regulation on safety managements of ships, No. 337/2009.[7]

[5] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/390-2009.

[6] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/033-2009.

[7] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/337-2009.

The objective of the Regulation is to enhance the safety management and safe operation of ships as well as the prevention of pollution from ships. The Regulation was passed to implement regulation No. 336/2006/EC of the European Parliament and of the Council of 15 February 2006 on the implementation of the International Safety Management Code within the Community and repealing Council Regulation (EC) No 3051/95.

Regulation No. 738/2009 amending Regulation on safety managements of ships, No. 337/2009.[8]
The objective of the Regulation is to enhance safety of seafarers and the safety management of ships. The Regulation was passed to implement Commission Regulation 540/2008/EC of 16 June 2008 amending Annex II to Regulation 336/2006/EC of the European Parliament and of the Council on the implementation of the International Safety Management (ISM) Code within the Community, as regards format of forms.

Regulation No. 565/2009 amending Regulation on coastal stations and vessel traffic monitoring, No. 672/2006.[9]
The objective of the Regulation is to enhance safety of seafarers. The Regulation was passed in order to stipulate the duty of every fishing ship, longer than 15 meters, sailing under the flag, is registered or engaged in fishing in the jurisdiction or unloads in an EEC country, to be equipped with an automatic identification system (AIS-A device) which meets the standards of the International Maritime Organization.

Regulation No. 948/2010 amending Regulation on coastal stations and vessel traffic monitoring, No. 672/2006.[10]
The Regulation imposes the duty on all Icelandic fishing vessels to notify their departure and arrival in harbours through an automatic notification system. A minimum number of location notifications of the ships are also an inherent obligation of the Regulation.

Regulation on European Union committee on a Committee on Safe Seas and the Prevention of Pollution from Ships, No. 652/2009.

The objective of the Regulation is to establish and implement Regulation 2099/2002/EC of the European Parliament and of the Council of 5 November 2002 establishing a Committee on Safe Seas and the Prevention of Pollution from Ships (COSS) and amending the Regulations on maritime safety and the prevention of pollution from ships.

With the adoption of the Regulation, the following Regulations came into effect:

a. Regulation 2099/2002/EC of the European Parliament and of the Council of 5 November 2002 establishing a Committee on Safe Seas and the Prevention of Pollution from Ships (COSS) and amending the Regulations on maritime safety and the prevention of pollution from ships.
b. Commission Regulation 415/2004/EC of 5 March 2004 amending Regulation 2099/2002/EC of the European Parliament and of the Council establishing a Committee on Safe Seas and the Prevention of Pollution from Ships (COSS) and amending the Regulations on maritime safety and the prevention of pollution from ships.

[8] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/738-2009.

[9] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/565-2009.

[10] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/948-2010

c. Commission Regulation 93/2007/EC of 30 January 2007 amending Regulation 2099/2002/EC of the European Parliament and of the Council establishing a Committee on Safe Seas and the Prevention of Pollution from Ships (COSS).

III. In the air.

Regulation on flight and working hours limits and resting periods of aircraft crews, No. 1043/2008.[11]

The objective of the Regulation is to regulate the working and resting hours of flight crews. The Regulation applies to all commercial flights by entities licensed to operate commercial aircrafts by the Icelandic Civil Aviation Administration. It also applies to flights that companies and institutions operate by themselves. Moreover, the Regulation applies to all aviation school flights.

With the adoption of the Regulation, the following Regulations came into effect:

a. Regulation 1899/2006/EC of the European Parliament and of the Council of 12 December 2006 amending Council Regulation 3922/91/EEC on the harmonisation of technical requirements and administrative procedures in the field of civil aviation.
b. Commission Regulation 8/2008/EC of 11 December 2007 amending Council Regulation 3922/91/EEC as regards common technical requirements and administrative procedures applicable to commercial transportation by aeroplane.
c. Commission Regulation 859/2008/EC of 20 August 2008 amending Council Regulation 3922/91/EEC as regards common technical requirements and administrative procedures applicable to commercial transportation by aeroplane.

With the adoption of the Regulation, certain provisions of Council Directive No 2000/79/EC concerning the European Agreement on the Organisation of Working Time of Mobile Workers in Civil Aviation concluded by the Association of European Airlines (AEA), the European Transport Workers' Federation (ETF), the European Cockpit Association (ECA), the European Regions Airline Association (ERA) and the International Air Carrier Association (IACA), came into effect.

Protection of temporary workers.

Comment by the Committee of Independent Experts.

Conclusions XIX-2(2009,) p. 269.

The situation in Iceland regarding the protection of the temporary workers has been considered in conformity with the Charter in the Committee's last conclusion (Conclusion XVIII-2). The Committee nonetheless reiterates its question regarding medical supervision available to this type of workers.

Reference is made to the previous reports where it was stated that the Act on Working Environment, Health and Safety, with subsequent amendments, applies to all workers in the workplace, irrespective of the form of their engagement. According to Article 67 of the Act and Article 31 of Regulation on the organization and implementation of health and safety at workplaces, No. 920/2006, workers shall have the opportunity to have a medical check-up at the employer's expense before they are engaged for work, while they are employed and after they cease employment provided that their working conditions are such as may result in damage to their health and there is reason to believe that this may prevent or limit occupational diseases and work-related illnesses. The medical check shall be performed by a

[11] http://www.reglugerd.is/interpro/dkm/WebGuard.nsf/key2/1043-2008

healthcare professional and the risk assessment of the work place and the profession shall be taken into account. All workers shall be entitled to a medical check, irrespective of the form of their engagement. The employer shall guarantee that health protection supervision, medical examinations, tests and examinations do not cause a financial loss to the employees.

Article 3, para 2 – Provision for the enforcement of safety and health regulations by measures of supervision.
The Administration of Occupational Safety and Health is responsible for the enforcement of safety and health regulations on land.

General establishment inspections.
According to Statistics Iceland, 57,525 enterprises were registered in Iceland in 2008. By the year 2009 the number had risen to 59,753 and the number rose again in the following year to 60,945. 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 Occupational Health and Safety Administration still classifies enterprises in four risk categories, the frequency of regular inspections being determined to some extent by the risk that is assumed to exist in the individual enterprises.

The following table shows the number and classification of establishments in adapted and regular inspections. The number of establishments decreased in the year 2010 compared to 2009. The explanation is that in late 2010, an extensive effort was made to delist inactive establishments.

Table 1. Registered establishments according to risk categories in 2008–2011.

	2008	**2009**	**2010**	**2011**
Adapted inspections – establishments employing 30 employees or more	**49**	**145**	**341**	**441**
Regular inspections – establishments employing fewer than 30 employees:				
Category 1, annual inspection	2,637	2,513	3,291	3,139
Category 2, inspection every two years	3,622	3,597	2,831	2,699
Category 3, inspection every four years	2,874	3,197	3,490	3,477
Category 4 irregular inspections	7,201	7,298	2,152	1,867
Total	**16,334**	**16,750**	**12,105**	**11,182**
Temporary construction projects inspected more than annually	801	-	-	-
Total of inspected establishments	**17,135**	**16,750**	**12,105**	**11,623**

Source: Administration of Occupational Safety and Health.

The frequency of inspection visits to an establishment depends to some extent on the risk assumed to be present in the workplace. Other aspects are also taken into consideration, e.g. employee complaints, previous accidents and mishaps, initiative projects in sectors, risk aspects receiving particular focus in inspections each year, or follow-ups on the implementation of new regulations.

Adapted inspections – establishments employing 30 employees or more.
In 2008 the Administration of Occupational Safety and Health kept on working on

implementing adapted inspection. One of Administration's objectives was that all establishments employing 30 or more employees will be taken into adapted inspections at the end of the year 2012, and 40% of the establishments in this segment had been inspected under the new method at the end of 2010. By the end of the year 2011 51% of the establishments in this segment had been inspected under the new method. Establishments are ranked into three categories by performance. The classification determines the inspection frequency. Establishments, in category 1 and 2, make self-timed action plans for improvement and will be inspected every sixth (category 1) and fourth year (category 2). Companies in category 3 get scheduled orders of completion of improvements and are visited more often than the companies performing better.

Regular inspections – establishments employing fewer than 30 employees.
New procedures for regular inspections in establishments employing fewer than 30 employees came into effect in early 2010. At the beginning of the inspection, the inspector has a meeting with the manager and the employees about health and safety at the workplace, where inter alia it is checked if a written schedule on health and safety in the workplace including a risk assessment and a plan for prevention has been made. The establishment is then inspected comprehensively with regard to health and safety in the workplace in accordance with the nature of the establishment. If deemed necessary, instructions are given. In the years 2006−2008 the focus in the inspections was similar as there were large and comprehensive amendments followed by new procedures that were necessary to follow up on. Workplaces were examined according to sector-based working environment checklist to promote harmonized working practices in establishment inspections through the country.

Frequency of inspections in smaller establishments is determined by the sector-based working environment checklists. In 2010, revisions of the sector-based working environment checklists were completed in terms of new knowledge in the field of occupational health and safety. Changes were made to focus on the establishments with the greatest risk. Inspection frequency is every two to six years depending on the establishment´s sector. When the results from the inspection of an establishment are inadequate working condition which creates a risk to employees, the Administration of Occupational Safety and Health will change the classification temporarily, and have annual inspections.

Table 2. Inspection visits to establishments in 2008–2011.

Establishment inspections- number and type	**2008**	**2009**	**2010**	**2011**
Regular inspections-comprehensive inspection	1,931	2,161	1,508	1,152
Regular re-inspections	88	85	54	29
Adapted inspection	28	96	196	109
Adapted inspection re-inspection	0	1	1	1
Partial inspections	876	738	916	854
Re-inspections following on from partial inspections	13	13	11	9
Inspections, total	**2,936**	**3,094**	**2,686**	**2,154**
Other visits to establishments	540	475	539	407
Visits to establishments, total	**3,476**	**3,569**	**3,225**	**2,561**
Measurements and tests performed	536	291	208	184
Call-outs due to accidents	257	119	124	155

Source: Administration of Occupational Safety and Health.

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

Table 3. Number of inspectors in 2008–2011.

	2008	**2009**	**2010**	**2011**
In Reykjavík	15	15	12	12
Outside Reykjavík	17	16	15	13

Source: Administration of Occupational Safety and Health.

Until 2008, the construction sector in Iceland was the priority of the Administration of Occupational Safety and Health as there were big expansions in that field until then. In 2008, the construction companies' headquarters were visited and safety at the workplace was discussed with the managers, security guards and/or the security committee. Despite this big emphasis on the construction sector, the Administration of Occupational Safety and Health

did not reach acceptable results and had to give the same companies instructions regarding security at the workplace repeatedly, and therefore decided to follow new procedure and strengthen the surveillance on construction work. That included stopping all constructions if the contractor did not fulfil all the security factors necessary. In the beginning of 2010, a brochure covering the new procedure was sent to all contractors and to the customers in the construction field.

Once the Administration of Occupational Safety and Health has completed its visit, a report is prepared describing conditions and issuing instructions on what improvements should be made, making reference to acts of law, rules and regulations. The report is in writing and is delivered to the establishment. There are, however, exceptions in the case of acute problems that must be addressed without delay. Administration of Occupational Safety and Health has increasingly focused on following-up on its instructions. If notifications are not received from establishments within the deadline given to make the improvement, written reminders are sent which lead to reassessment and enforcement measures if a reply is not received from the establishment in question. Administration of Occupational Safety and Health also visits the place to investigate whether the improvements have been made if it considers such a visit necessary. The table below summarizes measures taken by the Administration of Occupational Safety and Health due to non-compliance in establishments.

Table 4. Measures taken by Administration of Occupational Safety and Health due to non-compliance in establishments in 2008–2011.

	2008	2009	2010	2011
Instructions on improved health standards	1,295	1,192	1,017	920
Instructions on improved safety standards	2,159	1,921	1,762	1,199
Instructions on improvements to facilities	350	261	241	242
Instructions on health and safety efforts	1,057	1,264	1,311	1,030
Other instructions	15	16	2	12
Instructions issued, total	*4,876*	*4,654*	*4,333*	*3,403*
Recommendations on improved health standards	507	474	331	240
Recommendations on improved safety measures	557	459	367	199
Recommendations on improved facilities	79	82	53	35
Recommendations on improved facilities	489	513	274	175
Other recommendations	1	6	2	11
Recommendations, total	*1,633*	*1,534*	*1,027*	*630*
Instructions and recommendations, total	**6,509**	**6,188**	**5,360**	**4,033**
Per diem fine threats	2	9	21	28
Per diem fines decisions	0	2	1	2
Use/work prohibited	69	88	85	75
Measures to achieve compliance, total	**69**	**90**	**86**	**77**

Source: Administration of Occupational Safety and Health.

Most often, or in 81% of inspections, the inspectors gave instructions for improvement, which are then followed up on by the Administration of Occupational Safety and Health. The employer is obliged to ensure that the Administration of Occupational Safety and Health is notified of improvements, but if no such notification is received despite reminders by the Administration, it takes actions of enforcement. Instructions on safety were the most common, 40% of all given instructions. Nearly 30% of instructions given were about risk assessments, the election of safety representatives and safety managers and their education and training.

Instructions given by the safety inspectors decreased by 21% and recommendations decreased by 39% between the years 2010 and 2011. Generally or in 84% cases the safety inspectors gave instructions on improvements that were followed systematically by the Administration of Occupational Safety and Health. The most common instructions were on security or 35 % of all instructions given in the year 2011.

The number of per diem fine threats almost doubled in 2010 from the year 2009. Employers respond most often quickly to these letters, consequently per diem decisions are not often taken. In 2010, a per diem fine was only once imposed.

The Administration of Occupational Safety and Health has kept companies with 30 or more employees under special surveillance with the goal of increasing the number of companies that fulfill their obligation to appoint safety representatives and a safety guards at their workplace. In 2010, 60−70% of companies with 30 or more employees fulfilled their

obligations while approximately 40% of companies with 30 or fewer employees fulfilled their obligations regarding safety representatives and a safety guards.

In 2010, the Administration of Occupational Safety and Health handled two cases where there were complaints regarding Chapter IX of the Act on Working Environment, Health and Safety in Workplaces on Rest time, Holidays and Maximum Working Hours and decision was taken in three cases (one case was from 2009). After a closer investigation, the Administration of Occupational and Health came to the conclusion that two companies had not violated the Working Hour clause and in one case the conclusion was that the company had violated the Working Hour clause and was appointed to make improvements immediately.

The following table shows the division of health and safety inspection issues.

Table 5. Safety and health categorized according to inspection issues in 2008–2010.

	Number of instructions				**Number of recommendations**			
Health and safety inspection issues	**2008**	**2009**	**2010**	**2011**	**2008**	**2009**	**2010**	**2011**
Chemicals and chemical effects	562	490	431	419	204	185	130	72
Psychosocial working environment	30	19	18	22	16	3	4	3
Noise	37	38	46	43	36	37	22	21
Air quality inside	219	238	208	196	94	89	45	25
Carcinogenic substances	3	0	2	3	5	4	1	0
Biological risk agents	12	1	3	1	10	0	11	0
Lighting	93	86	57	41	29	39	32	14
Vibration	1	0	0	1	1	0	0	0
Workstations- physical strain /ergonomics	139	134	132	101	31	37	32	21
Work space	199	186	120	94	81	80	54	53
Total	**1,295**	**1,192**	**1,017**	**920**	**507**	**474**	**331**	**210**

Source: Administration of Occupational Safety and Health.

In 2010, the number of instructions on health and safety issues were reduced by 15% and recommendations by 30% compared to the year 2009. In 2009, instructions and suggestions regarding occupational health were mostly given in the field of chemical and chemical effects (10%), workers facilities (5,5%), air quality inside (4,7), work space (3,2%), workstations-physical strain/ergonomics (3,1%) which is similar to previous years.

Psychosocial working environment.
The Administration of Occupational Safety and Health received 11 formal complaints about alleged bullying in the workplace. The Administration of Occupational Safety and Health then sought to provide relevant information and instructions in this regard. When such complaints are received, the Administration of Occupational Safety and Health has a meeting with the workplace´s managers and safety representatives to ensure preventive measures that promote good psychosocial working environment, including a risk assessment and a response plan when bullying occurs.

In 2010, the Administration of Occupational Safety and Health gave 13 instructions on grounds of lack of risk assessment on psychosocial working environment factors or because

of lack of adequate response plan to employees' complaints about bullying according to Regulation on measures against bullying in the workplace, No. 1000/2004.

Machinery and Equipment inspections.
One aspect of the supervision of the Administration of Occupational Safety and Health is inspections of machinery and equipment. The Administration of Occupational Safety and Health examines various safety equipment, such as brakes, steering controls, work lights, structure, etc. The following tables show the number of machines and equipment registered and inspected by the Administration of Occupational Safety and Health.

Table 6. Total number of registered machinery and equipment in 2008–2011.

	2008	**2009**	**2010**	**2011**
Machinery (67 categories of variable machines)	19,899	19,133	18,573	18,464
Ski lifts (3 categories)	54	56	56	49
Passenger and goods lifts (5 categories)	2,673	2,752	2,839	2,927
Car lifts (2 categories)	1,306	1,346	1,398	1,443
Boilers and compressed air containers	640	638	634	641
Total	**24,572**	**23,925**	**23,500**	**23,524**

Source: Administration of Occupational Safety and Health.

Table 7. Inspections on machinery and equipment in 2008–2011.

	2008	**2009**	**2010**	**2011**
Regular inspections	12,782	12,374	11,568	11,906
Re- inspections	587	444	168	177
other inspections	1,835	2,117	1,616	1,498
Total	**15,204**	**14,935**	**13,352**	**13,611**

Source: Administration of Occupational Safety and Health.

Table 8. Measures taken due to non-compliance involving working machinery and equipment in 2008–2011.

	2008	**2009**	**2010**	**2011**
Full approval- without remarks	11,766	11,516	10,895	11,061
Half approval	1,603	1,302	1,086	1,283
Use prohibited	1,832	2,112	1,369	1,267
Sealed	3	5	2	0
Total	**15,204**	**14,935**	**13,352**	**13,611**

Source: Administration of Occupational Safety and Health.

"Half approval" in table 8 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. Each year, 24–33 general courses are held for safety shop stewards and security guards, managers, foremen and groups of employees. Tables 9 and 10 show the number of courses held by the Administration of Occupational Health and Safety and the number of participants attending them.

Table 9. Number of courses and participants in courses for workers´ safety representatives and safety managers in 2008–2011.

Year	Courses	Participants
2008	24	292
2009	26	316
2010	33	421
2011	27	413

Source: Administration of Occupational Safety and Health.

According to the Act on Working Environment, Health and Safety at the Workplace and Regulation on the organization and implementation of health and safety at workplaces, the employer shall be responsible for having a special risk assessment made, in which the risks involved in the work shall be evaluated with regard to the safety and health of the workers and the risks in the working environment. The following table shows the number of risk assessment courses.

Table 10. Risk assessment courses and number of participants in 2008–2011.

Year	Number of courses	Number of participants
2008	16	151
2009	10	96
2010	14	150
2011	19	261

Source: Administration of Occupational Safety and Health.

Certification courses for machine management are regularly held by the Administration of Occupational Safety and Health. The following table shows the number of machine management certification courses.

Table 11. Certification courses in 2008–2011.

Certification 2011	2008		2009		2010		2011	
Machine operation courses	**Course**	**Particip**	**Course**	**Particip**	**Course**	**Particip**	**Course**	**Particip**
Machine operation	47	897	33	574	56	641	39	578
Construction crane operation	4	66	2	14	1	10	1	6
Other courses	40	590	38	443	41	523	47	923
Total	**91**	**1,553**	**73**	**1,031**	**98**	**1,174**	**87**	**1,507**
ADR courses								
Basic course	9	83	8	67	10	63	10	83
Cont. Education	11	76	9	53	7	43	11	94
Advanced course	15	90	14	75	16	57	18	89
Cont. Edu. for advanced course	14	69	16	58	12	39	19	101
Total	**49**	**318**	**47**	**253**	**45**	**202**	**58**	**367**

Source: Administration of Occupational Safety and Health.

Initative projects of the Administration of Occupational Safety and Health.

***Year 2008*.**

A targeted occupational safety campaign is mounted every year. The focus in 2008 was on risk assessment in the workplace, an issue addressed by the European Week for Safety and Health at Work. The goal was twofold; to draw attention of the importance of risk assessments for all workplaces, without exemptions and; to increase the knowledge of employers, employees and everyone involved in the design and organization of workplaces on the importance of assessing the risks of various jobs and the work environment in the workplace. Awards were given to companies who had adopted effective preventive measures that were considered to be exemplary. Furthermore, the Administration of Occupational Safety and Health sent encouragement letters to companies employing 100 or more employees with a list of action ideas in connection with the aims of the week and a brochure covering health and safety practice in the workplace including a special presentation of the safety representative system. During the week the Administration of Occupational Safety and Health's safety inspectors also visited selected workplaces in order to draw particular attention to risk assessment making and preventive measures in workplaces. Posters, checklists and various educational materials were distributed.

All Nordic Administrations of Occupational Safety and Health decided to cooperate on coordinated marked surveillance on ladders used in workplaces. In Iceland, inspectors visited companies producing, selling and renting ladders to inspect whether ladders were in compliance with standards ÍST EN 131-1:2007 and ÍST EN 131-3:2007.

In 2008, construction companies' headquarters were visited throughout the country. The purpose of the visits was to meet with managers, safety managers, safety committees and safety representatives of those companies to review the companies' security and safety issues. A special form with 15 questions was made along with additional information relating to the management of security and safety issues, education and training, etc. The Administration of Occupational Safety and Health met with managers and aforementioned occupational safety

representatives in 32 companies with 162 active temporary workplaces.

The Administration of Occupational Safety and Health took an active part in one of the first actions taken by the government as a reaction to the financial crisis. Materal was put on its website and lectures given on the responses of workplaces from the standpoint of occupational health and safety. The Administration of Occupational Safety and Health also participated in joint operations with the Directorate of Health and The Public Health Institute of Iceland.

Year 2009.

In 2009, as in the year before, the European Week for Safety and Health at Work was focused on the making of risk assessment for all companies. The risk assessment is done to strengthen occupational safety work in companies with clear responsibility and activity of employers, managers and systematic involvement of employees with the help of safety representatives and safety managers. Awards were given to companies that made exemplary risk assessments.

The Administration of Occupational Safety and Health continued to take active part in the government's first actions as a result of the financial crisis by putting out information and reference material on the institution´s website. The Administration of Occupational Safety and Health gave lectures on responses of workplaces from the standpoint of occupational health and safety as well as participating in joint operations with other government organizations. The specialists at the Administration of Occupational Safety and Health gave lectures on the impact of economic hardship on health and wellbeing of employees. The lectures were based on the results of studies submitted in March 2009.

In the autumn of 2009, the Administration of Occupational Safety and Health, decided to focus on monitoring building maintenance's. A major shift occurred in the construction industry as there was a significant decrease in the construction of new buildings. Instead, there was an increase on projects related to maintenance as the government encouraged such projects. A decision was made to map out maintenance work carried out in Reykjavík.

In September 2009, a letter was sent to 2,700 employers and managers. The letter contained an introduction of risk assessment and employer's responsibilities in that context, it also contained an introduction of the European Week for Safety and Health at Work. The letter introduced the safety representative's system. A great awakening in occupational safety issues was caused by the letter, and the number of announcements of new safety representatives and safety managers to the Administration of Occupational Safety and Health increased significantly.

Year 2010.

In the spring 2010, a decision was made to map out the maintenance work carried out in the whole country.

The occupational safety campaign in connection with the European Week for Safety and Health at Work focused on **safe maintenance and the best and safest ways in maintenance.** Maintenance is an essential element in the workplace, but maintenance work can be dangerous for employees carrying it out. **The** aim of the week was to promote interest in safe maintenance in order to make the workplace healthier and safer. The Administration of Occupational Safety and Health made a special brochure on safe maintenance. During the week, companies all across the country were visited by inspectors delivering posters and

brochures on safe maintenance. The opportunity was used to discuss maintenance with companies' representatives and how such work should be carried out for the safety of employees, risk assessment, the selection of equipment and requirements for sub-contractors, etc.

Collaboration began with one of the Icelandic insurance companies, VIS Insurance Ltd. (*Vátryggingafélag Íslands hf.*), about preventive measures. A conference was held on risk assessment and incident registrations, focusing on municipalities and farms. Representatives of different companies introduced their way of incident registration and risk assessment.

The Administration of Occupational Safety and Health has begun collaborating with representatives of various interest groups and unions, similar to the British "Partnership" model. Occupational safety issues are addressed on a broad basis by group representatives who introduce their occupational safety work and its success. This helps interest groups and their representatives to establish improvements in occupational safety for their members. They get help and assistance from the Administration of Occupational Safety and Health if requested.

In the autumn of 2010 a circular was sent to municipalities on their obligations to make risk assessments and prevention plans for their workplaces according to the Regulation on the organization and implementation of health and safety at workplaces. The Regulation stipulates a clearer demand on employers with regards to systematic occupational safety work. A survey was made amongst municipal representatives on the status of risk assessments at their workplaces. In 40% of municipalities, a risk assessments had been done for all their workplaces or were well underway. In 60% of them, little or nothing had been done in this context. In the winter 2010, the Administration of Occupational Safety and Health put special emphasis on following up on this with the municipalities concerned.

Initiative was carried out on hazardous substances movement surveillance in partnership with the Police School, Reykjavik Police Traffic Department, Icelandic Road Administration and the Road Accident Analysis Group.

Iceland also participated in Senior Labor Inspector Committee's occupational safety week on hazardous substances in workplaces. The objective of this project was to assist companies in preparing for chemical risk assessment and to simplify that operation. The campaign was directed at certain professions. Cleaning services and auto repair services were chosen in Iceland. A total of 163 companies in these sectors were chosen to be involved in the project. The execution was basically the same in both professions. The project was divided into two parts; firstly, companies received information on how to make chemical risk assessment and information on where supplementary material on chemical hazards in the profession could be reached. Secondly, a follow up was carried out where companies were visited and advised if needed. A survey was conducted and it reflected the priorities in the project and inspectors gave the rating of "satisfactory, good and outstanding", according to company performances. The survey showed clearly that treatment of chemicals in these sectors could be improved by for example using of Safety Data Sheets, using personal protective equipment and conduct in the workplace. In both these sectors, use of hazardous substances has decreased significantly.

Year 2011.

The European Week for Safety and Health at Work in the year 2011 focused on safe maintenance as in the previous year. A safety campaign is mounted every year in connection

with the European Week for Safety and Health at Work and a conference was held in Iceland with the main focus on systematic preventive maintenance of machinery and devices. Methods to diagnose failure in machinery in early stages were presented and how preventive measures could be used before the equipment breaks and causes physical damage or financial.

The Administration of Occupational Safety and Health collaborated with representatives from various groups in the year 2011 on numerous project related to safety and health at work. It worked on major accidents prevention policy in collaboration with the Environment Agency of Iceland, Iceland Construction Authority, **Civil Protection and Emergency Management in Iceland and the** Capital District Fire and Rescue Services.

In 2010, collaboration began between one of the Icelandic insurance companies, VIS Insurance Ltd. (*Vátryggingafélag Íslands hf.*) and the Administration of Occupational Safety and Health in preventive measures. As a part of the aforementioned collaboration between VIS Insurance Ltd. and the Administration of Occupational Safety and Health, a conference was held in February 2011, where the main focus was on safety matters regarding seafarers, farmers, safety in the food industry and fire prevention in work places.

Accidents at work.
The total number of work accidents on land dropped from 1,849 in 2008 to 1,329 in 2010 but rose again up to 1,521 2011. The number of call-outs due to accidents decreased over 50% in 2009. The explanation is *inter alia* a sharp decline in the construction industry in 2008 and 2009, where the greatest number of accidents has been in the past.

During the period from 2007 to 2010 reported work accidents in the construction and maintenance sector declined about 80%. That can also explain why the table also shows that reported work accidents did not decline for women as it did for men.

Table 12. Number of work accidents on land in 2008–2011.

	Total	Men	Women
2008	1,849	1,362	487
2009	1,350	930	420
2010	1,329	855	474
2011	1,521	996	525

Source: Administration of Occupational Safety and Health.

When the position of the workers exposed to work accidents is observed, it is still apparent that work accidents are prevalent among uneducated workers. Out of all the workers exposed to work accidents, 50% are uneducated workers. The Administration of Occupational Safety and Health considers it important to strengthen training for this group of workers and focus on bettering the working environment for it.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 271.
The committee asks to be kept informed of measures taken to reduce the number of accidents in the construction sector.
As previously mentioned, construction companies' headquarters were visited throughout the country in 2008 with the aim of reviewing the companies' security and safety issues. The Administration of Occupational Safety and Health met with managers and occupational safety representatives in 32 companies with 162 active temporary workplaces.

Reported work accidents in the construction sector have decreased in the recent years; 599 work accidents were reported to the Administration of Occupational Safety and Health in 2007; 380 work accidents were reported in 2008; 162 work accidents were reported in 2009; 129 work accidents were reported in 2010 and; 86 work accidents were reported in 2011.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 271.
It further asks that the next report produces a standardized incident rate of accidents, more specifically of those involving a three days' absence.

According to Art. 78 of the Act on Working Environment, Health and Safety in Workplaces, the employer shall, without undue delay, inform the Administration of Occupational Safety and Health of all accidents in which a worker dies or becomes incapable to work for one day or more in addition to the day on which the accident occurred. Furthermore, the employer shall record all accidents that occur in the workplace and result in the death or the incapacity of a worker for one day or more in addition to the day on which the accident occurred. The employer shall also record mishaps that occur in the workplace which could cause accidents.

Unfortunately, no record is kept of the rate of those accidents involving a three days' absence.

Table 13 shows the numbers of persons injured in accidents on land, by occupation. It reveals, amongst other things, that most were injured when working in the construction and maintenance industries, and large numbers of injuries also occurred in metalworking, machine work, shipbuilding and ship repairs and fish-processing and freezing.

Table 13. Number of persons injured in 2008–2011, by occupation.

	2008		2009		2010		2011	
Occupation	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Aluminium and ferro-silicon production	30	6	27	2	31	8	30	3
Automobile trades	12	0	11	2	18	0	13	1
Construction and maintenance	377	3	159	3	117	3	86	0
Construction and maintenance, other	8	1	6	0	3	2	3	0
Chemical industry	7	3	6	3	9	3	7	5
Operation of real estate and business services	34	17	26	18	15	18	25	12
Fish-processing and freezing	41	34	44	20	51	32	80	53
Fishing	4	0	1	0	4	0	1	1
Transport, etc.	95	19	77	11	89	18	71	8
Public works	23	1	22	3	18	6	11	2
Primary schools	3	29	5	30	5	24	6	27
Road sweeping and rubbish collection	14	1	5	0	4	3	20	2
Wholesaling	60	23	57	14	42	16	34	20
Agriculture	8	7	12	6	14	4	10	6
Food industry (processing of agric. products)	56	14	32	15	30	16	31	9
Food industry (other)	23	10	20	8	25	7	37	8
Metalworking, machine work, shipbuilding and ship repairs	90	1	107	5	81	0	97	5
Cultural activities	12	16	7	17	13	10	5	7
Public administration	126	73	116	51	81	66	147	85
Public services, etc.	22	82	32	102	33	115	27	95
Activities of an unclear nature	90	15	28	9	13	3	15	5
Paper industry	5	3	6	0	5	3	5	0
Financial institutions	2	1	1	5	0	7	1	4
Personal services other than car services	7	3	6	2	4	2	5	1
Electricity, heating and water utilities	27	3	19	3	15	2	17	4
Operation stopped or is temporarily down	7	1	0	0	0	1	0	0
Post and telecommunications operations	31	54	20	50	26	33	27	28
Herring salting and fish meal factories	4	0	1	0	4	0	1	1
Retail trading	34	30	12	12	20	23	18	17
Mineral production and processing	70	4	32	1	20	0	7	1
Woodworking industries	15	0	2	0	12	1	11	0
Insurance	0	3	1	0	1	2	1	4
US Iceland Defence Force and foreign embassy staff	0	0	0	0	0	0	0	0
Textile industry	4	0	2	1	3	1	2	0
Hotel and catering trades	11	20	12	18	12	24	16	18
Other industries and construction	4	0	3	1	8	1	5	0
Total	**1,364**	**491**	**934**	**423**	**847**	**469**	**879**	**433**

Source: Administration of Occupational Safety and Health and The Icelandic Marine Accidents Investigation Board.

Table 14 shows a summary of the number of fatal accidents at work in Iceland in 2008 to 2011.

Table 14. Number of fatal work accidents on land in 2008–2011.

2008	5
2009	3
2010	3
2011	3

Source: Administration of Occupational Safety and Health.

In comparison, in 2005 to 2007, thirteen people had fatal accidents at work on land. The number has been decreasing in the years 2009, 2010 and 2011 and being again almost the same number as it was in the period 2001 to 2004 when it had never been lower or a rate of 2.25 individuals per year. Nevertheless, the Administration of Occupational Health and Safety will continue its work in influencing on that development with the aim to reduce the number of fatal work accidents and work accidents in general.

In 2008, five fatalities in work accidents on land:

1. A delivery van driver died after a collision with a pickup truck. The pickup truck´s driver had fallen asleep after a nightshift.
2. A shipping company employee was loading a cargo ship and got pinched between a container raft and the ship.
3. Two craftsmen working on a power plant went into a tube and died as a result of oxygen deprivation.
4. An electrician, connecting an outside light, fell to the ground. He had been standing on a platform placed on the forks of a forklift.

In 2009, three fatalities in work accidents on land:

1. An air tank capsule was thrown at a guest at a workplace when the air tank was being tested. Examination revealed that no calculations had been done on the air tank´s construction materials, the compressibility or permitted pressure.
2. An intern working on a new building died when a wire of a construction crane lifting a shuttering leave broke and fell on the intern. Examination of the wire revealed corrosion in the wire´s core where it broke.
3. A carpenter fell down nine meters from a roof of an apartment block. No fall protections were on the edges of the roof. No other protections, for example safety belts with an attached line, were used. Scaffoldings by the house were also highly defective.

In 2010, three fatalities in work accidents on land:

1. A contractor company employee fell four meters down, from a working platform to concrete floor when he was steering a laminboard. No guardrails were on the scaffolding.
2. An oven guardian was hit by burning and hot gaseous- and solid materials after an eruption of out of the oven.
3. Lorry driver died when his lorry ended outside the road after his trailer collided with another lorry trailer coming from the opposite direction.

In 2011, three fatalities in work accidents on land:

1. A five year old boy passed away when he got caught in a shaft drive of a vehicle in a barn at a farm at Mýrar in Borgarbyggð. The boy was a guest at the farm.
2. A 72 year old man passes away when working in an excavator in a stone mine. There was a rock-fall high up in the mine that landed on the excavator were the man was sitting in the driving seat.
3. A 41 year old worker at a fish market in Djúpivogur when unloading salt boxes from a cargo ship when a loading crane broke and landed on the man.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 271.

The report states that steps are also envisaged to reduce the number of fatal accidents of workers on land. The committee asked to be kept informed on what measures have been taken.

