Health policy in Iceland

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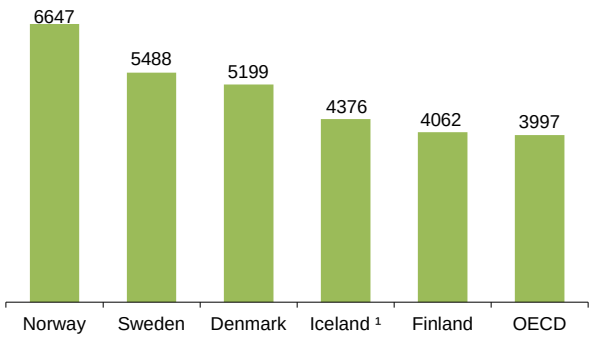
Health spending per capita in Iceland has started to rise again in recent years following sharp reductions after the economic crisis in 2008, and is above the OECD average. Iceland reports good health outcomes (the life expectancy at birth in 2015 was 82.5 years, about two years more than the OECD average) and tobacco and alcohol consumption are relatively low. Increasing obesity rates and issues related to access to care are important public health and health system challenges in Iceland.

Health expenditure has started to rise again in recent years

Following reduction in health spending after the economic crisis, health expenditure per capita has started to rise again since 2012 and is above the OECD average

In 2016, Iceland spent the equivalent of US$ 4376 on health per capita. This level of spending is slightly higher than the OECD average, but lower than in most other Nordic countries, with the exception of Finland.

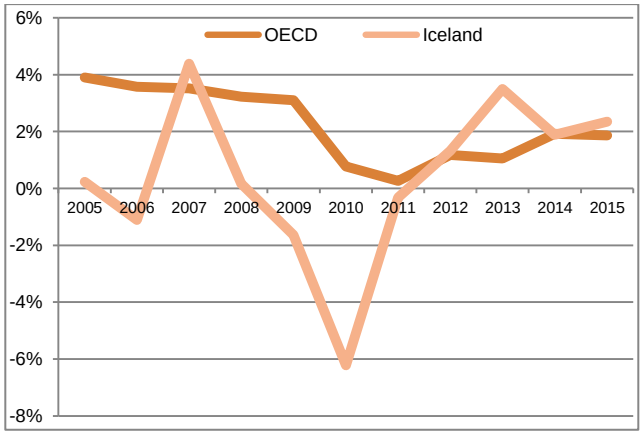
Health expenditure per capita (US$ PPP), 2016



Note: Expenditure excludes investments, unless otherwise stated. 1. Includes investments. Sources: OECD Health Statistics 2017, WHO Global Health Expenditure Database.

Health spending per capita (including both public and private spending) fell in Iceland between 2008 and 2011, before starting to rise again since 2012, at a rate of about 2% per year in real terms in 2014 and 2015.

Health spending growth (per capita in real terms), 2005 to 2015



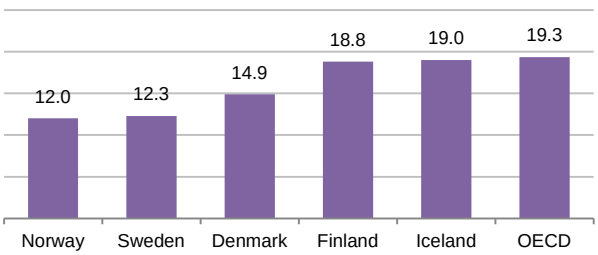
To read more about our work: Health at a Glance: Europe 2016

Tackling rising burden of obesity

Obesity rates are increasing

Obesity rates among adults in Iceland have increased over the past decade, from 12.4% in 2002 to 19.0% in 2015, which is close to the current OECD average and higher than in other Nordic countries. Children obesity has also increased, from 17% in 2001-02 to 21% in 2013-14.

Rate of obese among adults (%), 2015



Source: OECD Health Statistics 2017

Obesity means higher risk of hypertension, diabetes, heart attack and other cardiovascular diseases, and it is also a risk factor for some forms of cancer.

Obesity rates in Iceland are much higher among people in the lowest-income group than those with the highest income. This contributes therefore to health inequalities.

