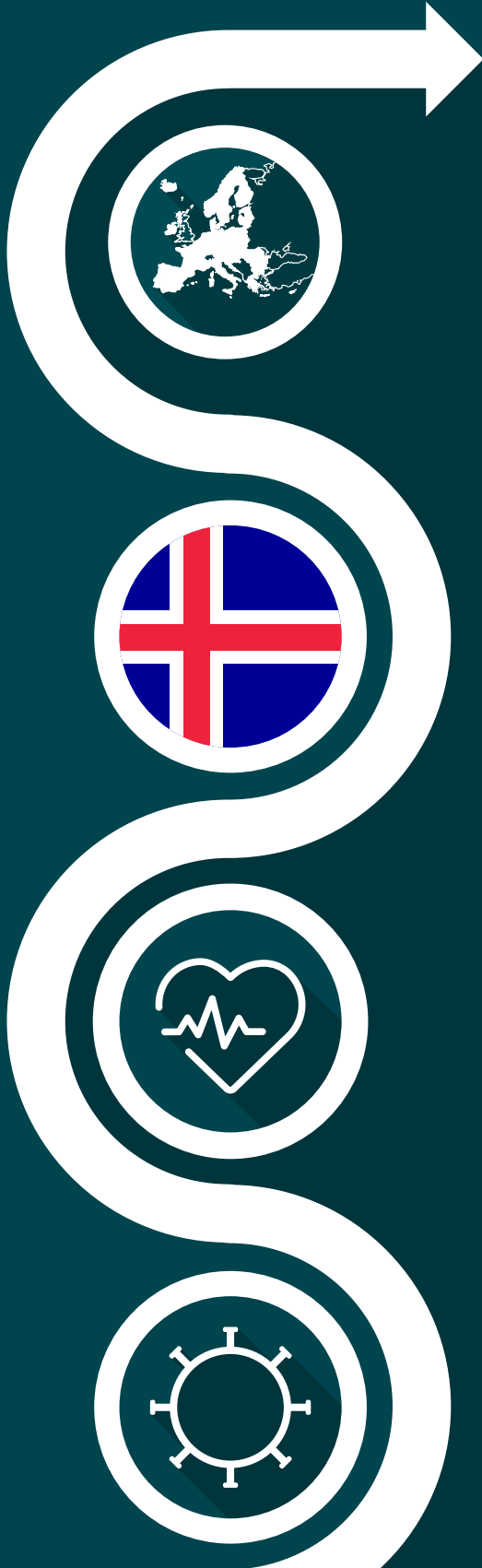




State of Health in the EU

Iceland

Country Health Profile 2023

The Country Health Profile Series

The *State of Health in the EU's Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Iceland, 2022

Demographic factors	Iceland	EU
Population size	376 248	446 735 291
Share of population over age 65 (%)	15.0	21.1
Fertility rate ¹ (2021)	1.8	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	44 923	35 219
Relative poverty rate ³ (% , 2018)	8.8	16.5
Unemployment rate (%)	3.8	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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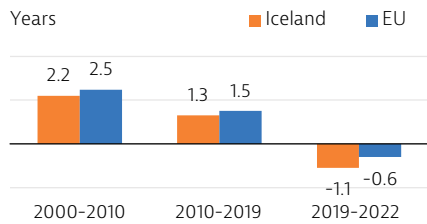
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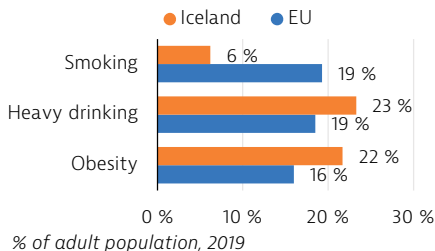
1 Highlights



Changes in life expectancy at birth

Health Status

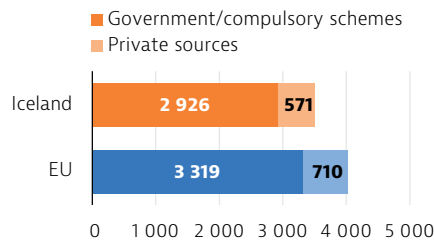
In the two decades leading up to the COVID-19 pandemic, life expectancy at birth in Iceland increased by 3.5 years. Although it remained stable during the first two pandemic years, in 2022 it fell by over one year to 82.1 years. Circulatory diseases and cancer were the main causes of death, collectively accounting for over 57 % of all fatalities in 2020.



% of adult population, 2019

Risk Factors

In 2019, behavioural risk factors were associated with 36 % of all deaths in Iceland. Smoking rates were among the lowest in Europe, following a drastic reduction over the last decade. Obesity is a public health concern, despite Iceland's high rates of physical activity. While alcohol consumption is relatively modest, heavy episodic drinking is more common than in most EU countries.



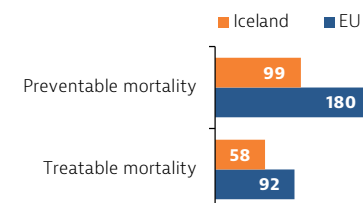
EUR PPP per capita, 2021

Health System

In 2021, Iceland's per capita health spending was EUR 3 497 – over 13 % below the EU average. Following a 4.3 % rise in 2020, it increased by over 7 % in real terms in 2021, driven by continued growth in public spending and a robust rebound in private spending. Public sources accounted for nearly 84 % of health spending – a higher share than the 81 % EU average.

