

Omar H. Kristmundsson and Steinunn Hrafnisdóttir

The Role of Non-Profit Organisations in the Development and Provision of Welfare Services in Iceland

ABSTRACT

In the article the role of non-profit organisations in the development and provision of welfare services in Iceland is discussed. As Iceland has adopted the so-called Nordic welfare model or social democratic regime, the country should – according to Lester M. Salomon and Helmut K. Anheier’s social origin theory – have a limited role in welfare service provision. Instead it should have a primarily supplementary role, advocating citizens’ rights and responding to unmet public needs. Based on analysis of historical data and official statistics, our findings for Iceland only partly support the theory. Non-profit organisations, both in the past and presently, do have an important role in providing welfare services. This is especially the case of certain functional areas like services for the elderly and disabled, rehabilitation and treatment of alcohol and drug users. Non-profit organisations providing public services can be considered quasi-government agencies and have not grown in number in the past decades. Organisational growth has however continued among associations with smaller-scale operations, i.e. the so-called member-oriented groups and campaigning associations responding to unmet citizens’ needs.

Introduction

According to the classification of regime types by the Danish Political Scientist Gøsta Esping-Andersen,¹ the Nordic welfare model or social democratic regime is characterised by welfare services largely provided and funded by the public sector and a well-developed social security system based on the principle of universalism. In academic discourse this

1 Gøsta Esping-Andersen: *The Three Worlds of Welfare Capitalism*, Cambridge, 1990, p. 27; Jorma Sipilä/Margit Andersson/Sten-Erik Hammarqvist/Lars Nordlander/Pirkko-Liisa Rauhala/Kare Thomsen/Hanne Warming Nielsen: *A Multitude of Universal Public Services – How*

model is frequently associated with the five Nordic countries – Denmark, Finland, Norway, Sweden and Iceland – though the last has frequently been excluded from academic writings on the subject.²

The Icelandic welfare state has, indeed, in some respects deviated from its sister countries in the north. Stefan Ólafsson has suggested that the Icelandic welfare system is a hybrid of the Scandinavian social democratic model (with its universal rights and comprehensive welfare services), and the liberal model implying extensive income testing and lower benefits.³ The development of Icelandic welfare agencies occurred later than in the other Nordic countries. In addition, the political landscape in Iceland has also been quite different from the other Nordic states: the largest party in Iceland since 1944 has been the right-wing Independence Party, and the Social Democrats did not play a significant government role until very recently. Iceland's levels of spending on welfare and health services have been lower overall than in other Scandinavian countries.

In their social origins model of non-profit organisations, Lester M. Salomon and Helmut K. Anheier build upon Esping-Andersen's theories on the origin of the modern welfare state and Moore's work on the social origins of fascism and democracy.⁴ They argue that the size and structure of the non-profit sector reflects a complex pattern of historical and political forces and is not a product of any single factor. Complex relations exist between social forces such as the strength of the working class, middle class, elites, the state and the church. Accordingly, the theory proposes that the relations between the government and the non-profit sector are embedded in historical development and in the institutional path dependency of each regime. In order to explain the variations between sectors in different countries Anheier and Salomon use two key variables: a.) public expenditures on welfare services, and b.) the scale of the non-profit sector measured in terms of full-time equivalent employment. In line with Esping-Andersen's welfare theory, they propose four constellations of non-profit regimes: Statist, Corporatist, Liberalist and Social Democratic. Briefly, in the liberal regime low public welfare spending is associated with a sizeable non-profit sector. The corporatist model is characterised

and Why did Four Scandinavian Countries get their Social Care Service Model, in: Jorma Sipilä (ed.): *Social Care Services: The Key to the Scandinavian Welfare Model*, Aldershot 1997, pp. 27–50, p. 38.

2 Ingibjörg Broddadóttir/Guðný Björk Eydal/Sigurveig H. Sigurðardóttir/Steinunn Hrafnisdóttir: *The Development of Local Authority Social Services in Iceland*, in: Jorma Sipilä (ed.): *Social Care Services: The Key to the Scandinavian Welfare Model*, Aldershot 1997, pp. 51–76, p. 71.

