ESPN Thematic Report on Inequalities in access to healthcare

Iceland

2018

Stefán Ólafsson
June 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

European Social Policy Network (ESPN)

ESPN Thematic Report on Inequalities in access to healthcare

Iceland

2018

Stefán Ólafsson

Directorate-General for Employment, Social Affairs and Inclusion

2018

The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

Contents

Summary/Highlights

Iceland has universal healthcare within its social security system, primarily funded by the government. Total expenditure on healthcare amounted to 8.6% of GDP in 2016; private funding is about 1.5% of GDP (mainly out-of-pocket expenditure). All individuals who have been legally resident in the country for more than 6 months are covered. Those who come from other European Economic Area (EEA) countries are covered from day one.

Prevailing legislation on healthcare in Iceland from 2007 states the following aim for the population: 'all citizens should have access to healthcare services of the highest possible quality at all times, to protect their psychological, physical and social health' (Law 2007 no. 40, 27 March). This goal is to be attained irrespective of people's financial situation or residence.

As this report shows, the aim of full healthcare coverage for individuals, irrespective of their financial situation and residence, has still to be met.

Iceland has one of the best figures in EEA for low-income individuals in good health, while the difference between high- and low-income groups is also one of the smallest. To a large extent this reflects a high standard of healthcare in the decade leading up to 2008 and a low level of inequality in health status.

The biggest negative change in recent years has been the rising share of user charges, both for access to medical services and (particularly) for use of prescription medicines, where subsidies have been significantly cut for many patient groups. The rising cost of medication is now a significantly greater obstacle to access. Longer waiting lists for surgery are also a decisive factor.

After the crisis hit in 2008, the excessive cost of certain healthcare services (dental treatment, pharmaceuticals and mental healthcare) emerged as a growing problem; Iceland now has a higher level of unmet need for healthcare services – a level that is significantly above that of other Nordic nations. A new system of cost sharing and subsidies introduced in 2017 only shifted subsidies towards those with the very highest healthcare costs; meanwhile it increased the burden on patients with lower costs, who make up a much bigger population group. Overall spending on subsidies was not increased. Hence a large number of people experienced increased healthcare costs –in some cases very significant increases. This has been a growing cause for concern in the past year.

Spending cuts in the healthcare sector over the past decade have resulted in longer waiting lists. This crisis came to the fore after 2012 and peaked in 2016. Since then, there have been some improvements, but the situation remains unacceptable in most areas of surgical operations, according to the standard set by the national Directorate of Health. The slow recovery in this sector runs counter to Iceland's otherwise good economic recovery.

Recommendations:

- Subsidies for user costs should be increased, particularly for prescription medication, dental services and psychological services. One way of achieving this would be to lower the overall annual caps on user expenditure for visits to doctors and purchases of prescription medicines.
- Financing of operations in areas with excessive waiting lists should be significantly increased, irrespective of whether the operations are carried out in public hospitals or private clinics.
- Visits to clinical psychologists should be incorporated into the public health insurance, with subsidies for user costs.
- A longer-term aim should be to increase subsidies for the cost of dental care for the working-age population, with the aim of improving overall dental health.

1 Description of the functioning of the country's healthcare system for access

Iceland has universal healthcare services within the framework of its social security system. All individuals who have been legally resident in the country for more than 6 months are covered. Those who come from other European Economic Area (EEA) countries are covered from day one.

Prevailing legislation on healthcare in Iceland from 2007 states the following aim for the population: 'all citizens should have access to healthcare services of the highest possible quality at all times, to protect their psychological, physical and social health' (Law 2007 no. 40, 27 March). This goal is to be attained irrespective of people's financial situation or residence.

As this report shows, the aim of full healthcare coverage for individuals, irrespective of their financial situation and residence, has still to be met.

The Icelandic healthcare system is primarily publicly funded, administered and supervised. Hospitals are mainly state operated and most of the healthcare personnel are employed by the state. The Ministry of Welfare (formerly the Ministry of Health) has since 2011 had the administrative responsibility for the overall system, while the Directorate of Health has the main supervisory role, according to a law from 1 September 2007. The Directorate now has overall responsibility for supervising health institutions, healthcare personnel, the prescription of pharmaceutical products, measures for combating substance abuse and quality promotion of all public health services. There is also a special supervisory authority for medicines control and a supervisory commission dealing with the pricing of medicines (NOMESKO, 2017).[1]

A significant private sector operates alongside the public sector, but it is largely publicly funded. The main elements of the private sector are specialist services, some healthcare centres, physiotherapists, occupational therapists, psychologists, all dentists and some nursing homes and old people's homes (most often run by not-for-profit voluntary or social organisations). User fees are considerably higher in the private sector than in the public. Thus nursing homes and old people's homes are partly financed by users and partly by the public authorities.