Effectiveness

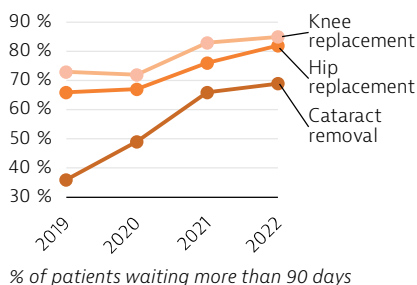
Preventable and treatable mortality in Iceland were significantly lower than the EU averages and the lowest among Nordic countries in 2020, reflecting a lower disease burden and generally effective treatment of life-threatening conditions. Colorectal cancer was the main cause of treatable mortality in 2020, followed by ischaemic heart disease.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

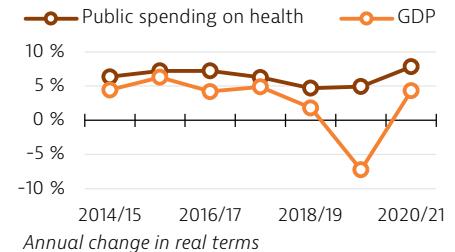
Iceland's universal public health insurance provides extensive coverage for a wide range of services. In recent years, increased demand and restricted hospital capacity resulted in excessive waiting times for most elective procedures. The COVID-19 pandemic had a significant impact on waiting lists.



% of patients waiting more than 90 days

Resilience

Public spending on health consistently outpaced GDP growth in the years before the pandemic in Iceland. The gap between health expenditure growth and GDP reached a record high in 2020 due to the significant decline in GDP. Nonetheless, the health spending share of GDP in Iceland in 2021 (9.7 %) remained lower than the EU average (11 %).



Annual change in real terms

Mental Health

In 2019, mental health disorders among Icelanders were estimated to be slightly less prevalent than the EU average, but the gap in prevalence of conditions such as depression across income groups was larger. Numbers of antidepressant prescriptions have increased steadily since 2010, surpassing numbers in other Nordic countries. The COVID-19 pandemic intensified demand for mental health services, worsening long waiting times. By 2022, the average wait for specialist adult mental health services was almost six months.

2 Health in Iceland

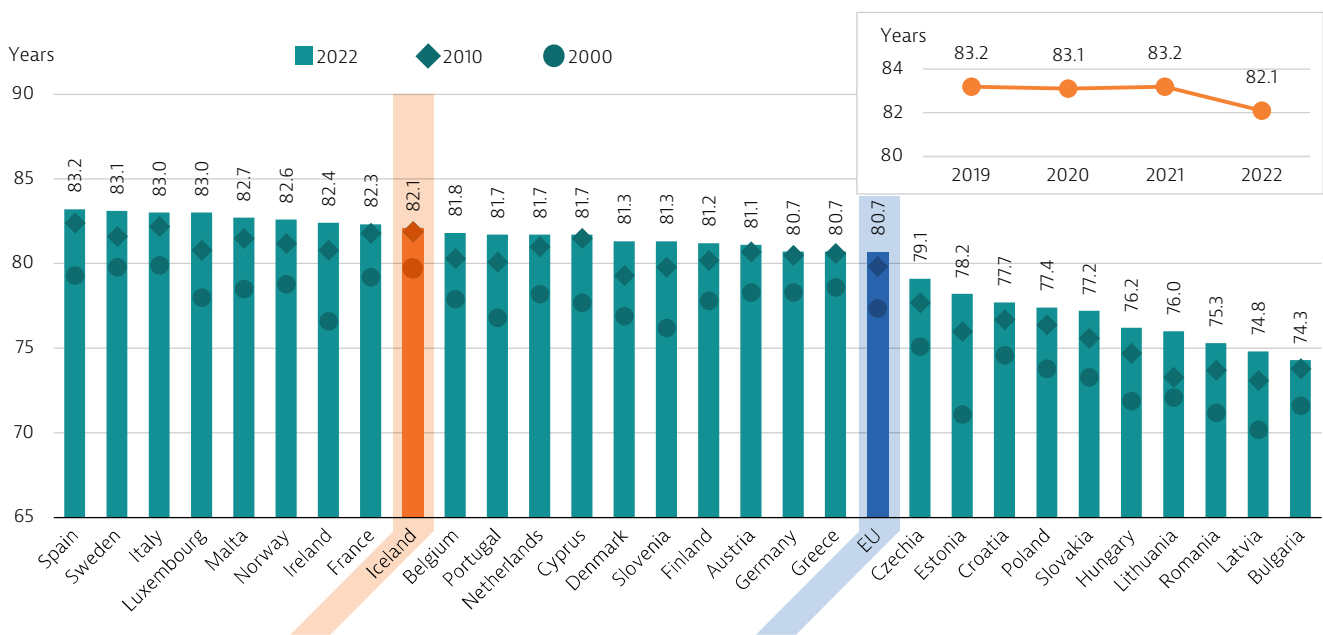
Increased COVID-19 mortality caused life expectancy to fall by over one year in 2022

Life expectancy at birth in Iceland stood at 82.1 years in 2022, surpassing the EU average by nearly 1.5 years. Between 2010 to 2019, Iceland's life expectancy grew at a slightly slower pace than the EU average. Following the onset of the COVID-19 pandemic, Iceland's life expectancy remained largely stable through 2020 and 2021, reflecting the minimal mortality impact of COVID-19 in the country. However, a significant

surge in COVID-19 deaths in 2022 led to an unprecedented life expectancy drop of 1.1 years (Figure 1).

As in other European countries, life expectancy in Iceland is characterised by a gender gap: men have a shorter expected lifespan than women. In 2022, women could expect to live 2.4 years longer than men (83.4 years compared to 81.0 years) on average. This was less than half the EU average gap of 5.4 years.