3 Stefan Ólafsson: *Velferðarríkið og þróun velferðarútgjaldanna*, in: Guðný Björk Eydal & Stefán Ólafsson (eds.): *Þróun velferðarinnar 1988–2008*, Reykjavík, 2012, pp. 29–46, p. 32.

4 Lester M. Salomon/Helmut K. Anheier: *Social Origins of Civil Society: Explaining the Non-profit Sector Cross-Nationally*, in: *Voluntas* 9:3 (1998), pp. 213–260.

by both relatively high public welfare spending and a large non-profit sector. The statist regime contains both low public welfare spending and a small non-profit sector. In the social democratic model where the cases of Sweden, Finland, Denmark and Norway are clustered, high public welfare spending is associated with a small non-profit sector. Looking at the social democratic regime in more detail, it is expected that non-profit organisations will have a small share in welfare provision because this is predominantly the responsibility of the public sector. The role of non-profit organisations and/or interest groups is advocacy on behalf of service users and/or the promotion of leisure interests, but not usually the provision of mainstream welfare services.⁵ As Adalbert Evers puts it:

In the Nordic countries marked by the strong service and state component of the welfare model, third sector organisations are strong, but have ‘crowded out’ as mainstream service providers; their main role is that of representing kind of citizen-consumers, that criticise the public systems, make suggestions from improving quality and innovation.⁶

In their later work Salamon and Anheier suggested that volunteering and membership could also account for the size of the non-profit sector in countries like Sweden, Norway and Finland, although the size of the non-profit sector was still small there in relation to employment in welfare services.⁷ They concluded that this was because of the strong power and policy role of working-class movements that successfully campaigned for comprehensive governmentally funded welfare services in these countries, and the presence of mass movements that traditionally also engaged in advocacy and interest representation. However, since the mid-1980s new winds seem to be blowing in Scandinavia, and the division between public, private and non-profit organisations is being transformed. It has been suggested that the traditional regime theories no longer apply today in a modern welfare state where transformations are taking place expressed in concepts like new public governance, collaborative public management, and public-private partnership and networks.

5 Lester Salamon/Wojciech Sokolowski/Helmut K. Anheier: *Social Origins of Civil Society: An Overview*. Working Papers of the Johns Hopkins Comparative Nonprofit Sector Project, no. 38, Baltimore 2000, pp. 1–22, pp. 16–17.

6 Adalbert Evers: *Third Sector Organizations and Welfare Services. How Helpful are the Debates on Welfare Regimes and an European Social Model?*, in: Aila-Leena Matthies (ed.): *Nordic Civic Society Organisations and the Future of Welfare Services. A Model for Europe?*, Copenhagen 2006, pp. 371–384, p. 376.

7 Helmut K. Anheier/Lester M. Salamon: *The Non-Profit Sector in Comparative Perspective*, in: Walter W. Powell & Richard Steinberg (eds.): *The Non-Profit Sector. A Research Handbook*, New Haven & London 2006, pp. 89–114, p. 106.

How about Iceland? According to the social origins theory, the non-profit sector's role in welfare services should be small as Iceland belongs to the Nordic countries. Is this correct? How has the non-profit sector actually developed and what has been its part in the evolution of the present welfare system in Iceland? Has its significance in service provision changed and what is its present role? In the present article, historical analysis, the available statistics, and research on the Icelandic non-profit sector will be applied to address these questions.

The Icelandic Welfare State and Non-Profit Organisations: Major Historical Trajectories⁸

In order to understand the impact of the non-profit sector in the development of the present welfare system, it is necessary to describe the key historical trajectories for both that sector and the official welfare system in Iceland during the 20th century.