In 2009, the Administration of Occupational Safety and Health made guidelines for the period 2009−2012. An effort was made to have the goals measureable if possible. The aim should always be that there will be no accidents, however it is considered realistic that in this period the rate of fatalities in work accidents will decrease by 50%, that is from 2,9 to 1,5 for every 100 thousand workers on the labour market. In 2011, fatalities were three, that equals 1,8 for every 100 thousand workers on the labour market. In the years 2010 and 2011 together, the rate is 1,5. The fatalities are so few that it is hardly possible to take that in to account when comparison is made.

In September 2008, following the increase of fatalities in work accidents, the Administration of Occupational Safety and Health sent a letter to all representatives in the construction industry and others that employed foreign workers. In the letter, the representatives were encouraged to organise dynamic training and education program for the workers with a special emphasis on beginners and foreign workers. In 2009, the Administration of Occupational Safety and Health participated in a Nordic project management and a Nordic meeting where the theme was fatal accidents in the Nordic countries in 2003−2008.

Accidents involving seafarers.

Table 15 shows the total number of registered accidents on sea in 2008 to 2010.

Table 15. Total number of registered accidents involving seafarers in 2008–2011.

2008	65
2009	57
2010	62
2011	69

Source: The Icelandic Marine Accidents Investigation Board.

Table 16 shows the types of accidents involving seafarers in 2008 to 2011.

Table 16. Number of inspected accidents that involving seafarers in 2008 -2011.

	2008	**2009**	**2010**	**2011**
Fatal accidents	0	2	1	0
Chemical accidents	0	2	1	1
Falls	21	18	19	23
Man overboard	1	0	0	1
Injured when embarking or disembarking	2	0	0	0
Injured at mooring	3	3	3	2
Injured when loading, unloading, lashing (merchant vessel)	1	1	1	2
Injured when working in hold	0	0	0	0
Accidents caused by surges	2	3	1	4
Injured from falling from a ladder	4	0	0	0
Injured while cleaning	1	0	0	0
Windlass work-something thrown by the windlass	4	3	5	0
Windlass work-pinched while lifting	7	0	0	4
Windlass work-stuck in a windlass	1	4	0	0
Windlass work- a wire breaks	0	1	0	0
Crush injuries	8	10	16	11
Cuts or stings	5	8	9	7
Accidents at fish processing machines	0	1	1	0
Other accidents	5	3	5	11
Got caught in fishing gear	0	0	0	2
Total	**65**	**57**	**62**	**68**

Source: The Icelandic Marine Accidents Investigation Board.

Table 17 shows the number of fatal accidents in 2008–2011.

Table 17. Fatal accidents within the Icelandic continental shelf in 2008–2011.

2008	0
2009	2
2010	1
2011	0

Source: The Icelandic Marine Accidents Investigation Board.

The average of fatal accidents at sea per year has been around three for the period 2001 to 2009. Two fatal accidents occurred at sea 2009. A diver drowned in the fjord Hvalfjörður after sea urchin fishing. A seaman died when a boat was hit by a surge and capsized. One fatal accident occurred in 2010. A seaman died when he was hit by an uploading chain that swept him to sea.

Occupational diseases.

Table 18 shows notifications of occupational diseases on land in 2008–2011.

Table 18. Notifications of occupational diseases in 2008–2011.

2008	11
2009	4
2010	7
2011	8

Source: Administration of Occupational Safety and Health.

Table 19 table shows the causes of occupational diseases in 2008–2011.

Table 19. Causes of occupational disease in 2008–2011.

	2008	**2009**	**2010**	**2011**
Acute toxicity	2			2
Long-term toxicity	1			
Severe infection	2			
Humidity and mold damage in workplaces	4			
Dust pollution	1			
Work related attack	1			
Asthma and Hypersensitivity		3	3	
Psychosocial work environment		1		
Infectious disease in healthcare			4	2
Allergy				4
Total	**11**	**4**	**7**	**8**

Source: Administration of Occupational Safety and Health.

The difference between the numbers in table 18 and 19 is explained by the fact that after a detailed enquiry, it became clear that no connection was between a disease and work in one case both in 2009 and 2010.

In 2008, 2009 and 2010, the Administration of Occupational Safety and Health encouraged all those who made risk assessments for establishments and healthcare employees to familiarize themselves with the EU's list of occupational diseases.

In 2009, three notifications involved hypersensitivity in workplaces. All of them are well known to cause occupational diseases in professions, i.e. hypersensitivity to chemicals used in hair salons, wheat allergy and hypersensitivity to chemicals used in health care.

The same year, the Administration of Occupational Safety and Health published instructions on work-related health inspections, and how to report and register accidents, occupational and work-related diseases.

In 2010 four notifications were connected to infectious diseases in healthcare, three of them involved tuberculosis and in one case of hepatitis C. Three cases involved asthma and hypersensitivity

A better occupational disease registration system was adopted in May 2011 with a Regulation on notifications and registration of occupational diseases, No. 540/2011.

Article 3, para 3 – Consultation with employers' and workers' organization on questions of safety and health.

Comment by the committee of Independent Experts.
Conclusions XIX-2(2009) , p. 272.
The committee asks that any changes having taken during the reference period in the next report.
The Government confirms there has no changes have been adopted and a reference is made to the previous reports.

Article 11
The right to protection of health

Article 11, para 1- Removal of the causes of diseases.
The Icelandic healthcare service's role is to improve the general health of the nation. All people living lawfully in Iceland have the right to receive state-of-the-art healthcare irrespective of their gender, religion, political views, age, national origin, colour, economic circumstances, origin and position. This entails that the healthcare services that are accessible for people must be as good as possible and must be of a comparable standard for all. In order to meet the aims of the services, all inhabitants in Iceland must be ensured equal access to efficient healthcare services and must be provided easy and direct access to the services.

The Government of Iceland has always emphasized the importance of providing an effective universal health care services, the promotion of healthier lifestyles, a strong insurance system and secure housing. A healthy welfare system and the struggle against long-term unemployment are important prerequisites for successful social reconstruction and that the most urgent task of welfare services and the guiding principle determining prioritisation after the financial crises should be to protect the situation of children and their families, together with those persons who are most vulnerable in the community. The government therefore regarded it as top priority to ensure that the consequences of economic contraction would not threaten families and individuals with losing their homes.

In 2010, total health expenditure as a share of GDP was 9.3%. In 2011, total health spending accounted for 9.0% of GDP and 80.4% of health spending was funded by public sources.

Table 20. Public expenditure on health in 2008–2011, % of GDP.

2008	2009	2010	2011
7.5	7.9	7.5	7.1

Source: OECD factbook statistics

Table 21. Private expenditure on Health in 2008–2011, % of GDP.

2008	2009	2010	2011
1.6	1.7	1.8	1.8

Source: OECD factbook statistics

Life expectancy at birth continued to increase in the reference period.

Table 22. Life expectancy at birth in the reference period.

	2008	2009	2010	2011
Total	81.3	81.5	81.5	81.8
Men	79.6	79.7	79.5	79.9
Women	83.0	83.3	83.5	83.6

Source: OECD factbook statistics

In 2011 life expectancy at birth was 81.8 years, 79.9 years for men and 83.6 years for women. This means that the life expectancy gap between the genders is less than four years and is among the lowest in the world.

Infant mortality was also with the lowest in the world and continued to decline down to 0.9 per 1000 population in 2011.

Table 23. Infant mortality per 1000 live births in the reference period.

2008	2009	2010	2011
2.5	1.8	2.2	0.9

Source: OECD factbook statistics

Age-standardised per 100,000 population mortality rates from all causes of death in 2010 were 604 with males, 422 with females with a total of 507. The decline in mortality rates from all causes from 1995–2010 is 29.

In 2011, Iceland had 3.5 practising physicians per 1000 population, compared with an average of 3.2 in OECD countries. Iceland also had 14.8 nurses per 1000 population, compared with an OECD average of 8.7. The number of CT and MRI scanners in Iceland, more than doubled between 2000 and 2011, rising from 6 CT scanners to 13, and 3 MRI scanners to 7.

Legislative amendments in the field of healthcare services.

Act on Dental Care, No. 38/1985.

The Act on Dental Care was amended three times in the reference period:

1. *Act No. 38/1985 was amended with Act No. 12/2008.* With this amendment, the responsibility of issuing licenses to health care professionals was moved from the Ministry of Health to the Directorate of Health.

2. *Act no. 38/1985 was amended with Act No. 162/2008* uniting the Ministry of Health and the Ministry of Social Affairs and Social Security into the Ministry of Welfare. This new Ministry became responsible for the implementation of the Act on Dental Care.

3. *Act No. 38/1985 was amended with Act No. 126/2011.* The amendment did not make substantive changes to the Act.

The Healthcare Services Act, No. 40/2007.

The Healthcare Services Act was amended six times in the reference period:

1. *Act No. 40/2007 was amended with Act No. 160/2007.* According to this new legislation which entered into force on 1 January 2008 the responsibility and supervision of the social pension scheme and state social assistance was transferred from the Ministry of Health and Social Security to the Ministry of Social Affairs. The two Ministries were given new names accordingly, the former was named the Ministry of Health and the latter the Ministry of Social Affairs and Social Security. The objective of this division of responsibilities between the Ministries was to streamline and simplify the administration as well as to put related fields under one command. The objective was also to make the arrangements in the healthcare and insurance system more accessible and easier to understand for the public.

2. *Act No. 40/2007 was amended with Act No. 12/2008.* With this amendment, the responsibility of issuing licenses to Health care professionals was moved from the Ministry of Health to the Directorate of Health.

3. *Act No. 40/2007 was amended with Act on Health insurance No. 112/2008.* With this amendment, the Healthcare Services Act was amended in accordance with Act on Health Insurance to ensure the effective exercise of rights provided under the Act on Health Insurance.

4. *Act No. 40/2007 was amended with Act No. 59/2010.* A provision on health care centres was amended providing a clear obligation for chief executives and executive boards of healthcare facilities to consult with the professional heads of healthcare centres when matters specifically concerning the centres are to be decided.

4. *Act No. 40/2007 was amended with Act No. 162/2010.* The Ministry of Health and the Ministry of Social Affairs and Social Security were united into the Ministry of Welfare. This new Ministry became responsible for the implementation of the Act on Healthcare Services.

5. *Act No. 40/2007 was amended with Act No. 126/2011.* The amendment did not make substantive changes to the Act.

The Chief Medical Officer and Public Health Act, No. 41/2007.

1. *Act No. 41/2007 was amended with Act. No. 12/2008.* With this amendment, the responsibility of issuing licenses to health care professionals was moved from the Ministry of Health to the Directorate of Health.

2. *Act No. 41/2007 was amended with Act. No. 112/2008 on Health insurance.* In this context, the amendment was made to ensure the surveillance authority of the Chief Medical Officer over the Icelandic Health Insurance. The Chief Medical Officer has the responsibility to evaluate whether the prospective operation of a health service meets professional standards and other conditions of health legislation. The Chief Medical Officer also has the obligation to maintain a register of operating parties in health service, and to notify the Minister and the Icelandic Health Insurance of all changes to the register. When the Icelandic Health Insurance gathers data in the field of health it is responsible for providing the Chief Medical Officer with access to the data gathered in their work, which is necessary in order to maintain health registers or in order to carry out monitoring.

3. *The Act No. 41/2007 was amended with Act. No. 162/2008.* The Ministry of Health and the Ministry of Social Affairs and Social Security were united into the Ministry of Welfare. This new Ministry became responsible for the implementation of the Chief Medical Officer and Public Health Act.

4. *Act No. 41/2007 was amended with Act No. 126/2011.* With this amendment, the Chief Medical Officer and the Public Health Institute were merged into one institution, i.e. the Directorate of Health. Reference is made to the discussion under paragraph 2 and the discussion on the work of the institutions. This amendment entered into force 1 January 2011.

6. *Act No. 41/2007 was amended with Act No. 126/2011.* The amendment did not make substantive changes to the Act.

The Act on Health Insurance, No. 112/2008.

The Act on Health Insurance was passed on 16 September 2008. The objective of the Act is to ensure the access of health-insured persons to the most advanced medical care possible at any time regardless of their financial status. In short, the Act defines who has health insurance in Iceland. The Act also defines the right itself, i.e. what services and benefits individuals are entitled to, who evaluates and meets these rights. It defines who ensures the processing of benefit applications and for access to health care. The Act is based on the Health Insurance chapter in the Social Security Act No. 100/2007. The content of the rights are unchanged, but put forward in a clearer and more accessible way for the public. Moreover, health insurance is defined in more detail than it was in the Social Security Act. These definitions take into account the provisions of the EEA Agreement on Social Security. The Act stipulates an establishment of a new institution, the Icelandic Health Insurance, and describes its functions. The institution has two main roles, i.e. to be responsible for the execution of health insurance for individuals, that is to make decisions on individual rights to governments funded health care and benefits under the Act, and to ensure access to health care services by negotiating health care services on behalf of the Minister with private or public entities.

The Act on Health Insurance was amended eight times in the reference period:

1. *Act No. 112/2008 was amended with Act No. 173/2008*. The Act provided a legal basis for a fee for hospitalization covering the costs of admission and facilities. The amount of the fee is lower for children, the elderly and persons with disabilities. The fee can only be charged once per each hospitalization or stay at a hospital. The Act prohibits other charges for indwelling patients and prohibits fees for birth related hospitalizations. These fees fall under the maximum contributions for health care for individuals.

2. *Act No. 112/2008 was amended with Act No. 55/2009 (The Health Records Act)*. The four main objectives of the Act were:
   a. To provide a comprehensive legal basis for the duty to enter health records, rules on health record storage and access to medical records and information.
   b. Stipulate in a clearer way the health care workers' duty to enter health records when a treatment is provided.
   c. To strengthen the legal base for individual autonomy when it comes to entering and handling medical files.
   d. To provide legal basis for interconnection of electronic medical record systems to make it possible to share medical information electronically in a fast and secure manner for the treatment of the patient.

   With regard to the Act on Health Insurance, this Act introduced a provision stating that healthcare professionals responsible for the safeguarding of medical records are required to provide medical doctors or, as the case may be, the appropriate healthcare practitioners of the Icelandic Health Insurance, with the information and data that the Icelandic Health Insurance needs to perform its monitoring role.

3. *Act No. 112/2008 was amended with Act No. 121/2009*. The Health Insurance Act states that the Icelandic Health Insurance has the responsibility to ensure access to health care services by negotiating health care services on behalf of the Minister with private or public entities. Temporary provisions in the Act allowed the Minister to determine with regulations the per diem rates for health services provided in the nursing facilities of hospitals, the nursing facilities of geriatric institutions and nursing homes until 1 January 2011.

4. *Act No. 112/2008 was amended with Act No. 131/2009*. The Act provides a legal basis for government charging for a stay at a patient hotel. Patient hotels provide a service, which the government is not obliged to provide, but can be necessary for individuals in treatment or examination who cannot stay at home for reasons relating to distance or home situation.

5. *Act No. 112/2008 was amended with Act No. 147/2010.* Another temporary provision was introduced into the Act allowing the Minister to determine with regulations the per diem rates for health services provided in the nursing facilities of hospitals, the nursing facilities of geriatric institutions and nursing homes until 1 January 2012.

6. *Act No. 112/2008 was amended with Act No. 162/2010.* The Ministry of Health and the Ministry of Social Affairs and Social Security were united into the Ministry of Welfare. This new Ministry became responsible for the implementation of the Act on Health Insurance.

7. *Act No. 112/2008 was amended with Act No. 126/2011.* The amendment did not make substantive changes to the Act.

8. *Act No. 112/2008 was amended with Act No. 155/2011.* Temporary provisions provided for by this Act allowed the Minister to determine with regulations the per diem rates for health services provided in the nursing facilities of hospitals, the nursing facilities of geriatric institutions and nursing homes until 1 January 2014.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 273.
The Committee asks that the next report indicate what these "other professional criteria" are and also provide an up-dated summary of the actual length of waiting times for different types of treatment.
Other professional criteria.
"other professional criteria" includes e.g. social circumstances. Social circumstances play for example a role in the assessment of the elderly when applying for admission to a nursing home, but strict assessment regulations are in place in the country.
Updated summary of waiting times for different types of treatment.
The Directorate of Health collects, monitors and disseminates information on waiting times with special emphasis on monitoring the number of patients waiting three months or longer for services, as well as estimated waiting time. This is done three times a year. The latest information on waiting lists can be found at the Directorate of Health website.[12]

Article 11, para 2 - Advisory and educational facilities.
The Public Health Institute.
Under the Healthcare Services Act, the Public Health Institute and the Directorate of Health were in 2011 merged into a new institution, i.e. the Directorate of Health. Corresponding amendments were made to the name of the Act. The Act states that the Chief Medical Officer shall appoint expert councils dealing with the principal fields of concern to the Directorate, e.g. prevention of alcohol and drug abuse and tobacco control, comprising of experts and representatives of agencies and organizations in the relevant field. The expert councils shall provide advice to the Chief Medical Officer.

The Act also states that a Public Health Fund shall be operated, whose role is to support public health work in accordance with the objectives of the Act, whether within the Directorate or outside of it. The board of the Public Health Fund makes allocations from the Fund in accordance with the provisions of regulations issued by the Minister. The Fund's board is comprised of seven people: four nominated by expert councils, two appointed by the Chief Medical Officer, and a chair, appointed by the Minister.

Health-enhancing work of the Chief Medical Officer.
Physical activity.
The aim of this initiative is to combat sedentary lifestyles and to promote physical activity for people of all ages. This is done by taking into consideration many factors that affect daily physical activity, including traveling, work, school, at home and leisure time. The Directorate of Health serves the role of being a professional consultant to the Government with regard to physical activity and provides recommendations concerning physical activity in collaboration with key experts in the field of physical activity. The office is a member of HEPA Europe, the European Network for the Promotion of Health-enhancing Physical Activity. HEPA works closely with the European Office of the World Health Organization. The Directorate of Health produces educational material and other material on physical activity and places emphasis on creating conditions that encourage physical activity in close cooperation with relevant stakeholders such as ministries, municipalities, organizations, businesses, schools and organizations. The Chief Medical Officer monitors the development of the physical activity habits in cooperation with other Nordic countries and has collected data on that subject, e.g. in relation to the national survey "Health and wellbeing Iceland" (i. *Heilsa og*

[12] www.landlaeknir.is/servlet/file/store93/item4301/Biðlistar%20júní%202013-lokaskjal.xls

líðan Íslendinga).

Alcohol.
The activities of the Directorate of Health in the field of alcohol and drug abuse prevention consist of health-enhancing work, collecting and sharing information and providing research grants from the Public Health Fund. The Directorate of Health is a centre for drug abuse prevention in Iceland and as such provides professional advice on policy, research and other issues related to alcohol and drug abuse. The office produces educational material about alcohol and drugs for professionals and the public. The main objective of the work in this field is to prevent young people from starting to use legal or illegal intoxicants and to reduce or minimize the damage that the consumption of intoxicants has on individuals, families and communities. The office conducts surveys on alcohol and drug abuse among the population. Statistics are also collected to indicate the status of these issues in Iceland and the damaging consequences of alcohol and drug consumption. The office works in collaboration with foreign and domestic research institutes, universities and health institutions at the research of alcohol and drug abuse prevention. The office also promotes the cooperation and coordination of work amongst those who work on drug abuse prevention.

Mental Health.
The activities of the Directorate of Health in the field of mental health are divided into projects concerning education, counseling and research, as well as various other projects. The aim of the work is to promote better mental health and to increase well-being among the Icelandic population. Emphasis is put on enhancing public and governmental knowledge in the mental health field as well as knowledge on the factors that contribute to good mental health. Moreover, emphasis is put on promoting mental health and communicational skill training in schools and workplaces. The Directorate aims to provide mental health programs for all ages. These programs can be used in schools, in the healthcare sector, within companies and among the public. The Directorate of Health also conducts research on mental health and the well-being of children and adults. The office works in cooperation with domestic and foreign researchers in the field of mental health and is a professional consultant on mental health to Government.

Nutrition.
Activities of the Directorate of Health in the field of nutrition consist of providing education, counselling and health-research. The main objective of the work in this field is to promote a positive development of the diet of the population in accordance with recommendations on diet and nutrients. The Directorate works on educational material on nutrition for all age groups: pregnant women, children, teenagers and young people, adults and the elderly. This material is intended for use in schools, in the healthcare sector, within companies and for distribution to the public in general. The Directorate of Health performs research on the nation’s diet and works in cooperation with domestic and foreign research institutions, universities and research in nutrition and health. It furthermore collects statistics on consumption and sale of food in the Iceland each year. The Directorate is also a professional consultant to authorities. The Directorate of Health works with schools, businesses, organizations and associations to promote the maintenance of a nutritious diet among the nation.

Violence and accident prevention.
The Directorate of Health is the centre for violence and accident prevention in Iceland. The office promotes cooperation among those who work on the field of violence and injury

prevention. The Directorate also works on educational material on violence and injury prevention for professionals and the general public for use in such places as schools, clinics and sports centre. The aim of the work is to reduce the frequency of accidents and violence in Iceland. Furthermore, through education about the consequences of trauma, the Directorate of Health works on preventing the trauma suffered by victims of accidents and violence from developing into chronic health problems. An important factor in the prevention of accidents is collecting information about the prevalence and analysis of risk. The Directorate maintains a centralized database on accidents, allowing for an annual evaluation of the frequency of accidents in Iceland. The main aim of the database is to promote prevention of accidents and provide opportunities for detailed analysis of accidents. Such research work leads to more effective prevention work that promotes a decrease in accidents. For example, great progress has been made in reducing the accident rate for children in Iceland due to a strong effort in prevention in this field in recent years. The Directorate works in collaboration with foreign and domestic research institutes, universities and health research on violence and injury prevention. The office participates in an EU-run project called "JAMIE" (Joint Action Monitoring Injuries in Europe), whose aim is to compare the frequency of accidents and causes of accidents in Europe. The office also participates in the "Decade of Road Safety", a UN-run project which aims to reduce traffic accidents in the next decade.

Dentistry.
The Directorate of Health provides governments, professionals, families and individuals with advice on dental health issues and is responsible for prevention and health promotion programs for all ages. The aim of the work in this field is to promote better dental health of the population through advisement, guidance and educational material in collaboration with national and international health, educational and research institutions.

Tobacco use prevention.
The main emphasis of the work in this field is to prevent young people from starting to use tobacco and to provide greater assistance to those who want to stop using it. The Directorate provides professional advice to the Government on all aspects of tobacco control, the tobacco control policies and new priorities. The aim of the work is to reduce illness and deaths caused by tobacco through a reduction of tobacco consumption, greater protection of people from the effects of tobacco smoke and promotion of the right of all to a second-hand smoke free environment. The Directorate of Health routinely conducts surveys on the extent of tobacco consumption in Iceland. The Directorate also collects other statistics that provide indication of the status of these affairs in Iceland and on the harmful consequences of tobacco consumption and shares this information with the public, professionals and health authorities.

Health Insurance.
Under Article 1 of the Health Insurance, 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 1,000 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 500 for visits to health services or to a GP. Health-insured persons are charged ISK 5,000 for visits to accident or emergency wards, but old age pensioners and disability pensioners are charged ISK 2,600. 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 *inter alia* the cost of registration and cost of medical services and the services of other healthcare workers.

Article 15 of Regulation on the proportional share of health-insured individuals in the cost of healthcare services, No. 1042/2010, with subsequent amendments, lays down the right of health-insured individuals between 18 and 70 years of age to discount cards when the individuals have paid ISK 28,000 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, radio diagnosis, 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 one person. The custodians of children are entitled to a discount card when payments of ISK 8,400 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, radio diagnosis, 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 7,000 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, radio diagnosis, 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 a Primary Health Care Clinic or to a GP pursuant to Article 4 during normal working hours:

   a. For health-insured persons in general: ISK 580.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 500.

2. For a visit to a Primary Health Care Clinic or to a GP pursuant to Article 5 outside normal working hours:

a. For health-insured persons in general: ISK 1,500.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 700.

3. For doctors' visits, i.e. the service of a GP outside of Primary Health Care Clinics during normal working hours:

a. For health-insured persons in general: ISK 1,600.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 700.

c. Children under the age of 18 and children with caretaker cards pursuant to Regulation No. 504/1997 on Financial Aid to the Providers of Disabled Children and Children suffering from Long-Term Illnesses: ISK 0.

4. For a doctor's visit, i.e. the service of a GP outside of the Primary Health Care Clinics outside of normal working hours:

a. For health-insured persons in general: ISK 2,300.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 900.

c. Children under the age of 18 and children with caretaker cards pursuant to Regulations No. 504/1997 on Financial Aid to the Providers of Disabled Children and Children Suffering from Long-Term Illnesses: ISK 0.

5. For visits to the accident ward and the emergency ward of hospitals:

a. For health-insured persons in general: ISK 2,300.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 0.

c. Children under the age of 18: ISK 0.

6. For visits to hospitals on account of hospitalisation:

a. For health-insured persons in general: ISK 3,000.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 1,000.

7. For visits to the outpatient ward of hospitals because of services from others than medical doctors:

a. For health-insured persons in general: ISK 1,540.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 770.

8. For a visit to a hospital day ward pursuant to paragraph 2 of Article 9:

a. For health-insured persons in general: ISK 1,540.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 60–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 770.

9. For a visit to a specialist outside a hospital and to a specialist in the outpatient ward of a hospital:

a. For health-insured persons: ISK 1,540, plus one-third of 40% of the agreed or determined total charges upon arrival which is in excess, however with a maximum of ISK 28,000.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: 1/9 of 3,600 plus 40% of the agreed or determined total charges upon arrival which is in excess, with a minimum, however, of ISK 720 and a maximum of ISK 28,000. For conal surgery, there is a maximum charge of ISK 900.

c. Children under the age of 18 pay 1/9 of 3,600 plus 40% of the agreed or determined total charges upon arrival which is in excess, with a minimum, however, of ISK 460 and a maximum of ISK 28,000, and no charge for a visit to a specialist at the outpatient ward of a hospital.

10. For laboratory tests and for the testing of samples sent for testing to a laboratory:

a. For health-insured persons in general: ISK 820.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension: ISK 310

c. Children under the age of 18: ISK 0.

11. For radio diagnosis, imaging and measurement of bone density:

a. For health-insured persons: ISK 770 and an additional one-third of 40% of the agreed or the determined total charges at arrival for that which is in excess however to a maximum of ISK 28,000.

b. Old age pensioners 70 years and older, disability pensioners, old age pensioners 67–70 years of age who have received disability pension up until the age of 67 and old age pensioners 60–70 years of age who receive full old age pension shall pay 1/9 of the charge that health-insured persons generally pay, i.e. ISK 2,000. However, the minimum shall be ISK 410 and the maximum shall be ISK 28,000.

c. Children under the age of 18: ISK 0.

For visits and revisits to hospital outpatient wards for services other than those of medical doctors where an anaesthesiologist will administer anaesthesia for a surgeon’s operation, the health-insured individual shall pay a maximum of ISK 28,000.

It is permissible to decide that discount card holders must pay the same consultation fee that others pay but will then later get the balance reimbursed through the health insurance against their showing of a doctor's receipt. Fees that are paid at the Primary Health Care Clinics and at the hospital will go to the operation of these institutions. A consultation fee is deducted from a contractual doctor's fee for consultation.

Health education in schools.
Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 274.
The Committee asks that the next report contain up-dated information on sexual and reproductive health topics in the school curricula.
Education on sexual and reproductive health is a compulsory subject in Icelandic schools under the Act on Counseling and Education Regarding Sex and Childbirth and on Abortion and Sterilization Procedures No. 25/1975, with subsequent amendments. The Education authorities shall in consultation with the Chief Medical Officer provide education on sex and sexual ethics in schools at the compulsory school level and this education shall also be provided at other educational levels.

Sex education is a part of the national curriculum with the aim of providing students with comprehensive sex education. The subject matter is adjusted to the students' age and maturity. The role of the school system is of importance in this context in light of the difficulties involved in other means of reaching all young people at various developmental stages. Through systematic instruction and attitude awareness on this subject at school, the aim is to improve the awareness of adolescents with regard to body development, as well as their emotions and communication and that they obtain critical thinking skills to apply to external influences and pressure.

The education is among other things aimed to prevent sexually transmitted diseases, unplanned pregnancies and sexual violence. The Compulsory School Act, No. 91/2008, states that the Icelandic National Curriculum Guide for Compulsory Schools shall *inter alia* stipulate the compulsory school's pedagogical role and general policy in teaching and instructional organization according to the role of the compulsory school. The curriculum itself states that in sixth grade every child shall be able to explain the physical difference between the sexes. By the end of seventh grade every student shall be able to explain different biological development of individuals and sexes, be able to describe changes that come with puberty and be able to recognize the importance of mutual respect in relations between the sexes. By the end of 10th grade every student shall be able to explain how pregnancy begins and the development of foetuses, explain what sexual responsible behavior is and be able to discuss responsibility for their own physical and mental health as well as the health of others. Additionally, the Primary Health Care of the Capital Area has issued guidelines for comprehensive sex education in schools. These guidelines are made for compulsory and secondary schools to instruct schools when educational material is made and selected. These guidelines focus on six specific key issues: the human development process, relationships, culture and community, personal skills, sexual behavior and sexual health.

Counseling and screening.
Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009) , p. 275
The Committee asks that the next report contain up-dated information on counseling and screening for the population at large.

In view of the fact that the Icelandic health care system is organized by the health care authorities and gate keepers are few if any, the population has good access to all health care services like health care centres and hospitals as well as specialist services that the health care system funds (although patients pay a minimum fee themselves) like, psychiatric specialist service, antanatal care, well baby care (including inoculations for communicable diseases), school children health care (including inoculations for communicable diseases), out-patient wards at hospitals, alcohol and drug abuse clinic and counselling, smoking cessation with public telephone advice etc., it can be said that the population has good access to counselling and screening.

Counselling.
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 in Iceland. These centres have the role to provide continuous and comprehensive health care. The services are based on expertise in the field of general medicine, nursing and health protection and are based on interdisciplinary collaboration. The Healthcare Services Act stipulates an obligation for the centres to cover health care of general medicine, nursing, health protection, prevention and emergency. These centres have a role in prevention and counselling in individual cases and in general. A wide range of educational materials is made by the Health care centres, and most often in partnership with others. The Centres hold courses on preparation of birth, on breastfeeding and upbringing. The various educational materials are for example on: pregnancy, birth, breastfeeding, growth and development, families and upbringing, nutrition, dental health, health protection and prevention, illnesses and behavioural problems. Health care centres offer childhood vaccinations as well as influenza inoculations along with inoculations for those travelling abroad.
The Directorate of Health has been providing counselling at health care centres, hospitals and other stakeholders (i.e. social services, schools, priests) for many years on issues like suicides and suicide prevention and counselling during the grieving process, mobbing, psychiatric health in general, counselling for children whose parents have psychiatric disorders, crisis management and counselling when disasters strike like earthquakes and volcanic eruptions.
Screening
Intimate partner violence
Recently it has been recommended with clinical guidelines that all women seeking health care should be screened for intimate partner violence and this is being implemented but is still mostly opportunitive.

Infant and children health monitoring.
A nurse administers infant care services in collaboration with GPs and paediatricians. Children's health and development is monitored.

Regular infant and child healthcare is performed from the time when the child returns home from the maternity ward. During the first weeks following the birth, nurses will visit the children in their homes. The first medical examination takes place at the age of six weeks and takes place at the Primary Health Care Clinic/Centre for infant care services. The growth and development of children is regularly monitored. When everything is normal, a child will visit the infant and child healthcare control center at a Primary Health Care Clinic every other month until the age of twelve months, and following this, the child returns at the age of eighteen months. Regular vaccinations are made according to the current instructions by the

health authorities at any particular time. Vaccinations start at the age of three months. Parents receive education and consulting as needed at any particular time.

Examples of points of instruction are*:* breast feeding/bottle feeding, the effects of passive smoking on children, accident prevention, exercising and resting for the mother and nutrition and pelvic floor exercises, as well as the well-being of the mother and the father. Additional points include screening for maternal postnatal depression, stimulation and the development of children, postnatal sex and contraception, ad-vitamin drops, information on vaccinations, motor development in children, teething and dental care, language stimulation, sleep, discipline and loving guidance. Selection of children's footwear, hygiene habits, TV watching, physical harassment, outdoor activities and exercising will also be discussed. When children start in compulsory school, their height, weight and eye sight is inspected along with other things.

Cancer screening.
Cancer screenings take place across the country. The Icelandic cancer society has organized and run nation-wide screening programs, for cervical cancer since 1964, resulting in a marked decrease in incidence and death from the disease. Women between the ages 20−69 are sent a letter every two years inviting them to come for a cervical cancer screening. 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 keeps on rising, the death rate is going down, with >90% survival after 5 years.
This is not an exhaustive list of counseling and screenings.
Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 275.
The Committee asks that the next report contain more detailed information on counseling and screening of pregnant women.
Clinical guidelines in Iceland on antenatal care recommend that a primiparous healthy pregnant woman in a normal pregnancy have 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. Further appointments are scheduled in view of the needs of the woman and family. High risk antenatal care is situated in special clinics and is obstetrician and midwife led care. A continuity of care is recommended and should be easily and readily accessible to all pregnant women. Emphasis is placed on the importance of sensitivity with regard to the individual needs of the women receiving care and on the creation of an environment at appointments that enables women to discuss sensitive issues such as mental illness, recreational drug use, sexual abuse and domestic violence. Counselling for these groups is organised through special clinics for cases of mental illness, high risk pregnancy clinics or through the health care centres. Counselling for women fearing childbirth is also made available through special high risk pregnancy clinics.

Early prenatal screening for Down's syndrome and congenital anomalies is available to all women and is optional. Women pay for the screening themselves, the charge is ISK 9,597 in 2013, but if further diagnostic test are considered necessary the health care system pays for them. At each appointment women should be given the opportunity to ask questions and emphasis placed on giving them information making them capable of making informed choices. Thus, the transmission of information to pregnant women is considered an essential part of antenatal care.

Screening factors in the antenatal care-routine.

- High-risk conditions leading to referral to high risk clinics.
- An ultrasound scan is recommended for all pregnant women in week 18-20 for structural anomalies.
- Alcohol use and consumption.
- Smoking.
- BMI measurement.
- Domestic violence
- Mental disorders.
- Anemia.
- Blood grouping and red-cell alloantibodies.
- Asymptomatic bacteriuria.
- Hepatitis B.
- HIV.
- Rubella.
- Syphilis.
- Pre-eclampsia.
- Hypertension.
- Fetal growth by symphysis – fundus measurements from week 24.
- Gestational diabetes according to guidelines for Gestational diabetes.
- Chlamydia trachomatis according to risk assessment.

A midwife follow up is offered 6–8 weeks after birth in association with the 6-week examination of the child.

Article 11, para 3 – Prevention of diseases.
Policies on the prevention of avoidable risks - Reduction of environmental risks.
Air Pollution.
One change was made to the Health and Anti-Pollution Act No. 7/1998. The Act was amended with Act No. 131/2011 in connection with the ratification of the Aarhus Convention. This amendment was made to ensure the right to appeal when decisions are made on the basis of the Act.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009) , p. 275.
The Committee asks the next report to provide details of result achieved in reducing air pollution.
In connection with the *World Health Day* in 2010 which was dedicated to the theme "Urban Health Matters", the Minister for the Environment and Natural Resources and the Minister of Health established a joint project of the two Ministries on improved air quality and public health.