Figure 1. After experiencing minimal changes in 2020 and 2021, life expectancy declined in 2022

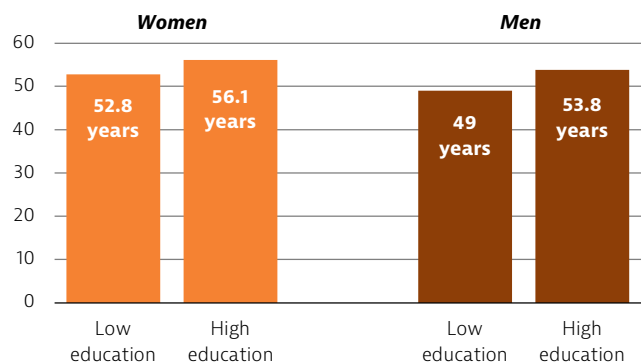


Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refers to 2021.

Source: Eurostat Database.

Disparities in life expectancy at birth are also evident between individuals with high and low levels of education (Figure 2). In 2021, the education gap in life expectancy was 3.6 years among women and 4.9 years among men. These differences can be explained in part by differing levels of exposure to various risk factors for health, which tend to be highest among men with low levels of education (see Section 3). While the education gap in life expectancy among men has stayed largely consistent since 2011, it has widened slightly among women due to increases in life expectancy among women with secondary and tertiary education (Statistics Iceland, 2022a).

Figure 2. The life expectancy gap by education at age 30 is particularly large among Icelandic men



Notes: Data refer to life expectancy at age 30. Low education is defined as people who have not completed secondary education (ISCED 0-2), whereas high education is defined as people who have completed tertiary education (ISCED 5-8).

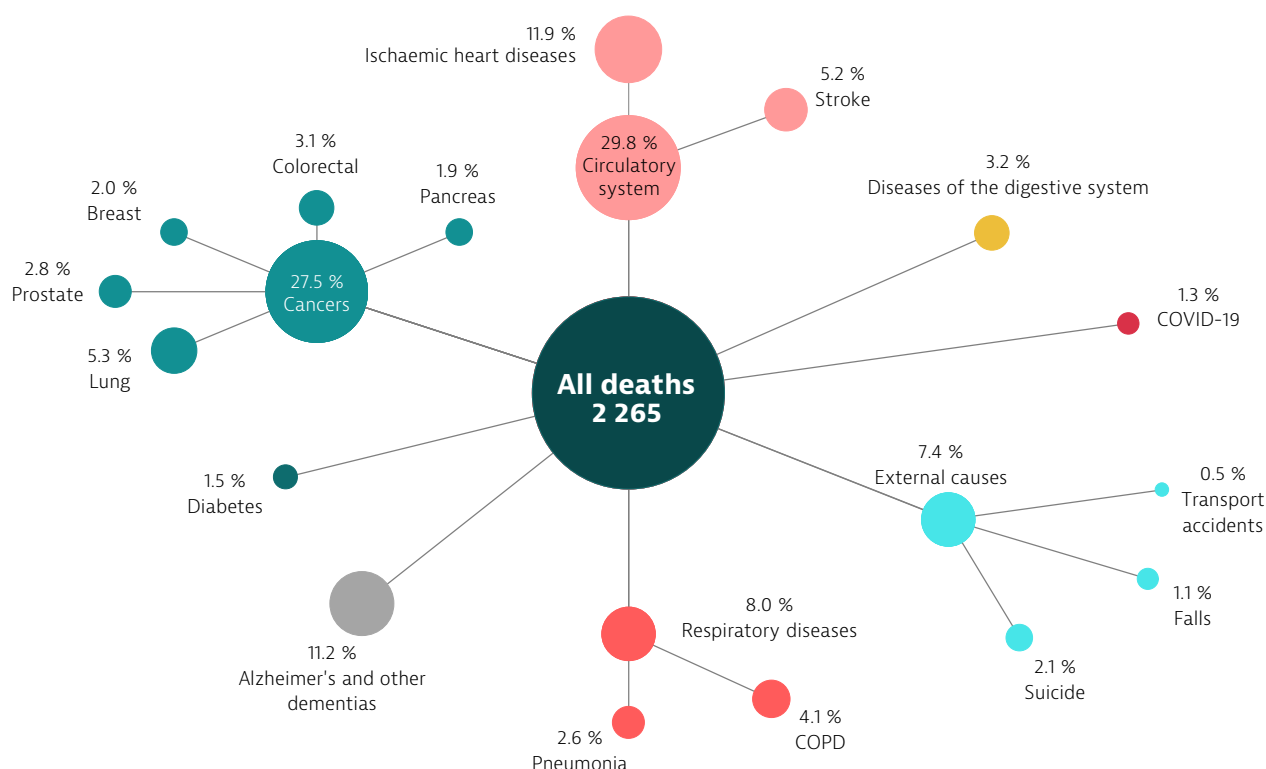
Source: Statistics Iceland (data refer to 2021).

Iceland has experienced large reductions in mortality rates in the past 20 years

Between 2000 and 2020, Iceland's life expectancy increased by nearly 3.5 years, primarily thanks to significant reductions in mortality rates associated with circulatory diseases. Despite these improvements, in 2020 circulatory diseases were still the leading cause of death in the country,

with ischaemic heart diseases accounting for nearly 12 % of all deaths (Figure 3). Between 2010 and 2020, mortality rates due to cancer declined by over 10 %, in line with the EU average. Cancer accounted for over 27 % of all deaths in 2020; the most common cancer sites were lung, breast and prostate. In 2020, COVID-19 was responsible for only 29 fatalities (1.3 % of total deaths).