At the turn of the 20th century Iceland, at that time a Danish colony, had 70,000 inhabitants of whom only some 10 per cent lived in urban areas.⁹ Urbanisation was starting to develop in the south-west region around the capital, Reykjavik, but 95 per cent of the whole nation still lived off agriculture and marine fishing. Despite the economic upswing following industrialisation in the fishing industry, poverty was widespread both in rural and urban areas. In the first decades of the 20th century, the number of urban inhabitants increased exponentially as did, concomitantly, unemployment and lack of housing. Public expenditure as a percentage of gross national income was only five per cent.¹⁰

The urbanisation and economic upswing following industrialisation created several mass movements that focused on human rights and public welfare objectives. Women's associations were established that, apart from fighting for their fundamental rights, performed charity and humanitarian work. In addition, a powerful abstinence movement became in a short time one of the largest mass movements in the country. Apart from fighting alcohol abuse and other social problems, the movement focused on poor relief.

8 The article is largely based on analysis of published documents such as government reports, laws and regulations, notes to parliamentary bills, and historical records of 10 nonprofit organizations. Parts of it originally appeared in Omar H. Kristmundsson: *The Changing Relationship between the Government and the Nonprofit Sector in Iceland*, in: *Stjórnmal og stjórnsýsla*, 2:5 (2009), pp. 249–265.

9 Gudmundur Jonsson/Magnus S Magnusson: *Hagskinna. Sögulegar hagtölur um Ísland*, Reykjavík 1997, pp. 779–819.

10 Magnus S. Magnusson: *Efnahagsþróun á Íslandi 1880–1990*, in: Gudmundur Halfdanarson/Svanur Kristjánsson (eds.): *Íslensk þjóðfélagsþróun 1880–1990*, Reykjavík 1993, pp. 112–214, p. 203.

These new movements established and began to run hospitals and other social and health institutions, mostly financed by the associations and patients themselves.

With home rule in 1904, an Icelandic Ministry Office was established. During the first decades of the 20th century the office was small and primarily responsible for supporting the daily routine of the Minister of Iceland.¹¹ The capacity of the public sector was very limited and involved mostly general administrative functions. The central government, as with local communities, allocated few resources to welfare and only a miniscule number of public institutions existed in the social and health care sector.¹² Direct financial support to private organisations was negligible.

In the first three decades of the 1900s, an explicit governmental policy towards financing and running health and social services was non-existent. Government did acknowledge the mass associations' efforts in welfare provision, but did not accept responsibility for operating governmental programmes in the area. Apart from poor relief – which had been the responsibility of local government and the church since the country was settled in the late ninth century – a general consensus was that if health and social services were to be provided at all, they should be in the hands of private entities.

In the second and third decades of the twentieth century the authorities' attitude began to change, leading finally to the foundation of the Icelandic welfare system. There were several reasons for these changes. The national income increased considerably as a result of industrialisation of the fishing industry, and consequently urbanisation grew. A new political system that focused more on domestic problems was established. Labour unions became influential in public policy making and, together with other associations, led the public debate on the need for improvement in health and social security.

All these factors paved the way for increasing public intervention and contributions to the welfare sector in the form of sickness, injury and support insurance. This development led to a substantial increase in welfare expenditure, and created the first stable foundation on which private entities operating in the welfare sector could emerge and establish themselves. The Icelandic government passed legislation on public insurance in 1936, and the social security act in 1947. These two acts formed the backbone of the state's welfare legislation.¹³ Despite this monumental legislation, however, non-profit institutions continued to take the initiative for new welfare institutions. The construction of hospitals was primarily in the hands of private organisations, such as the Catholic Church, women's associations, and affluent individuals. Thus the National Hospital at

11 Omar Kristmundsson: *Umbætur í starfsmannamálum hins opinbera: Tillögur millipinganefnda 1916 og 1934*, in: Úlfar Hauksson (ed.): *Rannsóknir í félagsvísindum V*, Reykjavík 2005, pp. 626–635, p. 626.