For the purpose of this project, a joint committee of the Ministry of Health and Ministry for the Environment and Natural Resources was established in 2010 to provide a forum for cooperation in this field between the two Ministries. The committee was *inter alia* assigned the tasks of collecting information about air quality in Iceland, providing an assessment of the effects of air pollution on public health and creating a plan of action with measurable steps and a defined time-schedule to improve air quality and reduce the effects of air pollution. The committee delivered its report in April 2013.[13] The work of this committee constitutes the first comprehensive study on the quality of air in Iceland.

Table 24. 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.*
Mold spores and bacterial remains	*Mold 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.*

[13] *Hreint loft, betri heilsa. Umfjöllun um loftgæði og heilsufar á Íslandi ásamt tillögum að úrbótum.* April 2013.

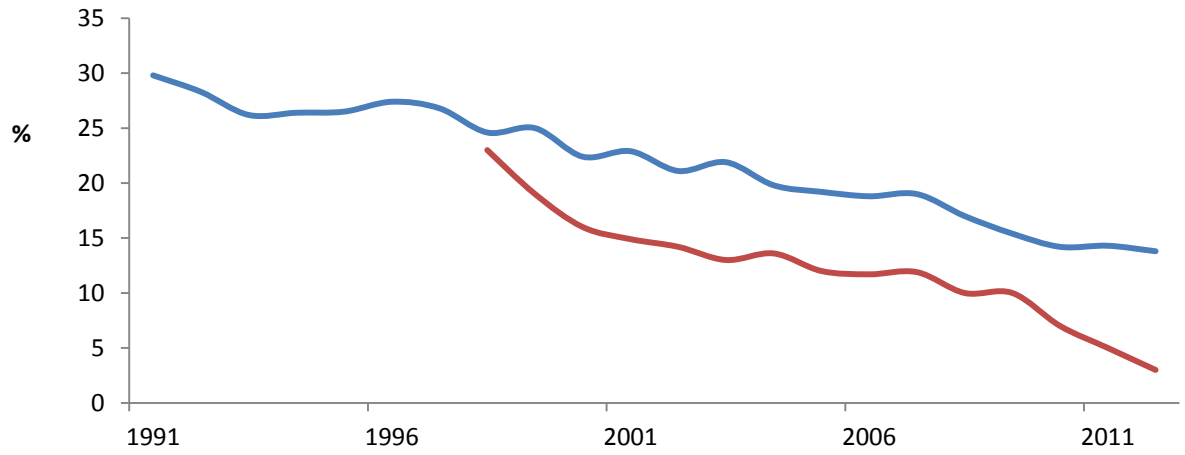
Odors	*Various sources, such as industrial activities, geothermal heat, animal keeping, chemical products, insufficient sanitation.*

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

Tobacco smoke.
According to the report of the committee, there has been a steady decline in smoking in Iceland over the past few decades, as can be seen from the figure below. In 1991, almost 30% of the population aged 15-89 smoked tobacco on a daily basis as compared to 14,3% in 2011. The frequency of smoking varies depending on the age of the smoker and is highest among individuals between the ages of 30-59 years old in which 61-18% of both men and women smoke tobacco on a daily basis. The frequency in daily smokers aged 15 and older 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 15-19. There has been a steady decline in the percentage of teen-smokers, as can be seen from figure 1, from 23% in 1998 to 3,4% in 2011.

Figure 25. Decrease in the percentage of daily smokers from 1991-2012.



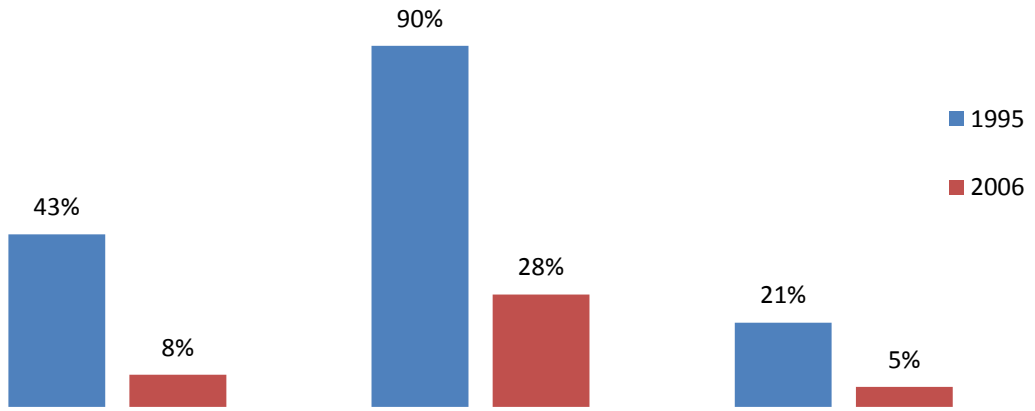
The blue line shows the percentage of daily smokers in Iceland, aged 15 and older, between 1991 and 2012. The red line shows the percentage of daily smokers in Iceland in the 10th grade (students aged 15), between 1998 and 2012.

A study from 1994 showed that the percentage of adults in Iceland subjected to second-hand smoke in their daily environment was 53%. In the same year, 23% of the adult population was subjected to second-hand smoke in their own homes. A more recent study shows that the number of adults subjected to second-hand smoke has decreased rapidly since then. In 2007, 14% of the Icelandic nation, aged 18-79, was subjected to second-hand smoke indoors in their daily environment and 8.3% were subjected to second hand smoke in their environment more than once per week.

Studies have also showed a significant decrease in the percentage of children being subjected to second-hand smoke in Iceland alongside a decrease in smoking in the homes of children.

Figure 2 shows *inter alia* that the percentage of 3 year old children of daily-smokers being subjected to second-hand smoke at least once per week decreased from 90% in 1995 to 28% in 2006.

Figure 2. The percentage of children age 3 that were subjected to second-hand smoke at least once per week classified by living conditions.



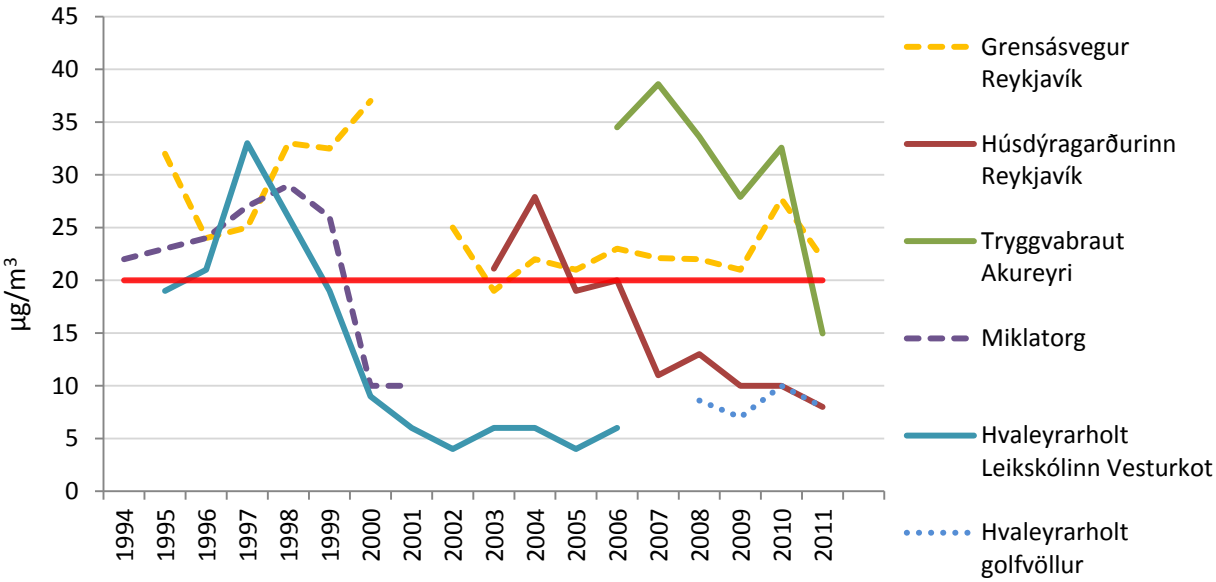
The red and blue columns to the left show the percentage of children living in homes in which smoking was allowed that were subjected to second-hand smoking at least once a week. The red and blue columns in the center show the percentage of children of daily-smokers that were subjected to second-hand smoke at least once a week. The red and blue columns to the right show the percentage of children of non-smoking parents that were subjected to second-hand smoke at least once a week.

This development is the result of a general decrease in smoking and an increased awareness of the public with regard to the harmful effects of second-hand smoking. Furthermore, Icelandic legislation on tobacco control has resulted in less distribution of second-hand smoke among the public.

Airborne particles.
Air pollution in Iceland due to airborne particles has generally decreased in recent years despite the growth of the population and an increase in automobiles.

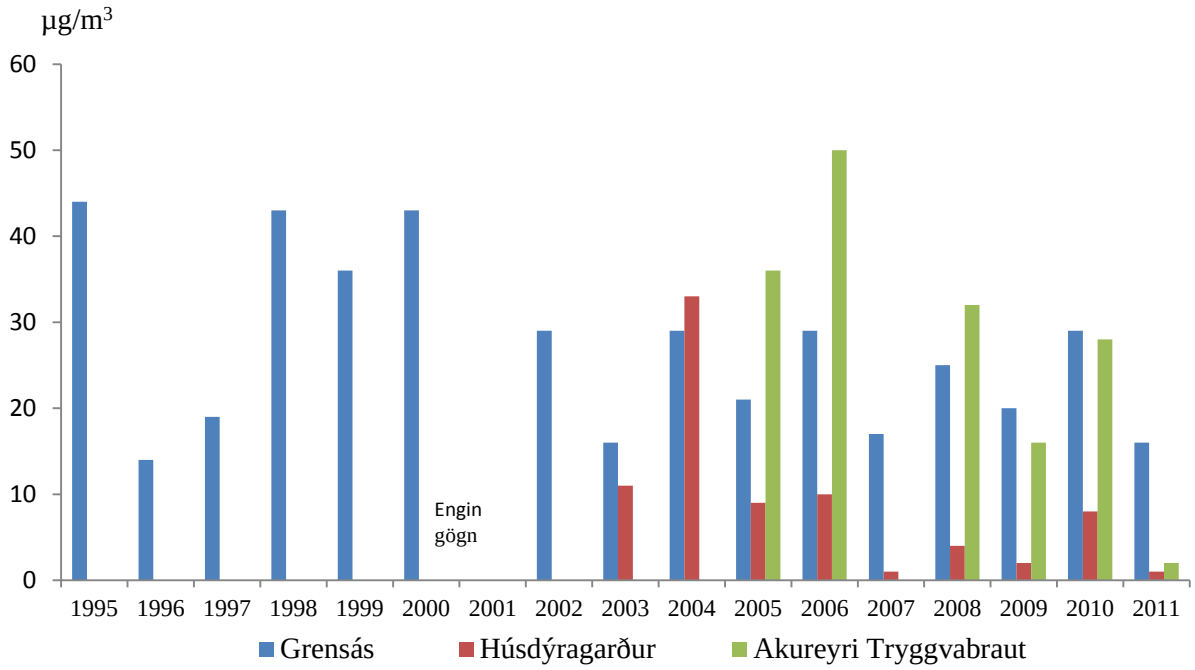
The development of air pollution due to airborne particles in the capital area has primarily been assessed with regard to the data from the measuring station on *Grensásvegur* in *Reykjavík*. Despite a massive increase in road traffic since monitoring began on *Grensásvegur* in 1994, air pollution due to airborne particles has decreased there. Until 2000, the annual average pollution fluctuated from 25 to 37 μg/m^3 but since 2000 the annual average has been about 20 μg/m^3. The annual average air pollution due to air particles has decreased in recent years and measurements from all measuring stations except the ones at *Grensásvegur* in *Reykjavík* and *Tryggvabraut* in *Akureyri* have shown that it has been below the 20 μg/m^3 threshold set out in regulations. The main reasons for this development are thought to be a change in weather and a decrease in the use of studded tyres. In March 2001, about 67% of vehicles were equipped with such tyres but that number had declined to 34% of vehicles in 2011. Moreover, the pavement now used for the roads in *Reykjavík* is much more durable than before due to improvements made in the choice of matierials used and production.

Figure 3. Average annual air pollution due to airborne particles measured at various measuring stations in Iceland.



Air pollution due to airborne particles is also assessed with regard to the number of times that such pollution goes over the limit values of health protection (50 µg/m^3) for a period of 24 hours. As the following table shows, the number of such days recorded by the measuring stations at *Grensásvegur* in *Reykjavík*, *Húsdýragarðurinn* in *Reykjavík* and *Tryggvabraut* in *Akureyri* has overall decreased over the reference period of 2008-2011, apart from the year 2010. The increase in air pollution due to airborne particles in that year is principally due to the volcanic eruption in *Eyjafjallajökull*.

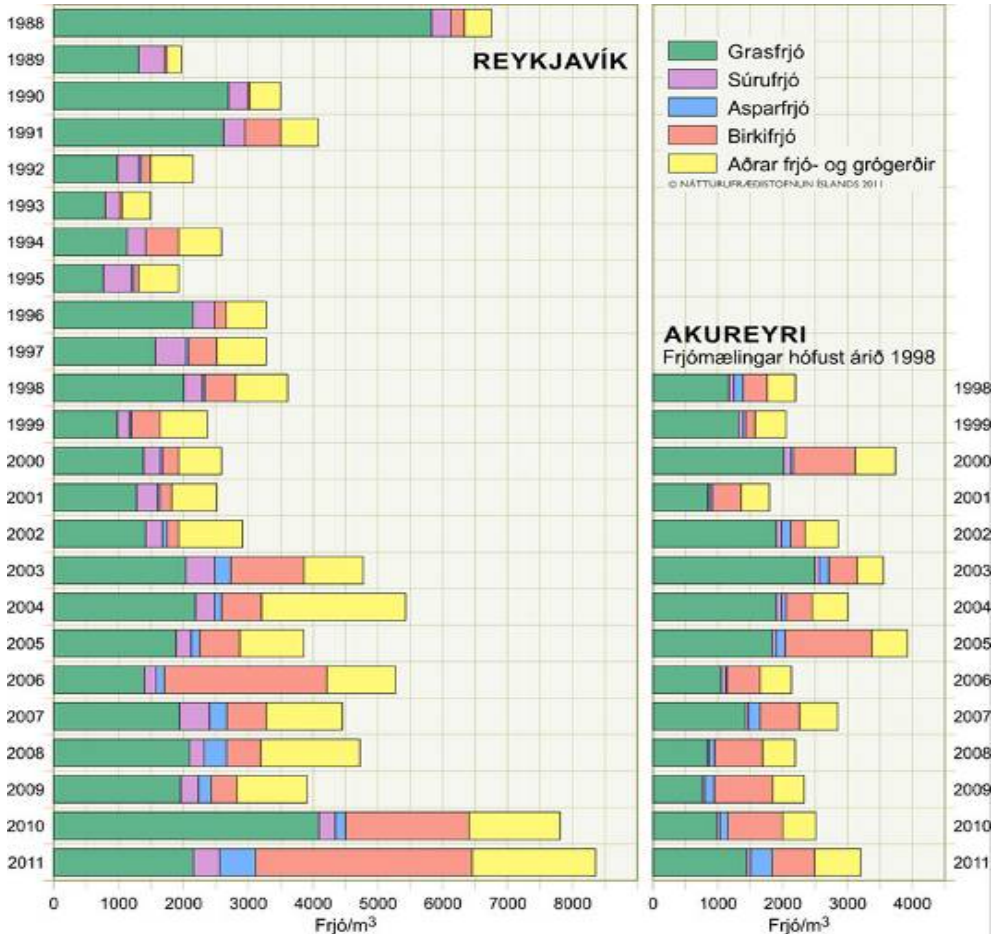
Figure 4. Number of times that air pollution due to airborne particles went over the limit values of health protection (50 µg/m^3) for a period of 24 hours in 1995-2011.



Allergens.

Figure 5 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 2011. The figure shows an increase in such measurements from 2003 with a record set in the summer of 2010 in *Reykjavík* which was unusually warm and sunny. Another record in measurements was set in 2011 due to a significant increase in the amount of birch pollen.

Figure 5. 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.

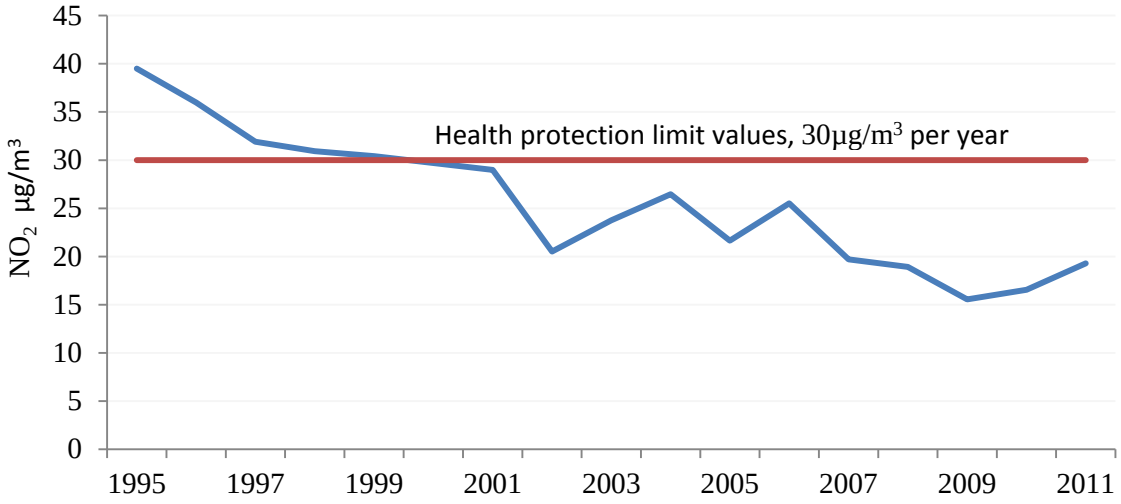
Mold spores and bacterial remains.

Currently, there are no recognized methods for measuring what part of the public in Iceland is subjected to indoor air pollution due to mold spores and bacteria and little is known about the correlation between moisture problems in housing and resulting health problems. More research is needed in order for such assessment to be made.

Nitric oxide and nitrogen dioxide (NOx).

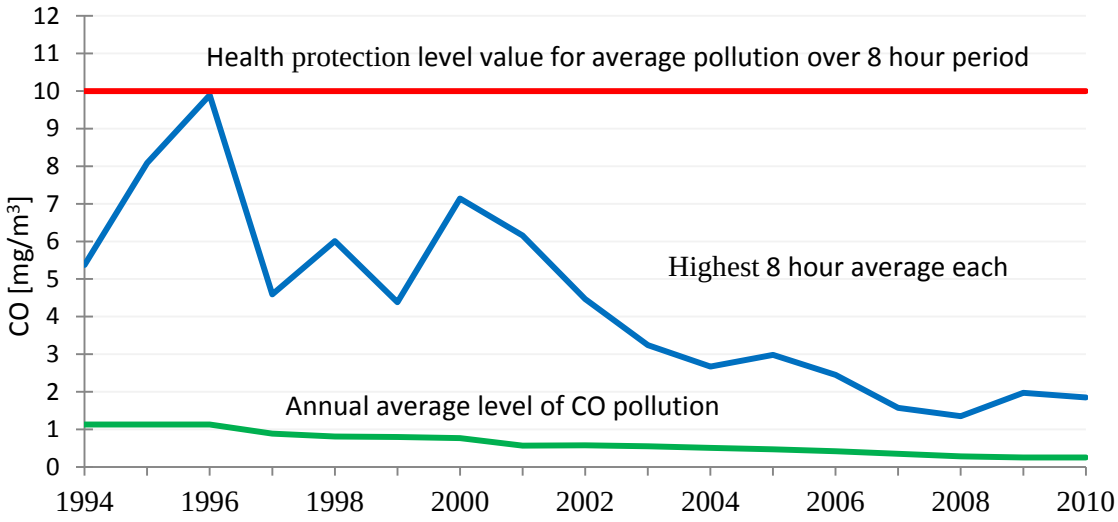
As can be seen from figure 6, NO_x pollution from automobiles has decreased in Iceland since 1995, mostly due to an increase in the use of catalytic converters.

Figure 6. Annual average NO_x pollution at *Grensásvegur* in 1995-2011.



Carbon monoxide (CO).
Following the emergence of catalytic converters in automobiles, much progress has been made with regard to a reduction in 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.

Figure 7. Annual average CO pollution from 1994-2010.



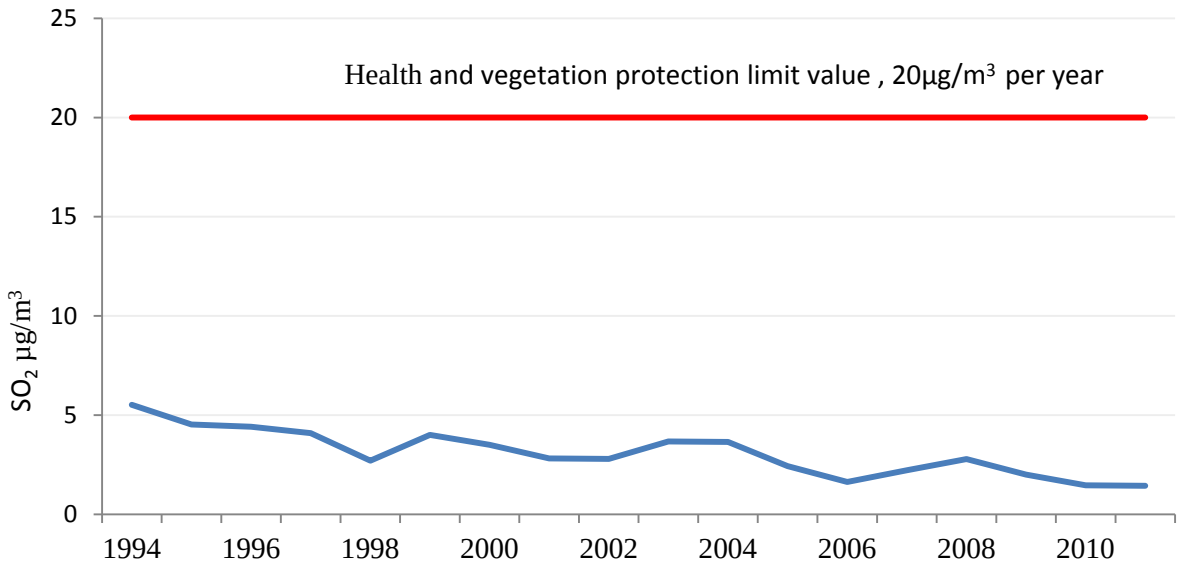
Carbon dioxide (CO_2).
A number of studies have shown high measurements of carbon dioxide in classrooms. In a German study published in 2009, carbon dioxide measurements proved to be over the limit value of 1000 ppm. Icelandic regulations provide for an obligation to ensure that carbon dioxide levels indoors are generally not higher than 0.08% (800 ppm) and that such levels do not go over 0.1% (1000 ppm) and set requirements regarding air ventilation and air ventilation systems.

The Health Surveillance Authority of the Kjós area published a report in 2002 on air quality in schools and preschools in Seltjarnarnes and Mosfellsbær in the capital area. The average level of carbon dioxide in 16 classrooms was 1704 ppm. The lowest value was 552 ppm but the highest 4053 ppm. In preschools the average value was 1254 ppm (620-3212 ppm).

A more recent study of air quality in classrooms in Reykjavík in 2008 found carbon dioxide levels in classrooms to be between 621-2353 ppm, and 1508 ppm on average.

Sulfur dioxide ($SO_{2)}$.
Figure 8 shows the annual average sulfur dioxide pollution at Grensásvegur in Reykjavík has decreased significantly since 1994 and is under the health and vegetation protection limit value (20 µg/m^3 per year).

Figure 8. Average annual sulfur dioxide pollution at Grensásvegur in Reykjavík from 1994-2011.



Sulfur dioxide measurements are also made at the largest industrial sites in Iceland at *Hvaleyrarholt*, *Grundartangi*, *Reyðarfjörður* and *Straumsvík*. At *Hvaleyrarholt*, the average annual measurement for the year 2010 was 1.2 µg/m^3 per year, in *Grundartangi* it was 3.2 µg/m^3 per year at the *Kríavarða* measuring station and 6.2 µg/m^3 per year at the *Stekkjarás* measuring station, in *Reyðarfjörður*, was between 2.1 µg/m^3 per year and 4.8 µg/m^3 per year, depending on the measuring stations (there are four located in *Reyðarfjörður*). All of these annual average measurements are well below the health and vegetation protection limit value of 20 µg/m^3 on average per year.

Hydrogen sulfide (H_2S).
The highest measurements of hydrogen sulfide are usually made at the measuring point on *Hellisheiði* next to the *Hellisheiði* geothermal power plant. The measurements made there were nevertheless under the limit values provided in Regulation No. 390/2009 on Pollution

Limits and Action Taken to Decrease Pollution in Workplaces.

Figure 9 displays the annual average hydrogen sulfide pollution measured in 2011 at the eight different measuring stations responsible for the measurement of such pollution. The annual measurements of hydrogen sulfide at all eight stations were under the limits set in regulations, i.e. 5 $\mu g/m^3$.

Figure 9. Hydrogen sulfide levels at each measuring station in 2011.

Level [$\mu g/m^3$]	Grensás-vegur Reykja-vík	Norðl-ingaholt Reykja-vík	Digra-nesheiði Kópa-vogur	Hval-eyrarholt Hafnar-fjörður	Finn-mörk Hvera-gerði	Reykja-hlíð við Mývatn	Grundar-tangi Hvalfjörður	Hellis-heiði Iðnaðar-svæði
≥500	0	0	0	0	0	0	0	66
≥150	0	0	0	0	2	0	0	556
≥100	0	6	2	0	10	3	0	758
≥50	33	55	40	30	68	65	1	1145
≥25	173	284	241	208	295	385	3	1679
≥7	858	1,103	1,000	955	1,103	1,403	210	2659
Annual average	3.0	3.7	3.1	2.5	4.0	2.5	0.7	31
Annual median	0.9	0.8	0.8	0.1	1.2	-	0.2	1.8

The table shows the total amount of hours annually that the measurement of hydrogen sulfide went over various values. The second to last row displays the annual average hydrogen sulfide pollution. The last row displays the annual median of hydrogen sulfide pollution.

Dioxins, dibenzofuran and polycyclic aromatic hydrocarbons (PAH).
Emission of dioxins has decreased greatly in recent decades, mainly due to the discontinuation of the open burning of waste. Currently, the main sources of dioxins are from fisheries and activities that require special authorization from the Environment Agency of Iceland, such as waste incineration.

The emission of polycyclic aromatic hydrocarbons has increased since 1990, mainly due to an increase in the production of aluminum and ferrosilicon. PAH levels are monitored by the aluminum plant in *Reyðarfjörður* and PAH levels found in mussels offshore from the industrial areas in *Straumsvík* and *Grundartangi*.

Odors.
No studies have been conducted on odor pollution in Iceland and such pollution is not monitored specifically except for in the case of hydrogen sulfide pollution.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 275.
The Committee asks for further information on noise mapping.
In 2005, the Regulation on Noise Mapping and Action Plans, No. 1000/2005 was passed to implement the Directive 2002/49/EC relating to the assessment and management of environmental noise. The aim of the Regulation is to provide a duty to map and assess environmental noises and provide a basis for action to be taken to reduce disruption and disturbances from environmental noise. The Regulation covers environmental noise which humans are exposed to in built-up areas, outdoor recreational areas, quiet areas in urban and rural areas, schools, hospitals and other noise-sensitive buildings. It does not apply to noise that is caused by the exposed person himself, noise from domestic activities, noise created by neighbours, noise at work places or noise inside means of transport or due to military activities in military areas.

In the Regulation the concept *noise map* is defined as a map presenting data on the measured or calculated noise in a given area from different noise sources and the concept *action plan* is defined as a plan of action aiming to control noise and reduce unwanted noise and its effects.

The Regulation states that authorities responsible for roads and operators of major airports are responsible for making noise maps for major roads[14] and major airports in Iceland and the local authority concerned is responsible for making noise maps for urban areas. The regulation makes the following minimum requirements for noise mapping, *cf.* Annex IV to the Regulation:

A strategic noise map is the presentation of data on one of the following aspects:

1. The situation in the previous year, *cf.* Article 7 of the Regulation. A noise map may also present data on the existing, a previous or a predicted noise situation in terms of a noise indicator.
2. The exceeding of a limit value.
3. The estimated number of dwellings, schools and hospitals in a certain area that are exposed to specific values of a noise indicator.
4. The estimated number of people located in an area exposed to noise.

Strategic noise maps may be presented to the public as:

1. Diagrams or graphical plots.
2. Numerical data in tables.
3. Numerical data in electronic form.

Strategic noise maps for urban areas shall put a special emphasis on the noise emitted by:

1. Road traffic.
2. Airports.
3. Industrial activity sites, including ports.

[14] Defined in the Regulation as a regional road, highway or other kind of road defined in a plan pertaining to region which has more than three million vehicle passages per year.

Noise mapping will be used for the following purposes:

1. Database to be sent to the Environment Agency of Iceland.
2. A basis for action plans, *cf.* Article 8 of the Regulation.
3. A basis for the delimitation of quiet areas, *cf.* Article 9 of the Regulation.
4. A source of information for the public, *cf.* Article 10 of the Regulation.

Minimum requirements for the noise maps concerning the data to be sent to the Environment Agency of Iceland are set out in paragraphs 5 and 6 of Chapter I and paragraphs 5, 6 and 7 of Chapter II of Annex VI to the Regulation.

For the purposes of informing the public in accordance with Article 8 and 10 additional and more detailed information must be given, such as:

1. Maps disclosing the exceeding of a limit value.
2. Difference maps, in which the existing situation is compared with various possible future situations.
3. Maps showing the value of a noise indicator at a height other than 4 m where appropriate.

Noise maps shall be presented in accordance with international standards such as ILO 1999-2:1987.

Noise maps for local or national application must be made for an assessment height of 4 m and the 5 dB ranges of Lden and Lnight as defined in Annex VI.

For urban areas, separate noise maps must be made for road-traffic noise, aircraft noise and industrial noise. Maps for other sources may be added.

If a noise map shows that noise in a certain area exceeds the relevant limit value provided for in Regulation on Noise, No. 724/2008 an action plan must be created with a view to reduce the effect of noise. The Regulation on Noise Mapping and Action Plans states that the local authorities concerned are responsible in their respective regions for making such action plans in cooperation with the authorities responsible for major roads and the operators of major airports in that region. Furthermore, the local health committee must be consulted when an action plan is made. The respective local authority shall publicize the action plan in a general manner in the municipality concerned for at least four weeks in which time individuals and other parties concerned may submit written observations on the plan. Subsequently, the local authorities are obligated to review the observations that have been received and to revise the action plans if necessary.

An action plan shall describe in a clear manner individual actions, their expected impact and prioritization in accordance with the priorities and decisions of the parties concerned. It shall at a minimum cover the following issues stated in Annex V to the Regulation:

1. A description of the urban area, the major roads, the major airports and other noise sources addressed in the action plan.
2. The local authority responsible.
3. The legislation and rules associated with the creation of the action plan.
4. The current limit values.
5. A summary of the results of the noise mapping.

6. An evaluation of the estimated number of people exposed to noise, identification of problems and situations that need to be improved.
7. A record of the public consultations organised in accordance with the provisions of the Regulation on action plans.
8. Any noise-reduction measures already in force and any projects in preparation.
9. Actions which the competent authorities intend to take in the next five years, including any measures to preserve quiet areas.
10. The long-term strategy.
11. Financial information (if available): budgets, cost-effectiveness assessment, cost-benefit assessment.
12. Provisions envisaged for evaluating the implementation and the results of the action plan.

Moreover, actions which the competent authorities intend to take in the fields within their competence may for example include:

- Traffic planning
- Land-use planning
- Technical measures at noise sources
- Selection of quieter sources
- Reduction of sound transmission
- Regulatory or economic measures or incentives

Furthermore, each action plan should contain estimates in terms of the reduction of the number of people affected (annoyed, sleep disturbed, or other) once the action plan has been implemented.

Action plans must be reviewed, and revised if necessary, at a minimum of every five years or more frequently if a major development occurs affecting the existing noise situation.

In accordance with the Regulation, the Icelandic Road Administration (IRA) and the municipalities concerned are currently creating noise maps for major roads and urban areas in Iceland. The noise mapping will take place in three phases. The first phase was concluded in July 2012 in which noise maps were made for major roads or parts of major roads that have more than six million vehicle passages per year, all of which are located within the capital area. These are roads No. 1, 40, 41, 49, 413 and 418. In some cases, the municipality concerned has taken action upon learning that the environmental noise in the area concerned exceeded the relevant limit value, e.g. by setting up noise barriers and affording grants to change glass in windows.

Phase two was concluded in February 2013. In this phase, noise maps were made for major roads that have between 3 million to six million vehicle passages per year in urban areas. These roads are located within the capital area, *Reykjanesbær*, *Selfoss* and *Akureyri*. Noise assessment and noise calculation and measurement had already been conducted with regard to most of these roads in phase one and in many cases municipalities had already taken action upon learning that the environmental noise in the area concerned exceeded the relevant limit value.

Food safety.
Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 276.

The previous conclusion found that the situation was in conformity with the Charter in this respect. The Committee asks the next report to provide updated information.

Reference is made to the summary on food safety in the 18th report of Iceland on the implementation of the European Social Charter. The following amendments were made to the Food Products Act, No. 93/1995, in the reference period:

1. *Act No. 93/1995 was amended with Act No. 167/2007.* The Act entered into force on 1 January 2008, amending various Acts in connection with the transfer of certain tasks between Ministries. With this Act, the administration and management of food affairs was moved from the Environmental Agency of Iceland and the Directorate of Fisheries to the Agricultural Authority of Iceland which was renamed the Icelandic Food and Veterinary Authority. Following this transition, an even greater emphasis has been placed on the monitoring of food safety in Iceland.

2. *Act No. 93/1995 was amended with Act No. 29/1998.* Two paragraphs were added to Article 14 on packaging and markings on packaging providing for:
    a. An obligation to ensure at all stages the traceability of packaging and other materials and objects intended to come into contact with food products. A legal basis is provided for the Minister to issue a regulation obligating producers and distributers to have in place a system and rules of procedure to ensure the traceability of packaging and other materials and objects intended to come into contact with food products to facilitate monitoring, recall of faulty products, transmission of information to consumers and to determine the responsibility for a faulty product.
    b. That a supervisory body can limit or stop the distribution of a product when it has serious grounds to believe, on the basis of new information or the reassessment of available information, despite appropriate measures regarding the safety of the product having been made, that the use of packaging or other materials or objects poses a threat to the health of humans.