Figure 3. Circulatory diseases were responsible for nearly one third of all deaths in Iceland in 2020



Note: COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

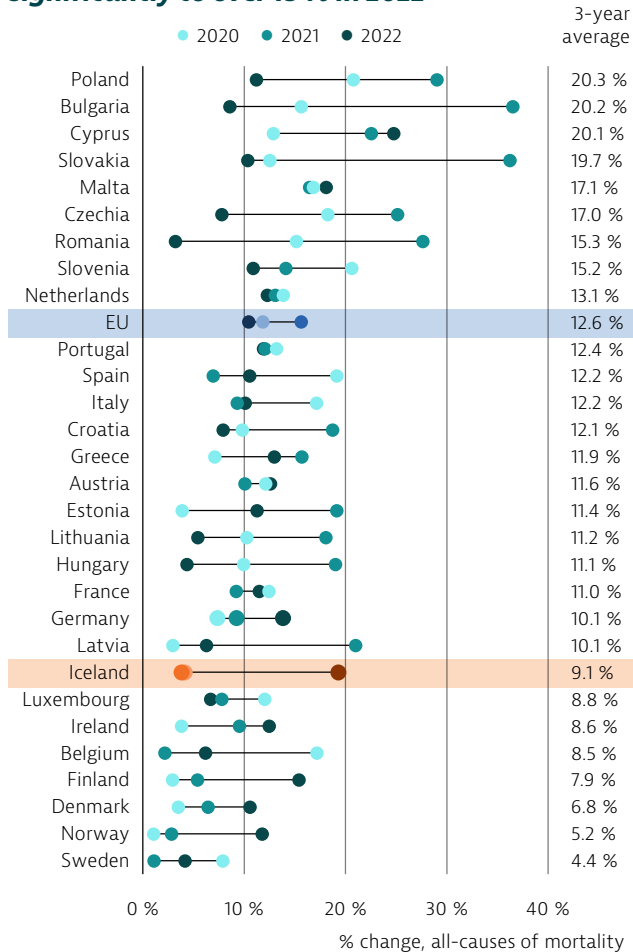
All-cause mortality deviated significantly from the pre-pandemic baseline only in 2022

Between 2020 and 2022, Iceland officially reported a total of 248 COVID-19 fatalities, 85 % of which occurred in 2022 alone. The indicator of excess mortality, defined as deaths occurring (regardless of their cause) above a baseline derived from pre-pandemic levels, provides a more comprehensive picture of the pandemic's mortality impact. During the first two years of the pandemic, excess mortality remained low, at less than 5 %. However, following a large increase in COVID-19 fatalities in 2022, it soared to over 19 %. The more than 650 excess deaths registered in Iceland between 2020 and 2022 accounted for an average level over 9 % above their pre-pandemic baseline (Figure 4). This was significantly lower than the

average excess mortality observed across the EU during the same period, but it stands out as the highest level among Nordic countries.

Throughout the first three years of the pandemic, the number of excess deaths in Iceland consistently surpassed the official number of COVID-19 deaths – a discrepancy that widened progressively (Figure 5). This inconsistency can be attributed to various factors, including the potential underreporting of COVID-19 deaths, disruptions in healthcare services and a rise in fatalities due to causes unrelated to COVID-19. During surges of COVID-19 following vaccine distribution, mortality relative to incidence remained low, thanks to a high vaccination rate (see Section 5.3).

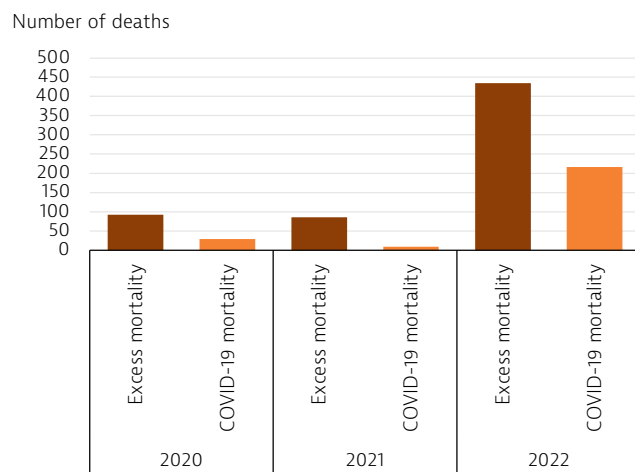
Figure 4. Following modest rates in 2020 and 2021, Iceland's excess mortality rate rose significantly to over 19 % in 2022



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).

Source: OECD Health Statistics 2023, based on Eurostat data.

Figure 5. Excess deaths consistently outweighed the number of reported COVID-19 deaths



Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the COVID-19 pandemic (2015-19).

Sources: ECDC (for COVID-19 mortality) and OECD Health Statistics based on Eurostat data (for excess mortality). COVID-19 mortality for 2022 is preliminary.

The majority of Icelanders rate their health as good

In 2018, when data were last available, over 75 % of the population reported that they perceived their own health as good or very good – a higher proportion than the EU average of 68.6 %. When examining trends between different socioeconomic groups, there was a distinct difference in perception of health between Icelanders on higher and lower incomes: 66 % of those in the lowest income quintile rated their health as good or very good, compared to 86 % of those in the highest quintile – a gap comparable to the EU average.