12 Jonsson/Magnusson: *Hagskinna*, pp. 779–819.

13 Stefan Olafsson: *Íslenska leiðin. Almannatryggingar og velferð í fjölþjóðlegum samanburði*, Reykjavík 1999, p. 115.

Reykjavik was first established with these parties' assistance, even if some expressed the view – importantly – that the government should lead the way.¹⁴

The number of associations operating in the welfare sector did not increase substantially during this period. However, patients' associations were established for the first time, advocating for their clients' interests, but also taking the initiative to establish and run treatment facilities. An example is the Icelandic Association of Tuberculosis and Chest Patients, formed in 1938. Other types of mass associations also emerged, including powerful unions and political parties, which formed strong alliances as in the other Nordic countries.¹⁵ Cooperative societies became prominent and were primary players in increasing the number of commercial and industrial jobs in the country.¹⁶ Apart from the social security system, the government directed its attention and resources to industrial and economic affairs.

Following Iceland's occupation by the British army in 1940 and later the establishment of US military facilities, Iceland experienced major social and cultural changes. During the Second World War migration from rural areas to Reykjavik increased faster than ever before. A serious housing problem resulted in the capital, and social problems arose, among other things, because of relations between Icelandic citizens and the US military – creating new concerns for charities. The Icelandic Red Cross, for example, established several summer camps for children from Reykjavik to counteract the negative influence of urbanisation upon them.

Despite the establishment of the social security system, associations continued to fund and operate various welfare institutions. The official system, however, provided an important regular income in the form of day rates, a payment from the government based on the care of one patient per day. In some cases governmental subsidies also covered construction expenses. Yet official funding levels remained low, so that an examination of the history of various associations from this period reveals constant financial problems and requests for increasing governmental support.

Legislation was passed in 1949 (Act no. 27/1949) that permitted one particular non-profit organisation to establish a lottery for financing construction costs. Previously, laws and regulations regarding the foundation and operation of non-profit entities were almost non-existent, aside from the fact that the latter enjoyed exemptions relating to income and property taxes since 1877. After the 1949 Act, lotteries and the operation of

14 Gunnar M. Magnuss: *Landspítalabókin. Gefið út í tilefni 50 ára afmælis Landspítalans 1980*, Reykjavik 1981, p. 20.

15 Jon Gunnar Gretarsson: *Upphaf og þróun stéttskipts samfélags á Íslandi*, in: G Guðmundur Halfdanarson/Svanur Kristjánsson (eds.): *Íslensk þjóðfélagsþróun 1880–1990*, Reykjavik 1993, pp. 215–264, p. 230.

16 Helgi Skuli Kjartansson/Jonas Guðmundsson: *Samvinnuhreyfingin í sögu Íslands*, Reykjavik 2003.

gambling machines became an important, independent and stable revenue base for the largest non-profit organisations in Iceland. However, these functions have been, and continue to be, limited to individual organisations and dependent upon government licensing.

In the latter part of the 20th century up to the 1990s, the Icelandic national product multiplied and public activities expanded greatly over this period. Government consumption was 10 per cent of gross domestic products in 1960 but rose to 19 per cent in 1990, and the number of employees in government service increased from 10 per cent to 18 per cent of the total labour force.¹⁷

In the 1970s and 1980s, a number of patients' and member-oriented associations formed an umbrella group that became a powerful voice demanding attention and insisting on a role in the policy-making process, notably in terms of influencing new legislation.¹⁸ Health and social legislation formally recognised some advocacy groups – such as associations for disabled people – as deserving influence over public policy making, and representatives from these associations were included in some policy-making bodies within the government.¹⁹

Partly as the result of a growing political interest and pressure from advocacy groups, legislation mandating new programs in health care and social services was passed.²⁰ This led to the creation of new labour-intensive public institutions, as well as strengthening agencies already in place. Many new health centres were established, all run by the government. With increasing professionalisation and high-technology medical treatment, hospitals gradually became state-run organisations. Other areas previously dominated by the non-profit sector, such as services for the disabled people and elderly people, were still left under a non-profit lead but with increasing government funding. Ambulance services were, until the second part of this period, also in the hands of non-profit institutions. Although services provided by non-profits were increasingly financed by public funds, formal contracts between the partners did not exist.

The growing collaboration between the government and the non-profit sector was not limited to financial support from the former and the latter's formal involvement in policy making. During this period a tradition was established for standing committees of the Icelandic parliament to seek opinions from non-profit organisations when discussing parliamentary bills. In a few instances, government representatives were even expected to occupy seats on the boards of directors of certain associations.