3. *Act No. 93/1995 was amended with Act No. 143/2009.* With Act No. 143/2009 significant changes were made to the principal legislation applying to the Icelandic Food and Veterinary Authority, *inter alia* to the Food Products Act, in connection with the obligations of Iceland under EEA law. Act No. 143/2009. Act No. 143/2009 authorized the Minister of Fisheries and Agriculture to issue regulations implementing the various Regulations of the European Union such as:
    a. Regulation (EC) 178/2002 of the European Parliament and of the Council of 28 January 2002 laying down the general principles and requirements of food law, establishing the European Food Safety Authority and laying down procedures in matters of food safety.
    b. Regulation (EC) 852/2004 of the European Parliament and of the Council of 29 April 2004 on the hygiene of foodstuffs.
    c. Regulation (EC) 854/2004 of the European Parliament and of the Council of 29 April 2004 laying down specific rules for the organisation of official controls on products of animal origin intended for human consumption.
    d. Regulation (EC) 882/2004 of the European Parliament and of the Council of 29 April 2004 on official controls performed to ensure the verification of compliance with feed and food law, animal health and animal welfare rules.

    Moreover, the Minister was authorized to issue a regulation to implement all other

Regulations of the European Union that become part of the EEA Agreement in the future concerning amendments to the aforesaid Regulations, or other Regulations issued based on them. Thus, necessary amendments were made with this Act to adapt Icelandic legislation such as the Food Products Act to EU legislation on foodstuffs and feed.

With regard to the Food Products Act, significant changes were made and various important provisions of EU foodstuffs legislation was incorporated into Icelandic law such as provisions defining key concepts, on food safety, the responsibility of producers of food products, the traceability of food products, authorization, fee collection, competences, sanctions and publishing of information gathered during monitoring.

Accordingly, the Icelandic Food and Veterinary Authority will continue to be responsible for monitoring of primary production of livestock products, slaughterhouses, the production of fish and other seafood products and the importation and exportation of food products. Moreover, with Act No. 143/2009 the Icelandic Food and Veterinary Authority was made responsible for monitoring meat production (except for meat production in retail stores) and meat packing, the production of milk and eggs. The Icelandic Food and Veterinary Authority and municipal health authorities are, however, authorized to delegate certain task which they are responsible for to one another.

4. *Act No. 93/1995 was amended with Act No. 126/2011.* The amendment did not make substantive changes to the Act.

Measures taken to combat smoking, alcoholism and drug addiction
Comment by the committee of Independent Experts.
Conclusions XIX-2(2009), p. 279.
The Committee refers to Article 11§2 for details of awareness raising activities on smoking, alcohol and drug use. It wishes to be kept informed of all trends in smoking, alcohol and tobacco use.
Smoking.
Reference is made to statistics and tables in discussion on art. 11, para 2, about air pollution and tobacco smoke. The Directorate of Health routinely processes surveys on the extent of tobacco consumption in the country. The office 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 to the public, professionals and health authorities.

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

Table 25. Percentage of adult smokers in 2008–2011.

	2008	2009	2010	2011
Have never smoked	44.4	46.6	47.5	46.7
Stopped more than a year ago	29.2	30.8	30.5	30.4
Stopped less than a year ago	4.8	3.9	3.5	3.9
Smoke occasionally	3.4	3.0	3.9	4.5
Smoke daily	18.1	15.8	14.6	14.5

Total	**100**	**100**	**100**	**100**

Source: Directorate of Health

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

The following table shows the percentage of 20 – 29 year old smokers.

Table 26. Percentage of 20 – 29 year old smokers in 2008–2011.

	2008	2009	2010	2011
Have never smoked	53.4	58.2	59.8	65.8
Stopped more than a year ago	15.3	15.3	14.2	11.8
Stopped less than a year ago	7.9	5.6	5.2	7.3
Smoke occasionally	4.0	4.3	6.7	5.8
Smoke daily	19.4	16.6	14.2	9.3
Total	**100**	**100**	**100**	**100**

Source: Directorate of Health

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 on smoking habits, which shows a steady decline in smoking in the youngest age groups. Numbers from 2009 and 2010 though show a rise in the sales of oral tobacco in the age group of 16 - 23 years old. Around 20% of men in the age group use it, 15% daily and 5% occasionally.
Measures taken by the government to reduce tobacco consumption have been:

1. Price is kept high with taxation.
2. Smoking is banned in public places.
3. Tobacco prevention is supported.
4. Tobacco advertisements are banned.
5. Warnings placed on tobacco products.
6. People are helped to stop.

According to The ESPAD report, mentioned above, the proportions of Icelandic students reporting use of cigarettes, were only a third of the ESPAD averages in 2011.

Alcohol
This table shows the sales figures in the reference period.

Table 27. Sold litres of pure alcohol per capita in 2008–2011, 15 years and older.

Year	Total sales	Sales in governmental stores
2008	7.26	6.11
2009	6.93	5.86
2010	6.77	5.48
2011	6.68	5.33

Source: The State Alcohol and Tobacco Company of Iceland and Directorate of Health

The table shows a slow decline in alcohol sales in the country.

Drunkenness of 15 years old at least twice in their lifetime is reported over 40% in some countries. Much lower rates are reported in Iceland 2009-2010, which are 18% among boys and 16% among girls. The average of EU countries is 36% among boys and 31% among girls.

ESPAD -The European School survey on Project on alcohol and other drugs- published a report in 2012 on substance us among 15-16 years old European students in the year 2011.[15] ESPAD´s aim is to collect comparable data on substance use among 15–16 years old European students in order to monitor trends within as well as between countries. The 2011 ESPAD Report showed a clear decline in Iceland in the criteria:

- The numbers of alcohol use the last 30 days - 17%
- Heavy episodic drinking past 30 days -13%
- Alcohol volume (cl 100%) last drinking day, among consumers - 4.8%

All these numbers have declined since the last report in 2007, and were in comparison with other ESPAD countries, only a third of the ESPAD averages.

In the report stated that numbers showed a continuation from the numbers seen in earlier surveys which have put Iceland in a leading position when it comes to low alcohol consumption and abstinence from different substances. The report also states that it should be emphasised, by comparison, Icelandic students relatively seldom use any alcohol at all. When the status of Iceland is summarized in the report in it underlines that in ESPAD context, the overall impression is that Iceland definitely belongs to the group of countries where substance use is less common.

Prophylactic measures

Epidemiological monitoring

Comment by the committee of Independent Experts.

Conclusions XIX-2(2009), p. 276.

The Committee previously found the situation to be in conformity with the situation. It asks the next report to provide updated information.

Vaccinations have been common in Iceland for more than 200 years, and participation is nowadays high, particularly regarding the vaccinations of children. Reference is made to article 11, para 3 in the last report. The present arrangement of the national Childhood Vaccination Program can be seen in the table below.

Table 28. Childhood Vaccination Program.

Age	Contents
3, 5, 12 months	DTaP, Hib, IPV, PnC
6, 8 months	MCC
18 months, 12 years	MMR
12 year	HPV
5 years	dTaP
14 years	dTaP, IPV

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

The coverage of vaccinations can be seen from a centralized vaccination database of the Chief Epidemiologist. The coverage of the primary vaccination against diphtheria, tetanus, pertussis, HIB, polio and pneumococcus is almost 95% while the coverage of the vaccination against mumps, measles and rubella is at 90–95%. In 2009, the connection of all primary health-care centres and all the major hospitals in the country to the centralised vaccination database was completed. The connection of the primary school health-care registration system to the database was also initiated. The central registry will make it possible to obtain reliable data on almost all vaccinations performed in Iceland. Health authorities began vaccination against pneumococcal infection and HPV vaccination against cervical cancer in 2011, in accordance with a resolution of Parliament from the year before. HPV vaccinations are now part of general vaccinations for girls in 7th grade. HPV vaccination takes place in schools but in some cases at health care centres. Totally, approximately 150.000 people had been vaccinated against the swine influenza in 2009-2010 or half of the population. It can be assumed that the extensive vaccination in Iceland played a part in preventing a still greater spread of the swine influenza in the country.

Table 29. Vaccination Program.

Age:	Vaccination against:
3 months	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot. Pneumococci in another shot.*
5 month	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot. Pneumococci in another shot.*
6 months	Neisseria meningitidis C
8 months	Neisseria meningitidis C
12 months	Pertussis, diphtheria, tetanus, Haemofilus influenzae type b (Hib) and polio in one shot. Pneumococci in another shot.*
18 months	Measles, mumps and rubella in one shot
5 years	Diphtheria, tetanus and pertussis in one shot.
12 years	Measles, mumps and rubella in one shot. Human papilloma virus (HPV) in three shots over a 6-12 month period (only for female children).**
14 years	Diphtheria, tetanus and pertussis with polio in one shot.

*Pnemuococci vaccination began in 2011.
**HPV vaccination began in 2011.

Physicians in Iceland are obliged to report certain communicable diseases to the health authorities. Those diseases, pathogens and events that are covered by the Act on Health Security and Communicable Disease Control are subject to notification (*notifiable diseases*) and, should they pose a threat to public health, they are also subject to the reporting of personally identifiable data (*reportable diseases)*.
Notification duty refers to the duty to submit data to the Chief Epidemiologist without personal identity while the reporting duty refers to the duty to submit data on diseases with personal identity.
The same applies to directors of laboratories, directors of health care departments, and institutions. Registers on communicable diseases shall be sent to the Chief Epidemiologist every month or more frequently if he deems it necessary.
The intention is to monitor the diseases and to respond to them. This information provides early warning of possible outbreaks.

Table 30. Notifiable diseases in 2008-2011.

Iceland, notifiable diseases By personal identity / laboratory confirmed 2008-2011	2008	2009	2010	2011
	Number	Number	Number	Number
Acute symptoms caused by toxin or radiological substance	-	-	-	-
Anthrax	0	0	0	0
Botulism	0	0	0	0
Brucellosis	0	0	0	0
Campylobacteriosis	92	217	426	245
Chancroid (ulcus molle)	0	0	0	0
Chlamydia trachomatis	1,586	1,550	1,687	1,819
Cholera	0	0	0	0
Diphteria	0	0	0	0
Enterohaemorrhagic E. coli infection	1	0	1	2
Giardiasis	24	33	47	47
Gonorrhoea	5	6	6	10
Hemophilus influenzae infection type b	0	0	0	0
Hepatitis A	3	2	1	0
Hepatitis B	21	15	45	49
Hepatitis C	53	66	84	87
Hepatitis E	0	0	0	0
Hepatitis non A-E	0	0	0	0
HIV infection	9	8	12	10
Invasive pneumococcal infections	-	-	-	-
Legionellosis	-	-	2	1
Lepra	0	0	0	0
Listeriosis	2	0	0	0
Measles	0	0	0	0
Meningococcal disease	20	16	21	18
Methicillin resistant *Stapylococcus aureus*	-	-	-	-
Mumps	0	12	44	0
New variant CJD	0	0	0	0
Pandemic Influenzae A	0	-	-	-
Pertussis	6	3	22	8
Plague	0	0	0	0
Poliomyelitis	0	0	0	0
Q-fever	0	0	0	0
Rabies	0	0	0	0
Rubella	0	0	0	0
Salmonellosis	89	97	167	360
SARS	0	0	0	0
Shigellosis	6	0	2	3
Smallpox	0	0	0	0
Syphilis*	6	5	11	9
Tetanus	0	0	0	0

Tuberculosis	10	17	12	13
Tularemia	0	0	0	0
Unexpected events with potential threat to human health	-	-	1	0
Vancomycin resitant *Enterococcus*,, VRE			1	0
Yellow fever	0	0	0	0

* Clinical diagnosis based on serology

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Accidents

The prevention of accidents forms one of the seven priority projects under the Health Plan 2010. The Committee asks the next report to provide details of some of the most important measures taken as well as information on trends in domestic and leisure time accidents.

Most important measures

The Directorate of Health is the centre for violence- and accident prevention in Iceland. The office promotes cooperation among those who work on the field of violence and injury prevention. The office also works on educational material on violence- and injury prevention for professionals and the general public for use in schools, clinics, in sports centre and other places. The aim of the work is to reduce the frequency of accidents and violence in this country. Furthermore, through education about the consequences of trauma, prevent that the trauma responses of those who suffer accidents and violence develop into chronic health problems. An important factor in the prevention of accidents is collecting information about the prevalence and analysis of risk. The office maintains a centralized database of accidents, which is an annual evaluation of the frequency of accidents in this country. The main aim of the database is to promote prevention and provide opportunities for detailed analysis of accidents. Such research work leads to more effective prevention work that increases the likelihood of decrease in accidents. As an example, great progress has been made in reducing the accident rate for children in Iceland due to a strong prevention in this field in recent years. The office collaborates with foreign and domestic research institutes, universities and health research in violence- and injury prevention. The office participates in EU run project called "JAMIE" (Joint Action Monitoring Injuries in Europe), whose aim is to compare the frequency of accidents and causes of accidents between Europe. The office also participates in the "Decade of Road Safety", a UN run project which aims to reduce traffic accidents in the next decade.

Info on trends in domestic and leisure time accidents.

Following tables show the trends in accidents in the country in the reference period.

Table 31. Number of accidents by type in 2008

Tafla 1 Fjöldi slysa eftir tegund, 2008
Table 1 Number of accidents by type, 2008

Tegund slyss *Type of accident*	Fjöldi *Number*	 %
Umferðarslys - *Traffic accidents**	11.831	28,2%
Vinnuslys - *Occupational accidents*	6.997	16,7%
Heima- og frítímaslys - *Domestic and leisure accidents*	14.322	34,1%
Flugslys - *Aircraft accidents*	0	0,0%
Sjóslys - *Marine accidents*	81	0,2%
Íþróttaslys - *Sports accidents*	3.464	8,2%
Skólaslys - *School accidents*	2.344	5,6%
Önnur slys - *Other accidents*	2.954	7,0%
Samtals - *Total*	41.993	100,0%

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

Table 32. Number of accidents by type in 2009.

Tafla 1 Fjöldi slysa eftir tegund, 2009
Table 1 Number of accidents by type, 2009

Tegund slyss *Type of accident*	Fjöldi *Number*	 %
Umferðarslys - *Traffic accidents**	10009	24,6%
Vinnuslys - *Occupational accidents*	5211	12,8%
Heima- og frítímaslys - *Domestic and leisure accidents*	16492	40,5%
Flugslys - *Aircraft accidents*	1	0,0%
Sjóslys - *Marine accidents*	61	0,1%
Íþróttaslys - *Sports accidents*	4075	10,0%
Skólaslys - *School accidents*	2322	5,7%
Önnur slys - *Other accidents*	2523	6,2%
Samtals - *Total*	40.694	100,0%

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

Table 33. Number of accidents by type in 2010.

Type of accident	*Number*	
*Traffic accidents**	6594	17,8%
Occupational accidents	4925	13,3%
Domestic and leisure accidents	16778	45,3%
Aircraft accidents	6	0,0%
Marine accidents	36	0,1%
Sports accidents	3882	10,5%
School accidents	2264	6,1%
Other accidents	2589	7,0%
Total	**37.074**	**100,0%**

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

Table 34. Number of accidents by type in 2011.

Type of accident	*Number*	%
*Traffic accidents**	7929	21,1%
Occupational accidents	5386	14,4%
Domestic and leisure accidents	16423	43,8%
Aircraft accidents	4	0,0%
Marine accidents	42	0,1%
Sports accidents	3714	9,9%
School accidents	2068	5,5%
Other accidents	1944	5,2%
Total	**37.510**	**100,0%**

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

The number of domestic and leisure time accidents rose between the years 2008 and 2009 from 14,322 up to 16,492. These numbers rose again in 2010 but began to decline slightly in 2011.
The following tables show the number of injured in domestic and leisure time accidents by gender and age per 1,000 in the reference period:

Figure 10. Number of injured in domestic and leisure time accidents by gender and age per 1.000 inhabitants in 2008.

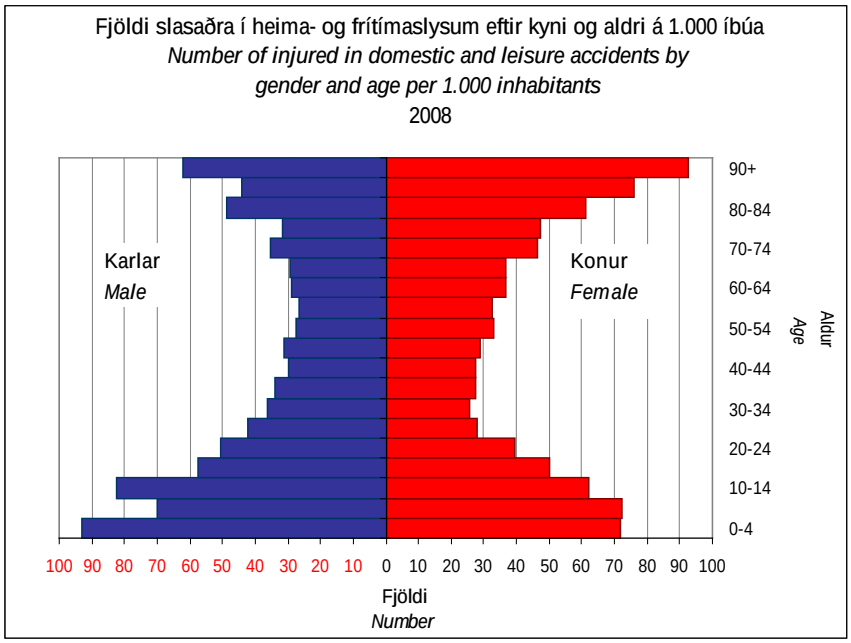


Figure 11. Number of injured in domestic and leisure time accidents by gender and age per 1.000 inhabitants in 2009.

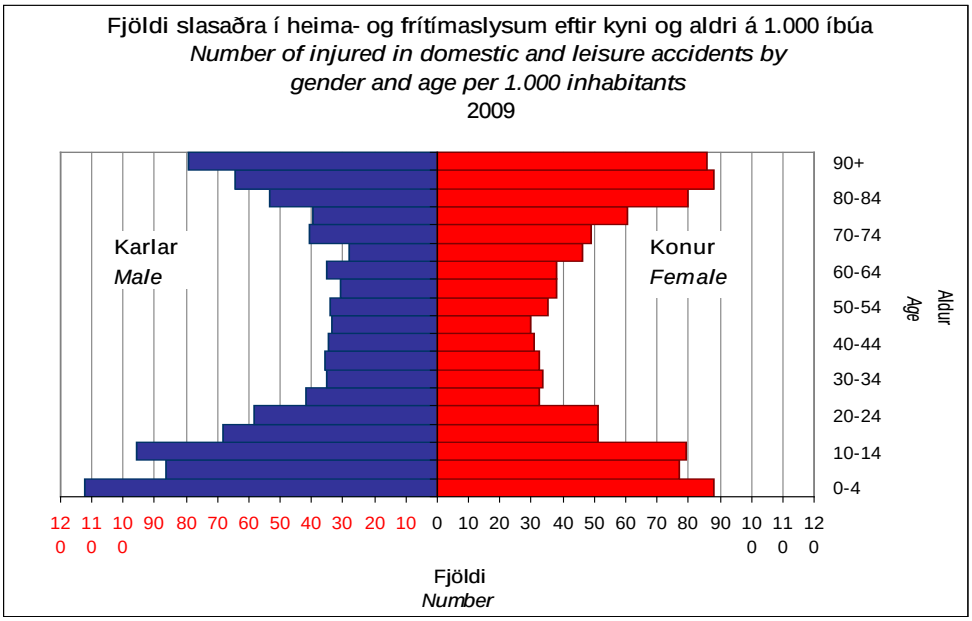


Figure 12. Number of injured in domestic and leisure time accidents by gender and age per 1.000 inhabitants in 2010.

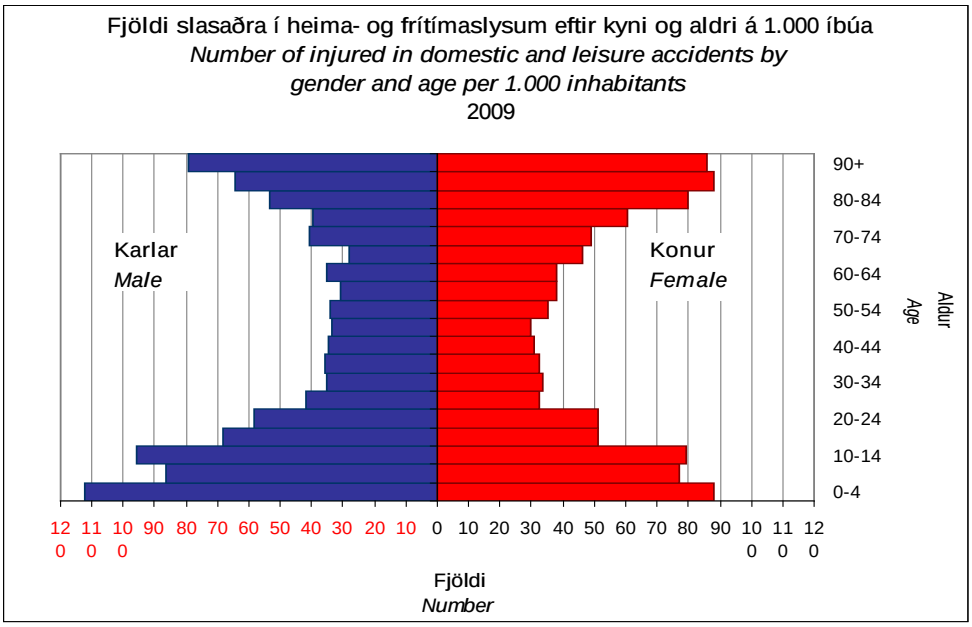
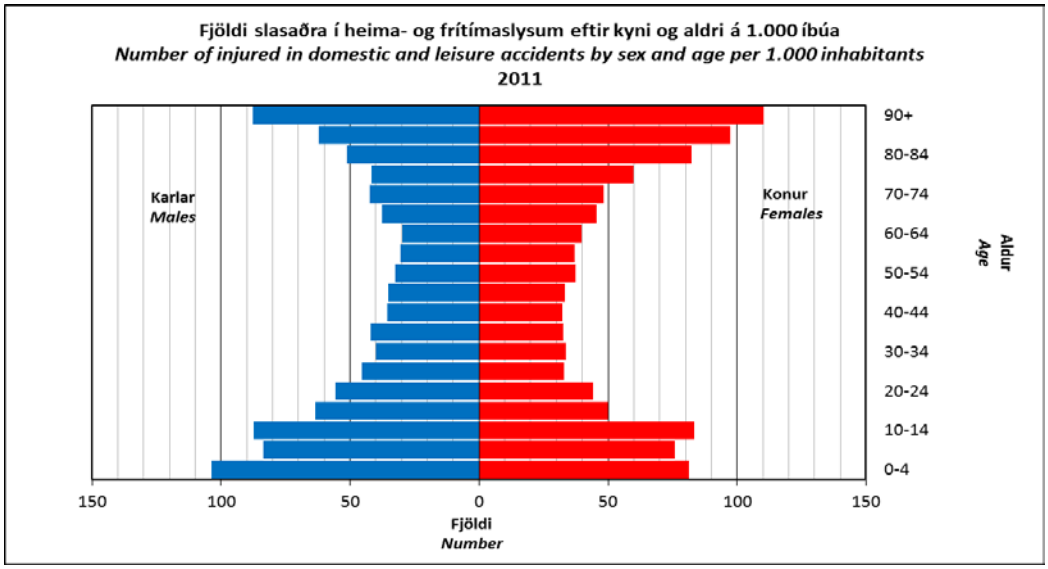


Figure 13. Number of injured in domestic and leisure time accidents by gender and age per 1.000 inhabitants in 2011.



Article 12
The right to social security

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

The Ministry of Welfare.

As was stated in the last report, the responsibility and supervision of the social pension scheme and state social assistance was transferred from the Ministry of Health and Social Security to the Ministry of Social Affairs from 1 January 2008. The two ministries were given new names accordingly, the former Ministry of Health and Social Security was given the name Ministry of Health and the Ministry of Social Affairs was hereafter called the Ministry of Social Affairs and Social Security. In addition the affairs of the elderly were transferred to the new Ministry of Social Affairs and Social Security from the Ministry of Health.

The Ministry of Health and the Ministry of Social Affairs and Social Security were merged into one Ministry, the Ministry of Welfare, from 1 January 2011, *cf.* the Act No. 121/2010, on amendments on the Act on Ministry Offices, No. 73/1969, with subsequent amendments. The new Ministry of Welfare is responsible for welfare and family issues, social security, health care and health insurance, housing, equality, occupational health and safety and labour market issues. This includes policy making, preparing legislation and issuing regulations, general supervision of the administrative bodies and the implementation of the legislation in the above mentioned fields.

The Social Security System.

The Parliament passed various changes to the Act on Social Security, which was reissued as Act No. 100/2007, regarding the national pension scheme that entered into force in stages during 2007 and 2008.[16] The objective was to improve the situation of the elderly and persons with disabilities. Further changes were made to the calculation of the income-testing of the national pension benefits, increasing the maximum income levels or free brackets, (i.e. a part exempt from income-testing) for employment earnings, occupational earnings and financial earnings.

The Social Security System is based on flat-rate benefits, where the amount is reduced or withdrawn if annual income of the pensioner from other sources exceeds a certain amount. A special income criterion is calculated on the basis of income from work, supplementary pension, and capital income, where each type of income weights a certain proportional. Maximum income levels have been increased in enabling pensioners to increase their income through employment, pension funds or capital without it curtailing their pension until the maximum income level is reached.

Furthermore, specific actions were taken to minimize overpayment and underpayment of insurance benefits as of 1 April 2008, for instance, by establishing an ISK 90,000 deduction-free capital gains income limit. The personal allowance of residents in care institutions, moreover, was increased by almost 30% from 1 April 2008, and the deduction-free income allowance was discontinued. As of 1 April 2008, the curtailment ratio of old age pensions was decreased from 30% to 25%. The deduction-free income allowance with regard to

[16] An English translation of the Act can be found on the Ministry of Welfare´s website: http://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Social_Security_Act_100_2007.pdf

income from employment for old age pensioners aged 67–70 was also increased to ISK 100,000 per month as of 1 July 2008 and from the same time the amount of the age-related disability pension supplement was increased. An ISK 300,000 deduction-free income allowance was introduced for disability pension recipients receiving income from pension funds from 1 July 2008. Moreover, the curtailment of pension payments due to withdrawals from private pension funds was discontinued from 1 January 2009.

During the reference period Iceland went through extensive financial difficulties and had to prioritize in a new way in every field of government expenditure. In 2009, the major concerns were related to the financial crisis and the need to cut public expenditures. Amongst other things the state had to take temporary measures to cut back costs in the social security system, the government aimed to alleviate the worst consequences, particularly directing its limited financial resources, towards lower income households and to protect the lowest income pensioners.

The cuts in 2009 were progressive, increasing with higher pension earnings. The maximum income levels in the social security system were lowered, except for the maximum income level regarding income from work of persons with disabilities, as it was seen to be important that they would work as long as possible. Free income bracket of 1,315,200 ISK per year for old-age pensioners was lowered to 480,000 ISK per year and pensioners could no longer choose between the income bracket and counting 60% of their employment income in supplement calculations. Pensioner´s income from a pension fund had an effect in calculation on basic pension, but before 1 July 2009 only capital income and employment earnings had effect on calculating basic pension. All capital income, instead of 50%, affected payments from social security from 1 July 2009, but an income bracket of 90,000 ISK per year was introduced at the same time. Age-related invalidity supplement was also made subject to the same rules as invalidity pension regarding periods of residence, invalidity assessment and reduction due to income from 1 July 2009. Finally the reduction rate for pension supplement was increased from 38.35% to 45%. These cut backs in the social security system have always been thought as temporary measures, and still are. Benefit amounts can be seen in tables below.

As stated before the main emphasis during the financial crisis was on protecting the lowest income pensioners. A regulation came into force in September 2008 which guaranteed a minimum amount of payments to pensioners. Further supplements may be paid to recipients of old-age or invalidity pensions if it is considered demonstrated that they are not able to live without them. Pensioners who lived alone and had total revenue under 150,000 ISK were guaranteed this amount per month and cohabiting individuals were guaranteed 128,000 ISK per month. The amounts were raised by 20% from 1 January 2009 up to 180,000 ISK per month for those pensioners who lived alone and ISK per month for cohabiting individuals and again by 3.5% from 1 January 2011 up to 184,140 ISK for pensioners who lived alone and 157,030 ISK for cohabiting individuals. These minimum amounts were guaranteed in law in the reference period and have been an important measure to alleviate poverty amongst pensioners in general. In 2013 around 12,000 pensioners (approx. 25% of all pensioners in Iceland) utilize this right.

In June 2011 all social security payments benefits were raised by 8.1%. At the same time further supplements (minimum amount) to pensioners with the lowest income was raised by 12,000 ISK per month up to 196,140 ISK for pensioners who lived alone and 169,030 ISK for cohabiting individuals. Special lump sum of 50,000 ISK was paid out to all pensioners

and lump sums paid out to all pensioners in August and December each year were temporarily raised in 2011.

Numbers of people domiciled in Iceland in the reference period.
The following table shows the number of individuals domiciled in Iceland in the reference period.

Table 35. Number of individuals domiciled in Iceland from the beginning of the year 2008 to the end of the year 2011.

1 January 2008	315,459
1 January 2009	319,368
1 January 2010	317,630
1 January 2011	318,452
1 January 2012	319,575

Source: Statistics Iceland

These numbers include those who had been in the country for less than six months. Under the Social Security Act, No. 100/2007, with subsequent amendments, six months' domicile in Iceland confers the right of medical insurance and three years' domicile confers the right to pension insurance, providing other conditions are met.

According to information from Statistics Iceland, 318,452 individuals were domiciled in Iceland on 1 January 2011. The age spread was as follows: 71,015 were 15 or younger, 213,554 were aged between 16 and 66 and 33,883 were over 67.

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

Table 36. Social Protection Expenditure in 2008 –2010, million ISK.

	2008	2009	2010
Social benefits, cash	**159,590**	**199,627**	**196,120**
Services	**166,085**	**180,416**	**180,774**
1. Sickness and health care	**130,674**	**135,538**	**131,651**
Cash benefits due to sickness	23,150	21,664	21,702
Health care services	107,524	113,873	109,950
2. Disability	**44,901**	**53,146**	**53,063**
Cash benefits due to disability	33,595	41,823	41,283
Disability services	11,306	11,323	11,780
3. Old age	**71,948**	**79,834**	**78,239**
Cash benefits to elderly persons	65,318	72,799	71,030
Services to elderly persons	6,630	7,034	7,209
4. Survivors	**7,485**	**9,130**	**8,901**
Cash benefits to survivors	7,485	9,130	8,901
Services to survivors	0	0	0
5. Families and children	**43,489**	**47,527**	**48,064**
Cash benefits to families and children	21,205	23,644	22,711
Services to families and children	22,283	23,883	25,354
6. Unemployment	**5,436**	**25,692**	**25,300**
Cash benefits to unemployed persons	4,817	25,124	24,273
Services to unemployed persons	619	569	1,027
7. Housing	**10,044**	**14,627**	**16,255**
Housing service	10,044	14,627	16,255
8. Social exclusion n.e.c.	**8,335**	**10,775**	**11,485**
Cash benefits due to social exclusion	4,019	5,442	6,221
Services due to social exclusion	4,316	5,333	5,264
9. Other social protection n.e.c.	**3,363**	**3,774**	**3,935**
Services on other social protection n.e.c.	3,363	3,774	3,935
Expenditure on social protection, total	**325,675**	**380,043**	**376,894**

Per capita in thous. ISK at 2010 price.
Social protection deflated by price index of government final consumption.
Source: Statistic Iceland

In 2008 the total social protection expenditure as defined in table 49 was 21.98% of GDP, 25.38% of GDP in 2009 and 24.52% of GDP in 2010. Unfortunately these figures are not yet available for 2011.

In 2010 payments from the public pension funds, i.e. old age pension, invalidity pension and child pension, accounted for ISK 54,748 million, or 3.6% of GDP.

Table 37 shows benefits by function, in percentage of total social benefits 2010.

Table 37. Benefits by function, in percentage (%) of total social benefits in 2010.

Old age & survivors	Sickness/ healthcare & disability	Family & children	Unemployment	Housing & social exclusion
23.5	49.4	12.9	6.8	7.4

Source: Statistics Iceland and Eurostat

Number of benefit recipients.

Table 38 shows the number of recipients in social security pension schemes and population in 2008-2011.

Table 38. Number of recipients in social security pension schemes and population in 2008-2011.

Year	*Number of recipients*	*Population*	*Ratio*
2008	63,807	319,368	20.0%
2009	64,470	317,630	20.3%
2010	61,832	318,452	19.4%
2011	63,273	319,575	19.8%

Source: Social Insurance Administration

In 2008, 63,807 individuals, or 20% of the population, received payments of some type from the Social Insurance Administration. The ratio was 20.3% the following year, and 19.4% the year 2010. Of the recipients of payments in 2010 from the Social Insurance Administration 7,344 received only child support. 49,679 received social security benefits or benefits based on the law on social assistance and additional 4,809 received payment based on both schemes.

The largest groups of recipients consist of old-age and invalidity pensioners, as seen in the following table.

Table 39. Number of old age pensioners and persons receiving invalidity pension in 2008 to 2011.

	2008	2009	2010	2011
Old age pensioners	27,925	25,266	25,113	26,293
Invalidity pensioners	14,103	14,507	14,714	15,197

Source: Statistics Iceland

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 40. Monthly benefits according to the Social Security Act, No. 100/2007 and the Social Assistance Act in 2008–2011, in ISK.

Benefits according to the Social Security Act, No. 100/2007	**Jan 2008**	**Feb.-Dec. 2008***	**2009**	**2010**	**2011**
Pension benefits					
Old age benefits (basic pension)	25,700	26,728	29,294	29,294	30,678
Pension supplement on old age pension	81,100	84,344	92,441	92,441	96.809
Invalidity pension (basic pension)	25,700	26,728	29,294	29,294	30,678
Pension supplement on invalidity pension	82,300	85,592	93,809	93,809	98,242
Pension supplement for each maintained child under age 18	19,000	19,760	21,657	21,657	21,675/ 23,411**
Personal allowance, hospital and nursing home residents	30,000	38,225	41,895	41,895	41,895/ 45,288**
Occupational injury benefits					
Per diem occupational injury benefits, individual	1,220	1,270	1,392	1,392	1,505
Per diem occupational injury benefits, for each maintained child	270	285	312	312	337
Widow/widower benefits (occupational injuries, 8 years)	28,300	29,500	32,257	32,257	34,951
Other					
Child maintenance for one child	19,000	19,760	21,657	21,657	23,411
Benefits according to the Social Assistance Act No. 99/2007					
Household supplement (only those who live alone)	23,900	24,856	27,242	27,242	21,675/ 23,411**
Supplement for the operating costs of an automobile	9,500	9,880	10,828	10,828	10,828/ 11,705**
Single parent allowance for two children	5,500	5,720	6,269	6,269	6,269/ 6.777**
Single parent allowance for three or more children	14,300	14,872	16,300	16,300	16,300/ 17,620**
Death allowance six months	28,300	29,500	32,257	32,257	32,257/ 34,870**
Death allowance 12-48 months	21,200	22,048	24,165	24,165	24,165/ 26,122**
Rehabilitation Benefits	25,700	26,728	29,294	29,294	29,294/ 31,667**

Source: Social Insurance Administration and Icelandic Health Insurance
*Amounts were raised in February 2008. The average amount per month will be displayed in relevant tables.
** Amounts were raised in May 2011.