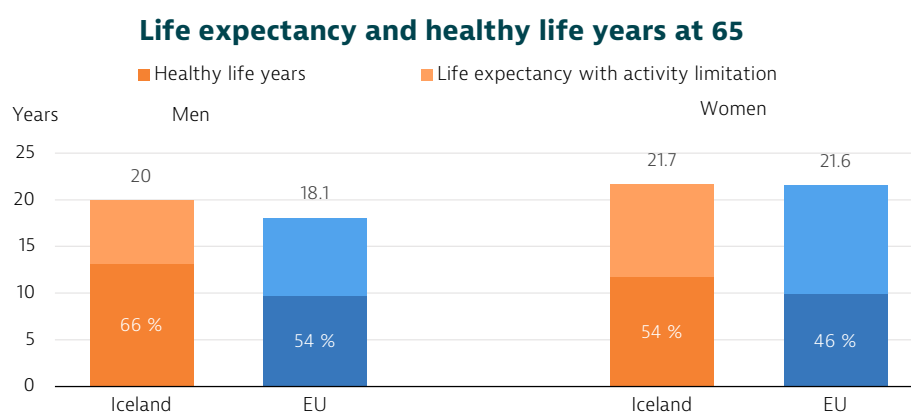
Icelandic women at age 65 live a greater portion of their lives with disability than men

Despite being one of the youngest countries in Europe, Iceland is projected to experience a significant increase in its older population in the coming decades – a shift driven by higher life expectancy and a below-replacement fertility rate. In 2022, 15 % of Iceland's population was aged 65 and over – a rise from about 11.6 % in 2000. This proportion is projected to reach 22 % by 2050 – a much lower share than the EU average of 30 %.

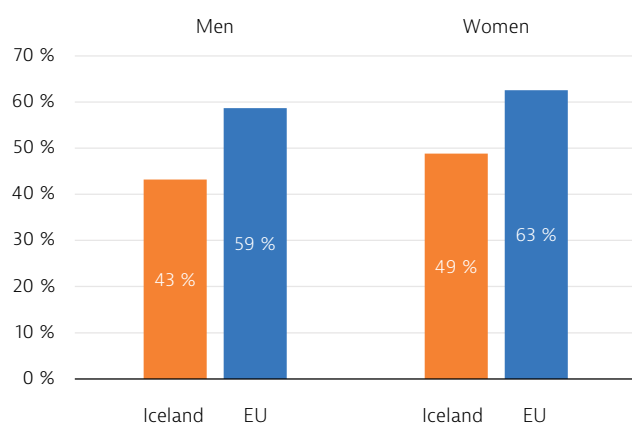
As of 2018 (latest available data), Icelandic women aged 65 could expect to live for another 21.7 years, while men could expect to live for a further 20.0 years (Figure 6). For women, 54 % of this additional time was anticipated to be lived in good health; for men the proportion was 66 %. Both proportions were above the EU averages – especially the one for men – resulting in a gender gap in healthy life expectancy at age 65 of nearly 1.5 years. Both men and women aged 65 and over reported a significantly lower prevalence of both longstanding health problems and limitations in daily activities due to health problems than the EU averages.

In recent years, Iceland has developed several policies to address population ageing (Huynh, Stjernberg & Cuadrado, 2022). These include the National Health Policy Plan, the Act on the Affairs of the Elderly, and the National e-Health Strategy. Elderly people in Iceland seem adept with new technology use for telehealth and access to telemedicine. Nearly half are comfortable with videocall technology, and a higher proportion use social media than in other Nordic countries.

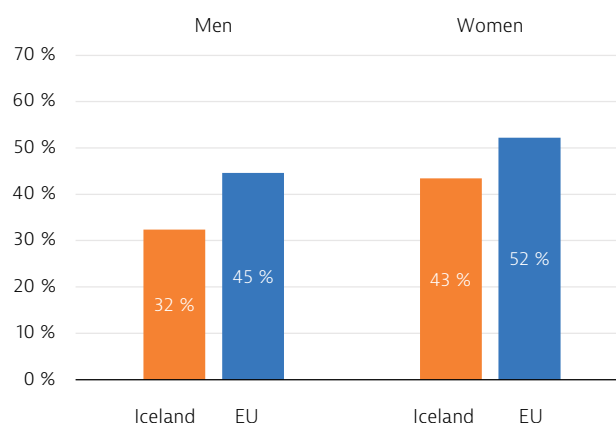
Figure 6. Lower proportions of older people report longstanding health problems and limitations in daily activities than the EU averages



Proportion of people aged 65 + with a long-standing health problem



Proportion of people aged 65 + reporting long-standing limitations in daily activities



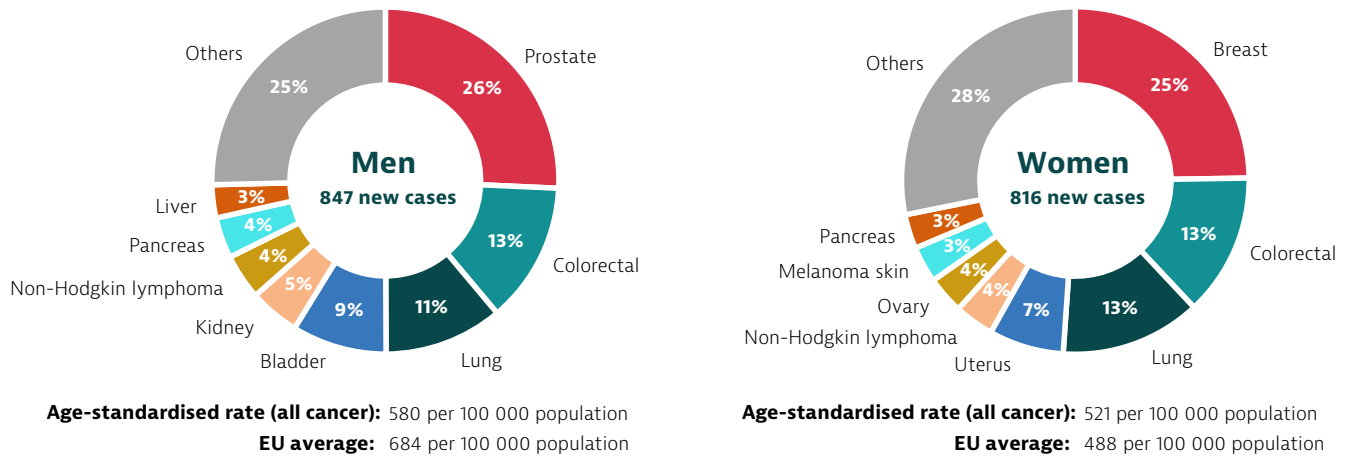
Sources: Eurostat Database (for life expectancy and healthy life years) and EU-SILC (for longstanding health problems and limitations in daily activities). Data refer to 2018.