17 Jonsson/Magnusson: *Hagskinna*, pp. 779–819.

18 Margrét Margeirsdóttir: *Fötlun og samfélag*, Reykjavík 2001.

19 Omar H Kristmundsson/Steinunn Hrafnisdóttir: *Félagasamtök og sjálfseignarstofnanir sem starfa að velferðarmálum á Íslandi*, in: *Stjórnmal og stjórnsýsla* 2:7 (2011), pp. 451–470.

20 Kristmundsson/Hrafnisdóttir, *Félagasamtök og sjálfseignarstofnanir*, p. 465.

The more active role taken by government in areas previously occupied by the non-profit sector did not force out the latter except when the non-profits themselves pressed for a government take-over. In some cases the organisations became “colonised”, becoming quasi-public so that their staff was *de facto* civil servants. Such was the case with group housing for the disabled, where the homes were entirely funded by the government and gradually became quasi-governmental units. This was seen among other things in the confused status of staff that resulted when they were hired by the association, but joined the governmental payroll and benefited from the state pension fund.

The closing decade of the 20th century was in many ways interesting for public administration in Iceland. In 1991, a new government based on a coalition of the Independence Party and The Peoples’ Party was established, which soon defined ambitious objectives for governmental reform based on the New Public Management Movement (NPM).²¹ This was the first time that a government White Paper included goals for privatisation and for outsourcing programmes to private organisations, in order to assure efficient and effective public service. Role models were sought from the United States and the United Kingdom and encouragement from the Organisation for Economic Co-operation and Development (OECD). Performance management was adopted, state-owned banks were privatised, and corporatisation of public enterprises took place. Management of financial and human resources was decentralised. Primary education was devolved to local authorities.

This development led to an increase in various types of formal service contracts at different administrative levels. In the spirit of Osborne’s and Gaebler’s catch phrase, “Steer but not row”,²² attempts were made to create a buyer-seller relationship between the public administration on the one hand and private individuals on the other. A legislative framework for contracting and tendering was created, meaning among other things that tendering for outsourced services became mandatory if costs exceeded certain limits. Previously, this requirement was limited to construction projects, but now became mandatory for operational projects as well. Also at this time, new legislation on public administration procedures and public information access was passed that called for more formal and transparent processing of cases.

Before these laws were passed, tendering in the realm of social and health services had been rare. A long tradition existed for tendering on the provision of certain goods and services, such as facility maintenance, supplies and catering. It was not until the year 2002, however, that the services to be provided by a nursing home were put out to tender for the first time, and a formal agreement was concluded with a for-profit

21 Omar Kristmundsson: *Reinventing Government in Iceland: A Case Study of Public Management Reform*, Reykjavik 2003.

22 David Osborne/Ted Gaebler: *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*, New York 1992.

organisation – both setting new precedents. A few years earlier there had been efforts to conclude formal contracts with existing health agencies run by non-profit organisations, including nursing homes for the elderly; but before that, formal contracts between the entities were non-existent.

A number of other new laws, like the Civil Service Act (no. 70/1996), called for a clear separation of public entities from non-governmental entities. An effort was accordingly made to clarify the legal status of previously quasi-governmental operations in the hands of non-profit institutions. However, most of the contracts made in this period were so-called “soft” and less specific contracts,²³ focusing – as seen earlier – on cooperation rather than competition and trust rather than distrust. State/non-profit communication in general was largely based on trust, although monitoring and surveillance were also part of the agreement. For the most part, the government contracted with parties who were considered trustworthy and had a good reputation.

The Present Role of Non-Profit Organisations in the Icelandic Welfare Sector

The historical analysis above has outlined the important entrepreneurial role of non-profit organisations in developing the welfare sector in Iceland. Among other things it highlights their part in managing welfare services that, in the latter part of the century, came to be largely financed by public funds. What then is these organisations’ present contribution to welfare services, and what levels and types of activities do they carry out?