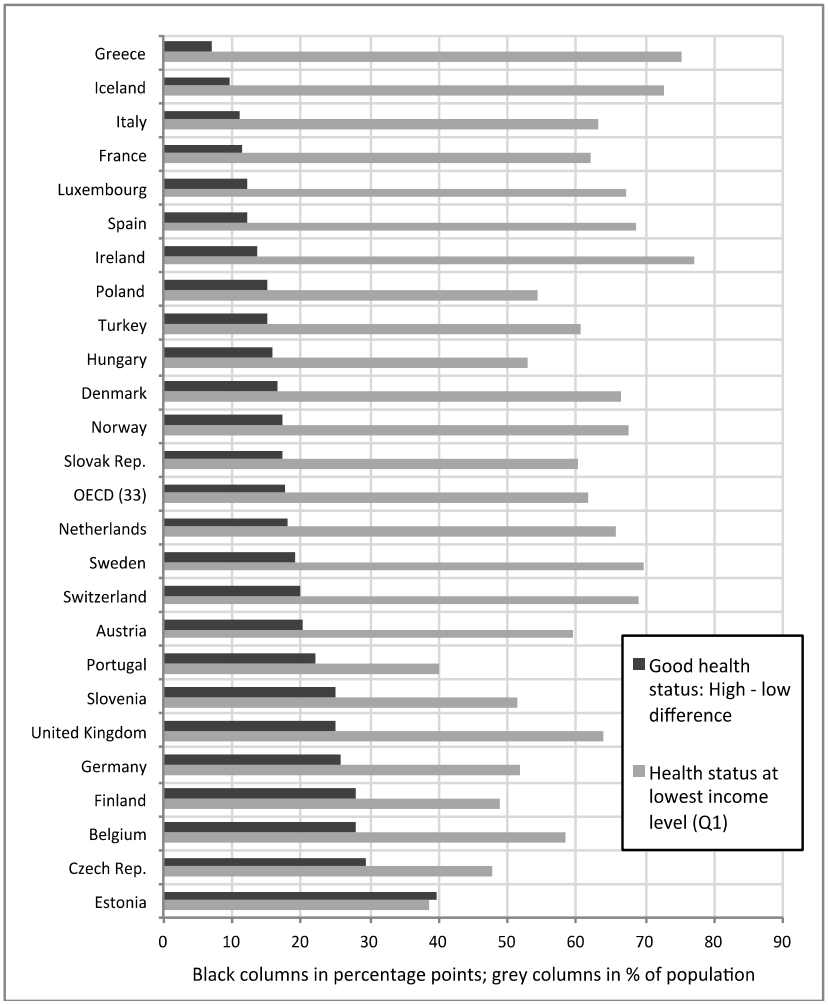
The Icelandic healthcare system can thus be classified as a Scandinavian healthcare system, with a large role for the government and mainly financed by taxes (McKinsey Global Institute, 2016; Thomson et al., 2012; Ásgeirsdóttir, 2009).

For a number of years in the early 2000s, the Icelandic healthcare system ranked among the most expensive in Europe in terms of cost as a proportion of GDP. In 2006, overall healthcare spending (public and private together) was about 9.6% of GDP, while the OECD average was 9.0%. In 2007, spending was 9.3%, against an OECD average of 8.9% (OECD, 2009), putting Iceland in 12th place on the OECD list of relative health expenditure. The latest OECD figures, for 2016, are 8.6% of GDP (public 7.1% and private 1.5%). Iceland is thus presently below the OECD average (9.0% of GDP). Thus Iceland has experienced significant spending cuts in this sector from its top expenditure year of 2003 (OECD, 2017). At the same time, aside from an increase in population and ageing, there has been a massive growth in tourism, which has also meant increased demand for services.

Cost constraints have thus had a negative effect on coverage in recent years, leading to longer waiting lists and a reduction in healthcare services in some of the more provincial areas of the country.

[1] See also Ministry of Health, www.velferdarraduneyti.is.

Figure 1: Health status of low-income individuals and difference between high- and low-income groups