Invalidity benefits.
Invalidity benefits are paid according to the Social Security Act, No. 100/2007, with subsequent amendments. The following table shows monthly unreduced invalidity benefits.

Table 41. Monthly unreduced invalidity benefits, single person, 2008–2011.

	2008	2009	2010	2011
Basic pension	26,642	29,294	29,294	30,678
Pension supplement and lump sum payments	88,884	97,718	97,718	108,089
Basic pension and supplement with lump sum payments	115,526	127,012	127,012	138,767
Household supplement	24,776	27,242	27,242	28,529
Special monthly supplement on pension	0	361	361	3,012
Total	**167,981**	**185,044**	**185,044**	**202,637**

Source: Social Insurance Administration

Rehabilitation benefits

Rehabilitation benefits are paid in accordance with the Social Assistance Act, No. 99/2007. The following table shows the number of rehabilitation benefits recipients and expenditure in 2008-2011.

Table 42. Number of recipients and expenditure 2008-2011.

Year	Number of recipients	Expenditure, millions ISK
2008	1,137	1,585
2009	1,240	1,964
2010	1,082	1,713
2011	1,112	1,827

Source: Social Insurance Administration

Retirement pension benefits (old-age benefits).

Retirement benefits are paid according to the Social Security Act, No. 100/2007, with subsequent amendments. The following table shows monthly unreduced retirement pensions.

Table 43. Monthly unreduced retirement pension benefits, single person, in 2008–2011.

	2008	2009	2010	2011
Old-age pension (basic pension)	26,642	29,294	29,294	30,678
Pension supplement, lump sum payments	87,588	96,293	96,293	106,573
Basic pension and supplement with lump sum payments	114,230	125,587	125,587	137,252
Household supplement/additional household supplement	24,776	27,242	27,242	28,529
Special monthly supplement on pension	4,691	31,023	31,023	35,123
Total	**144,733**	**184,987**	**184,987**	**202,554**

Source: Social Insurance Administration

Number of individuals with unreduced retirements-, rehabilitation- or invalidity pensions.
The next three tables show the number of individuals with unreduced pensions in the reference period.

Table 44. Number of recipients with unreduced pensions and allowances in 2008.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	26,311	417	121
Invalidity pensioners	12,462	5,583	2,029
Rehabilitation pensioners	1,056	750	228
Total number of recipients with unreduced pensions and allowances	39,829	6,750	2,378
Total number of pensioners in each category	43,165	39,196	12,847

Source: Social Insurance Administration

Table 45. Number of recipients with unreduced pensions and allowances in 2009.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	20,173	1,203	408
Invalidity pensioners	12,201	6,118	2,185
Rehabilitation pensioners	1,055	845	270
Total number of recipients with unreduced pensions and allowances	33,429	8,166	2,863
Total number of pensioners in each category	41,013	37,440	12,188

Source: Social Insurance Administration

Table 46. Number of recipients with unreduced pensions and allowances in 2010.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	20,080	747	246
Invalidity pensioners	12,265	5,826	2,135
Rehabilitation pensioners	956	742	259
Total number of recipients with unreduced pensions and allowances	33,301	7,315	2,640
Total number of pensioners in each category	40,909	37,164	12,110

Source: Social Insurance Administration

Table 47. Number of recipients with unreduced pensions and allowances in 2011.

Recipients in each category	Basic pension	Basic supplement	Household supplement
Retirement (old-age) pensioners	21,542	897	279
Invalidity pensioners	12,666	6,357	2,297
Rehabilitation pensioners	981	727	228
Total number of recipients with unreduced pensions and allowances	35,189	7,981	2,804
Total number of pensioners in each category	42,602	40,667	12,275

Source: Social Insurance Administration

Sickness benefits payments.
Reference is made to the previous reports regarding sickness benefits payments but the figures are updated in table 48.

Table 48. Per diem benefits according to Act No. 112/2008 on Health Insurance.

Sickness benefits	2008	2009	2010	2011
Per diem sickness benefits, individual	1,040	1,140	1,140	1,232
Per diem sickness benefits, for each maintained child	285	312	312	337

Source: Icelandic Health Insurance

Comment by the committee of Independent Experts.
Conclusions XIX-2(2009), p. 278.
However, as to sickness cash benefits, the Committee notes from the Mutual Information System on Social Protection (MISSOC) 1 that in 2007 per diem sickness cash benefits for sick persons who had to give up full time gainful employment was € 10 (ISK 966) and the daily amount for sick persons who had to give up less than full-time but at least have time employment was € 5.15 (ISK 483). The committee asks the next report to clarify this further, particularly highlighting whether unemployment benefits are also received while sick. Pending receipt of these clarifications, the Committee reserves its position as to the adequacy of sickness cash benefits.

The social protection is centralized. The main central institutions at state level in the social protection system are the Social Insurance Administration, the Icelandic Health Insurance and the Directorate of Labour. Collective agreements include provisions on the right to receive wages for specific times during absence from work due to illness or consequences of an accident. The collective agreements are important for the protection of employees during sickness as the collective agreements as negotiated between the social partners provide for the continued payment of wages and salaries during illness for a certain period depending on agreements.
The number of days of entitlement varies, however, from one collective agreement to another, and also according to the number of years the individual worker has been employed by the employer or at the enterprise where she/he works. There are also provisions in law stating that the provisions of wages and terms in the collective agreements apply as minimum terms, *cf.* Act on the Employees' Terms of Employment and Obligatory Pension Rights Insurance, No. 55/1980, with subsequent amendments.
Two random examples are explained below; firstly the collective agreement between *Efling*, which is a trade union of unskilled workers, and the Confederation of Icelandic Employers and secondly the agreement between the *VR*, trade union and the Confederation of Icelandic Employers. These are large unions, by Icelandic standards, in the private sector.

Under the collective agreement between *Efling* and the Confederation of Icelandic Employers, employees acquire more rights as they work longer for the same employer. During an employee's first year of service, she/he is entitled to two days' sick leave per month at "replacement worker's rates of pay"; the term "replacement worker's rates of pay" refers to the wages that the employee would demonstrably have received had she/he not been absent from work. When the employee has worked for one year for the same employer, she/he acquires the right to one month of sick leave on 12 month period at replacement worker's rates of pay; one year later she/he also acquired the right to daytime wage rates for an additional month. After three years' work for the same employer, she/he acquires entitlement to another month at daytime rates of pay, after five years, one month is paid at replacement worker's rates of pay, one month at full daytime pay rates (i.e. daytime wages, bonuses and wage supplements) and two months at daytime wage rates.

A worker who changes job after five years' continuous employment for the same employer retains two months' sick leave entitlement providing that the termination of his/her employment with the previous employer took place in a normal way and his/her entitlement is demonstrated. She/he then acquires greater entitlement after three years' continuous employment with the new employer. This sick-leave entitlement is a total entitlement over a 12-month period, irrespective of the nature of the illness.

Length of service for the same employer is also of importance in the agreement between the *VR*, trade union, and the Confederation of Icelandic Employers. During the first year of service with the same employer, the employee is entitled to payment during two days of sick leave for each full month she/he has worked. After one year's work for the same employee, she/he acquires the right to two months' sick leave during each 12 months, rising to four months after five years of service with the same employer, and later to six months after 10 years' service. If the employee changes job, she/he has at all times the right to payment for two months of sick leave in any 12 months.
Collective agreements concluded in the state sector contain rather different rules, under which employees are entitled to more days of paid sick leave than are specified in collective agreements on the private market. The trade unions in the public sector do not operate sickness funds like those in the private sector. As an example is the collective agreement between the Minister of Finance, on behalf of the Treasury, and the Association of Graduate Workers in the Government Ministries. This states that the employee retains full wages for 14 days of sick leave after working for 0-3 months, 35 days after 3-6 months' service, 119 days after six months' service, 133 days after one year's service, 175 days after seven years' service, 273 days after 12 years' service and 260 days after 18 years' service.
The sickness cash benefits from the Icelandic Health Insurance, which are flat-rate per diem benefits, are only paid after wages from the employer have ceased. The Icelandic Health Insurance pays per diem sickness cash benefits if an insured individual 16 years or older is unable to work and gets neither old age nor invalidity pension. Per diem cash benefits are paid to persons unable to work. In the vast majority of cases these per diem benefits are not the only payments individuals are entitled to.
The trade unions have also special sickness benefits funds (*sjúkrasjóðir*) but more than 80% of employees on the Icelandic labour markets are members of trade unions. Under Article 6 of the Employees' Terms of Employment and Obligatory Pension Rights Insurance Act, No. 55/1980, all employers are obliged to pay into the sickness fund of the relevant trade union. The social partners then agree in their collective bargaining negotiations on how payments are to be made. Reference should be made, however, to Article 7 of the Workers' Entitlement

to Notice and Sick Pay (Etc.) Act, No. 19/1979, which provides for employers paying 1% of disbursed wages to the relevant trade union's sickness fund unless higher rates of payment are decided in collective agreements. This has been the reference rate that has been agreed in collective bargaining, but the wage base used for calculating payments varies from one agreement to another.
The aim of these sickness funds is primarily to take over the function of making payments in cases of illness and accident when the employer's obligation ends but it also refunds health care costs of their members, that is the patients co-payments for health care and also in some cases costs that are not covered by the health insurance scheme. Each individual fund determines the rules applying to its members' entitlement to payments. When the rules of the individual funds are examined, it appears that their main aims and roles are comparable, irrespective of which trade union is involved. Even though there are certain basic rights in all funds, in accordance with their principal aim, it may be resumed the rights of members in each fund vary, partly according to the strength of the fund concerned. It should also be mentioned that the Icelandic Confederation of Labour has issued guideline regulations on the sickness funds of its constituent unions. The constituent unions are not bound by these guidelines, but the Confederation has nevertheless set certain minimum rules that all the sickness funds of the constituent unions are obliged to observe. Amongst other things, the funds are required to set themselves rules that must be approved by the appropriate national association and the central board of the Confederation.

If the employer´s duty expires before the employee is able to return to work, the employee is entitled to sickness benefits from his/her union´s sickness benefit fund according to the funds´ rules. The amounts from the unions are 80%-100% of employee´s last year´s average wage. These payments can last from 270 days up to 360 days. These payments are additions to governmental sickness benefits. Payments from sickness benefits funds are thus supplementary to *per diem* payments made by the Icelandic Health Insurance.
Unemployment benefits are not paid to persons while they are receiving per diem sickness benefits according to article 51 in Act on unemployment insurance, No. 54/2006. These types of benefits are of different nature and therefore cannot be paid to individuals at the same time.

Payments to Parents of Chronically Ill or Severely Disabled Children.
Act on Payments to Parents of Chronically Ill or Severely Disabled Children, No. 22/2006, was amended by Act No. 158/2007. The amendment came into force on 1 January 2008. The aim of the Amending Act was to assists parents of chronically ill or children with severe disabilities in a more efficient manner.

Benefits to parents of chronically ill or severely disabled children who have been active on the labour market and have to cease work to take care of their child are regulated by Act on Payments to the Parents of Chronically Ill or Severely Disabled Children. The goal of this system is to provide parents with financial support during the period that they are unable to pursue employment, as their children require substantial care due to very serious and chronic illness or disability.
Parents who are active in the domestic labour market are provided with the right to temporary income-linked payments when they need to cease work completely or partly due to the pressing conditions that arise when their child is diagnosed with a serious and chronic illness or severe disability. The provision does not apply to the incidental illnesses of children, such as chickenpox, ear infections or other similar illnesses, even if such illnesses can be prolonged. This right applies to parents irrespective of whether they are employees or self-

employed.
Parents have shared right to income-linked payments for up to three months. A prerequisite is that the parent must have been active on the domestic labour market for six consecutive months before the child was diagnosed with a serious and chronic illness or severe disability as attested by a certificate issued by a specialist at the specialised diagnostic and treatment facility providing services to the child. Moreover, the parent must cease working and the child must need the special care given by the parent, e.g. due to hospitalisation and/or treatment at home, provided that no other placement service can be provided by public bodies. This predominantly refers to the ability of a child to attend nursery school or enjoy special services offered to children with disabilities. The shared right of parents to income-linked payments may be extended for up to a further three months when their child requires extensive care due to very serious and chronic illness or disability.
These payments amount to 80% of average gross wages or calculated remuneration over the twelve-month continuous period ending two months before the child was diagnosed with a serious and chronic illness or severe disability. The payments, however, may never be higher than ISK 587,127 per month.
A parent who partially withdraws from paid employment when his/her child is diagnosed with a serious and chronic illness or severe disability may be entitled to proportional payments concurrently with reduced full-time employment ratio. The same applies when a parent returns to work in a full-time employment ratio that is less than that which existed before the parent temporarily left work and the reason that the parent is in a part-time position can be traced to the illness or disability of the child.
A parent who makes a break in his/her studies due to the pressing circumstances that arise when his/her child is diagnosed as suffering from a serious and chronic illness or severe disability may have a joint right, with the child's other parent, to receive payments for up to three months. The parent must have been engaged in studies for at least six months of the 12 months preceding the date that the child was diagnosed with a serious and chronic illness or severe disability as attested by a certificate from the specialist providing the child with services. Moreover, the parent must take a break of at least one semester in the educational institution in question to care for the child. Payments to parents in education were ISK 147,193 per month in 2009.
A parent who is neither able to pursue employment outside the home nor a course of studies because his/her child requires substantial care due to a very serious and chronic illness or disability may hold a joint entitlement, with the child's other parent, to basic payments with the other parent of the child provided that there is no requirement for participation in the labour market. Conditions for basic payments are otherwise the same as for the income-linked payments. Parents who are unable to return to their employment after their child has been diagnosed chronically ill or severely disabled are entitled to basic payments after the period of income-linked payments ends.
Parents who are entitled to basic payments are also entitled to additional payments for children under the age of 18 for whom they are obliged to provide. In such cases, parents were entitled to ISK 21,657 per month for each child in 2009. A single parent who provides for his/her two or more children under the age of 18 can, moreover, be entitled to special child support payments amounting to ISK 6,269 per month for two children and 16,300 per month for three children in 2009. These child support payments are comparable to the payments stipulated for children within the social security system. These payments were protected in line with Government's emphasis on the importance of resisting reduction in services for children and vulnerable groups but the amounts were not raised until the year 2012.
Parents are entitled to payments during the period that they fulfill the conditions for the

payments or until the child has reached the age of 18. The circumstances of parents are assessed regularly and at least once a year. Parents may also be entitled to payments for up to three months after the death of a child, and the same applies when a child recovers following a long-term illness that has persisted for more than two years. The reason for this is that it is clear that parents need some time to adjust after the death of their child in order to resume a normal life with employment. Furthermore, it can take some time to assist a child who has recovered after a long-term illness that has persisted for at least two years, to return to normal life, e.g. to return to school again after a long-term illness. It is therefore considered important that parents are given the opportunity to be available to their children under such circumstances while, at the same time, the parents are preparing themselves to return to being active participants in the labour market.

Parents decide for themselves whether and how they divide their right to payment. The general rule is that parents cannot be entitled to payment for the same periods. This, however, does not apply when a child is undergoing palliative treatment, in which case both parents may request payment for the same period for up to three months. The same applies to the income-linked payments.

If a parent has been in the labour market for less than six months from the time that his/her child has recovered until the child falls ill again or if a parent has not returned to the labour market following the illness of his/her child, the parent may be entitled to basic payments if other conditions are being met. The same applies if the condition of a child worsens due to illness or disability.

If a parent has income, including disability pension payments from public pension funds and private pension funds and investment earnings, such payments will be deducted in accordance with deduction rules, as provided for in Article 22 of the Act. This states that when the sum of the basic payment and income of a parent and other payments, including disability pension payments from the social security system and occupational pension funds and investment earnings, is higher than the basic payment plus a certain maximum allowable income, the basic payment shall be reduced by half of the amount of income exceeding this limit. Account shall only be taken of the income that the parent has received during the period that the parent receives the basic payment pursuant to the Act. Allowance for those caring for chronically ill children and/or children with disabilities intended to meet incurred costs as a result of the child's illness or disability shall not be deducted from payments under this Act. The Act's maximum allowable income was ISK 58,965 per month in 2009 and ISK 52,000 in 2008.

Parents apply for these payments to the Social Insurance Administration (*Tryggingastofnun ríkisins*), which evaluates whether and for how long parents are entitled to payments, given that the circumstances of parents and children can vary considerably.

Table 49. Payments to Parents of Chronically Ill or Severely Disabled Children, cf. Act No. 22/2006.

	2008	2009	2010	2011	2012
Maximum amount in income-linked benefits	518,600	584,127	584,127	584,127	584,127
Monthly basic benefits	130,000	147,193	147,193	147,193	164,685
Additional payments for each child	18,284	21,657	21,657	21,657	24,230
Special child support payments to single parents -two children	5,325	6,269	6,269	6,269	7,014
Special child support payments to single parents -three or more children	13,846	16,300	16,300	16,300	18,237
Number of recipients/parents	56	57	70	89	30

Total expenditure, million ISK	72	91	93	108	95

Source: Social Insurance Administration and Icelandic Health Insurance

Maternity/Paternity Leave and Parental Leave.
The Minister of Social Affairs and Social Security submitted a bill to the Parliament in February 2008 for the amendment of the Act on Maternity/Paternity Leave and Parental Leave. The bill was approved as an act of law in May the same year as Act No. 74/2008. The amendment to the Act applied to the rights of parents who have had children, have adopted children or received children for permanent foster care from 1 June 2008 or later.

The Act from 2008 involves, among other things, changes to the reference period on which the calculation of payments from the Maternity/Paternity Leave Fund are based. The object of the changes was to shorten the reference period from 24 months to 12 months, and to bring it closer to the birth date of a child, or the date on which a child enters a home due to adoption or permanent foster care. Calculations of payments to parents who are considered employees according to the Act on Maternity/Paternity Leave and Parental Leave will be based on a period of 12 consecutive months which ends six months before the birth of a child, or the date on which a child enters a home due to primary adoption or permanent foster care.

According to the Act from 2008, both parents may begin taking maternity/paternity leave up to one month before the expected birth of their child. Authorisation to transfer maternity/paternity leave, or entitlements to grants, was extended when one of the parents cannot utilise her or his right to leave, due to illness, the consequences of an accident or service of prison sentence.

Parents who do not enjoy custody of their children was entitled to maternity/paternity grants for the first time, provided that the parent who does have custody has granted visitation rights to the other parent during the period in which the grant is to be paid.

Following the economic difficulties as of the latter part of 2008, the Government has had to take action to improve the situation in public finances. Therefore, maximum payments from the Maternity/Paternity Leave Fund have been lowered three times since December 2008. As of 1 January 2009, the maximum payment from the Maternity/Paternity Leave Fund was reduced to ISK 400,000 per month. The maximum payment was again reduced as of 1 July 2009, when it was based on an average monthly wage of parents amounting to ISK 437,500. This meant that the Fund's monthly payment to parents was a maximum of ISK 350,000. As a result, payments to parents with a monthly wage amounting to less than ISK 437,500 on average were 80% of the average total wages during a specific reference period, as had previously been the case.

Maximum payments from the Maternity/Paternity Leave Fund were again reduced on 1 January 2010, when the maximum payment was set at ISK 300,000 per month. At the same time, the ratio of earlier wages over ISK 200,000 was decreased from 80% to 75%. Thus parents are entitled to payments amounting to 80% of the first ISK 200,000 and thereafter the equivalent of 75% of their income that exceeds that amount, but never, however, more than ISK 300,000 per month.

The authorities are aware that the payment ceiling of the Maternity/Paternity Leave Fund may contravene the aim of the Act if it is set very low considering the income of parents in

the domestic labour market. When account is taken of the income distribution between men and women in the domestic labour market, it has been deemed probable that the ceiling set on payments from the Maternity/Paternity Leave Fund would further reduce men's interest in availing themselves of their right to paternity leave, as they still generally receive higher wages than women. One may expect, therefore, that the reduction of maximum payments has militated against the aim of the Act. In the explanatory comments to the bills that lead to the above amendments to the Act, therefore, emphasis was placed on the changes being temporary and that the plan is to review the amount of maximum payments and adjust them upward as soon as circumstances in public finances permit. It should be noted that the Government already started to restore the system in 2013 when the Act was amended in December 2012. The payments to parents whose monthly wages were under ISK 350,000, on average, would be 80% of their total wages during the reference period. This applies to children who were born, adopted or taken in a permanent foster care from 1 January 2013.

It is estimated that these actions may have a greater impact on men's right to payments from the Maternity/Paternity Leave Fund as a ratio of their income than on women's, even though the majority of those availing themselves of maternity/paternity leave will not suffer reductions.

Table 50. The Maternity/Paternity Benefits and Parental Grants.

	2008	2009	2009***	2010	2011****
The maximum monthly income-linked payments from the Childbirth Leave Fund* to parents who have been active on the labour market	535,700	400,000	350,000	300,000	300,000
The minimum monthly payments from the Childbirth Leave Fund* to parents who have been active on the labour market in 25-49% jobs.	74,945	82,184	82,184	82,184	82,184/ 88,841
The minimum monthly payments from the Childbirth Leave Fund* to parents who have been active on the labour market in 50-100% jobs	103,869	113,902	113,902	113,902	113,902/ 123,128
Parental grants for parents outside the labour market or in less than 25% jobs**	45,324	49,702	49,702	49,702	49,702/ 53.728
Parental grants for students (75-100%)	103,869	113,902	113,902	113,902	113,902/ 123,128

*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.
*** Children born 1 July 2009, or later.
**** Amounts were raised on 1 June 2011.
Source: Directorate of Labour

Table 51. Total number of parents receiving maternity/paternity benefits and parental grants in 2008–2011.

	2008	2009	2010	2011
Fathers	6,677	6,776	6,424	5,781
Mothers	7,446	7,696	7,652	7,224
Total	14,123	14,472	14,076	13,005

Source: Directorate of Labour

Table 52. Total expenditure on Maternity/paternity leave/grants in 2008–2011, million ISK.

	2008	2009	2010	2011
Total expenditure	9,526	10,268	9,250	8,106

Source: Directorate of Labour

Unemployment insurance.

Unemployment in Iceland has been very limited through the years and for example in 2007 it was only 1%. However, one of the consequences of the financial crisis which hit Iceland during the autumn of 2008 was a rise in unemployment. By the end of 2008 unemployment was 4.8% and on average 7,902 individuals were registered as unemployed. Numbers rose further in 2009 and 2010 up to 8.1% average monthly unemployment. The unemployment rate can be seen in the following table.

Table 53. The average monthly registered unemployment in 2008–2011.

	2008	2009	2010	2011
Percentage				
Monthly average	1.6%	8.0%	8.1%	7.4%
Men	1.5%	8.8%	8.6%	7.6%

Women	1.8%	7.1%	7.6%	7.3%
Numbers, average				
Monthly registered unemployment	2,745	13,407	13,309	12,167
Men	1,491	8,270	7,873	6,832
Women	1,253	5,137	5,436	5,336

Source: Directorate of Labour

The statistics show a significant decline in registered unemployment rate the last two years. The latest available figure is 4.0% registered unemployment rate in August 2013.[17]
An unemployed individual has the right to income-linked unemployment benefits for up to three months after basic benefits have been paid for ten weekdays. Income-linked unemployment benefits for an employee amount to 70% of his or her average income and is based on a six month period measured from two months before the individual become unemployed. Income-related unemployment benefits for the self-employed amount to 70% of the average income in the year preceding the year when the individual became unemployed.
Immediately in October 2008, negotiations began between representatives of the government and the social partners on ways to meet the needs of the labour market. Companies facing temporary difficulties were urged to consider the possibility of reducing the job proportions of their employees rather than laying off staff, since it was regarded as important that workers should remain active on the labour market to some extent. At the same time, the Unemployment Insurance Act was amended in November 2008, *cf.* Act No. 131/2008, to enable those who had partly lost their jobs to apply for partial unemployment benefit without their earnings for part-time work resulting in a reduction of benefit levels. The condition for this was that they remain in at least 50% of full-time employment. In this way, efforts were made to enable as many people as possible to continue to be active on the labour market.

Efforts were also made to meet the needs of self-employed individuals, enabling them to receive unemployment benefit payments as their work levels declined without their activities coming to a complete stand-still; allowance was made for them to accept occasional assignments up to a certain limit. This was worked out in collaboration between the tax authorities and the Directorate of Labour. Both these measures were temporary, and ended 31 December 2011.

In the autumn 2009 it was clear that a large number of jobseekers would make full use of their rights within the unemployment insurance system at the end of the year 2009 and in the year 2010. The registered unemployment rate was still high at that time. Consequently, the Minister of Welfare decided after a consultation with the Social Partners to submit a bill to the Parliament in order to amend the Unemployment Insurance Act. The Bill was adopted in December 2010, *cf.* Act No. 153/2010, where the period when the unemployment benefits can be paid was temporary lengthened from 36 moths to 48 months. The amendments was meant to apply to those jobseekers who had lost their jobs in relation to the financial crisis and had for the first time received unemployment benefits on 1 March 2008 or later providing that he/she met the conditions of the Act. This measure was temporary and ended 31 December 2012.

Table 54. The Unemployment Benefits in 2008-2011.

	January2	**February**	**2009**	**2010**	**January -**	**May –**

[17] Source: Directorate of Labour

	008	2008			May 2011	December 2011
The maximum monthly income-linked payments from the Unemployment Insurance Fund for the first three months*	191,518	220,729	242,636	242,636	242,636	254,636
The basic unemployment benefits to the unemployed which had been in full employment last twelve months	118,015	136,023	149,523	149,523	149,523	161,523

Source: **Ministry of Welfare and** Source: Directorate of Labour

Comment by the committee of Independent Experts.
Conclusions XIX-2(2009), p. 279.

As to the adequacy of unemployment benefits, it is established inter alia also by considering whether there is a reasonable initial period during which an unemployed person may refuse a job offer or a training not matching his/her previous skills without losing his/her unemployment benefits.

In this regard, the Committee notes from the MISSOC that the payment of unemployment benefits may be terminated if a job offer made through the local unemployment agency is refused.

The Committee requests the Government to specify whether any offer has to be accepted, how often the payment of unemployment benefits is terminated following the refusal of a job offer and whether the decision to do so may be appealed. In the affirmative, the report should contain information on any relevant case law. Pending receipt of the above clarifications, the Committee reserves its position as to the actual guarantee of the unemployment risk for which every worker has contributed during his working activity.

Article 57 of Act No. 54/2006, on unemployment insurance, with subsequent amendments, stipulates an obligation for an unemployment beneficiary not to refuse a job offer after the first four weeks from the time when the Directorate of Labour received an application. In other words, the act does not distinguish the jobs by nature, even though a job refusal can be justifiable on grounds of individual circumstances. The article also gives every unemployment beneficiary four weeks of flexibility to look for a preferred job. Beneficiary shall not be entitled to receive benefits until 40 days, for which they would otherwise have received benefit payments, have elapsed from the date on which the decision by the Directorate of Labour to impose a penalty is announced to them.

In cases where a jobseeker turns down an offer of work for a second time, cumulative effects may come into effect, with the result that he or she will not qualify for unemployment benefits until 60 days following the decision by the Directorate of Labour to invoke the cumulative effect. If the jobseeker turns down an offer of employment for the third time, he or she does not qualify for unemployment benefits until he or she has worked for at least eight weeks on the domestic labour market. The 60 day rule was extended into 90 days from 1 January 2010.

When deciding whether to impose a penalty, it is the responsibility of the Directorate of Labour to consider whether the insured person´s decision to reject a job is justifiable on grounds of his or her age, social circumstances in connection with reduced working capacity or the obligation to care for young children or other close family members. Furthermore, the Directorate of Labour may give consideration to the insured person´s domestic circumstances

if the person rejects a job that is far from his or her home and also if the person is engaged to start a permanent job within a certain period of time. Consideration may also be given to the personal circumstances of individuals who are unable to undertake certain jobs because they have reduced working capacity as attested by a medical certificate from a specialist physician. In such cases, penalties may apply if the insured person deliberately concealed information regarding his or her reduced working capacity.

Unfortunately there is no data to be found on how often the payment of unemployment benefits is terminated following the refusal of a job offer. The right to unemployment benefits is based on Act No. 54/2006, on unemployment insurance. According to articles 11 and 12, a Complaints Committee makes decisions in individual complaint cases which may arise under the act. Therefore decisions on termination of unemployment on these grounds benefits payments can be appealed.

It has been customary in public administration in Iceland to entrust, by law, ministerial power of adjudication in instances of complaint to special complaints committees. These are independent administrative committees appointed to function in parallel with the ordinary administrative systems of the ministries. Thus, it is decided in legislation that instead of it being possible to lodge appeals with the relevant specialist ministries against the decisions of specific institutions, such appeals must be referred to the appropriate complaints committee. The decisions of such committees may not subsequently be referred to the minister or any other authority and are therefore final decisions in the executive structure.

In the Complaints Committee's Decision No. 1/2008 the Committee overturned the Directorate of Labour´s unemployment benefits payment denial on the grounds of an individual refusal of a job offer. The directorate of Labour failed to comply with rules of administrative law to instruct the applicant. Neither standard text on application papers nor verbal instructions were given about the effects of a job refusal.

In the Complaints Committee´s Decision No. 21/2009 the Committee confirmed Directorate of Labour´s unemployment benefits payment denial on the grounds of an individual refusal of a job offer. The applicant failed to inform the institution on his reduced working capacity in accordance with law.

In the Complaints Committee´s Decision No. 147/2009 the Committee overturned the Directorate of Labour´s unemployment benefits payment denial on the grounds of an individual refusal of a job offer. It was not considered proven that the applicant deliberately concealed information regarding reduced working capacity. The applicant sent medical certificates before the Directorate made its decision.

In the Complaints Committee´s Decision No. 63/2010 the Committee confirmed the Directorate of Labour´s unemployment benefits payment denial on the grounds of an individual refusal of a job offer. The applicant failed to inform the institution on his reduced working capacity in accordance with law.

Child benefits.
In Iceland, child benefit is paid to parents for children who they support under 18 years of age. Table 68 shows the number of parents who received child benefits in 2008 to 2011. The change in numbers of parents who received child benefits in 2010 and in 2011 can be explained by the amendments made to the Income Tax Act in December 2010. Consequently,

in the year 2011 all child benefits was income-based irrespective of the age of the child but certain part of the child benefits for children under the age of 7 years had been paid irrespective of the wages of their parents.

Table 55. Number of parents receiving child benefits in 2008 – 2011.

	2008	2009	2010	2011
Number of parents receiving child benefits	66,542	69,129	69,827	55,991

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[18] Iceland has one of the lowest at-risk-of-poverty rate in Europe or 10.2% in 2009. This rate has been relatively steady over the past years and new numbers for the year 2010 shows that the rate has gone down from 2009 to 9.8%.

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

Table 56. At risk-of-poverty rate by age and gender.

	Rate				2010		2011	
	2008	2009	2010	2011	CI	Estimated number	CI	Estimated number
All ages								
Total	10.1	10.2	9.8	9.2	+/- 1.2	29,700	+/- 1,2	27,700
Males	10.2	9.3	8.9	9.0	+/- 1.4	14,900	+/- 1,3	13,500
Females	10.7	11.1	9.8	9.5	+/- 1.5	14,900	+/- 1,5	14,200
18 and over								
Total	9.4	9.9	10.5	9.9	+/- 1.4	27,900	+/- 1,3	26,100
Males	9.5	9.6	10.8	9.8	+/- 1.5	14,400	+/- 1,4	12,900
Females	9.4	10.1	10.2	10	+/- 1.6	13,600	+/- 1,6	13,200
18-64 years								
Total	8.7	9.9	9.6	9.3	+/- 1.2	17,900	+/- 1,2	17,300
Males	9	9.8	10	9.4	+/- 1.5	9,400	+/- 1,5	8,800
Females	8.4	9.9	9.1	9.3	+/- 1.4	8,500	+/- 1,5	8,600
65 and over								
Total	15	12.4	4.6	4.3	+/- 1.7	1,800	+/- 1,8	1,600
Males	9.5	6.1	2.5	3.0	+/- 1.8	500	+/- 1,9	500
Females	19.7	17.9	6.5	5.5	+/- 2.8	1,300	+/- 2,6	1,100

Source: Statistics Iceland.

Table 57. A-risk-of poverty threshold (illustrative values) in 2008–2010.

ISK per month	2008	2009	2010	CI 2010	2011	CI 2011
One person household	141,100	160,800	156,900	+/- 3,400	153,600	+/- 2,700
Two adults and two children	296,300	337,700	329,500	+/- 7,200	322,500	+/- 5,600

Source: Statistics Iceland.

Although there is no national definition of poverty to measure a minimum standard of living the Minister of Welfare has recently presented a report on an Icelandic standard budget. The standard budget is built amongst other things on a household expenditure survey run by Statistics Iceland.

A standard budget is in general a list of goods and services that a family of a specified size and composition would need to live at a designated level of well-being, together with the costs of those goods and services. However, standard budgets have in general not been used to develop official poverty lines and it is stressed that this will also be the case for Iceland. The report on the Icelandic standard budget was made at the request of the Minister of Social Affairs and Social Security (now the Minister of Welfare).

In 2011 a report on standard budgets three different budgets was introduced for Iceland. A typical standard, a short term standard and a basic standard. The typical standard (long term standard) measures moderate expenditure. The short term standard is based on the premises of the typical standard but assumes that households can postpone certain expenditures for nine months. The basic standard (long term standard) attempts to approach a measurement of a minimum cost of living for households. In addition to the report a web based calculator was developed for households to put in their own assumptions to see what the standard of living for their family type is. In table 71 and 72 two examples for different family types are

presented, exclusive of transportation and housing cost. Table 71 shows the three types of budget standards for three expenditure categories: Consumer products, services and hobbies for a single person. In table 72 the same example is presented for a family of four persons, a couple with two children.

Table 58. Icelandic budget standards for a single person excluding housing and transportation cost.

Expenditure	Typical standard	Short term standard	Basic standard
Consumer products	ISK 64,079	ISK 41,051	ISK 48,263
Services	ISK 33,401	ISK 19,370	ISK 19,370
Hobbies	ISK 36,055	ISK 7,615	ISK 13,298
Total, excl. transportation and housing cost	**ISK 133,535**	**ISK 68,036**	**ISK 80,931**

Source: Ministry of Welfare

Table 59. Icelandic budget standards for a couple with two children excluding housing and transportation cost.

Expenditure	Typical standard	Short term standard	Basic standard
Consumer products	ISK 167,052	ISK 117,534	ISK 137,202
Services	ISK 116,339	ISK 81,843	ISK 81,843
Hobbies	ISK 86,052	ISK 31,888	ISK 44,920
Total, excl. transportation and housing cost	**ISK 369,443**	**ISK 231,265**	**ISK 263,965**

Source: Ministry of Welfare.