Finding exact data on the number of active non-profit organisations and their operations has been problematic since official statistical information does not separate active organisations from non-active ones, and some organisations do not need to return financial statements. A legal framework for associations does not exist in Iceland in the same way as for some other Nordic countries like Norway and Sweden.²⁴ This makes official registration of their activities non-mandatory. However, if the entity has staff on payroll or if it receives grants from the government, registration is mandatory under the existing general law on foundations. The purpose and operation of foundations, which make up approximately one-third of all non-profit organisations in the welfare sector, are no different from those of associations in practice.²⁵ To respond to these deficiencies in official data, the present authors have created a database making use of information on non-profit entities paying income tax from the National Register; the active web-pages of

23 Kristmundsson/Hrafnisdóttir: *Félagasamtök og sjálfseignarstofnanir*, p. 467.

24 Hrafn Bragason/Omar Kristmundsson: *Réttarumhverfi félagasamtaka á Íslandi*, in: *Stjórn-mál og stjórnýsla* 2:7 (2011), pp. 437–450.

25 Bragason/Kristmundsson, *Réttarumhverfi félagasamtaka*, p. 447.

associations and foundations; and records of Icelandic parliamentary proceedings relating to these types of organisations.

Based on the authors' definition, 144 non-profit organisations were operating in the welfare sector in the year 2010 with an estimated total expenditure of 18.8 billion Icelandic kronas (€ 112 million). For comparison, the operational costs of organisations under the welfare ministry (previously social and health ministries) amounted to 95.7 billion Icelandic kronas in 2010.²⁶ Spending by individual non-profits varied significantly as seen in Table 1, averaging 185 million Icelandic kronas. (€ 1.1 million). The median was however only 21 million Icelandic kronas (approx. € 126,000), as there are a few extreme cases of relatively large non-profit organisations. The running costs of five such organisations exceeded one billion IKR (€ 5.9 million), amounting to nine billion in all.

Table 1: Non-profits in the Welfare Sector in Iceland 2010

	Operating expenditure			FTEs		
	Mean (Millions of					
	Total	%	Icelandic kronas)	Median	Mean	Median
Total	110	100,0	185	21	24,2	2,0
Service provision*	64	58,2	315	56	42,5	6,3
Member-oriented**	25	22,7	8	5	0,9	0,7
Campaigning***	21	19,1	15	6	1,8	1,0

In 2010 the labour of full-time employees (FTEs) working in non-profit organisations was estimated as equivalent to 2,500 man-years, of which 1,400 took place within the five largest organisations. At the same time, employment in the public social and health sector amounted to some 10,000 FTEs. The average number of full-time employees for a non-profit was 24, but the median was much lower for the reasons already explained – only two. A total of 45 per cent of these organisations had less than two full-time employees, while the single largest organisation consisted of 560 full-time employees.

Economic size and the number of employees can be correlated with the primary purpose of each non-profit organisation. Based on Hudson's classification,²⁷ three different types can be identified. Even though organisations are frequently multi-purpose, this categorisation helps to distinguish between functionally different operations. Into the first category fall organisations (both associations and foundations) offering labour-intensive services, such as hospitals and other health organisations. This type normally has relatively high operational costs, a high number of paid staff and a relatively low number

26 Fjarmalaraduneytid: Frumvarp til fjárlaga 2012, Reykjavík 2011, p. 331.

27 Mike Hudson: *Managing without Profit. The Art of Managing Third-Sector Organization*, London 2004.

of volunteers. The second category involves member-oriented organisations like patient and support associations, which are typically relatively small in terms of activities and paid staff, but with a proportionally high number of volunteers. The third group consists of entities with the main purpose of campaigning for a cause, such as fighting drug abuse among young people, providing support on HIV/AIDS,²⁸ or campaigning for the rights of a specific clientele like the disabled. This type of organisation commonly has a rather small number of specialised staff and few working volunteers, but a high number of fee-paying members. Organisations of the second and third type focus on activities normally not covered by the government and can be considered supplementary to the public services. These are frequently grass-root organisations established explicitly to respond to public needs not provided for.