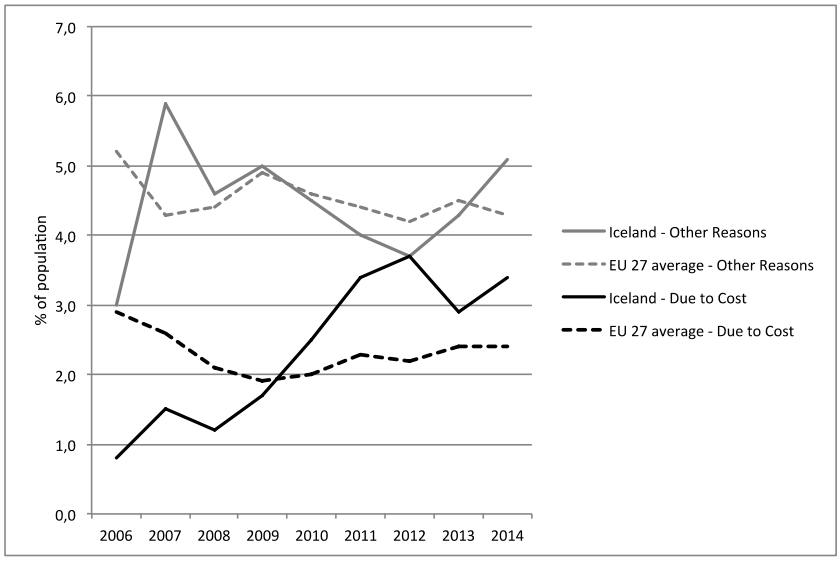


Source: OCED (for year 2013).

Though Iceland has seen a decline in health status in recent years, pre-crisis the situation was very good, and the health status of the nation is still quite good (Figure 1). The country has one of the highest proportions of the population with good health status among low-income individuals; and the difference between high- and low-income groups is also one of the smallest. This to a large extent reflects a high standard of healthcare in the decade leading up to 2008 and a low level of inequality in health status.

The main changes in access are thus related to spending constraints and reduced purchasing power during the crisis years. Figure 2 surveys these developments, as seen from the users' perspective, disaggregating changes due to cost or other reasons (regional accessibility, waiting lists, etc.). The clear conclusion is that the main change in accessibility in this period (since 2006) is due to cost. Iceland went from having a lower proportion of unmet need for medical treatment due to cost than the EU average (1% as against 3% in 2006), to an equal proportion in 2009; since then, Iceland has had a higher level than the EU average. In fact, in 2015 only Greece, Romania, Latvia, Italy, Cyprus and Bulgaria had higher levels on that dimension (cf. EU-SILC data). That is an unusual position for a Nordic welfare state to be in. It is perhaps not surprising that Iceland's level should have increased a lot during the crisis, but the slow recovery in recent years is somewhat surprising.

Figure 2: Unmet need for medical examination due to cost or other reasons, Iceland and EU-27 compared (% of population)



Source: Statistics Iceland.

Iceland is a large country with a small population (about 350,000). Hence there are structural limits on the provision of healthcare services, particularly in the more sparsely populated areas (Gústafsdóttir et al., 2016). There is only one high-tech university hospital in the country, in the Reykjavík area. There used to be mini-hospitals in the biggest urban areas in each of the main country quarters (Vestland, Vestfjords, Northern part, Eastern and Southern parts). But in the period of austerity, the service levels were cut and some functions closed down fully, meaning that people from such areas are expected to get their special services from the Reykjavík capital area. An example of this is the Vestmanna Islands (south of Iceland with a population of some 4,500). Previously the islands had a mini-hospital, providing – among other things – full maternity and birth care services; but this has now been closed down. Couples expecting a baby thus have to move temporarily to Reykjavík well in advance of the expected date of birth – or else rely on emergency services by helicopters. So a higher level of cost, insecurity and inconvenience becomes a part of life in such places. Given the sometimes difficult weather conditions during the winter, the reduced service provision has a significantly negative impact on the local community.

The biggest negative change in access in recent years has been the rising share of user charges, both for service access and – especially – for use of prescription medicines, where subsidies have been significantly cut for many patient groups. So the rising cost of medications is now a significantly increased obstacle to access. Longer waiting times for operations are also a decisive factor.

At the beginning of the crisis (from about 2009 to 2012), the waiting lists for common operations did not increase significantly; however, since then they have increased. That is now one of the greatest concerns in the area of access to services. In light of the longer waiting times, private providers have pushed for greater freedom to access public funding for such services as hip or knee replacements. That is highly controversial, however, and governments have refrained from increasing funding for private providers, even preferring to send people on the waiting lists to Scandinavian hospitals at full cost to the government (a more expensive option than allowing private providers to carry out the treatment in Iceland). The opposition to increasing private provision (at public cost) in this area reflects a deep public opposition to increasing the private sector's role in the healthcare sector of Iceland.

The biggest unresolved waiting-list issue is currently the waiting list for knee and hip joint replacement. While there has been some improvement on both scores, the situation in February 2018 was still that 66% of people had been waiting more than 3 months for a knee operation and 62% had been waiting that long for a hip replacement. The improvement since 2016 has thus been very slow, even though the number of knee operations performed in public hospitals has more than doubled over the period.

Generally speaking, between 40% and 80% of those on the waiting lists for other operations have been waiting for more than 3 months, despite some improvements in most categories. The situation was really bad around 2016 and is still unacceptable in most categories of diseases that require surgical operations.