At the Minister of Welfare's initiative the Standard budget was in a negotiating process where partners involved and the general public were asked to give their opinion. On the grounds amongst other things on the responses received by interested partners and the general public the Standard budget was revised in 2012 where it was decided to have two standard budgets instead of three; a typical standard and a basic standard. It has already been clearly stated by the Minister of Welfare that they will not be a determining factor in decisions affecting e.g. cost of pensions, disability benefits and unemployment benefits, nor 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 Ombudsman for Debtors will base his standard for cost of living on the published Standard Budget, as he is obliged to publish and update such standard regularly.

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.

The 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 ground and it has been one of the Government's top priorities to maintain a good, universal health care system covering all residents and include all morbid conditions even though it has gone through a rough financial phase.

Numbers showing the aforementioned can be seen in other parts of the report. Therefore, reference is made to Article 12, para 1 and to Article 13.

2) ***Sickness*** *benefit,*

Table 60. Monthly benefits according to Act on Health Insurance in 2008– 2011.

Sickness benefits	**2008**	**2009**	**2010**	**2011**
Per diem sickness benefits, individual	1,040	1,140	1,140	1,232
Per diem sickness benefits, for each maintained child	285	312	312	337

Source: Icelandic Health Insurance.

Reference is made to Article 12, para 1 of this report.
The right to sickness benefits is decided by law and collective bargaining. An employee, unable to work because of an illness or the consequences from an accident, is entitled to wages from his employer for a certain time. The number of months depends on the time an employee has worked for his or her employer. If the employer´s duty expires, the employee is entitled to per diem sickness benefits from his or her union´s sickness benefit fund according to the funds´ rules. These funds are operated by most unions. The amounts from the unions are 80%-100% of an employee´s average wage for the last year and can last from 270 days to 300 days. These payments are additional to governmental sickness benefits. Large majority of individuals on the labour marked are members of a union and are therefore entitled to additions to governmental sickness benefits.

*3) **Unemployment** benefit,*

Table 61. Unemployment benefits in 2008 – 2011.

	January 2008	February 2008	2009	2010	2011
The maximum monthly income-linked payments from the Unemployment Insurance Fund for the first three months*	191,518	220,729	242,636	242,636	254,636
The basic unemployment benefits to the unemployed who was in full employment last twelve months	118,015	136,023	149,523	149,523	161,523

Source: **Directorate of Labour.**

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

*4) **Old-age** benefit,*

Table 62. Retirement benefits for a single person per month in 2008-2011.

Year	Old-age pension	Pension supplement and lump sum payments	Basic pension and supplement with lump sum payments	Household supplement	Special monthly supplement on pension	Total
2008	26,642	87,588	114,230	24,776	4,691	144,733
2009	29,294	96,293	125,587	27,242	31,023	184,987
2010	29,294	96,293	125,587	27,242	31,023	184,987
2011	30,678	106,573	137,252	28,529	35,123	202,554

Source: Social Insurance Administration.

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

*5) **Employment injury** benefits,*

Table 63. Occupational injury benefits in 2008-2011.

Occupational injury benefits	2008	2009	2010	2011
Per diem occupational injury benefits, individual	1,220/ 1,270*	1,392	1,392	1,505
Per diem occupational injury benefits, for each maintained child	270/285*	312	312	337

Source: Social Insurance Administration.

*Amounts were raised in February 2008.

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 benefits right as sickness and three months of day time salary are paid out as an addition. Employers are obliged to purchase occupational accidents 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 percentage of reduced working capacity. Per diem benefits are paid because of temporary disability and widow(er) benefits are paid when a breadwinner has died.

*6) **Maternity** benefit,*

Table 64. The Maternity/Paternity Benefits and Parental Grants in 2008-2011.

	2008	2009	2009***	2010	2011****
The maximum monthly income-linked payments from the Childbirth Leave Fund* to parents who have been active on the labour market	535,700	400,000	350,000	300,000	300,000
The minimum monthly payments from the Childbirth Leave Fund* to parents who have been active on the labour market in 25-49% jobs	74,945	82,184	82,184	82,184	82,184/ 88,841
The minimum monthly payments from the Childbirth Leave Fund* to parents who have been active on the labour market in 50-100% jobs	103,869	113,902	113,902	113,902	113,902/ 123,128
Parental grants for parents outside the labour market or in less than 25% jobs**	45,324	49,702	49,702	49,702	49,702/ 53,728
Parental grants for students (75-100%)	103,869	113,902	113,902	113,902	113,902/ 123,128

*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.
**Childbirth benefits for those who are not active on the labour market and students.
*** Children born 1 July 2009, or later.
**** Amounts were raised on 1 June 2011.
Source: Childbirth Leave Fund

Reference is made to Article 12, para 1 of 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 65. Pension supplement per month for each maintained child under age 18 in 2008-2011.

	2008*	2009	2010	2011**
Amounts	19,000 / 19,760	21,657	21,657	21,675 / 23,411

Source: Social Insurance Administration.
* Amounts were raised in February 2008.
** Amounts were raised in May 2011.

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.

Table 66. Child benefits per year in 2008 – 2011.

	2008		2009		2010	
	Co-habilitation parents	**Single parents**	**Co-habilitation parents**	**Single parents**	**Co-habilitation parents**	**Single parents**
With one child	144,116	240,034	152,331	253,716	152,331	253,716
With every child after that	171,545	246,034	181,323	260,262	181,323	260,262
Supplement with every child under 7 years	57,891	57,891	61,191	61,191	61,191	61,191

Source: Directorate of Internal Revenue.

Amounts of child benefits remained unchanged in 2011. Reference is made to Article 12, para 1 of this report.

*8) **Invalidity** benefit,*

Table 67. Monthly unreduced invalidity benefits, single person in 2008 – 2011.

Year	Basic pension	Pension supplement and lump sum payments	Basic pension and supplement with lump sum payments	Household supplement	Special monthly supplement on pension	Total
2008	26,642	88,884	115,526	24,776	-	167,981
2009	29,294	97,718	127,012	27,242	361	185,044
2010	29,294	97,718	127,012	27,242	361	185,044
2011	30,678	108,089	138,767	28,529	3,012	202,637

Source: Social Insurance Administration

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

*9) **Survivors'** benefit,*

Table 68. Monthly unreduced invalidity benefits, single person, in 2008-2011.

Survivors´ benefit payments per month	2008	2009	2010	2011
Widow/widower benefits (occupational injuries, 8 years)	28,300	29,500	32,257	32,257/ 34,870*

Source: Social Insurance Administration.

* Amounts were raised in May 2011.

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

Widow(er) benefits are also paid in accordance with mandatory occupational insurance. Employers are obliged to purchase occupational accidents insurance for their employees in accordance with collective bargaining agreements. This insurance applies to accidents at work and on a direct route to or from work.

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

Article 12, para 3 – Development of the social security system.

Comment by the committee of Independent Experts.

Conclusions XIX-2(2009), p. 279.

The committee notes that the Act on Social Security was reissued as Act No. 100/2007 and that legislation on old age and invalidity pension was simplified, income testing was decreased and pension amounts increased.

The committee asks the next report to contain a description of the new legislation referred to and the results achieved by the amendments introduced.

1. Description of the legislation.

The Social Security Act, No. 100/2007, is a general act on social security pension insurance and social security occupational injury. The act covers the social security pension insurance on one hand, i.e. retirement benefits and invalidity benefits, and on the other hand it covers the social security occupational injury insurance.

2. Results achieved:

2.1. Invalidity and old age benefits simplified

When the Act was passed, one specific change simplified old-age and disability benefits. The benefit types "pension supplement" and "additional pension supplement" were merged into one benefit type.

2.2. Income testing decreased

Changes in 2007

a) Over the years the beneficiary´s employment income and spouse´s employment income have had the same effect in calculation on pension supplement. From 1 January 2007 employment earnings to pension recipients counted for 65% and employment earnings to their spouses counted for 35%.

b) Beneficiary´s income from a pension fund and the spouse´s income from a pension fund had the same effect in calculation on pension supplement before 1 January 2007. From that time, pension payments to pension recipients counted for 80% and pension payments to their spouses counted for 20%.

c) From 1 January 2007 old-age benefits do not begin to decline until beneficiaries gain income from employment of more than 300,000 ISK a year.

d) Income testing in supplement payments was decreased. Income had 45% effect on payments but was reduced to 39.95% on 1 January 2007.

e) Employment earnings of old-age pensioners, 70 years and older, did not affect their benefit rights after 1 July 2007.

Changes in 2008

a) Spouse´s pension fund income does not affect supplement calculations from 1 January 2008. This income counted for 20% before. Therefore, connection with spouse´s pension fund income was abolished.

b) Benefit reduction because of spouse´s employment earnings was abolished from 1 April 2008. This income counted for 35% before. Therefore, connection with spouse´s employment earnings was abolished.

c) Financial income does not affect invalidity and retirement benefit payments unless it reaches 90,000 ISK per year. Before the change financial income had an instant affect. This change came into force on 1 April 2008 but was retroactive from 1 January 2007.

d) Employment income threshold for invalidity and retirement pensioners from 67-70 years old was increased from 300,000 ISK to 1,200,000 ISK per year from 1 July 2008. Pensioners can choose between this threshold and counting 60% of their employment income in supplement calculations.

e) Disability pensioner´s pension fund income of 300,000 ISK became deduction-free from 1 July 2008.

2.3. Other changes

a) Individuals were allowed to delay their old-age pension rights from 1 January 2007. By doing that old age pensioners could collect enhanced rights and increase their pension amounts.

b) Payments from private pension savings do not have any effect on pension or pension supplements from 1 January 2009.

c) After the financial crisis the state had to prioritize in the state budget. In the reference period the main emphasis was on protecting the lowest income pensioners and to raise benefit supplements. A regulation came into force in September 2008 which guaranteed a minimum amount of payments to pensioners. Further supplements may be paid to recipients of old-age or invalidity pensions if it is considered demonstrated that they are not able to live without them. Pensioners who lived alone and had total revenue under 150,000 ISK were guaranteed this amount per month and cohabiting individuals were guaranteed 128,000 ISK per month. The amounts were raised by 20% from 1 January 2009 up to 180,000 ISK per month for those pensioners who lived alone and ISK per month for cohabiting individuals and again by 3.5% from 1 January 2011 up to 184,140 ISK for pensioners who lived alone and 157,030 ISK for cohabiting individuals. This minimum was guaranteed in law in the reference period.

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

Article 12, para 4. – Social security of persons moving between states
On bilateral agreements guaranteeing equal treatment
No bilateral agreements guaranteeing equal treatment exist with Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, "the former Yugoslav Republic of Macedonia", Moldova or Ukraine. The Committee recalls that States Parties can comply with their obligations not only through bilateral or multilateral agreements, but also through unilateral measures. The Committee asks that the next report indicate whether the Government plans to conclude agreements with these states and, if so, when. The Committee also asks whether the conclusion of such agreements is foreseen with States which have ratified the Charter outside the reference period, i.e. Serbia and the Russian Federation.

The Committee wished to know whether such agreements existed with the following countries: Albania, Armenia, Georgia and Turkey. The report states that there are no agreements with these countries and that none of them have requested such agreements. The Committee recalls that States Parties can comply with their obligations not only through bilateral or multilateral agreements, but also through unilateral measures. The Committee asks that the next report indicate whether the Government plans to conclude agreements with these states and, if so, when. The Committee also asks whether the conclusion of such agreements is foreseen with States which have ratified the Charter outside the reference period, i.e. Serbia and the Russian Federation.

The Icelandic government has agreements in this field with every EU and EFTA state as a member of the European Economic Area applied EU regulations No. 883/2004 and 987/2009 on Social Security for migrant workers.

However no other bilateral agreements or multilateral agreements apply to the social assistance and Iceland has not received requests from countries that are members of the Social Charter but not members yet of the EEA agreement to make such agreements.

In the reference period Iceland has been going through extensive financial difficulties and has had to prioritize the government tasks. As Iceland has a very small administration it has not been possible for the government to put the states manpower and resources in such

agreements.

The Icelandic government has not yet taken any decision on whether it should conclude agreements or not with Albania, Armenia, Georgia and Turkey. In this context it has to be borne in mind that not many exchanges take place between nationals of the countries. The same applies to States which have ratified the Charter outside the reference period.

Reference is made to 22nd and 17th report of the Icelandic government.

Article 13
The right to social and medical assistance

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

Act on Municipalities' Social Services, No. 40/1991.

No changes were made to the Municipalities' Social Services Act, No. 40/1991[19], in 2008 and 2009. In 2010 the Act on Municipalities' Social Services was amended to eliminate the differentiation provided for in the wording of the Act between cohabiting same sex couples and cohabiting heterosexual couples. The amendment was made in connection with the repeal of the Act on Registered Partnership which was replaced with a Single Marriage Act that sought to eliminate legal discrimination against same sex relationships inter alia by legalizing same sex marriages. Further, the Social Services Complaints Committee was merged with the Complaints Committee on Housing into one Complaints Committee, i.e. the Social Services and Housing Complaints Committee, *cf.* Act No 66/2010. Finally, the time limit to challenge a social services committee's decision was extended from four weeks to three months, *cf.* Act No. 152/2010.

Act on Health Insurance, No. 112/2008.

In September 2008, the Act on Health Insurance, No.112/2008[20], was adopted, but the Act was previously a part of the Social Security Act, No. 100/2007. The main objective of the Act is to ensure assistance to health insured persons for the protection of their health and equal access to health service, irrespective of financial position. Furthermore, it aims to promote the efficiency and economic viability of health service and maximise its quality to the extent possible at any time. Moreover, the aim of the Act is to strengthen the role of the State as a buyer of health services and to analyse the cost of the health service. The intention was to keep the rights to health insurance unchanged but wordings were clarified and defined in more detailed way than before, definitions were also to align them with the EEA agreement on Social Security. A new institution, Icelandic Health Insurance, was established on the basis of the law. The act was amended eight times on the reference period. None of them included a significant change. A list of the changes can be found in discussion on Art. 11.

Reference is made to the previous reports.

Financial assistance provided by municipalities, cf. chapter VI of the Municipalities' Social Services Act. Rent benefits provided by municipalities, cf. Act on Rent Benefits, No. 138/1997.

The following tables show the number of households that sought financial assistance from municipalities in the period 2008–2011 according to the records of Statistics Iceland. During this period, 5,029 to 7,715 households received financial assistance from the municipalities each year. The largest group receiving financial assistance, 42.3% on average, were single men without children, the second-largest group, 28.6% on average, consisted of single mothers.

[19] An english translation of the act can be found on the Ministry of Welfare's website:

http://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/The_Municipalities_Social_Services_Act_No_40_1991_with_subsequent_amendments.pdf

[20] An English translation of the Act can be found on the Ministry of Welfare´s website:

http://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act_on_Health_Insurance_No_112_2008.pdf

Table 69. Number of households receiving financial assistance, average payment per month and average number of montly payments in 2008–2011.

Year	Total	Average payment per month in ISK	Average number of monthly payments
2008	5,029	86,490	3.9
2009	5,994	91,540	4.2
2010	6,910	101,342	4.3
2011	7,715	103,517	4.6

Source: Statistics Iceland

Table 70. Households receiving financial assistance, by family type of recipients in 2008–2011.

	2008	2009	2010	2011
Total	5,029	5,994	6,910	7,715
Single men with children	119	145	140	150
Single men without children	1,963	2,532	3,016	3,336
Single women with children	1,650	1,755	1,871	2,066
Single women without children	856	1,036	1,322	1,506
Married/cohabiting with children	327	401	401	455
Married/cohabiting without children	114	125	160	202

Source: Statistics Iceland.

Table 71. Households receiving financial assistance, by age of recipients 2008-2011.

		*Capital area**			*Municipalities outside the capital area with over 300 inhabitants*
	Total	*Total*	*Reykjavík*	*Other municipalities*	
2008					
Households, total	**5,029**	**3,651**	**2,801**	**850**	**1,378**
Age of recipients					
24 and under	1,349	996	715	281	353
25-39 years	2,112	1,535	1,209	326	577
40-54 years	1,124	795	609	186	329
55-64 years	279	211	175	36	68
65 years and over	165	114	93	21	51
18 years or older, total**	5,470	3,903	2,974	929	1,567
2009					
Households, total	**5,994**	**4,399**	**3,309**	**1,090**	**1,595**
Age of recipients					
24 and under	1,755	1,282	909	373	473
25-39 years	2,491	1,854	1,399	455	637
40-54 years	1,281	927	725	202	354
55-64 years	337	239	191	48	98

65 years and over	130	97	85	12	33
18 years or older, total**	6,520	4,687	3,511	1,176	1,833
2010					
Households, total	**6,910**	**5,113**	**3,799**	**1,314**	**1,797**
Age of recipients					
24 and under	2,254	1,659	1,167	492	595
25-39 years	2,791	2,084	1,554	530	707
40-54 years	1,327	982	777	205	345
55-64 years	376	267	202	65	109
65 years and over	162	121	99	22	41
18 years or older, total**	7,471	5,433	403	1,400	2,038
2011					
Households, total	**7,715**	**5,705**	**4,155**	**1,550**	**2,010**
Age of recipients					
24 and under	2,417	1,746	1,221	525	671
25-39 years	3,228	2,429	1,781	648	799
40-54 years	1,480	1,105	815	290	375
55-64 years	409	298	234	64	111
65 years and over	181	127	104	23	54
18 years or older, total**	8,372	6,071	4,426	1,545	2,301

Source: Statistics Iceland.

* The municipalities within the capital 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.

Comment by the Committee of the Independent Experts
Conclusions XIX-2(2009), p. 283.

The Committee asks what is the average amount of this benefit as well as any other supplementary benefits paid to a single person in receipt of financial assistance provided by municipality social services.

The aim of the municipalities' social services is to guarantee their inhabitants' financial and social welfare and to contribute towards their well-being on the basis of mutual assistance and equal entitlement to the quality of life. The municipalities are obliged to lay down rules on basic financial assistance as well as other supplementary benefits based on the Act on Municipalities' Social Services. The supplementary benefits paid to single persons and families can vary between the municipalities and unfortunately, any average amount of such supplementary benefits is not available.

Nevertheless, to give an example from one municipality, the following table shows the average amount of supplementary benefits in Reykjavík, which is by far the largest municipality in Iceland.

Table 72. Average amount of financial assistance in Reykjavík, by type of assistance in 2008–2011, ISK.

Types of financial assistance	2008	2009	2010	2011
Basic financial assistance	399,646	499,340	530,397	581,796
Additional summer financial assistance for families with children	0	0	7.291	0
Special occupational assistance, three types	72,586 0 0	67,213 0 0	64,914 0 0	77,929 0 0
Financial assistance for students 18 years and older for fees and books	36,570	40,615	40,159	37,512
Financial assistance for students 16 and 17 years for fees and books	32.062	33,361	36,551	18,888
Financial assistance for students far from their local community	63,778	25,000	120,529	340,137
Special financial assistance for students	452,986	566,344	607,175	610,013
Counseling	45,403	44,179	42,890	41,181
Assistance to families with children	62,138	64,262	70,310	78,437
Assistance because of special difficulties	99.676	137,287	116,182	122,773
Grants for housing deposit	185,691	179,018	163,758	211,757
Dentist financial assistance	39,748	37,036	36,520	35,785
Grants for housing equipment	85,016	90,013	82,593	82,375
Financial assistance regarding funerals	152,958	151,945	145,653	148,444
Financial assistance to storage furniture from the household	83,978	73,819	59,533	83,009
Trauma assistance	62,581	64,498	85,121	75,384
Other assistance	80,588	59,513	60,672	56,551
Special December financial support for families with children	0	9,073	18,375	20,313
Financial assistance when a child stays outside the home	67,218	0	83,683	132,800
Loan changed into a grant	0	0	0	168.282

In 2010, basic financial assistance provided by *Reykjavík* could amount to ISK 125,540 per month for an individual and ISK 223,500 per month to a married or cohabiting couple, irrespective of whether or not there were children living in the household since child benefit, child maintenance and child pension payments are deemed to suffice to meet financial needs due to children. Moreover, loan-interest benefits and house rent benefits meet different housing costs depending on whether houses are privately owned or in rent. However, it should be noted that if an applicant has not received full child benefit payments following a divorce or termination of cohabitate, that is taken into account with regard to the assessment of the financial needs of that applicant. Furthermore, applicants with dependent children can apply for additional financial assistance, i.e. supplementary benefits, for certain expenses, e.g. expenses relating to day-care, pre-school, school, and recreational activities. In 2011, the amount of the basic financial assistance provided by Reykjavík was raised to ISK 149,000 per month for an individual but stayed the same for a married or cohabiting couples. The following tables show the number of households that received financial assistance in Reykjavík.

Table 73. Number of households receiving financial assistance in Reykjavík in 2008–2011.

	2008	2009	2010	2011
Number of households	2,774	3,292	3,704	4,112

Source: Reykjavík City´s Welfare Division´s Annual report 2010.

Table 74. Number of households receiving financial assistance in Reykjavík, by type of assistance in 2008–2011.

Types of financial assistance	2008	2009	2010	2011
Basic financial assistance	1,876	2,487	2,924	3,285
Additional summer financial assistance for families with children	0	0	395	0
Special occupational assistance	365	307	319	562
Financial assistance for students 18 years and older for fees and books	242	283	325	486
Financial assistance for students 16 and 17 years for fees and books	28	23	31	6
Financial assistance for students far from their local community	0	1	1	2
Special financial assistance for students	231	267	312	420
Counseling	194	168	142	145
Assistance to families with children	148	205	308	379
Assistance because of special difficulties	165	155	123	102
Grants for housing deposit	172	137	116	167
Dentist financial assistance	78	74	111	126
Grants for housing equipment	66	78	92	94
Financial assistance regarding funerals	62	85	62	62
Financial assistance to storage furniture from the household	17	14	11	11
Trauma assistance	5	4	4	10
Other assistance	320	256	254	254
Special December financial support for families with children	0	248	324	356
Financial assistance when a child stays outside the home	0	1	3	3
Total*	**2,701**	**3,211**	**3,596**	**4,015**

* More than one type of financial assistance is common for recipients.
Source: Reykjavík City´s Welfare Division´s Annual report 2010.

Basic financial assistance provided by *Kópavogur*, a municipality on the Reykjavik capital area with 30,779 inhabitants in 2011 could amount up to ISK 127,090 per month for an individual in 2010 and ISK 135,000 in 2011. The respective amount was ISK 100,950 ISK in 2008 and ISK 118,212 in 2009. In 2011, basic financial assistance provided by *Akureyrarkaupstaður* to an individual aged 18 or older could amount to up to ISK 131,617 per month (basis of support). The respective amount was ISK 101,626 in 2008 and ISK 118,251 in 2009. In 2011, the basis of support for married and cohabiting couples amounted to 1.6 times the basis of support for individuals aged 18 or older in *Kópavogsbær* as well as in *Akureyrarkaupstaður*. As in *Reykjavík*, the number of children living in the respective household does not affect the aforesaid amounts in these municipalities.

Persons living in rented accommodation may be entitled to *rent benefits* provided by the municipalities; the object of these benefits is to cut housing costs of those who rent and have low-income and reduce inequalities with regards to their position on the housing market.

All those who rent residential premises and live in them are entitled to rent benefits according to the Act on Rent Benefits. Foreign nationals who are domiciled in Iceland have the same entitlement to rent benefit as Icelandic citizens.

In 2011 and 2012, the basic sum for each apartment was ISK 13,500 (it was raised to ISK 17,500 in January 2013); 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. The 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. The maximum monthly amount of rent benefit was ISK 46,000 (it was raised to ISK 50,000 in January 2013) and it may never exceed 50% of the rent. In 2011, 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 children in her/his care was ISK 32,000; if the children are two the highest amount possible was ISK 40,500; and ISK 46,000 if the children 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 payment from the Social Insurance Administration, rent benefit for the previous year and income payments that are not subject to tax shall be 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 shall be added to the income figure used to calculate rent benefit. In 2011, the threshold was 6,063,975 (in 2012, the threshold was ISK 6,383,000 and in 2013 it is ISK 6,651,000).

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

In 2012, the average amount of rent benefit paid to a tenant renting an apartment on the common 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.[21] Unfortunately, the average amount of rent benefit for the years 2008–2011 is not available.

At-risk-of-poverty rate of persons by household type.
A relatively high proportion of single people, with or without children, are below the poverty threshold compared to other household types. In 2008 persons living alone who are 65 or older are those who are most at risk of falling below the threshold, with a rate of 35.8% but in 2011 it was single parent with one or more dependent child, with a rate of 28.4%. The next largest group in 2008 consisted of women living alone (28.6%) and single parents (28.0%). In 2011 the second largest group consisted of single person under 65 years (25.2%) and single male (22.5%). The confidence interval in statistics on these groups is broad because of the small numbers sampled; this means that the differences recorded from one year to the next are not statistically significant.

Table 75. At-risk-of-poverty rate of persons, by household type in 2008–2011.

[21] 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

	Rate				2011	
	2008	2009	2010	2011	*CI*	*Estimated number*
Households without dependent children	11.6	13.2	9.6	9.1	±1,5	10,600
One person household, under 65 years	20.4	25.9	23.2	25.2	±4,9	6,400
One person household, 65 and over	35.8	31.1	12.7	7.7	±4,1	1,000
One person household, female	28.6	33.2	16.1	16.0	±4,9	2,900
One person household, male	22.4	22.4	23.2	22.5	±5,3	4,500
Two adults under 65 years, no children	6.8	9.5	6.8	5.8	±2,2	2,100
Two adults, at least one 65+, no children	5.0	2.7	1.1	2.7	±1,8	700
Other no dependent children	3.7	4.1	3.4	2.7	±2,1	500
Households with dependent children	9.1	8.3	10.0	9.3	±1,7	17,000
Single parent, one or more dependent child	28.0	22.8	30.1	28.4	±7,5	6,900
Two adults, 1 dependent child	6.0	5.8	5.8	6.8	±2,9	2,400
Two adults, 2 dependent child	3.8	4.2	5.8	6.9	±2,5	3,700
Two adults, 3 dependent child or more children	12.9	10.3	12.0	8.0	±3,3	3,600
Other households with dependent children	4.2	5.8	0.4	1.8	±1,6	400

Source: Statistics Iceland.

Reference is also made to the information given on at-risk-of-poverty rate in the discussion of the Article 12, para 1.

The Well-Being Watch.

Reference is made to the last report about the work of *the steering committee to monitor welfare issues, so-called Well-Being Watch,* in the reference period. The committee's role is to monitor systematically the social and financial consequences of the economic situation resulting from the economic recession in autumn 2008 for families and individuals and to promote measures to be taken to meet the needs of households. The Welfare Watch consists of 21 members, including representatives of the social partners, the government ministries NGO's and municipalities. The committee has set up eight task forces to examine various urgent matters.

The Well-Being Watch and the task forces have submitted several reports to the minister of Welfare and one to the Icelandic Parliament.[22] The committee is currently working on a report on its work from 2009 to 2013. The committee will continue to monitor developments and make proposals to the government on possible measures designed to tackle the situation and its effects on Icelandic society. Reference is also made to the discussion on the Well-being Watch under Article 14 in this report.

The Stability Pact.

An agreement, the so-called *Stability Pact*, was made in 25 September 2009 between the Icelandic Federation of Labour (ASÍ), the Confederation of University Graduates (BHM), the Federation of State and Municipal Employees (BSRB), the Icelandic Teachers' Association (KÍ), the Confederation of Icelandic Bank and Finance Employees (SFF), the Confederation of Icelandic Employers (SA), the Government of Iceland and the National Association of Municipalities. The objective of the Stability Pact was to promote economic recovery. Upon commencing the negotiations, the contracting parties agreed on specific benchmarks in order to create conditions for increased investment and economic growth: by the end of 2010 inflation would not be higher than 2.5%; the deficit in public finances would not exceed

[22] The reports can be found on the Ministry of Welfare's website:

http://www.velferdarraduneyti.is/velferdarvaktin/skyrslur/

10.5% of GDP; the exchange rate would be stabilized and the ISK strengthened and moved closer to the real equilibrium exchange rate. The difference between domestic and Eurozone interest rates would be less than four percentage points. The parties also agreed on the importance to support Icelandic households, safeguard the foundation of the welfare system, protect the educational system and preserve jobs, both in the public and private sector, to the greatest extent possible. Alongside the negotiations and completion of the Stability Pact, the social partners joined forces in eliminating uncertainty on the labour market by signing collective agreements which were valid until the end of November 2010. These agreements emphasized on improving the situation of the lowest income groups.

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

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

Table 76. Health insurance in comparison with public expenditure on health care in 2008–2011, ISK million.

	Health Insurance	Public expenditure on Health care	Ratio
2008	22,158	111,688	19,8%
2009	30,837	118,429	26,1%
2010	29,317	114,633	256%
2011	29,985	115,589	25,9%

Source: Icelandic Health Insurance and Statistics Iceland.

Table 77. Total expenditure on social protection in 2008–2010*, ISK million.

	2008	2009	2010
Total expenditure on social protection	325,675	380,043	376,894

* The numbers for 2011 have not yet been published.
Source: Statistics Iceland.

Table 78. Social Protection Expenditure, by type of benefits in 2008-2010*, ISK million.

	2008	2009	2010
1. Sickness and health care	130,674	135,538	131,651
1.1. Cash benefits. sickness and health care	23,150	21,664	21,702
1.1 1 Sickness and injury benefits	1,859	1,905	1,529
1.1.1.1 Public per-diem sickness benefits	636	599	548
1.1.1.2 Employers per-diem sickness benefits	1,224	1,306	980
1.1.2 Other sickness and injury benefits	21,290	19,759	20,173
1.1.2.1 Patient benefits	176	176	199
1.1.2.2 Wages and salaries during sickness	21,114	19,583	19,974
1.2. Health care services	107,524	113,873	109,950
1.2.1 Hospital care	74,630	78,032	75,260
1.2.2 Outpatient services	20,682	21,654	21,658
1.2.3 Pharmaceutical products	9,287	10,743	9,594
1.2.4 Other medical products	2,345	2,873	3,008
1.2.5 Health n.e.c.	580	571	430
2. Disability	44,901	53,146	53,063
2.1. Cash benefits due to disability	33,595	41,823	41,283
2.1.1 Disability pension	33,595	41,823	41,283
2.1.1.1 Social security cash benefits to disabled persons	23,508	28,622	28,005
2.1.1.1.1 Disability pension	17,187	20,708	20,442
2.1.1.1.2 Disability allowances	220	243	243
2.1.1.1.3 Child pension for parents with disabilities	2,256	2,521	2,556
2.1.1.1.4 Rehabilitation pension to disabled persons	1,585	1,964	1,713
2.1.1.1.5 Household supplement to disabled persons	1,242	2,042	1,992
2.1.1.1.6 Other disability benefits	1,018	1,143	1,059
2.1.1.2 Private pension funds. benefits to disabled persons	10,087	13,202	13,278
2.2 Services for disabled persons	11,306	11,323	11,780
2.2.1 Homes for disabled persons	6,332	7,125	7,765
2.2.1.1 Public homes for disabled persons	6,332	7,125	7,765
2.2.1.1.1 Central gov. homes for disabled persons	5,063	5,588	6,068

2.2.1.1.2 Local gov. homes for disabled persons	1,182	1,454	1,389
2.2.1.1.3 Investment on homes for disabled persons	88	83	308
2.2.2 Home care for disabled persons	1,997	1,128	774
2.2.2.1 Public home care for disabled persons	1,997	1,128	774
2.2.2.1.1 Local home care for disabled persons	1,997	1,128	774
2.2.3 Other services to disabled persons	2,977	3,070	3,241
2.2.3.1 Other services by central gov. for disabled persons	2,977	3,070	3,241
3. Old age	71,948	79,834	78,239
3.1 Cash benefits to elderly persons	65,318	72,800	71,030
3.1.1 Old-age pensions	65,318	72,800	71,030
3.1.1.1 Social security old age pensions	26,813	25,870	25,326
3.1.1.1.1 Old age pensions	23,117	22,214	21,722
3.1.1.1.2 Household supplement to elderly persons	1,517	1,847	1,724
3.1.1.1.3 Other benefits to elderly persons	2,179	1,809	1,881
3.1.1.2 Private pension funds. benefits to elderly persons	38,505	46,930	45,704
3.2 Services to elderly persons	6,630	7,034	7,209
3.2.1 Retirement homes for elderly persons	3,239	3,295	3,933
3.2.1.1.1 Public retirement homes for elderly persons	3,239	3,295	3,933
3.2.1.1.1 Central gov. retirement homes for elderly persons	2,447	2,407	3,051
3.2.1.1.2 Local gov. retirement homes for elderly persons	792	888	882
3.2.2 Home care of elderly persons	1,409	1,472	1,361
3.2.2.1 Public home care for elderly persons	1,409	1,472	1,361
3.2.2.1.1 Local gov. home care for elderly persons	1,409	1,472	1,361
3.2.3 Other services to elderly persons	1,982	2,266	1,914
3.2.3.1 Other public service to elderly persons	1,982	2,266	1,914
3.2.3.1.1 Other local gov. service to elderly persons	1,982	2,266	1,914
4. Survivors	7,486	9,130	8,901
4.1 Cash benefits to survivors	7,486	9,130	8,901
4.1.2 Death grants	139	135	131
4.1.3 Other death grants	231	250	254
4.1.4 Private pension funds. benefits to survivors	7,116	8,745	8,517
4.2 Services to survivors	0	0	0
5. Families and children	43,489	47,527	48,064
5.1 Cash benefits to families and children	21,206	23,644	22,711
5.1.1 Parental leave	9,539	10,274	9,230
5.1.3 Family or child allowance	8,875	10,084	10,342
5.1.4 Mother-and fatherhood allowances	314	334	320
5.1.4 Other family and child allowances	2,478	2,951	2,820
5.1.4.1 Spouse and home care payments	1,351	1,483	1,466
5.1.4.2 Childpension. incarceration	58	61	69
5.1.4.3 Child maintenance	974	1,308	1,282
5.1.4.4 Other cash benefits to families and children	95	99	3
3.2 Services to families and children	22,284	23,883	25,354
5.2.1 Daycare for children	12,390	13,874	14,518
5.2.3 Home-help services for families with children	386	421	421

5.2.4 Other services to families and children	9,508	9,589	10,416
6. Unemployment	5,436	25,692	25,300
6.1 Cash benefits due to unemployment	4,817	25,124	24,273
6.1.1 Unemployment benefits	4,642	24,855	23,305
6.1.4 Support for training and education	15	0	0
6.1.6 Other unemployment support expenditure	160	268	968
6.2 Services to unemployed persons	619	569	1,027
6.2.1 Other services to unemployed persons	619	569	1,027
7. Housing	10,044	14,627	16,255
7.2 Housing support	10,044	14,627	16,255
7.2.1 Rent benefit	1,535	2,584	2,704
7.2.2 Subsidized rent	1,454	1,571	1,802
7.2.3 Alleviating costs of owner-occupiers	7,054	10,473	11,748
8. Social exclusion n.e.c.	8,335	10,775	11,485
8.1 Cash benefits due to social exclusion n.e.c.	4,019	5,442	6,221
8.1.1. Financial assistance provided by municipalities	1,620	2,287	2,949
8.1.2. Special financial assistance (social exclusion)	2,399	3,155	3,272
8.2 Services related to social exclusion	4,316	5,333	5,264
8.2.1 Shelter houses due to social exclusion	0	0	0
8.2.2 Rehabilitation of alcohol and drug abusers	967	890	933
8.2.3 Other assistance due social exclusion	3,348	4,443	4,332
9. Other social expenditure (administration costs)	3,363	3,774	3,935
Total expenditure on social protection	**325,675**	**380,043**	**376,894**

* The numbers for 2011 have not yet been published.
Source: Statistics Iceland.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 286.
The Committee asks for more specific information concerning those social services which are responsible for providing personal advice and information to persons without resources with a view to informing them of their rights to social and medical assistance and the ways to exercise these rights.