Table 1 shows how the three types of organisations differ in regard to operating expenditure and man-power. As might be expected, the level of activities in service-oriented organisations is by far the highest, even when the extreme cases with the highest running costs are excluded. The member-oriented and campaigning organisations in general run small operations, the former normally with only part-time paid employees and the second with one full-time employee. Activity levels among campaigning non-profits are substantially higher on the average than among the member-oriented.

In 2010, roughly 60 per cent of all spending by the Icelandic ministries of social affairs and health – when personnel benefits are excluded – was channeled to local municipalities and private entities through service contracts.²⁹ The service-providing organisations responsible for executing public services in this way receive revenues based on formal long-term contracts, with the government covering their operational costs. Member-oriented and campaigning organisations often also receive some government support in the form of grants, but this normally covers only a small portion of their work and is sporadic.

To evaluate the economic significance of the non-profit sector in the welfare sector in Iceland it is necessary to analyse its involvement in individual fields of activity. As mentioned in the previous section, non-profits do not presently manage general hospitals – in contrast to the past – nor do they run primary health care. Non-profits in service provision do however participate in four primary fields of activities: namely nursing homes, rehabilitation centres, residential services for disabled people, and alcohol- and drug-related treatment. In 2010 non-profits were operating 14 out of 69, or 20 per cent, of all nursing homes in Iceland,³⁰ while most others were run by local municipalities. This statistic does not however accurately reflect the importance of non-profit involve-

28 Human immunodeficiency virus infection/acquired immunodeficiency syndrome

29 Kristmundsson/Hrafnisdóttir: Félagasamtök og sjálfseignarstofnanir, p. 464.

30 Heilbrigðis- og tryggingamálaráðuneytið: Áætlun um uppbyggingu öldrunarþjónustu 2002–2007, Reykjavík 2002, pp. 22–48.

ment in this area, as many small nursing homes exist in the rural areas while Iceland's five largest – all in the capital area – are run by non-profit organisations (either associations or foundations). Of a total of 14 nursing homes in the capital area, seven are run by non-profits: and 77 per cent of beds are provided in the non-profit homes. The three general rehabilitation centres operating in Iceland are all operated by non-profit organisations. In 2010 non-profit organisations providing services for the disabled had some 400 employees in a total of six organisations, while at the end of 2011 approximately 1400 state employees were working in the same sector. All alcohol- and drug-related treatment outside general hospitals is provided by non-profits. In the year 2002, 85 per cent of alcohol and drug patient detoxification programmes were offered by such units and roughly 74 per cent were attending a single programme run by the largest non-profit treatment centre, the National Centre of Addiction Medicine.

Discussion and Conclusion

The analysis points to a significant role played by the non-profit sector in welfare services in Iceland. This finding only partly coincides with the premises of the social origin theory, which states that the Nordic countries – including Iceland – have adapted a social democratic model characterised by a high public spending and by a limited role of non-profits in welfare provision, as measured in economic terms and employment. Even if such actors have historically been mainstream service providers, they are expected by now to have been displaced by public agencies and to be engaging instead in advocacy for new or improved services.

Following industrialisation and urbanisation in the first part of the 20th century, newly founded associations had a major entrepreneurial role in developing welfare services in Iceland. They founded hospitals, poor-relief programmes and services for the elderly and disabled. In the latter half of the 20th century the direct involvement of government in welfare programmes increased, as the government gradually took over the operation of general hospitals and some other activities in the health sector. Some non-profit organisations became quasi-government agencies in consequence. Certain welfare services however remained the responsibility of the non-profit sector, albeit with government funding: notably running nursing homes, rehabilitation centres, residential services for the disabled, and alcohol- and drug treatment facilities. In these areas, non-profit organisations are still large or even dominant today as measured by their level of activity (like the number of beds) and number of staff.

Why did the government not take over these latter operations as well as the general hospitals? Volunteers do not have an essential role in their activities. Further, as these organisations' financing comes from public funds based on service contracts, they must already observe much of the same regulatory framework as a public agency. They can in that sense be considered quasi-government entities. The theories normally used to explain the merits of non-profit organisations running public services, as reflected

in functional premises like non-distributional constraint and the type of goods (trust goods),³¹ also fail to explain why these activities are not run by government.