The subsidy system for pharmaceutical products is similar to that in the Scandinavian countries. The user pays the full cost up to a fixed sum, and then a lower proportion of the cost in incremental steps up to an overall limit of EUR 508 per 12-month period. Costs above that are free of charge for users. Old-age pensioners, disability pensioners, children and young people under the age of 22 pay two thirds of that maximum.

The services of psychologists are not subsidised, and nor are the costs of various private providers, such as physiotherapists, occupational therapists and the like. All pharmacies in Iceland are privately operated and are subject to fewer restraints on pricing than prevail in the other Nordic countries. Hence the pricing level may be higher in Iceland.

Dental services for individuals aged 18-67 are generally not subsidised and no dental insurance schemes are available. From 1 January 2018, all children under 18 have been covered by a new scheme that involves a fixed registration fee of EUR 21, but thereafter treatment is free. This scheme was gradually phased in between 2003 and 2018. Gold and porcelain crowns, dental bridges and orthodontic treatments are excluded. Orthodontic treatment may, however, attract a subsidy of about EUR 1,200 under special rules (NOMESKO, 2017: 211). Those suffering from chronic illness, as well as old-age pensioners and disability pensioners, are eligible for a partial subsidy.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Table 1 shows an overview of the unmet need for medical services among those who reported some need over the previous 12 months.

Table 1: Unmet need for medical services by reason, EU average and Iceland compared: proportion of those in need of some services in the past 12 months

	3 reasons	Financial reasons	Distance, travel	Waiting lists
EU average 2014	26.5	14.8	3.6	18.7
Iceland 2015	33.7	20.7	4.0	28.8

Source: Eurostat and Statistics Iceland.

Here we see that Iceland is above the EU average for all categories identified. The difference is most marked for reasons of long waiting lists and cost. Despite the small population and the size of the country, distance/travel is not the biggest drawback. The waiting lists and cost problems are both results of the crisis, since they increased after 2008 (the cost reason) and after 2012 (the waiting lists). Hence both are leftovers from the crisis situation; their persistence is somewhat strange, given Iceland's good economic recovery from 2011 onwards (Ásgeirsdóttir and Jóhannsdóttir, 2017). Unmet need for healthcare services seems to be one of the largest drawbacks of the Icelandic welfare state at this time.

Which services have been most affected and for which social groups?

Table 2 shows how different region types and age groups are differently affected by lower access to healthcare services due to cost.

Table 2: Unmet need for healthcare service due to cost, by type of service, degree of urbanisation and age group, 2015: proportion of those in need of the respective service some time during the past 12 months

	Medical services		Dental services		Prescription medicine		Mental health services	
	Could not afford service		Could not afford service		Could not afford service		Could not afford service	
Total	8		19		10		33	
Densely populated	8		19		8		33	
Intermediate density	12		22		14		39	
Sparsely populated	5		17		9		25	
15-24 years old	10		19		11		33	
25-34 years old	11		34		14		44	
35-44 years old	8		22		12		36	
45-54 years old	10		17		10		33	
55-64 years old	8		15		10		24	
>=65 years old	2		8		4		6	

Source: Statistics Iceland: Healthcare survey of 2015.

Some 60% of the population report some need for medical and dental services and for prescription medicines, and some 20% had need of some mental health services. The figures in the table are proportions of these bases (hence the higher figures than population percentages). The distribution by sub-group is our main concern here.

Looking first at the different types of regions (by degree of urbanisation), what stands out is the higher level of unmet need for services among those living in areas of intermediate density, i.e. inhabitants of smaller localities in the provinces (villages and small towns). This applies to all service types. The sparsely populated areas refer primarily to farmers and the very smallest villages, and expectations of local service provisions may be more modest there than in the intermediate density areas.

What is interesting in terms of the age groups is that it is those aged 25-34 that have the highest level of unmet need in all service categories. The level then declines gradually for higher age groups, ending with the very lowest level in the pensioner population. Regarding the very high level of those in need of mental health services and who cannot afford the treatment, one should note that Iceland does have an exceptionally high level compared to the EU countries. This is probably a measurement effect, due to the wording of the question. But apart from that, there is growing awareness now of inadequate service provisions for those in need of mental healthcare in Iceland. The number of psychiatric beds per 100,000 is somewhat lower than in the other Nordic countries (cf. Eurostat).

Given that the elderly have generally the greatest need for healthcare services, it is important that they also have the lowest level of unmet need. Dental services are only provided privately in Iceland and are only subsidised for children under 18 (fully since 2018) and partly for the elderly. Hence working-age individuals, particularly those who have recently got their own homes and started a family, most often feel the need to forgo the services of dentists (which are expensive).