All government employees in Iceland are obliged by Article 14, para 2 of the Government Employees Act, No. 70/1996, to render necessary assistance and guidance to those who seek it from them, for instance by informing them where they should direct their inquiries. Correspondingly, Article 7 of the Administrative Procedure Act, which applies to state and municipal administration, provides for a duty of guidance. The Article states that an authority shall provide those who apply to it with the necessary assistance and guidance in cases that fall within its competence. If an authority receives a written application concerning a matter outside its competence it shall forward the application to the proper authority as soon as possible. Thus, a universal duty of guidance applies to all government employees irrespective of their activities and field of work as well as the municipalities' employees.

With more specific regard to social services responsible for providing individuals without resources with personal advice and information about their rights to social and medical assistance and the manner in which they can exercise such rights, the duty of guidance is additionally widely reiterated in Icelandic legislation on social and medical assistance.

According to the Municipalities' Social Services Act, municipalities are responsible for guaranteeing the financial and social security of its inhabitants (*cf.* Article 1, para 1 of the Act). The social services provided by the municipalities consist of service, assistance and counseling in connection with social counseling, financial assistance, social assistance in the home, the affairs of children and young persons, services for adolescents, services for the elderly, services for disabled people, housing, assistance for alcoholics and the prevention of drug abuse, unemployment registration and employment services (*cf.* Article 2, para 1 of the Act). Each municipal council elects a social services committee which is responsible for the implementation of the social services in the municipality as an agent of the municipal council. Under Article 16 of the Act, social services committees shall offer social counseling to furnish information and guidance on social rights, on the one hand, and provide support in cases of social and personal hardship, on the other. According to Article 17, such social counseling covers issues such as counseling in the field of finances, housing, children's upbringing, divorce, including cases concerning custody and rights of access and adoption.

The Act on Health Insurance was passed on 16 September 2008. The objective of the Act is to ensure the access of health-insured persons to the most advanced medical care possible at any time regardless of their financial status. In short, the Act defines who has health insurance in Iceland. The Act also defines the right itself, i.e. what services and benefits individuals are entitled to, who evaluates and meets these rights. It defines who ensures the processing of benefit applications and for access to health care. The Act is based on the Health Insurance chapter in the Social Security Act No. 100/2007. The content of the rights are unchanged, but put forward in a clearer and more accessible way for the public. Moreover, health insurance is defined in more detail than it was in the Social Security Act. These definitions take into account the provisions of the EEA Agreement on Social Security. The Act stipulates an establishment of a new institution, the Icelandic Health Insurance, and describes its functions. The institution has two main roles, i.e. to be responsible for the execution of health insurance for individuals, that is to make decisions on individual rights to governments funded health care and benefits under the Act, and to ensure access to health care services by negotiating on health care services on behalf of the minister with private or public entities.

The Social Security Act states in Article 52, para 4 that the staff of the Social Insurance Administration, which is in charge of the execution of pension insurance under the Act (*cf.* Article 2, para 2 of the Act), and its agents are obliged to make a thorough investigation of applicants´ and benefit recipients´ circumstances and explain to them their rights under the Act, the regulations issued under the Act and the rules of the institute in every detail.

Moreover, according to Article 14, para 1 of the Social Assistance Act, No. 99/2007, the provisions of the Social Security Act shall apply to benefits under the Social Assistance Act as appropriate. The duty of guidance provided for in the Social Security Act thus applies to the employees of the Social Insurance Administration, which is responsible for the payment of benefits under the Social Assistance Act (*cf.* Article 1, para 3 of the Act), with regard to social assistance benefits under the Social Assistance Act. These benefits consist of single parent's allowance, child pension in connection with school studies or vocational training of young people aged 18–20, home-care allowance, spouse's benefit, homecare benefit, death grant, rehabilitation pension, household supplement, additional supplements, automobile purchase grants, automobile purchase supplements, automobile operation supplements and reimbursements of substantial expenses in connection with medical assistance and

medications.

The Health Insurance Administration is responsible for the implementation of health insurance under the Act on Health Insurance, the implementation of occupational injury insurance under the Social Security Act and the implementation of patient insurance under the Patient Insurance Act. Under Article 5, para 4 of the Act on Health Insurance, the Health Insurance Administration shall regularly publish concise information on all its activities. Furthermore, the Administration shall disseminate information to the public concerning their rights under the Act. According to Article, 2 para 2 of the Social Security Act, the staff of the Health Insurance Administration is obliged to make a thorough investigation of applicants´ and benefit recipients´ circumstances and explain to them their rights under the Act, the regulations issued under the Act and the rules of the institute in every detail. Likewise, Article 18 of the Patient Insurance Act provides that the Health Insurance Administration is obligated to inform the general public of the provisions of the Act, and that such information shall reveal, inter alia, that in cases involving self-employed health service workers, claims shall be addressed to insurance companies.

According to Article 4, para 1(1), of the Chief Medical Officer and Public Health Act, one of the principal roles of the Chief Medical Officer is to provide advice and information on matters within the sphere of the Directorate to the public. Moreover, Article 4 of the Patients´ Rights Act, on access to information on patients´ rights, states that the Ministry of Welfare shall ensure that information is available concerning patients´ rights, patients' associations and health insurance. It further states that this information shall be made accessible to patients on the premises and places of work of health institutions and self-employed healthcare practitioners.[23]

Finally, it should be noted that information on rights to social and medical assistance and the ways to exercise these rights is available on the Ministry of Welfare's website and in more detail on the websites of most of the municipalities.

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

Comment of the Committee of Independent Experts
Conclusions XIX-2(2009), p. 287.
The committee notes that the Icelandic legislation provides for a legally established right to the satisfaction of basic human material need. It asks what is the nature and extent of emergency social assistance provided in such cases and whether a lawfully present (but not resident) foreigners can be repatriated on the sole ground that they are in need.
In Iceland, the municipalities provide social services for lawfully present persons in need, who are not residents, in accordance with specific regulation. The assistance is among other things in the form of financial assistance for living expenses and housing until the person can be repatriated to his or her home country or to the country the foreigner came from if he or she wish. However, before a lawfully presented foreigner can be repatriated a checkup is carried out on his or her situation to make it possible to decide whether he or she can be repatriated. The situation of the foreigner is evaluated in all respect so the decision on repatriation is not only based on the fact that the foreigner is in need. If a decision is made to repatriate a foreigner the assistance is also in the form of payment of the travel expenses from

[23] This information can also be accessed on the Ministry of Welfare´s website:
http://www.velferdarraduneyti.is/verkefni/heilbrigdisthjonusta/rit-og-skyrslur/nr/32047

Iceland, including airfare and where appropriate, the necessary allowance for incidental expenses during the ride.

In cases where the result from the survey of the situation of the person is that he or she can not be repatriated, the assistance is among other things in the form of financial assistance for living expenses and for housing as long as necessary while staying in Iceland.

Furthermore, interpretation assistance shall be available if necessary.

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 municipalities provide the inhabitants of their areas with the necessary financial assistance, a variety of types of social counseling and assistance with the upbringing of children. Financial assistance from the local authorities is most often given in response to unforeseeable circumstances and difficulties arising from sudden setbacks, with special attention being given to the interests of the children involved.

In 2010 the Act on Municipalities' Social Services, No. 40/1991, was amended to ensure that individuals of the same sex living together were not discriminated against within the system of social services.

In 2008 the Social Services Complaints Committee received 7 cases regarding the Act on Local Authorities' Social Services, 54 cases in 2009, 28 cases in 2010 and 43 cases in 2011.

The Financial Crisis in October 2008.

In the wake of the onset of the economic recession in autumn 2008, the Minister of Social Affairs and Social Security appointed a steering committee, named the Well-Being Watch (former Welfare Watch), to monitor welfare issues in accordance with a resolution made on 10 February 2009 by the Government. The committee is expected to monitor systematically the social and financial consequences of the economic situation for families and individuals and to propose measures to be taken to meet the needs of households.

Task forces were established within the Well-Being Watch in connection with special issues to monitor the consequences of the financial crisis on individuals and families. Working groups were established with regard to such issues as children, youth and young persons (15–25 years), marginalized individuals and groups, the unemployed, the financial situation of families, health in times of crises, social indicators and basic services. Over 100 individuals took active part in an effort of widespread cooperation with the task forces collecting information from the community to give to the Well-Being Watch, the government and local authorities. The research and university community were also involved in the project.

Shortly after the financial crisis began in October 2008, the Government decided to find ways to protect the basic services provided by the local authorities. In June 2009 the Well-Being Watch, was commissioned, in collaboration with the Union of Local Authorities and the social partners in Iceland, to come up with proposals in that regard.

A special Task Force on Basic Services was formed in connection with a Stability Pact between the Government, local authorities and the social partners to undertake this task. The Minister of Social Affairs and Social Security supported the committee's view that the task force should also examine basic services provided by the state. The task force included representatives from the social partners, NGOs, the Union of Local Authorities and the Ministries.

The task force stressed that the Government should use this opportunity to streamline financially as many areas as possible in the executive system, while maintaining at the same time the welfare system, *inter alia* to safeguard the basic services provided by municipalities.

It was considered important to define the term *'Basic services'* which was at that time a new term in public administration and has been used extensively in the debate on streamlining and spending cuts since October 2008. There was a general consensus on the need to defend and maintain 'basic services', although difficulties arose in deciding the meaning of the term. Priority ranking was unavoidable in all public administration, both at the national and local government levels, and it was therefore necessary to distinguish between basic services and other services.

The task force came to the conclusion that the basic services should consist, firstly, of legally-prescribed services and, secondly, of a standard of services which has been established by tradition with regard to what individuals and families are entitled to and what can be regarded as essential even though it is not defined in law. Thirdly, basic services include those services which, though not defined in law, are needed by people with special requirements, i.e. because of disabilities or poor health, in order to tackle the challenges of daily life and to play an active role in society.

The task force's opinion was that attention must be given to the following points when the Government makes decisions on reducing specific services due to the economic situation:

1. The level of basic services must be ensured, with no lowering of the standard of services available to the most vulnerable groups.

2. Satisfactory information must be available regarding the consequences of such decisions for the receivers of the services meaning that decisions should be made in the spirit of transparency and democratic choice and in full consultation with those whom it will affect, including the receivers of services and their organizations, where these exist and, as appropriate, family members and specialists in the relevant field. Furthermore, the social partners should be consulted when the decision has a bearing on them.

3. Flat-rate cuts 'across the board' should not be applied where their full force is felt by the receivers of services; rather, streamlining should be implemented in a strictly-defined area, with compensatory measures taken to ameliorate the consequences of such cuts.

4. Equality, consistency and proportionality must be applied in all respects, ensuring that no specific groups suffer more than others as a result of streamlining measures.

5. Rationalizing and savings in one area must not result in increased expenditure and strain in other areas of public services. In particular, care must be taken to ensure that expenses are not transferred between central government and the local authorities without simultaneous changes being made to their income bases.

6. When any decision on streamlining is announced, it shall be stated whether it is a temporary measure, and if so then for how long it is to apply, or a permanent measure. All emergency measures taken during times of difficulty must be of such a nature that it will be possible to reverse them when circumstances improve without damage having been caused in the interim period.

7. When streamlining measures are applied in schools, it should be a priority to involve the immediate community, especially the parents and the 'third sector', i.e. NGOs.

If cuts are made in spending without compensatory measures being taken to ensure standards of service and equality, it will result in a cut in service levels, but not in real streamlining. Local authorities and government institutions were urged to draw up lists of services that may not be reduced, with the points above to be used as guiding principles in all levels of decision making.

From the beginning of the crisis, the Government emphasized, in line with the advise from the Well-Being Watch, the importance of resisting all reductions in services for children and families with young children, and also for other vulnerable groups including immigrants. One of the pillars of the welfare system is the school system, and special care must be taken when it comes to streamlining measures there.

Children in homes in which the single parent, or both parents, have lost their jobs or stand outside the labour market for other reasons such as disability or loss of health are in a serious risk category, and care must be taken to ensure that such children do not suffer as a result of cuts in the benefit system or streamlining measures in the school system. Rather, attention should be given to increasing assistance to such families and improving collaboration between institutions such as the social service department, the Directorate of Labour and the 'third sector' (NGOs). In December 2010 there were more than 10,000 children in Iceland that had a parent that was unemployed, and more than 300 lived in homes in which both parents were unemployed.

Most of the people who had already been in a vulnerable position before the economic recession began were in December 2010 in an even worse position. These included people with disabilities, the chronically ill, poor elderly people, the unemployed and people who depend on financial assistance from the local authorities for their survival.

A strong welfare system, and streamlining measures based on special consideration towards those in the most vulnerable positions, with appropriate priority ranking, are among the premises for Icelandic society's being able to survive the economic recession.

It can be said that the red thread in the work of the Well-Being Watch has been a focus on the welfare of children in all areas, long-term unemployment and unemployment among young people and vulnerable groups. Examples of actions taken by the Well-Being Watch were that the Watch appealed to all local authorities that lunch should be provided to all schoolchildren and extra costs for families kept as low as possible. It should be noted that many schools started already in October 2008 to offer free oatmeal in the morning before the classes started to make sure that students had a chance to eat breakfast.. The Well-Being Watch made an earnest request to the Budget- and Social Committees of the Parliament and the local governments to use caution in cutbacks in welfare services and appealed to the Minister of Health to ensure the availability of dental services for children in poor families. They also sent a letter to the Minister of Social Affairs and Social Security on securing employment and access to training for young people. One example of what was done in that respect was the establishment of *Job Square (i. Atvinnutorg).*

The Well-Being Watch criticized the cutting of payments to parents taking maternity/paternity leave. They gave warnings that the payments should not been reduced any further and should preferably be restored to their former level. Cuts in the maternity/paternity programme would in their opinion result in preventing fathers from

taking their leave and the Well-Being Watch urged the Icelandic Community to be aware of the fact that lost opportunities in childhood may not be restored later in life. The Government started in 2013 to restore the payment of maternity/paternity leave when the monthly payment ceiling was raised from ISK 300.000 to ISK 350.000.

Five years have passed from the beginning of the financial crisis and assessment of the Well-Being Watch is that most findings show that Iceland has so far succeeded in preventing serious consequences of the crisis on families and individuals. Most children are in general well cared for both at home and in schools and according to research children seem to feel better than before the crises, many of them spending more time with their parents.

People with disabilities.
In December 2010 the Parliament, Althingi, passed an Act amending the Act on Affairs of People with Disabilities, where the responsibility for services for people with disabilities was moved from the state to municipalities. No changes were made to the rights enjoyed by people with disabilities. To ensure that the rights of people with disabilities would not be violated the state established a new monitoring system with clearly defined goals and possessing the necessary resources for the task. In addition, a new amendment to the law provided for the establishment of a new committee of representatives from different Ministries, municipalities and the NGOs. This board was afforded a supervisory role to ensure that the replacement of the services from the state to the municipalities will be successful.

Iceland is now divided into fifteen operational regions in this field and the service is integrated with other local authorities' social services. In every region, people with disabilities have access to a Monitorial Officer. The Monitorial Officer supervises the conditions of the people with disabilities. If people with disabilities believe that their rights are being infringed upon, the Confidential Officer, shall give the necessary support and immediately investigate the matter. If relatives of the people with disabilities, associations of people with disabilities or others concerned with the condition of people with disabilities believe that the rights of a people with disabilities are not being respected, they shall notify the Monitorial Officer who shall immediately investigate the matter.

The Act on the Protection of the Rights of People with Disabilities, No. 88/2011, was adopted on 30 September 2011. The Act was amended in June 2012, *cf.* Act No. 59/2012, where a new Chapter V., containing provisions on compulsion in the care of persons with disabilities was added. The Act entered into force on 1 October 2012. The new rules are meant to ensure that the rights of people with disabilities are respected and aim to lessen compulsion in the care of people with disabilities. With the entry into force of the new provisions, all use of compulsion in dealing with people with disabilities is prohibited except for emergency situations or if exemptions have been granted.

According to Article 14 of the Act No. 88/2011, *cf.* Act No. 59/2012, a specialist team shall be appointed, consisting of individuals with an expert knowledge of people with disabilities' affairs and with experience of measures meant to avoid the use of compulsion. The specialist team shall give advice to service providers, comment on applications for exemption from the prohibition on the use of compulsion and receive notifications on the use of compulsion.

Any applications for exemptions from the prohibition on the use of compulsion shall be examined by a three-man exemption committee, consisting of members with expert

knowledge of human-rights issues, services to people with disabilities and the application of law in this area.

The main core of the ideology in the disability policy is social inclusion of all people with disabilities within the mainstream of society. Thus, it is strongly underlined that all persons with disabilities live and work amongst other citizens, whether regarding their residence, occupation, rehabilitation or leisure-time activities. The importance of people with disabilities‘active participation and inclusion in the society in general is therefore a major factor and a basic principle of the disability policy in Iceland. The aims of the policy are based on the mainstreaming concept and ensuring access based on the principle of Design for All.

There is quite a long tradition for people with disabilities, mainly physically disabled, participating in political activities in Iceland and, of course, public life as well. Lately, visually impaired and deaf people have also been represented to a greater degree in the political arena.

In January 2011, the City Council of Reykjavik agreed on a future plan for services to people with disabilities in Reykjavik, which was a collaborative effort with interested parties, based on the United Nations' charter on the rights of persons with disabilities, and intended to meet the miscellaneous needs of citizens by offering flexible and individually targeted services based on responsibility, respect, and expertise. The plan states that access to these services shall be ensured in the citizens' close vicinity. Furthermore, extensive consultation shall be ensured with users, interested parties, staff, and the academic community on development within the available services. Citizens who need help in their daily life shall have a say in how that help is carried out. The development of userdirected personal assistance will be implemented. A collaborative work meeting was held in September 2011 with users, supporters, administrators, key workers, and council representatives, under the heading: "Development of services to people with disabilities in the Reykjavik and Seltjarnarnes service area – next steps." The objective was to commence preparations for policymaking regarding services for the future.

Comment by the Committee of Independent Experts.
Conclusions XIX-2 (2009), p. 288.
The Committee asks what proportion is allocated to social services within the meaning of Article 14 of the Charter.

Table 79. General government total expenditure for Social Protection 2008-2011 (in millions ISK)

	2008	2009	2010	2011
Sickness	900	872	832	808
Disability	35,084	40,941	42,034	47,687
Old age	33,118	33,346	32,469	41,975
Survivors	288	313	316	319
Family and children	37,407	41,708	42,017	39,214
Unemployment	5,436	25,692	25,300	24,887
Housing	10,044	14,627	16,255	23,648
Social exclusion n.e.c.	4,609	5,882	6,714	7,724
Social protection n.e.c.	5,020	5,919	6,127	3,477
Social protection Total	**131,905**	**169,301**	**172,065**	**189,739**

Source: Statitistic Iceland.

The classification of the expenditure in table 79 is based on the COFOG standard. The total expenditure for social protection was 15.5% of the total general government expenditure in 2008, it was 22.2% in 2009, it was 21.7% in 2010 and it was 24.6% in 2011. Reference is also made to Article 12 and 13 in this report where the definions of social protection is more comprehensive.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 289.
The committee again asks whether social services are evenly distributed across the country.
Municipalities are obliged to ensure the well-being of their inhabitants and the local authorities' social services is regulated by the Local Authorities' Social Services Act No. 40/1991, with subsequent amendments. According to Article 1 of the Act, one of the purposes is to offer assistance so that the inhabitants will be able to live as long as possible in their own homes, work and live as normal life as possible. In special circumstances, i.e. when there is need for specialized services regarding employment and rehabilitation, the specific laws and regulations are applied. The welfare services offered by the municipalities include also assistance according to the Act No. 125/1999 on the Affairs of the Elderly, the Act No. 59/1992 on the Affairs of Persons with Disabilities, Act No. 59/1992 on Child Protection and Act No. 138/1997 on Rent Benefits.

Execution of the work is handled by the municipalities themselves, controlling their own affairs within the framework and standards of law. The aim of the municipalities´ social services is to guarantee their inhabitants' financial and social welfare and to contribute towards their well-being on the basis of mutual assistance and equal entitlement to the quality of life. This means that individuals in difficulty have the right to assistance in order to improve their standard of living and in order to enable them to lead independent lives and take an active part in their community. This applies to all inhabitants, no matter where they live their life. And as stated in the previous reports of the Icelandic Government, access to

social services provided by the municipalities is very easy, and all persons are entitled to seek assistance, irrespective of the nationality or standing in other respects.

As an example, the local authorites' social services 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 local authorities are obliged to lay down rules on financial assistance where the minimum amount is determined. The Ministry of Welfare has provided guidelines for the determination of the minimum.

The role of the Municipal Equalization Fund is to equalize the position of different municipalities of the country, so that they can fulfill their roles in the service of their inhabitants. In the beginning its mission was to assist municipalities, where population declined, to fulfill their roles, but after the financial breakdown it has been directed in greater extent to assist local governments in financial difficulties. The fund makes either special contributions or equalization contributions. In 1 April 2008 the Icelandic Government and the Association of Local Authorities in Iceland made an agreement on the payments of house rent benefits. The Municipal Equalisation Fund pays for 51.5% of rent benefits and 60% of special rent benefits.

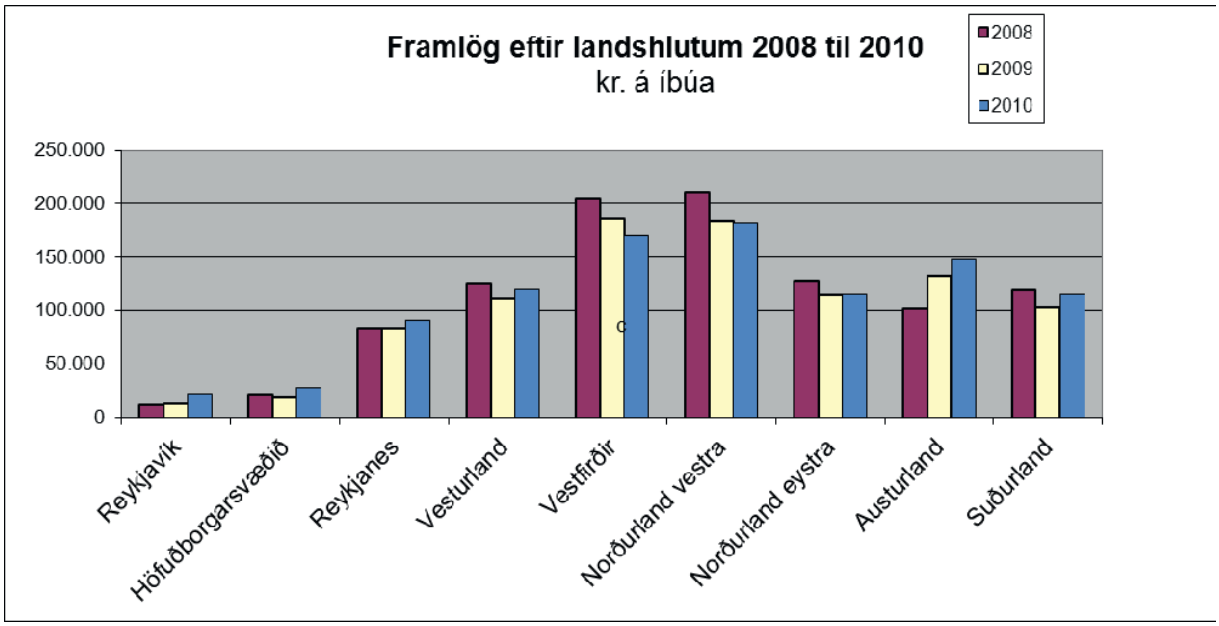
Table 80. Special contributions from the Municipal Equalisation Fund to municipalities (million ISK).

	2008	2009	2010	2011
Contributions for rent benefits	1,257	1,921	2,535	2,635
Contributions in respect of financial difficulties	0	68	187	106

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 need.

The following figure shows contributions per inhabitant from the Municipal Equalisation Fund divided into regions 2008-2010 in ISK.



Source: Municipal Equalisation Fund[24]

Figure 1. All Municipal Equalization Fund contributions divided between regions.

As an example there are statistics from two municipalities. In 2011 there were 118,898 people living in Reykjavík being by far the largest municipality in Iceland. At the same time there were 17,754 people living in Akureyri which is on the North coast of the country and is the largest municipality outside the Reykjavik capital area.

In 2010, basic financial assistance provided by *Reykjavík* could amount to ISK 125,540 per month for an individual and ISK 223,500 per month to a married or cohabiting couple, irrespective of whether or not there were children living in the household since child benefit, child maintenance and child pension payments are deemed to suffice to meet financial needs due to children. In 2011, the amount of the basic financial assistance provided by Reykjavík was raised to ISK 149,000 per month for an individual but stayed the same for a married or cohabiting couples.

[24] Höfuðborgarsvæðið: Capital Area, Reykjanes: South-West Iceland, Vesturland: West-Iceland, Vestfirðir: West-fjords, Norðurland vestra: North-west Iceland, Norðurland eystra: North-east Iceland, Austurland: East Iceland and Suðurland: South-Iceland.

Table 81. Number of households receiving services of the Reykjavik social services, by type of service in 2008 to 2011.

	2008	2009	2010	2011
Social home assistance	3,780	3,789	3,777	3,571
Financial assistance	2,774	3,292	3,799	4,150
Rent benefits	6,239	7,858	8,370	8,433
Special rent benefits – municipality's housing	2,008	2,111	2,183	2,177
Special rent benefits – private market	698	896	1,036	1,163
Personal assistance				
Number of people receiving personal assistance or supervision	451	533	570	606
Number of children receiving assistance from support families	163	137	134	124
Child welfare of Reykjavik				
Number of notifications	3,814	4,332	4,255	4,170
Number of children in child welfare cases	2,589	2,662	2,646	2,752
Number of families	2,089	2,106	2,103	2,200
Rent apartments				
Number of rent apartments	1,826	1,829	1,847	1,749
Number of housing allocations	195	185	193	184
Number of people on the waiting list at the end of the year	688	648	675	716
Service apartments for the elderly				
Number of service apartments	339	357	375	373
Number of housing allocations	44	65	84	78
Number of people on the waiting list at the end of each year	412	410	386	350
Home delivered food to the elderly or patients				
Number of people	1,063	1,066	1,128	1,139
Number of meals	123,285	130,162	135,739	135,522

Source: Annual report of the Reykjavik Social Services for 2008–2011.

Table 82. Number of households receiving services of the Akureyri social services, by type of service in 2008 to 2011.

	2008	2009	2010	2011
Rent benefits				
Expenditure thousand ISK	155,800	200,800	223,600	225,000
Number of recipients at the end of the year	785	1,186	1,251	1,230
Special rent benefits				
Expenditure thousand ISK	***	2,887	12,700	17,100
Number of recipients	***	63	131	156
Average monthly amount	***	13,000	13,000	14,000
Municipal income support				
Number of recipients	365	365	352	377

Source: Akureyri´s Annual Reports 2009 and 2010

In 2011, financial assistance provided by Akureyrarkaupstaður to an individual aged 18 or older could amount to up to ISK 131,617 per month (basis of support), it was ISK 101,626 per month in 2008 and ISK 118,521 per month in 2009. Reference is also made to the discussion of Article 13 in this report.

Social home assistance.
Municipalities are obliged to establish rules on social home assistance according to Act on Municipalities' Social Services for those who live in their own homes and due to reduced capacity, family circumstances, strain, illness, childbirth or disability cannot take care of the home and or personal hygiene without assistance.

Table 83. Numbers of households receiving social home assistance.

	The Elderly	Persons with Disabilities	Other	Total
2008	6,019	1,413	432	7,864
2009	6,160	1,517	383	8,060
2010	6,493	1,258	397	8,148
2011	6,687	858	454	7,999

Source: Statistics Iceland

In 2011 there were taken steps in Reykjavik to integrate home-services, i.e. the social home-services, night and weekend services and home-nursing was placed under one hat. It was started in one service district which reaches 1,500 users which was a third of all who receive home–services in Reykjavik and was provided by 150 employees. The objective was to improve service to those who needed it the most, to assist those individuals to enjoy a better quality of life and to make it possible for them to live an independent life at home as long as possible.

Retirement homes and nursing homes.
The following table shows the numbers of people living in retirement homes and nursing homes in 2008-2011. The state is responsible for the nursing home.

Table 84. Numbers of people placed in retirement homes and nursing homes in the years 2008 – 2010.

	Total[1]	64 years and younger	65-69 years	70-79 years	80 years and over
2008	3,284	69	97	683	2,436
Males	1,174	33	46	289	805
Females	2,111	36	51	393	1,630
2009	3,191	62	99	643	2,387
Males	1,160	34	48	281	797
Females	2,031	27	51	363	1,590
2010	3,144	65	130	597	2,352
Males	1,126	38	64	258	766
Females	2,018	27	66	239	1,586

Source: Statistics Iceland
*Number of people living in retirements and nursing homes and the elderly nursing care and geriatric wards at hospitals.

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, but they 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 occupational pension scheme and supplementary pension scheme if they had paid premiums to such schemes. 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. In 2011, 181 individuals aged 65 or older received financial assistance in Iceland; these represented 2.3% of all recipients of such assistance that year.

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. Table 85 shows the numbers of elderly people and people with disabilities who receive payments from the Social Security Institute.

Table 85. 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**
2008 – 27,925	2008 - 24,947, thereof basic pension 8,594
2009 – 25,266	2009 - 24,225, thereof basic pension 8,617
2010 – 25,113	2010 - 23,554, thereof basic pension 8,034
2011 – 26,293	2011 – 32,254, thereof basic pension 10,713
Disability pension	**Disability pension**
2008 – 14,103	2008 – 18,656, thereof basic pension 4,409
2009 – 14,507	2009 – 22,749, thereof basic pension 4,982
2010 – 14,714	2010 – 22,404, thereof basic pension 4,911
2011 – 15,197	2011 – 26,274, thereof basic pension 6,063

Source: Statistic Iceland

Allowances under the Social Assistance Act.
Table 86 shows the number of persons supporting children who were entitled to mother's or father's allowance and care-givers' allowance under the Social Assistance Act, No. 99/2007.

Table 86. Number of persons supporting others who received allowances under the Social Assistance Act, No. 99/2007, during the period 2008-2011.

	Number	Expenditure, million ISK.
Motherhood/fatherhood allowances		
2008	2,989	314
2009	2,871	334
2010	2,763	320
2011	2,655	315
Home care payments		
2008	2,203	1,351
2009	2,200	1,483
2010	2,162	1,466
2011	2,213	1,471
Spouse benefits/home care payments		
2008	135	164
2009	127	169
2010	93	139
2011	80	110

Source: Statistics Iceland

In 2008, 6,775 children were supported by motherhood and fatherhood allowances paid to their parents, 6,502 children were supported in 2009, 6,258 children were supported in 2010 and 6,042 children were supported in 2011.

In 2008, 2,833 sick and/or children with disabilities were supported by home care payments, 2,883 children were supported in 2009, 2,750 children were supported in 2010 and 2,758 children were supported in 2011.

Comment by the committee of Independent Experts.
Conclusions XIX-2(2009), p. 288.
The Committee again asks for details of the criteria public and private providers must fulfil to provide these services and the supervisory procedures to ensure that they are met in practice.
The regulation and inspection of the quality of welfare services in Iceland is split between health and social services. In the Ministry of Welfare there is a Working Group working on proposals with the aim of co-ordinated health and social services regulating body, where there is a division between the inspection role and the guiding role with the supervisory procedures and the setting of criterias and standards that the service providers, public and private, must meet.

The Directorate of Health in Iceland is responsible for supervisory procedures and inspection in the health care system. The health care system is partly responsible for the matters of the elderly. The Icelandic Health Insurance has an inspection and supervisory role towards private producers of health care, and is according to law assigned to work closely with the Directorate of Health. The Directorate of Health inspections mainly rest on laws and regulations applying in each field of service, partly on criterias and standards set by the

Ministry and partly on other grounds such as evidence based knowledge and research results. The Directorate of Health has a double function of inspection and a supervisory role.

In the field of social services and social care there is no one governmental agency responsible for the monitoring of services, as is the case in the health care system, leaving the monitoring in the social care system more fragmented. This discrepancy between monitoring of health and social care does at least partly rest on the fact that the health care system is run by central government, while the social services system is run mainly by the municipalities, such as counselling, advice, child care, home assistant services (the running of the home, personal hygiene, social support, delivery of meals, etc.) special and sheltered housing and social assistance. The services run by the local authorities are mainly monitored at local level by the local authorities themselves. Complaints over decisions at local level can be appealed to state run complaints commissions in different fields of services.

In the field of child care the Government Agency for Child Protection has the role to supervise and monitor the work of Child Protection Committees on local level and supervise and monitor institutions and homes operated by national government. According to the principle that service provision and inspection should not be at the same hand, the monitoring of homes and institutions run or supported by central government has been transferred to the Ministry of Welfare. The Government Agency for Child Protection has set its standards for fosterhomes and institutions run by the agency.

The field of rehabilitation and unemployment are under the auspices of the Ministry of Welfare. A working process is ongoing as to how to monitor and safeguard these services and its users. Development is strong, new projects are being launched in co-operation between the state, the social partners, municipalities and the third sector, not all involved at once, but to some extent all of them, some of the time. Decisions on matters as to where contracts for services are to be housed, what standards and criterias should be used for monitoring of the services and who will be the responsible partner for the monitoring, has been one of the chores of the Ministry of Welfare in 2012 and 2013.

In December 2010 the Parliament, passed an Act on Affairs of People with Disabilities, with subsequent amendments, where the responsibility for services for people with disabilities was moved from the state to municipalities. A new committee of representatives from different ministries, municipalities and the NGOs has a supervisory role to to watch over the transfer of service provision from the state to the municipalities. The Ministry of Welfare is responsible for the monitoring of services, the definition of register data that local authorities are obliged to hand in with monitoring purposes in mind and the setting of standards, in co-operation with the national Associaton of Local Authorities. These tasks are for the time being in the Ministry of Welfare. The standards for the services are definde by law, new guidelines and an Action plan for People with Disabilities valid until 2014.