Two different reasons may be put forward in Iceland's case. A possible generic argument, although a controversial one, is that private entities running public services will lead to cost-savings and maximum efficiency. Evidence does not indicate, however, that efficiency in the given service areas has been an explicit governmental policy issue. While government funding entails tight budgetary control for the organisations, government public records do not suggest that the premises for deciding public funding for private entities have been any different from those for public agencies. Reflecting this, private entities providing public service have through the years had a budget heading in the national budget just like agencies run by the government.

The second and more plausible possible explanation relates to the attributes of the Icelandic government. The Icelandic public administration has been characterised as being a small and reactive public administration with limited policy capability. Despite growing government involvement in providing welfare services in the 1960s to 1980s, advocacy associations became key players in public policy-making. It was not until the 1990s that the government began to consider defining the non-profit role in providing welfare services and saw a need to establish a structure for monitoring non-profit entities. This was in contrast to the *laissez-faire* approach which had dominated for most of the 20th century. Despite the efforts made since to define a formal contractual relationship in the spirit of new public management, it can be questioned whether any real changes took place. Non-profits continued to be autonomous in their operation and have informal and infrequent interactions with the government even today.

The most noteworthy development in the non-profit sector in the past decades is the growing number of member-oriented and campaigning organisations running small operations relying on volunteer work. Economic non-profit theories like that of Burton Weisbrod may provide an explanation for this development.³² Weisbrod argues that when preferences are heterogeneous, the government responding to the "median voter" is not able to fulfill the needs of all citizens. Certain needs in the provision of public goods are therefore left unsatisfied and the field is open for the non-profit sector to fill the gap. Citizen preferences can vary widely across governmental areas or domains. For example, citizen preferences can be expected to be homogeneous in the areas of general health service, so that non-profit involvement here is less important. In the case of advocacy for specific interests individual preferences can differ extensively, so that the role of non-profits in serving/promoting such interests can become very significant.

31 See e.g. Anheier theoretical summary: Helmut Anheier: *Nonprofit Organizations: Theory, Management, Policy*, London 2005.

32 Burton A. Weisbrod: *The Voluntary Nonprofit Sector: An Economic Analysis*, Lexington MA 1977.

Member-oriented organisations, many of them managing patient self-help groups, do for example provide an important treatment alternative for chronic patients that is not offered by the general health system. Campaigning associations have a key role in advocating patient rights and promoting health care improvements.

The growing literature on hybrid arrangements based on a joint public and private role in public policy-making and operations provides an updated basis for accepting the role of non-profit organisations in welfare service provision. For example, Salamon's third-party government theory explains why the non-profits can have an important role in addressing social problems, as well as finding new approaches for solving these problems at even lower cost than the government.³³ On the other hand, non-profits cannot usually provide the financial resources or stability of funding available to governments. The weakness of non-profits is the strength of governments, and vice versa.

Steinunn Hrafnisdóttir is an associate professor and head of the Faculty of Social Work, University of Iceland. She holds a doctorate in social work and a master's degree in management from the University of Kent. Her main research focus is on third-sector organisations, welfare management, and volunteering. She has published book chapters and papers on these subjects. She is a co-founder with Professor Kristmundsson of a newly-established research centre on the third sector at the University of Iceland.

Omar H. Kristmundsson is a professor and head of the Faculty of Political Science, University of Iceland. He holds a doctorate in public administration and public policy from the University of Connecticut. His research includes public governance, public leadership, decision-making in public administration, and the governance of third-sector organisations. He has published books and papers on the third sector in Iceland with Dr. Hrafnisdóttir.

33 Lester M. Salamon: Of Market Failure, Voluntary Failure, and Third-Party Government: Toward a Theory of Government-Nonprofit Relations in the Modern Welfare State, in: *Non-profit and Voluntary Sector Quarterly* 16:1-2 (1987), pp. 29-49.