Table 3: Unmet need for healthcare service due to cost, by type of service, income decile and educational group, 2015: proportion of those in need of the service some time over the past 12 months

	Medical services Could not afford service	Dental services Could not afford service	Prescription medicine Could not afford service	Mental health services Could not afford service
Total	8	19	10	33
Primary education	18	36	20	53
Secondary education	9	23	13	34
Tertiary education	5	14	5	28
Bottom income quintile	17	33	17	45
Second income quintile	12	30	15	44
Third income quintile	7	16	10	25
Fourth income quintile	3	14	4	24
Top income quintile	3	8	3	21

Source: Statistics Iceland: Healthcare survey of 2015.

This table shows a considerable social class effect in access to the main healthcare services. The lowest educational group has between two and four times the level of unmet need for services they required in the previous 12 months than the highest educational group. Similar differences apply to income groups. It is not just those in the lowest income quintile that have a high level of unmet need due to cost: the difference between quintiles 1 and 2 is not that large. Thus needy individuals in the lowest 40% are significantly hampered, particularly when it comes to dental or mental health services.

Unmet need for medical treatment due to reasons other than cost did not change much in Iceland during the crisis period to 2014, and in fact stayed close to the EU average. But it was previously generally higher than unmet need due to cost, and so the regionally different access to services seems to have been an important factor.

2.1 Cost subsidies

There are primarily two features within the Icelandic healthcare system that aim to alleviate cost restrictions to access: discount rates for visits to doctors and subsidies for prescription medications (NOMESKO, 2017).

Children under 18 do not pay anything for a visit to a general practitioner (GP) and they have a lower rate for a consultation with a specialist. The elderly (67+), disability pensioners and the long-term unemployed pay half for a GP appointment. The cost of a specialist consultation is about four times the cost of an appointment with a GP. The same groups get a lower rate for that (see the appendix for an overview of user charges for various services, as of 1 March 2018).

Since 1 May 2017, there has been a cost ceiling for visits to doctors, totalling EUR 571 per 12 months for regular patients. Pensioners, disability pensioners and the long-term unemployed pay a maximum of two thirds of that. The system has shifted overall cost from those with the very highest healthcare service costs to those with lower costs – without any increase in expenditure. This has been rather unpopular and there have been demands for a lower overall ceiling and increased subsidy levels.

According to OECD figures, Iceland has the second-highest out-of-pocket payments (as a percentage of GDP) of all the Nordic countries, after Finland (OECD, 2017). That is still not far above the OECD average. The OECD, however, states that direct household payments for dental care and pharmaceuticals are high in Iceland compared to other OECD countries. That explains part of the relatively high cost barrier to using those healthcare services in Iceland, but the distribution of costs and subsidies seems on the whole to be somewhat more unfavourable for lower-income groups in Iceland than in the Scandinavian countries. The cost to the user is usually paid up front (with discounts subtracted for those eligible) and the rules for this are quite transparent (see appendix).

2.2 Waiting lists and privatisation issues

The Directorate of Health (Landlæknisembættið - https://www.landlaeknir.is/), which is Iceland's supervisory authority in the healthcare sector, has stipulated that it is not acceptable for patients to have to wait more than 3 months (90 days) for an operation after diagnosis and the need for an operation has been identified.

As previously mentioned, waiting lists did not lengthen much in the first years after the crisis hit. But after 2012 they became an increasing problem. By 2016, the situation was so bad that the health authorities took special steps to reduce the waiting lists. In February 2018, the goal of ensuring that all those who need an operation get one within the 3-month limit is still a long way from being achieved in most areas, although there have been some improvements in the past 2 years (Directorate of Health, 2018).

The biggest success has been in the area of cataract operations: in 2016, some 85% had to wait more than 3 months for an operation; however, in February 2018 only about 38% of those on the list had waited for longer than 3 months. The main reason for this success is that the number of operations undertaken at the University Hospital has greatly increased, as has the number of operations performed at one particular private clinic. Other service providers did not improve their results significantly. In the case of cataract operations, the original crisis was due to inadequate funding by government.

Waiting lists for coronary heart surgery are nearly acceptable, with only 9% having waited more than 3 months in February 2018, a great improvement from 2015. In general, private payments or 'informal payments' cannot be used to jump the queue where there are waiting lists.

The Minister of Health is currently embarking on a major new effort to reduce the numbers on the waiting lists for knee and hip replacements, but improvements are clearly needed in other categories as well.

The long waiting lists have also led to a political debate about the public and private provision of healthcare services, such as for joint replacement. Providers in the private sector have asked for permission to enter the sector with government payment for their services, while others suspect pro-private sector politicians of starving the public sector in order to facilitate more private sector provisions. Those who argue for increased private provision in Iceland frequently mention the increased private provision of healthcare services in Sweden in recent decades as an example to follow.