A new Act which applies to the protection of the rights of people with disabilities has been launched. The Act on Protection of the Rights of People with Disabilities in 2011. The ministry shall supervise people with disabilities‘rights and shall set up a special rights monitoring unit within itself and its role is to monitor the work of rights protection officers for people with disabilities and give them guidance, to gather data on matters relating to people with disabilities‘rights. The minister shall appoint a specialist team on messurest to avoid the use of compulsion and also a committee on excemptions from the prohibition on the use of compulsion. The Act entered into force on 1 October 2012. The new rules are

meant to ensure that the rights of people with disabilities are respected and aim to lessen compulsion in the care of people with disabilities.

Services related to alcohol and drug abuse.
Alcohol and drug rehab is largely in the hands of the National Center of Addiction Medicine (SÁÁ), which is a non-governmental-organization. Its main goal is to combat prejudice and to promote knowledge on alcohol- and drug addiction, and to ensure that drug addicts and their families have access to the best treatment and services available.

The following table shows the numbers registered for treatment at the National Center of Addiction Medicine (SÁÁ) 2008-2011.

Table 87. Numbers registered for treatment at the National Center of Addiction Medicine in 2008–2011.

Year	Number
2008	2,206
2009	2,219
2010	2,085
2011	2,180

Source: National Center of Addiction Medicine (SÁÁ)

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

Table 88. State Contributions to the National Center of Addiction Medicine (SÁÁ).

Year	Millions ISK
2008	766
2009	733
2010	665
2011	614

Source: State Treasury

Human Trafficking
The Government of Iceland adopted its first National Action Plan against Trafficking in Human Beings on 17 March 2009. The National Action Plan against Trafficking in Human Beings lays down the priorities of the Government of Iceland with regard to combating trafficking in human beings.

The objective of the National Action Plan is to enhance coordination between parties in dealing with trafficking in human beings in order to prevent human trafficking in Iceland and to further study trafficking in human beings. Furthermore, it specifies actions that are aimed at prevention and education regarding this matter and aimed to ensure that aid and protection to victims is provided. Emphasis is placed on actions that aim at facilitating the prosecution of the perpetrators. At the same time, the intention is to initiate necessary legislative amendments.

The priorities include: *(a)* the ratification of the Palermo Protocol and the Council of Europe 2005 Convention on Action against Human Trafficking, and the legislative amendments the ratifications require; (*b)* the establishment of the supervisory specialist and co-ordination

team; *(c)* the establishment of a specially trained police unit to investigate alleged cases of human trafficking; and *(d)* education and training of various professional groups that may encounter possible victims of human trafficking in their work.

Responsibility for these issues was transferred from the Ministry of Social Affairs and Social Security (now the Ministry of Welfare) to the Ministry of Justice and Human Rights (now the Ministry of the Interior) on 1 October 2009, and the Minister of Justice and Human Rights appointed a Specialist and Coordination Team on Human Trafficking on 21 October 2009. The team's role is wide-ranging: amongst other things, it is expected to maintain an overview and knowledge of human trafficking activities in Iceland, to follow up tip-offs about human trafficking, recognise potential victims of human trafficking and guarantee them protection and assistance. Furthermore, the team is expected to record alleged cases of human trafficking, provide education and awareness-raising concerning human trafficking, monitor the execution of the Plan of Action and act in an advisory capacity to the Government on human trafficking issues.

During the period from October 2009 to the end of 2010, the team examined the cases of nine alleged victims of human trafficking: seven women and two men. Seven of these cases involved trafficking for the purpose of sexual exploitation, while two concerned suspicions of trafficking with forced labour as the aim. These cases were of very different types and called for different types of measures, including helping a victim to find support structure in her/his country of origin through the International Organization of Migration and providing extensive social support and health care for rehabilitative purposes. In one of the cases, offers of assistance were rejected. Also during this period, one judgement was delivered in which the court handed down a conviction for a human trafficking offence, while in two cases the defendants were acquitted of charges of human trafficking.

Among the changes made under the Plan of Action against Human Trafficking has been Iceland's ratification of the UN Convention against Transnational Organized Crime of 2000 and the Protocol to it to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (one of the 'Palermo protocols'). Iceland ratified the Convention on 13 May 2010 and the Protocol on 22 June the same year. As a measure in preparation for the ratification, Article 227 a of the General Penal Code was amended so as to bring the definition of trafficking in human beings into line with that of the Palermo Protocol. Also, under the Act No. 115/2010, which was passed by the Althingi on 9 September 2010, two new categories of residence permit were added to the Foreign Nationals Act, No. 96/2002. These are designed to guarantee the interests of victims of human trafficking in accordance with the European Convention against Trafficking in Human Beings of 2005. These are, on the one hand, a six-month residence permit to give victims time for recovery and reflection, and on the other a one-year renewable residence permit. The Council of Europe's Convention on Action against Trafficking in Human Beings was ratified by Iceland on 23 February 2012 and took effect vis-à-vis Iceland on 1 June the same year.

The vast majority of the measures outlined in the Plan of Action have already been implemented or are in preparation. Funding amounting to ISK 10 million was secured for the Specialist and Coordination Team for 2011.

In September 2011, a reception centre, *Kristínarhús*, was opened by the Educational and Counselling Centre for Victims of Sexual Violence (*Stígamót*). This is intended specifically for women who are leaving backgrounds in prostitution and/or human trafficking. They are

able to stay there in private rooms for short or long stays, and various services are available to them.

Prostitution.
An amendment to the General Penal Code, No. 19/1940, with subsequent amendments, was approved by the Althingi in April 2009 under which purchasing the services of a prostitute was made a criminal offence. The actual form of payment or reimbursement – in cash, alcohol or drugs, items or some form of assistance, favour or service – makes no difference. Legislation of this type is often referred to as 'the Swedish way' and is based on the view that it is the responsibility of the legislature to stand against the sale of sexual favours as it is unacceptable to regard the human body as a sellable good. It should be mentioned that there was broad support among members of the women's movement for the criminalization of the purchase of the services of prostitutes. In autumn 2003, 14 organisations had sent members of the Althingi an appeal to enact such a prohibition in law. In a statement accompanying this appeal they highlighted the connections between the pornography industry and prostitution and affirmed the view that prostitution was a form of sexual abuse that should be opposed. Making the purchase of prostitutes' services punishable was seen as an active means of protection.

In March 2010 the Althingi passed an amendment to the Restaurant, Guesthouse and Entertainment Act, No. 85/2007, with subsequent amendments, banning commercial displays of nudity (strip-tease acts) in restaurants. This includes an absolute prohibition on the commercial exploitation of nudity of employees or other persons on the premises.

Committee on violence against women.
The consultative committee on measures to combat violence against women was reappointed in 2007, its appointment to run from 26 November 2007 to 31 December 2010. Representatives of the Ministry of Justice and Ecclesiastical Affairs, the Ministry of Health, the Ministry of Education, the Ministry of Social Affairs and Social Insurance, the Gender Equality Agency and the Association of Local Authorities. The committee's main assignment was to supervise the implementation of the Plan of Action against domestic violence and gender-based violence.

Study of violence perpetrated by men against women in intimate relationships.
The Ministry of Social Affairs and Social Security commissioned the Research Centre on Child and Family Protection Issues at the University of Iceland to undertake a study of violence perpetrated by men against women in the context of intimate relationships. Preparations for this study were made in the ministry, drawing on specialist advice from a criminologist. The study was divided into six investigative modules, the first of which took the form of a telephone survey, after which studies were made of the situation in the municipalities' social service departments, covering matters including child protection, in kindergartens and junior schools, in the health services, and in the police and non-governmental organisations.

1. The telephone survey.
It was expected that this broad-coverage telephone survey would provide important information on the extent and nature of violence perpetrated by men against women, the remedies used by women who are the victims of such violence and how effective they have proved, and also information on the perpetrators. The findings produced by this survey will be used as the basis of further measures taken by the Government in this area.

The report on the telephone survey states that its aim is to add to knowledge on the nature, extent and consequences of the physical and sexual violence which women suffer at the hands of men. A random sample of 3,000 women was selected from the National Register, covering the whole country and the age range 18-80. The upper age limit was chosen because it was considered important to include older women. The study drew on a study devised by the United Nations and the questionnaire designed for it (*the International Violence against Women Survey*).

The women were interviewed by telephone during the period 22 September – 7 December 2008, and the response ratio was 73%. A detailed report on the findings was issued by the Research Centre on Child and Family Protection Issues at the University of Iceland. The main findings were that over 22% of the women said they had experienced violence in an intimate relationship at some time from the age of 16 onwards. This indicates that 23,000-27,000 women in Iceland have experienced violence of this type during their lives. About 20% of the women said the violence had been physical. More than 6% of the women said it had taken the form of sexual violence. A higher proportion (19%) said they had suffered violence at the hands of an ex-spouse or partner than at the hands of their present spouse or partner (7%). A higher proportion (51%) of the women who had experienced violence were now divorced; the proportion of those married was 17%, while 18% were neither married nor divorced. This distribution is explained by the fact that most women who suffer violence in intimate relationships either divorce their partners or leave the abusive relationship. About 75% of the respondents had children living in the home at the time of the last violent incident, and about 24% thought that the last violent incident had been witnessed by children. Between 1% and 2% of the women reported having suffered violence in intimate relationships in the past twelve months, which indicates that 1,200-2,300 women experience violence each year. Only a small proportion (13%) of women who had suffered violence presented charges to the police; in 4% of cases, the police became aware of the violence by other means. Of those women who pressed charges, 65% were satisfied with the way the police tackled the matter, while 35% were not. Women who did not report violence to the police mentioned various reasons for this. Most of them (44%) said they regarded the incidents as being minor and not sufficiently serious, or that it did not occur to them to press charges; about 20% said they tackled the matter themselves, 9.5% said they felt it was an embarrassing or shameful matter, or else blamed themselves, and 7.3% mentioned fear of the perpetrator or fear of subsequent acts of vengeance.

2. Studies of the situation in the social services and child welfare departments.
The findings of this part of the study are seen as providing important information on the extent to which violence perpetrated by men on women in intimate relationships comes to the notice of the municipalities' social services, including the child welfare departments, and what remedial measures are taken. It is hoped that this data will later be of use as the basis of further measures taken by the social services and the child welfare departments.

The main findings of the study indicate that children seem in most cases to be a factor in applications for assistance from the municipalities' social services; it is rare that childless women seek help. The presence of children in the home is also the reason for notifications in cases of this type. At the same time, the recording of cases involving domestic violence is far from ideal, so it is not possible to extract data showing the numbers of women who seek help because of it. Limited information is available on violence towards sensitive groups of women, e.g. elderly women, women of foreign origin and women with disabilities. In

addition, the report noted that the Women's Refuge (*Kvennaathvarfið*) is considered the most important cooperative body in cases connected with domestic violence and that a great deal of confidence is placed in its staff. The report also states that mental cruelty towards women is thought to have become more prevalent in recent years; it can be difficult to tackle such cases and provide the women with the necessary support or assistance. Special attention is given to the situation regarding children in homes where domestic violence takes place and providing these children with support. Many of those interviewed considered that in most cases where assistance was sought in cases of domestic violence, alcohol abuse was also involved. The report found that more education was called for regarding domestic violence for employees involved in counselling in the municipalities' social services and child welfare departments and also for employees involved in home-help services and in-home nursing services, and also other persons involved in handling such cases, such as staff of kindergartens and the police.

3. Study of the situation in elementary schools.
The findings of this part of the study are seen as providing important information on how cases involving violence perpetrated by men on women in intimate relationships come to the attention of school principals and the procedures employed in responding to them. This information may lead at a later stage to further measures being taken by the elementary school authorities in this area.

The principal findings of the study show that school principals have limited knowledge of violence against the mothers of their pupils. They inform the child welfare departments or social services of the municipalities if they receive information regarding violence in their pupils' homes. At the same time, the role of the schools in this context is unclear. There seems to be an incompatibility between their educative and care-providing function, and school principals take different views of the situation. Furthermore, the roles of individual members of staff are unclear if cases of domestic violence in their pupils' homes become known to them. The report states that more discussion of violence against women is needed within the school community. There is virtually no discussion of such matters in the schools. Awareness of violence against women needs to be increased among teachers and other school staff, and it is vital that awareness-raising measures will be aimed at enabling teachers to recognise the symptoms when their pupils come from violent homes, and that efforts be made to change the response procedures followed by the schools. Finally, it was found that there was a lack of specialist knowledge regarding personal counselling in the schools, and that steps needed to be taken to ensure that school pupils had access to personal counselling.

4. Study of the situation in the health services.
The aim of this part of the study was to examine the responses made by the health services when women who had experienced violence at the hands of their spouses/partners or ex-spouses turned to them for help.

In this part of the study, interviews were taken with employees of the health services who were considered most likely to have an over-view of the situation regarding these matters in their respective institutions. Altogether, 19 people employed in nine institutions were interviewed. These included five interviews in the National and University Hospital (*Landspítalinn - Háskólasjúkrahús*) in which eight staff members took part, one in the National Center of Addiction Medicine (*SÁÁ*) and interviews with two employees of the Akureyri District Hospital. Other interviews involved employees at the *Seltjarnarnes* and *Breiðholt* Primary Health Clinics (both in the metropolitan area) and staff at clinics in

Ólafsvík, Eskifjörður, Southern Iceland and in *Akureyri.* The interviews lasted between 40 minutes and one and a half hours.

The authors of the report draw the conclusion that registrations in the health-care system cannot be used as the basis of an assessment of the frequency of domestic violence or of whether such cases are on the increase or on the decline. No concrete procedures exist for dealing with cases in which women report violence. Furthermore, those interviewed in this part of the survey called for more education on these issues, including recognition of principal symptoms, how to ask questions and how to respond if they themselves experience violence. The report states that these issues need to be addressed in the basic training of workers in the health-care services and also in their continuing education courses. Furthermore, it has often been pointed out that it is important to have a central institution to which cases involving violence could be referred for appropriate handling.

5. The situation in non-governmental organisations (NGOs).
The findings of this part of the study are seen as providing important information on the extent to which cases involving violence perpetrated by men on women in intimate relationships come to the notice of NGOs which are either primarily concerned with assisting women in abusive relationships or which occasionally assist women in such cases. Findings indicate that the level of services is highest in the metropolitan area; both the Women's Refuge (*Kvennaathvarfið*) and the Women's Counselling Service (*Kvennaráðgjöfin*) are located in Reykjavík. The type of services required depends primarily on the women's circumstances. The report states that about half of the women who stayed in the Women's Refuge returned home to unchanged circumstances following their stay. It also states that women with disabilities, elderly women and foreign women are not taken adequate account of in these services, and that foreign women are in a very different position from others. Women either seek assistance themselves or else are brought to the refuge by others. In their conclusions, the authors of the report point out that the scope of these services is limited, with only one women's refuge operating in the country (in Reykjavík), in addition to which the Women's Counselling Service is also in Reykjavík. They also state that interpreting services leave much to be desired. Everyone who was interviewed was of the opinion that the interpreting services available were far from adequate, and in many cases no services at all were on offer. The report also states that professional workers' attitudes are of great significance. Where professional workers are informed and on the alert for symptoms of violence, then violence will be more visible. More sophisticated medical certificates would result in a clearer view of violence. Finally, the report states that educational and awareness-raising materials on violence against women in intimate relationships need to be improved.

6. The study of the situation as it involves the police.
The study was directed towards gaining a knowledge of the steps and decisions taken by the police when they receive notifications of violence perpetrated by men against women. Those conducting the study talked to police commissioners or other actively-employed police officers in five of the regional police jurisdictions in the country: in *Akureyri*, in the metropolitan area, in *Ísafjörður*, Southern Iceland and *Suðurnes*. They also talked to persons with qualifications in Social Science who are employed by the Office of the National Commissioner of the Icelandic Police and the Office of the Metropolitan Police Commissioner, and with the principal and teaching staff of the Police Academy.

The questions asked concerned six principal aspects of the registration of cases of this type: the procedures followed by the police, specialisation, collaboration with other institutions, the

views of the police regarding whether they had sufficient measures at their disposal to deal with cases of violence perpetrated by men against women in intimate relationships and finally the interviewees' opinions regarding the training provided by the Police Academy regarding offences of this type. In their findings, the authors of the report state that improvements were made in the registration and handling of cases after the National Commissioner of Police issued special rules of procedure. None the less, the criminological data published by the police cannot be used to assess the scale of the problem or whether offences are on the increase or on the decline. According to the report, most of the violent crimes registered by the police are minor, in a legal sense, and it is rare that charges are pressed. Some specialist expertise in the handling of domestic violence and sexual offences has been developed in the Metropolitan Police, with the establishment of a special department to handle cases of this type, and police officers there receive special training. Elsewhere, attempts are made to ensure, as far as possible, that the same members of staff handle cases of this type. In the opinion of those interviewed, this had produced good results. They also declared their satisfaction with the training given in the Police Academy on handling cases of this type. The authors of the report consider it evident that the measures best suited to achieving results lie outside the scope of the police, since in most cases what is needed are solutions in the spheres of social work and psychological services.

Domestic violence.
Combating violence against women is a high priority of the Icelandic government. It is of concern that only a small portion of rape victims file charges, and few of them lead to indictments or convictions. Extensive consultation on the matter has been launched under the auspices of the Ministry of the Interior, with the participation of academics, police, NGOs working with rape victims, the State Prosecutor and the judicial branch.

The General Penal Code contains provisions prescribing heavier sentences in cases concerning sexual abuse and other violent cases where there are close relations between the perpetrator and the victim as can be seen in the court practice.

Law No. 85/2011 has replaced the law No. 122/2008. The new law include a fundamental change, giving the police power to make decisions about restraining order and expelling the accused from homes in cases of domestic violence, "the Austrian-Model". The aim of these changes is to make these resources more effective and more efficient so the victim does not have to wait for up to 3 days for the a Courts Judgement, like the older legislation required them to do. The arrest warrant gives victims undoubtedly increased protection since the police can arrest the offender right away in the beginning of the case and the police can keep the offender for up to 24 hours or until formal decision has been made about the restraining order and the expelling the offender from home.

The process of these cases is now more efficient and increase protection for those who are victims of offences and seek the assistance of the police. The police experience is the conduct and procedures of these cases are easier since the decision making has moved to the police right in the beginning and it has obviously much shorter procedure time than it had before with the old laws. So far it cannot be said cases have increased due to the change of legislation, there have been less than 10 cases since the law entered into force. It must be noted in this context that restraining order under the law are not only resources used for the benefit of a criminal investigation, it can also be used even though a charge has not been filed or a charge has and a claim of punishment have been filed. There has no criminal case been so far where the offender has violated the restraining order. In cases where a restraining order

is a provision in connection to a charge of a physical assault, threats or disturbance the Court Order does not discuss the restraining order particularly if the offender has not violated the restraining order.

The 'Men's Responsibilities' project (*Karlar til ábyrgðar*) was revived in May 2006. This is an offer of specialised treatment assistance for men who use physical violence in the home in Iceland. Such treatment programmes have produced good results, both in Iceland and abroad. Psychologists administer the treatment, the aim of which is to cater for men who have employed violence in the home and to assist them if they are prepared to seek assistance. Priority is attached to having perpetrators seek treatment voluntarily and accept responsibility for having resorted to violence. Treatment is based on individual therapy sessions, which may last for periods between six months and two years. Concurrently with these services, a special management committee is in charge of the project with representatives from the Ministry of Welfare, the Centre for Gender Equality and the Women's Refuge; the Women's Refuge's representative is the manager of the project. The role of the management committee includes defining the direction in which the project is to be developed in future in consultation with those who actually provide the treatment, to monitor day-to-day operations and to make assessments of the results achieved.

From the time when the project was revived in May 2006 until the end of 2010, 108 individuals had attended one or more therapy sessions. From January to August 2010, 25 new men came for therapy sessions, in addition to which 13 continued with their therapy sessions that had begun the previous year. During this period, twelve women attended sessions in the capacity of spouses/partners. Group therapy sessions were fully-booked throughout 2010. In 2011, 32 new men attended sessions and 19 continued with treatment that had begun the previous year. Twenty spouses attended therapy sessions in 2011. The group therapy sessions were fully-booked all year (with 6 persons in each group).

Sexual Offences.
Seventy-one cases were referred to the Department of Public Prosecutions in 2007 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. Forty-nine cases were dropped, but indictments were issued in 19. Acquittals were rendered at the district court level in two cases and convictions in 17 cases. Appeals were lodged against 11 of these judgements with the Supreme Court, which acquitted one appellant and convicted ten. In 2008, 46 cases were referred to the Directorate of Public Prosecutions, of which 14 resulted in indictments. Seven of these cases led to convictions at the district court level. Seven appeals were lodged with the Supreme Court and it rendered acquittals in three of them. In 2009, 42 cases were referred to the Directorate of Public Prosecutions, of which 14 resulted in indictments. Seven of these cases led to convictions at the district court level, and six in acquittals; one case has yet to be judged, as the accused left the country. Altogether, six cases were appealed against to the Supreme Court, which delivered a verdict of acquittal in one case and convicted in the other five.

In 2010, 49 cases were referred to the Directorate of Public Prosecutions. Twenty-three indictments were issued; 24 cases were dropped and investigations were curtailed in two. Sixteen of the indictments led to convictions at the district court level and seven to acquittals. Thirteen cases were referred to the Supreme Court; in nine cases the Supreme Court upheld convictions, rendering acquittal rulings in four.

In 2011, 64 cases were referred to the Directorate of Public Prosecutions Twenty-seven indictments were issued and 32 cases were dropped. Investigations were curtailed in four cases, and one was sent abroad for treatment. Of the 27 cases in which indictments were issued, acquittals were rendered in 10 cases and convictions in 15; two remain to be judged. Appeals were lodged with the Supreme Court in 14 cases. The Supreme Court rendered convictions in nine cases and acquittals in three; two cases are yet to be judged by the Supreme Court.

The Safe Shelter/ Women´s Refuge (Kvennaathvarfið)

The aim of the organization running the Safe Shelter/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. It is also the organization's aim to provide counselling and information and to stimulate publicity and discussion of the problem of domestic violence.

Table 89. Admissions and interviews at the *The Safe Shelter/Women´s Refuge* 2008-2011.

	2008	2009	2010	2011
Total admissions	549	605	864	671
Interviews*	419	487	746	546
Stay periods	130	118	118	107
Number women without children	81	74	79	62
Number of women with children	49	44	39	45
Number of children	77	60	54	67
Total number of clients	341	319	375	299

Source: Women´s Refuge´s Annual report for the year 2010 and 2011
*Interviews during stay are not in this number.

The total number of women that sought assistance from the Women's Refuge in 2009 was 319. There was a rapid increase in the number of women staying at the shelter from 2007 to 2008, but the number decreased considerably between 2008 and 2009, or from 130 to 118. The number of children who stayed at the shelter dropped from 77 to 60. In 2009 the women spent an average of 11 days at the refuge or seven days less than the year before. The average number of days that children spent at the shelter was 10 days. In average did six individuals stay at the shelter a day, four women and two children.

The number of admission in 2006 was a record at that time (712) but reach a new record in 2010 (864). Many women were admitted more than once, either for interviews or periods spent in the refuge; this figure represents 107 women who sought admission to stay there during the 2010, including 54% who had not previously applied to the refuge. The number of women staying at the refuge was the same in 2009 and in 2010. The number of children staying at the shelter decreased on the other hand. Between 2009 and 2010 the number decreased from 60 children to 54 children. The average number of individuals staying at the shelter in 2010 was 15 days. In average, women with children stayed for a longer period of time than women without children did and women with a foreign origin stayed longer then Icelandic women did. The average number of days that children spent at the shelter was 23 days. In average, there were four women and four children at the refuge every day during 2010. The number of interviews taken during that year was 746 which was a record. In average did each woman that registered at the centre attend two interviews during the year.

107 arrivals were registered at the shelter in 2011 and 564 interviews were taken, in total 671 but that number has only two times before been so high in one year in the shelter's history. Many women arrived more than once, especially those who came for an interview but overall did 299 women seek assistance at the shelter during the year. The arrivals of women had than decreased between years. The number of women staying at the shelter decreased from 118 in 2010 to 107 in 2011. The number of children staying at the shelter had increased on the other hand from 54 in 2010 to 67 in 2011. In 2011 the women spent an average of 15 days at the refuge. The average number of days that children spent at the shelter was 23 days. In average did eight individuals stay at the shelter a day, four women and four children.

The number of women applying to the Women's Refuge indicates not so much the extent of gender-based violence in Iceland but rather whether or not the victims know of the services provided by the refuge and whether they are prepared to use them. Studies indicate that the actual extent of violence is far greater than the statistics from the Women's Refuge suggest, and it is therefore seen as a positive thing that the number seeking assistance there should be

large rather than small.

On arrival at the Women's Refuge, either to stay or to attend a counselling session, the women are asked the reason for their visit. Most give more than one reason; for example, mental cruelty is generally found together with physical violence. In most cases, they are also seeking support to get through a difficult phase in their lives. It is much more commonly the case that women apply to the Women's Refuge because of mental cruelty than because of physical violence; mental cruelty can be no less serious a situation. It can take the form of threatening behaviour, financial dominance, isolation and degradation. More women give mental cruelty, physical violence and sexual abuse as the reasons for their visits to the refuge than used to be the case; in the same way, more now come to the centre because of threats and persecution than before. This is worrying, as it seems that violence is assuming a harsher form, but the reason may also be increased awareness of gender-based violence and the forms that it can take.

The Education and Counselling Centre for Survivors of Sexual Abuse and Violence (Stígamót).

About 1612 individuals came to the Education and Counselling Centre for Survivors of Sexual Abuse and Violence, (*Stigamót*), in the period 2008–2010; 547 did so in 2008, of which 253 were making their first visit to the centre. In 2009, 539 individuals came to the centre, including 210 who were seeking help for the first time. In 2010 the total number was 526, of which 251 were seeking assistance for the first time. The breakdown by sex for the years 2008-2010 is presented in the following table.

Table 90. Persons received by Stigamót for the first time: breakdown by sex

	2008		2009		2010		2011	
	Number	Proportion	Number	Proportion	Number	Proportion	Number	Proportion
Women	210	89%	191	91%	226	90%	246	88.5%
Men	26	11%	18	8.6%	24	9.6%	32	11.5%
Information missing	-	-	1	0.5%	1	0.4%	-	-

Source: Education and Counseling Center for Survivors of Sexual Abuse and Violence Annual report for 2008, 2009, 2010 and 2011.

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. Ninety-three individuals contacted the centre in 2010 in connection with incest and its consequences and 108 in connection with rape. Thirteen contacted the organization in connection with prostitution and seventy-nine in connection with sexual harassment.

Tafla 91. Reasons for seeking assistance at Stígamót, 2010 and 2011.

	2010		2011	
	Number	**Proportion**	**Number**	**Proportion**
Incest	93	18,6%	103	17,0%
Suspicion of incest	3	0,6%	5	0,8%
Rape	108	21,6%	143	23,6%
Suspicion of rape	12	2,4%	12	2,0%
Attempted rape	15	3,0%	29	4,8%
Porn	13	2,6%	23	3,8%
Prostitution	13	2,6%	12	2,0%
Sexual Harassment	79	15,8%	101	16,6%
Psychological abuse	75	15,0%	89	14,7%
Physical abuse	48	9,6%	63	10,4%
Persecution of an abuser	23	4,6%	20	3,3%
Other	12	2,4%	3	0,5%
Uncertain	5	1,0%	4	0,7%
Total	**499**	**100%**	**607**	**100%**

The above table 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 2010 and 2011 and it shows as well the reasons for their arrival. The people who use the service that the Education and Counselling Centre for Survivors of Sexual Abuse and Violence has to offer, often seeks their assistance to work their way through old traumas, often more than one trauma. That is the reason why the reasons for arrivals are more than the individuals arriving.

Tafla 92. Age of people when seeking assistance at Stígamót, 2010 and 2011.

	2010		2011	
	Number	**Proportion**	**Number**	**Proportion**
17 years and younger	10	4,0%	17	6,1%
18 - 29 years	137	54,6%	150	54,0%
30 - 39 years	46	18,3%	46	16,5%
40 - 49 years	28	11,2%	37	13,3%
50 - 59 years	17	6,8%	19	6,8%
60 years and older	3	1,2%	7	2,5%
Information missing	10	4,0%	2	0,7%
Total	**251**	**100%**	**278**	**100%**

The table above shows the age of people when assistance was sought in 2010 and 2011. More than half of the people that used the service of the Education and Counselling Centre for Survivors of Sexual Abuse and Violence for the first time were 10-39 of age.

Aflið á Akureyri.

A similar shelter against sexual and domestic violence is run in Akureyri on the North Coast of Iceland, named *Aflið*. Private interviews there, including by phone, were 285 in 2008, 324 in 2009 and 427 in 2009. The number of new individuals in 2009 were 66, 50 females, 3 males and 13 related persons or supporters. The number of new individuals in 2010 were 82, 48 females, 8 males and 26 related persons or supporters. *Aflið* has received state grants in the reference period, 2.5 million ISK in 2009, 1.6 million in 2010.

The Emergency Reception Centre.
The Emergency Reception Centre for Victims of Sexual Violence is a part of Landspitali, the university hospital, and the main hospital of Iceland. The emergency´s aim is to ensure the welfare of victims of rape, attempted rape or other sexual violence. The services purpose is to reduce or prevent mental and physical health effects which are often the result of sexual violence.

Table 93. Number of men and women that sought help at the Emergency Reception Centre.

	2008	2009	2010	Average from 2005-2010	2011
Women	116	129	108	125	117
Men	2	1	8	4	1
Total	118	130	116	129	118

Table 94. Number of persons that sought help at the Emergency Reception Centre. Breakdown by age.

Age	2008	2009	2010	2011
10 to 15	17	26	9	6
16-18	28	19	14	15
19-25	45	50	60	63
26-35	18	14	19	18
36-45	4	12	11	11
46-55	4	7	3	2
>55	2	2	0	3

Number of arrivals at the Emergency Reception Centre has not risen after the economic crisis. In 2009 the incident number was similar to previous five years, but in 2010 the number of incidents fell 10% from the year before.

As one can see are women the majority of those who seek assistance at the Emergency Reception Centre. Nevertheless, the number of men who seek assistance has increased in the last few years. According to the Emergency Reception Centre it is not possible to draw any conclusions from that fact, except perhaps that the debate on sexual offenses against men and boys is more open now in the community than it was before. Overall are more than 70% of the cases that come before the centre defined as rape cases and in more than one third of the cases has the alleged victim been in an alcoholic and/or drug coma. The background of the cases is usually a brief encounter between the alleged victim and the alleged perpetrator and usually it as associated with nightlife.

Article 14, para. 2 – Public participation in the establishment and maintenance of social welfare services.

The state has continued to support institutions active in the sphere of social services. Total allocations under the budget for 2011 amounted to ISK 414 millions, divided as shown in table 95. This is not necessarily an exhaustive list of public support grants to NGO's.

Table 95. State grants to institutions active in the sphere of social services 2011 (Thousands ISK).

Name

1. ADHD-association 2,700
2. Multicultural Center..... 3,500
3. *Barnaheill* (child welfare)..... 5,000
4. *Blátt áfram*, preventive project 2,700
5. National Association of the Blind..... 10,600
6. National Associaltion of the Deaf and Blinds..... 700
7. National Association of the Deaf 19,900
8. *Strókur* – Rehabilitation centre for people with mentally disabilities ...…… 9,800
9. Society of Parents Equality …..... 1,000
10. Single Parents' Society.. 2,900
11. Education for the families of the disabled..... 800
12. The Charity of the Church..... 12,000
13. *Hlutverk* – Association of rehabilitation..... 500
14. Women's Counselling Service..... 800
15. *Landsbyggðin lifi* 1,000
16. National Senior Citizens' Association..... 4,000
17. *Þroskahjálp* (the National Federation for the Aid of the People with Disabilites)..... 9,000
18. *Höndin* Charity organization 1,000
19. *Mæðrastyrksnefnd Reykjavíkur* Charity organization..... 8,000
20. New Dawn (association for the bereaved)..... 500
21. *Regnbogabörn* (rainbow children)..... 3,000
22. *Krossgötur*, rehabilitation home 23,000
23. Samtökin 78 (Gay People Association)..... 5,200
24. *Sjálfsbjörg*, National federation of people with disabilities..... 7,600
25. *Sjónarhóll* 17,900
26. *Systkinasmiðjan* 500
27. *Táknsmiðjan*, myndver heyrnarlausra …… 2,500
28. Táknsmiðjan, táknmál á heimasíður …… 1,000
29. Society for persons who care for autistic people..... 1,200
30. *Vernd* (rehabilitation for ex-prisoners)..... 2,000
31. Drug-free youth.. 10,000
32. The Centre for Sexual Abuse Victims (*Stígamót)*.....40,300
33. The Women's Refuge (*Kvennaathvarfið*)..... 36,800
34. Aflið, Centre against sexual and domestic violence …….. 1,600
35. *Geðhjálp* (support association for the mentally disturbed..... 20,800
36. *Geysir*, work exchange for the mentaly disturbed 32,000
37. *Krýsuvíkurskóli*, rehabilitation home …….. 68,100
38. Shelter for homeless people …… 26,700
39. Dyngjan, shelter for homeless women …….. 2,000
40. The Homes Association of Iceland (*Hagsmunasamtök heimilanna*) ….. 2,500
41. Ísland Panorama …… 500
42. Equality House, education …… 2,000
43. MND-society in Iceland …… 800
44. Summer-camp in *Reykjadalur* …….. 5,500
45 *Hver*, rehabilitation centre …….. 4,000

Total **413,900**

Comment by the Committee of Independent Experts. Conclusions XIX-2(2009), p. 289.

The Committee also asks again:

- *Whether there is guaranteed equal and effective access to social services offered by non-public providers.*

When the Government or Local Authorities has a special agreement with non-public providers offering social services of any kind because of public funding then it is stated in the agreement that equal and effective access should be guaranteed with a reference to the principle of equality where anybody may not be discriminated against on the grounds of their ethnic origin, gender, colour, nationality, religion, political conviction, family, or other comparable considerations.

Comment by the Committee of Independent Experts.
Conclusions XIX-2(2009), p. 289.
The Committee also asks again:

- *Whether the various voluntary organisations are consulted in the policy making process, in a similar way to those representing elderly persons.*

The Government always emphasise on having a good co-operation and consultation with NGO‘s in the policy making process in social welfare services. As an example according to the Article 1, para 2, of the Act No. 59/1992, on the Affairs of the People with Disability, with subsequent amendments, the Government is obliged to guarantee that the national federations of people with disabilities and their constituent associations will have an influence on policymaking and decisions regarding the affairs of people with disabilities.

Another example is the Well-Being Watch but the committee consists of 21 members, including representatives of the social partners, the government ministries, NGO’s and the local authorities. NGO’s which are participating within the Well-Being Watch is for example the Icelandic Red Cross, Icelandic Human Rights Centre, the National Organization of Elderly Citizens, Umbrella Organizations of Persons with Disabilities and the Social Partners. The role of the committee is to gather information on the social and financial consequences of the economic situation for families and individuals, to gather information on the experience of other nations of dealing with economic recessions, to identify means that the state, the local authorities and NGO’s can use to respond to the situation and to stimulate consultation and collaboration between those who can make a contribution in view of their skills and experience.

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 the Icelandic Confederation of Employers, 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.
The Confederation of Icelandic Employers.
The Federation of State and Municipal Employees.
The Alliance of Graduate Civil Servants.