Cancer incidence in Iceland is lower than the EU average

According to incidence estimates from the Joint Research Centre based on historical trends, about 1 600 new cancer cases were projected in Iceland in 2022. Cancer incidence was expected to be about 11 % higher among men than among women – a difference that was less than a third of the EU average. This smaller gap reflects comparatively lower projected incidence among Icelandic men, whose overall cancer incidence rate was over 15 % below the EU average, while the rate among Icelandic women was nearly 7 % above the EU average. Prostate cancer was projected to remain the single most common cancer site among men, accounting for 26 % of new cancers in 2022. Among women, breast cancer was expected to account for 25 % of new cancer cases (Figure 7). Among both men and women, colorectal and lung cancers were anticipated to be the second and third most common cancers.

To reduce the burden of cancer, Iceland approved its first National Cancer Plan in 2019. This focuses on nine policy areas that correspond to the EU's Europe's Beating Cancer Plan, including prevention, education and human resources development, evidence-based care, patient- and family-centred care, geriatric oncology, performance improvement and research. However, implementation was interrupted in 2020 owing to the COVID-19 pandemic. Recently, the Icelandic Cancer Society renewed calls for a national plan to address predicted increases in both cancer incidence – due to the growing and ageing population – and cancer survival (Icelandic Cancer Society, 2023).

Figure 7. More than 1 600 people were expected to be diagnosed with cancer in Iceland in 2022



Notes: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
 Source: ECIS – European Cancer Information System.

3 Risk factors

Over one third of deaths in Iceland are attributable to behavioural risk factors

As in other European countries, behavioural risk factors have a significant impact on mortality in Iceland, contributing to as many as 36 % of all deaths in the country in 2019. Among these factors, tobacco smoking played a prominent role: it was associated with 17 % of all fatalities – a proportion equal to the EU average, despite the fact that Iceland has a comparatively lower prevalence of smoking within its population (Figure 8). Albeit to a lesser extent than the EU averages, dietary

risks (15 % of all deaths) and alcohol consumption (3 %) also had significant impacts on mortality in Iceland.

Iceland's obesity rate is a public health concern

In recent years, prevalence of overweight and obesity among both Icelandic adolescents and adults have increased at a faster rate than the EU averages, resulting in among the highest rates across European countries. In 2019, nearly 22 % of Icelandic adults reported being obese, up from 18 % in 2014. The rate of obesity among men increased

Figure 8. Tobacco and dietary risks are major contributors to mortality in Iceland



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to fine particulate matter (PM_{2.5}) and ozone.
 Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

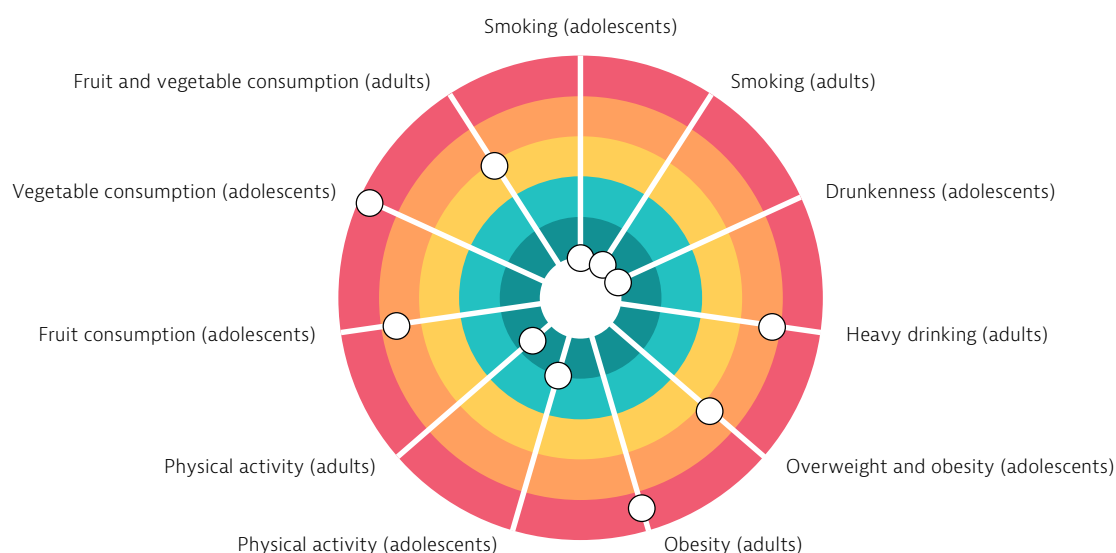
by nearly 5 percentage points, whereas the rate among women increased by only 2 percentage points. Further, over 21 % of 15-year-olds were overweight or obese in 2022 – a slightly higher proportion than the EU average.