Iceland now has EU regulations allowing patients on waiting lists to seek operations in other EEA countries (mainly the other Nordic countries), which then have to be fully paid by public health insurance, including travel costs. That is understandably unfavourable, since the private sector in Iceland could sometimes do the job at lower cost. The pressure for increased private provision in some of the areas most affected by excessive waiting lists thus seems likely to grow in the near future. The present Minister of Health has, however, declared herself to be opposed to increased private provision and has vowed to increase public provision instead. How that deadlock will be resolved remains to be seen.

In sum, after the crisis hit in 2008, the excessive cost of some healthcare services (dental services, pharmaceutical products and mental healthcare) has emerged as a growing problem, leading to Iceland having a higher level of unmet need for healthcare services – significantly above the level of other Nordic nations. A new system of cost sharing and subsidies in 2017 only shifted subsidies towards those with the very highest healthcare costs, while increasing the cost for patients with lower expenses (a much bigger population group). Overall expenditure on subsidies was not increased. Hence a large number of users of healthcare experienced increased user costs, quite significantly in some cases (OECD, 2017; Einarsson, 2013). This has been a growing cause for concern in the past year.

The spending cuts in the healthcare sector over the past decade have led to the crisis of longer waiting lists coming to the fore since 2012 and reaching a peak in 2016. Since

then, some progress has been made in shortening them, but the situation remains unacceptable in most areas of surgery, according to the standard set by the national Directorate of Health. The slow recovery in this sector runs counter to Iceland's otherwise good economic recovery.

Recommendations:

- Subsidies for user costs should be increased, particularly for users of prescription medications, dental services and psychological services. One way of doing that would be to lower the overall expenditure ceilings for user costs over a 12-month period for visits to doctors and purchases of prescription medications.
- Financing of operations in areas with excessive waiting lists should be significantly increased, irrespective of whether operations are carried out in public hospitals or private clinics.
- Visits to clinical psychologists should be incorporated into the public health insurance, with subsidies on user costs.
- A longer-term aim should be to increase subsidies for dental care for the working-age population, with the aim of improving dental health. Due to the high cost of private provision in that sector, too many delay or forgo treatment. Alternatively, efforts to increase price competition among dentists might be tried, for example by setting public price ceiling references for individual operations. These might restrain escalating or excessive pricing of dental services.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The available indicators are reasonable as measures of the extent of unmet need for healthcare services. Tapping into reasons with more detailed questions is also reasonable. But on the whole, these indicators can be improved – something that is already being done.

What primarily comes to mind is the idea of better filtering the actual need for healthcare services and medications, and then asking the needy part of the population about affordability and other aspects of access. Simply using the proportion of the total population that cannot afford to use the healthcare services downplays the extent of the problem for specific groups of patients/users, by including those who did not need any services during the previous year. This latter group also has inadequate knowledge of cost, waiting lists and the price a user has to pay for medications. Hence a more detailed questioning of access conditions for those in need of healthcare services would improve measurements in this area.

The way in which waiting lists are measured could be better standardised and better publicised. That would put more pressure on operators and financing authorities.

Statistics for the use of healthcare services outside the public health insurance system should be improved, for example with surveys of visits to psychologists, psychiatrists, physiotherapists and the like. Presently there is incomplete knowledge about the importance of the various types of healthcare services and the costs involved.

A more direct collection of statistics about the real cost of doctors' appointment and the use of medications (particularly user cost ceilings) would be very useful for more concrete measures of cost barriers. The Nordic countries have centrally produced overviews of such information in the NOMESKO reports that are produced every 2 years, but these could be improved and simplified, and perhaps applied at the European level (cf. NOMESKO, 2017: 202 and 207).

References

Ásgeirsdóttir, Tinna L. (2009), The Icelandic healthcare system, in Magnusses, Vrangbaek and Saltman eds. *Nordic Health Care Systems – Recent Reforms and Current Policy Challenges*. Maidenhead: Open University Press.

Ásgeirsdóttir, Tinna L. and Jóhannsdóttir, Hildur M. (2017). Income-related inequalities in disease and health conditions over the business cycle, Health Economics Review, 7:12.

Directorate of Health (2018). Biðlistar eftir völdum aðgerðum [Survey of waiting lists for common operations]. Available at www.landlaeknir.is

Einarsson, Ingimar (2013). Greiðsluþátttaka almennings í heilbrigðiskerfinu: Vaxandi útgjöld krabbameinssjúklinga. Reykjavík: Krabbameinsfélagið.

Eurostat (2018). Statistics on living conditions, available at https://ec.europa.eu/eurostat/data/database.