What can be done?

- Implement a comprehensive policy package to prevent obesity, targeting different age groups and determinants of obesity (unhealthy diet and lack of physical activity)
- Encourage primary care physicians to counsel at-risk patients about making healthy lifestyle choices

To read more about our work: Obesity Update 2017; Obesity and the Economics of Prevention: Fit not Fat

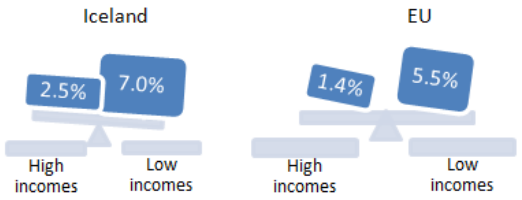
Promote better access to care

Iceland reports relatively high levels of unmet needs for medical and dental examinations, with large inequalities by income group

Based on the EU "Statistics on Income and Living Conditions" survey, more than 4% of the population in Iceland reported unmet needs for a medical examination for financial reasons, geographic reasons or waiting times in 2015. This is higher than the EU average. Similarly, more than 10% of the population reported unmet needs for dental care in 2015, which is more than two times greater than the EU average (4.5%).

There is a substantial gap in unmet needs for medical and dental care by income group in Iceland: 7.0% of people in the lowest income group reported some unmet needs for a medical examination compared with 2.5% only for people in the highest income group.

Percentage of people with unmet needs for medical examination (by income quintiles, 2015)



Source: Eurostat Statistics Database, based on EU-SILC

The share of out-of-pocket spending in Iceland is generally lower than the OECD average, but direct household payments are high for dental care and pharmaceuticals

In Iceland, private households directly financed 17.5% of all health spending in 2014. While this level is slightly lower than the OECD average of 20%, out-of-pocket spending in Iceland is particularly high for dental care and pharmaceuticals. Nearly 60% of pharmaceutical expenditure is paid directly by households, a much greater share than the OECD average (about 40%).

What can be done?

- Monitor inequality in health care access and utilisation
- Tackle any financial and non-financial barriers to care, particularly for socioeconomically disadvantaged groups

To read more about our work: Health at a Glance: Europe 2016

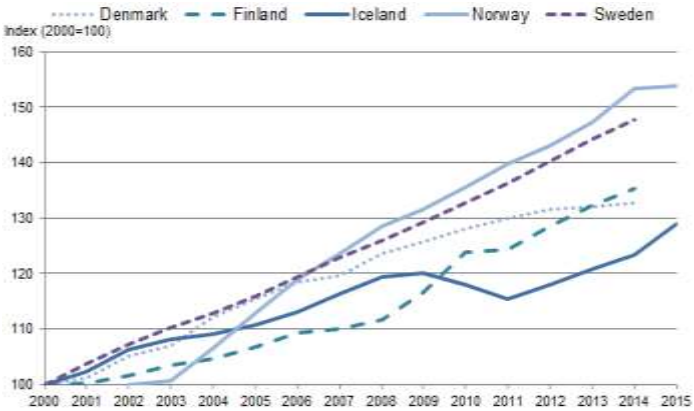
The number of doctors and nurses has started to rise again

The number of doctors and nurses in Iceland is relatively high

The number of doctors and nurses per population in Iceland has increased since 2000 and is above the OECD average, with 3.8 doctors per 1 000 population in 2015 (compared with an OECD average of 3.4) and 15.5 nurses per 1 000 population (compared with an OECD average of 9.0).

Most doctors (73%) have a recognised specialisation, but only one-fifth of them are specialists in general medicine (meaning that only about 15% of all doctors are general practitioners).

Evolution in the number of doctors in Iceland and other Nordic countries since 2000



More advanced training programmes for nurses are being put in place, along with more advanced nursing roles in primary care, to promote better task sharing and skills use.

What can be done?

- Promote a proper balance between generalist and specialist doctors through both financial and non-financial incentives
- Remove any unnecessary barrier to the extension of the scope of practice of nurses in primary care to promote greater access for the population

To read more about our work: Health at a Glance: Europe 2016