To tackle the growing rates of overweight and obesity, the Icelandic government has implemented measures to encourage healthier eating habits. These include setting nutritional standards for school meals, prohibiting food and beverage advertisements on TV and radio during peak child audience times, and adopting the Nordic keyhole nutrition label (also used in Denmark, Norway and Sweden) to highlight healthier choices within product categories. Additionally, in 2020, Iceland released its first clinical guidelines for managing obesity in adults. However, despite these efforts and initiatives, limited progress has been observed thus far.

Iceland's population is one of the most physically active in Europe

Despite a high and rising prevalence of overweight and obesity, Iceland's population boasts some of Europe's highest levels of physical activity (Figure 9). In 2019, nearly 56 % of Icelandic adults spent at least 150 minutes engaging in moderate-to-vigorous physical activity weekly – a considerably higher proportion than the EU average of 33 %. Physical activity rates among children were also high: 19 % of Icelandic 15-year-olds participated regularly in moderate-to-vigorous physical activity in 2022 compared to the EU average of 15 %.

Figure 9. The high prevalence of overweight and obesity is a public health concern in Iceland



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.

Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

Smoking rates have declined drastically with the rise in popularity of alternative products

Since the enactment of the Tobacco Control Act in 2002, Iceland has progressively implemented various tobacco control measures, including high excise duties, advertising bans, packaging regulations mandating warning messages and prohibition of tobacco product vending machines. As a result, over the past two decades smoking rates have experienced a notable decline, plummeting from over 21 % of adults smoking daily in 2002 to only 6.2 % in 2022 – one of the lowest rates among European countries.

Adolescents also exhibited lower smoking rates than their EU peers: only 7 % of 15-year-olds reported smoking in 2018. However, the popularity of e-cigarettes is growing among adolescents, with around 17 % of those aged 15-16 regularly using e-cigarettes in 2019 – surpassing the EU average of 14 %. Additionally, use of tobacco-free nicotine pouches has surged significantly in recent years – particularly among young people – making it the predominant form of nicotine consumption in Iceland, used by over 10 % of the population (Kristjánsson, Jónsson & Jensson, 2023).

Alcohol consumption in Iceland is comparatively low, but heavy drinking is more common than on average across EU countries

Based on annual estimates of alcohol consumption, Iceland's per capita consumption stood at 7.4 litres in 2020 – approximately 25 % lower than the EU average of 9.8 litres per capita. Iceland has implemented various policies to curb alcohol consumption, including advertising bans, high excise duties and a legal drinking age of 20. Until 2022, the sale of alcoholic beverages with over 2.25 % alcohol by volume was restricted to the state-run monopoly retailer Vínbúðin. However, new legislation enacted in 2022 allows breweries to sell directly to customers, and alcohol sales by

private retailers appear to be growing, although they remain in a legal grey area (RÚV, 2022).

While total consumption was comparatively low, harmful consumption patterns such as regular heavy drinking¹ are more prevalent in Iceland than in most other European countries. In 2019, approximately 23 % of adults reported engaging in heavy drinking (29.4 % of men and 19.9 % of women), while the EU average was 18.5 %. The prevalence of heavy drinking decreased at the start of the COVID-19 pandemic in 2020, but in 2022 it rebounded close to pre-pandemic levels (Kristjánsson, Jónsson & Jensson, 2023).

4 The health system

Iceland provides universal health coverage through a mostly publicly funded health system

The health system in Iceland is primarily funded through government revenue, and covers all legal residents. It operates under an integrated purchaser-provider model, wherein the government serves as both the payer and the owner of most healthcare organisations. Policy, administration and financing are centralised at the national level. The majority of primary care is provided by public healthcare centres, and all hospitals are also public. Several proposals for private hospitals have been put forward in the last decade, but none have been implemented.

In recent years, the number and scope of private clinicians (non-profit and for-profit) have increased at a larger rate than the overall increase in doctors, which is roughly on a par with overall EU trends. Outpatient care provided by private specialists is a significant feature of the system. Roughly 75 % of costs related to private sector healthcare are reimbursed by the government.

Health expenditure as a share of GDP increased significantly during the pandemic

Health expenditure as a share of GDP increased greatly during the first two years of the pandemic, rising from 8.6 % of GDP in 2019 to 9.6 % in 2020 and 9.7 % in 2021, although this remained below the EU average of 11.0 % in 2021. This growth was mainly due to increased public spending during the first two years of the pandemic (see Section 5.3),

as well as a reduction in Iceland's GDP in 2020. In per capita terms, health spending increased to EUR 3 497 in 2021, up from EUR 3 224 in 2019, which nevertheless remained more than 13 % lower than the EU average of EUR 4 028 (Figure 10).