Gústafsdóttir, S., Fenger, K., Halldórsdóttir, S. and Bjarnason, Th. (2016). Social justice, access and quality of healthcare in an age of austerity: Users' perspective from rural Iceland, International Journal of Circumpolar Health, 75:1.

McKinsey Global Institute (2016). Evaluating Landsspítali University Hospital. Reykjavík: Ministry of Welfare, available at https://www.stjornarradid.is/media/velferdarraduneyti-media/media/frettir2016/20160907_Evaluating-Landspitali-university-hospital_final-presentation.pdf

NOMESKO (2017). Health Statistics in the Nordic Countries. Copenhagen: Nordic Medico-Statistical Committee.

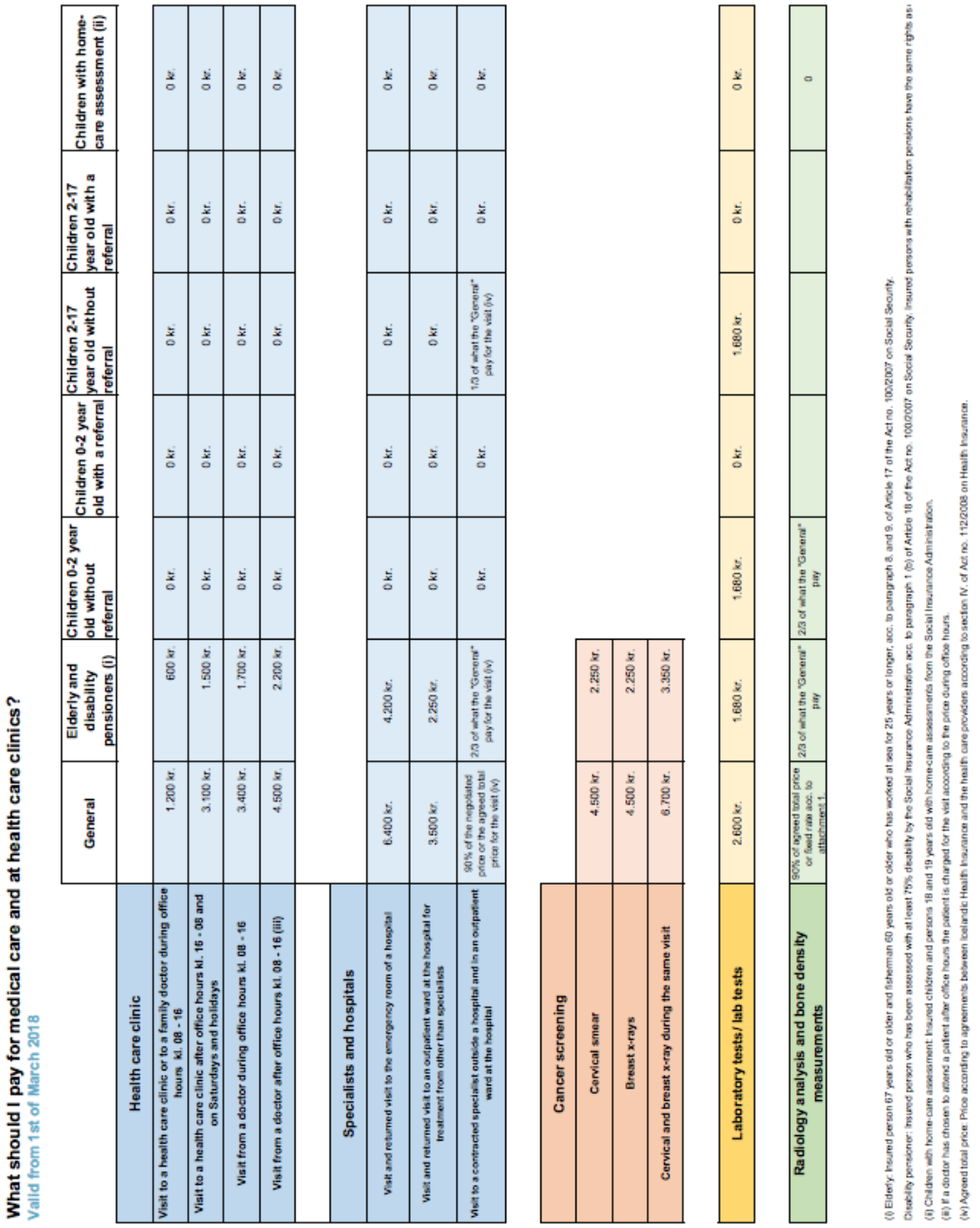
OECD (2009). Health at a Glance. Paris: OECD.

OECD (2017). Health at a Glance. Paris: OECD.

Statistics Iceland (2015). Healthcare survey of 2015. Reykjavík: Hagstofa Íslands.

Thomson, Sara, Osborn, Robin, Squires, David and Jun, Miraya (eds), International Profiles of Healthcare Systems 2012. Commonwealth Fund, available at http://apps.who.int/medicinedocs/documents/s19988en/s19988en.pdf.

Appendix: Cost scheme for healthcare services in Iceland, as of 1 March 2018 (accessed 14 May 2018)[2]



What should I pay for medical care and at health care clinics?

Valid from 1st of March 2018

	General	Elderly and disability pensioners (i)	Children 0-2 year old without referral	Children 0-2 year old with a referral	Children 2-17 year old without referral	Children 2-17 year old with a referral	Children with home-care assessment (ii)
Health care clinic							
Visit to a health care clinic or to a family doctor during office hours kl. 08 - 16	1.200 kr.	600 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Visit to a health care clinic after office hours kl. 16 - 08 and on Saturdays and holidays	3.100 kr.	1.500 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Visit from a doctor during office hours kl. 08 - 16	3.400 kr.	1.700 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Visit from a doctor after office hours kl. 08 - 16 (iii)	4.600 kr.	2.200 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Specialists and hospitals							
Visit and returned visit to the emergency room of a hospital	6.400 kr.	4.200 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Visit and returned visit to an outpatient ward at the hospital for treatment from other than specialists	3.500 kr.	2.250 kr.	0 kr.	0 kr.	0 kr.	0 kr.	0 kr.
Visit to a contracted specialist outside a hospital and in an outpatient ward at the hospital	90% of the negotiated price or the agreed total price for the visit (iv)	2/3 of what the "General" pay for the visit (iv)	0 kr.	0 kr.	1/3 of what the "General" pay for the visit (iv)	0 kr.	0 kr.
Cancer screening							
Cervical smear	4.500 kr.	2.250 kr.					
Breast x-rays	4.500 kr.	2.250 kr.					
Cervical and breast x-ray during the same visit	6.700 kr.	3.350 kr.					
Laboratory tests/ lab tests	2.600 kr.	1.680 kr.	1.680 kr.	0 kr.	1.680 kr.	0 kr.	0 kr.
Radiology analysis and bone density measurements	90% of agreed total price or fixed rate acc. to attachment 1	2/3 of what the "General" pay	2/3 of what the "General" pay				0

(i) Elderly: Insured person 67 years old or older and fisherman 60 years old or older who has worked at sea for 25 years or longer, acc. to paragraph 8. and 9. of Article 17 of the Act no. 100/2007 on Social Security.
Disability pensioner: Insured person who has been assessed with at least 75% disability by the Social Insurance Administration acc. to paragraph 1 (b) of Article 18 of the Act no. 100/2007 on Social Security. Insured persons with rehabilitation pensions have the same rights as
(ii) Children with home-care assessment: Insured children and persons 18 and 19 years old with home-care assessments from the Social Insurance Administration.
(iii) If a doctor has chosen to attend a patient after office hours the patient is charged for the visit according to the price during office hours.
(iv) Agreed total price: Price according to agreements between Icelandic Health Insurance and the health care providers according to section IV. of Act no. 112/2008 on Health Insurance.

[2] http://www.sjukra.is/media/althjodadeild/Payment-1-march-2018.pdf and http://www.sjukra.is/media/althjodadeild/Payment-1-march-2018_2.pdf

Payments for insured persons

Maximum per month	
General	Elderly, disability pensioners, children, children with home-care assessment
25.100	16.700

Minimum per month	
General	Elderly, disability pensioners, children, children with home-care assessment
4.183	2.783

Payments for insured persons							
	General	Elderly and disability pensioners	Children 0-2 years old with referral	Children 2-17 years old with referral	Children 0-2 years old without referral	Children 2-17 years old without referral	Children with home-care assessment
Health care clinic	Fixed rate	Fixed rate	0	0	0	0	0
Visit from a doctor	Fixed rate	Fixed rate	0	0	0	0	0
Hospital visits	Fixed rate	Fixed rate	0	0	0	0	0
Visits to a specialist at the hospital	90%	60%	0	0	0	0	0
Visits to a specialist outside of the hospital	90%	60%	0	0	0	30%	0
Physiotherapy, occupational therapy and speech therapy	90%	60%	0	0	0	30%	0
Cancer screening	Fixed rate	Fixed rate	0	0	0	0	0
Laboratory tests	Fixed rate	Fixed rate	0	0	Fixed rate*	Fixed rate*	0
Radiology analysis	90%	60%	0	0	60%*	60%*	0

*Exception if treatment is directly related to an accident

Payments for skin diseases with B-rays, B- og A-rays or PUVA					
	General	Elderly and disability pensioners	Children with referral	Children without referral	Children with home-care assessment
	90%	60%	0	0	0