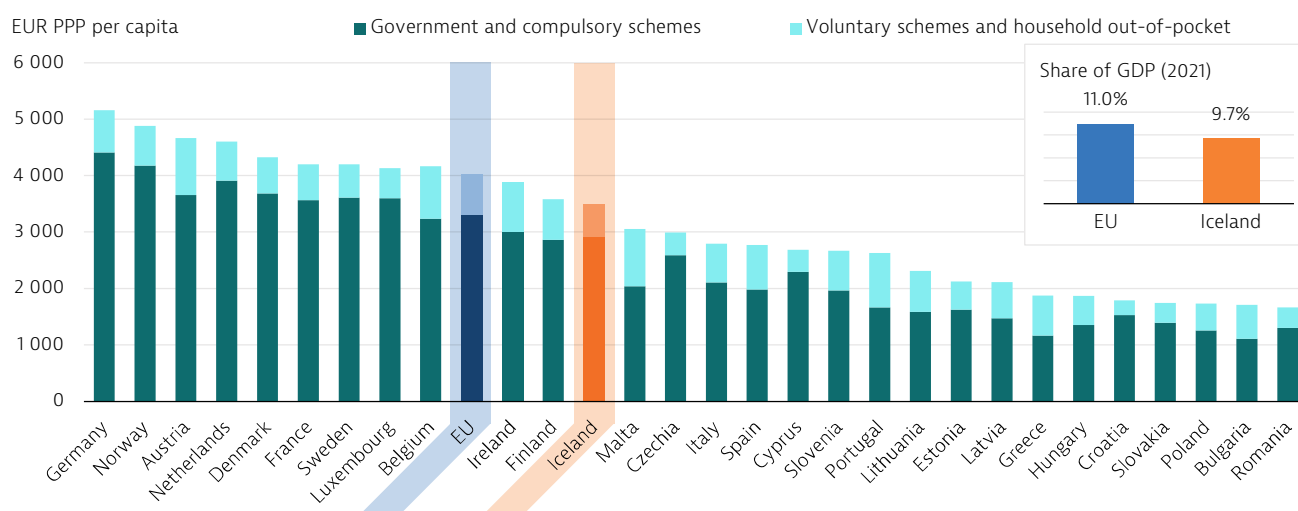
Most health spending in Iceland is publicly funded, accounting for 83.7 % of health expenditure in 2021 – slightly above the EU average of 81.1 %. At the same time, out-of-pocket (OOP) payments accounted for 14.6 % of health expenditure – on a par with the EU average of 14.5 %. These payments are mainly copayments for primary care visits, outpatient care and outpatient pharmaceuticals, although reductions or exemptions exist for vulnerable groups. Voluntary health insurance (VHI) is virtually non-existent, making up just 1.7 % of health expenditure. Such insurance is the primary source of coverage for individuals who have resided in Iceland for fewer than six months and are not yet eligible for public coverage (Sigurgeirsdóttir, 2016).

Inpatient and outpatient care absorb over 60 % of health spending

Inpatient and outpatient care each make up almost one third of Iceland's current healthcare expenditure (Figure 11). In 2021, 19.8 % of health expenditure was allocated to long-term care, making it the next largest category and surpassing the EU average of 16.1 %. Iceland reduced the proportion of spending on pharmaceuticals and medical devices from 18.7 % in 2010 to 14.2 % in 2021 thanks to a range of measures pursued by

¹ Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

Figure 10. In per capita terms, Iceland spends less on health than any other Nordic country



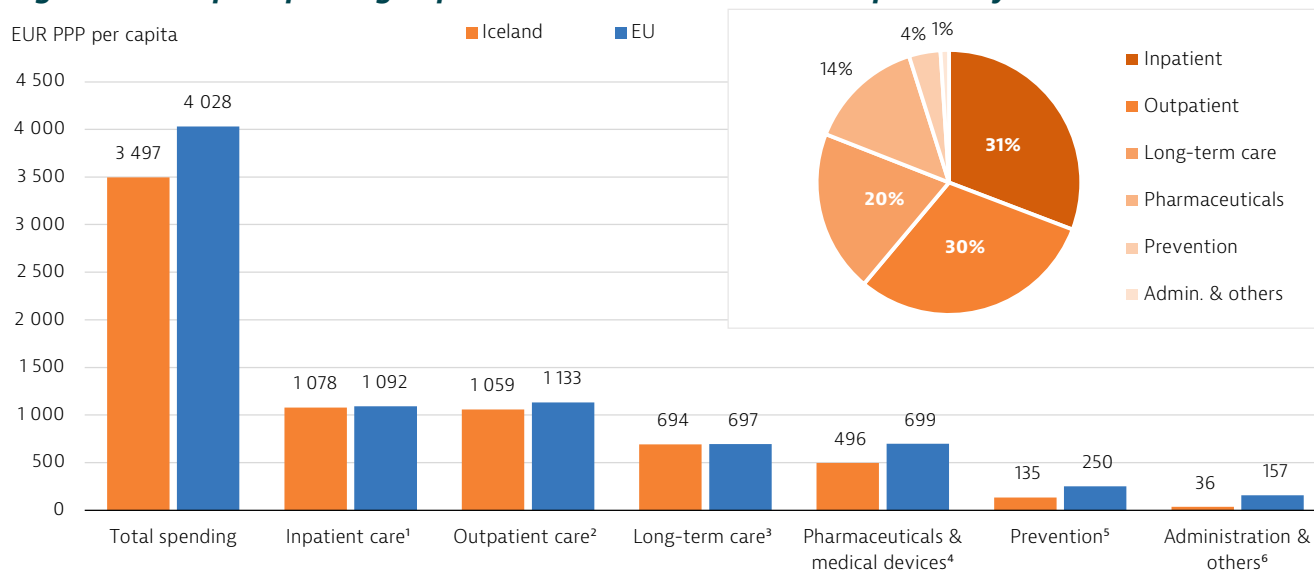
Note: The EU average is weighted.

Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

the commissioning agency for pharmaceuticals, including reference lists and competition between retailers, in addition to increases in the overall health budget over time. Conversely, the proportion

of budget allocated to prevention increased by almost one percentage point during the pandemic from 2.6 % in 2020 to 3.4 % in 2021.

Figure 11. Per capita spending on pharmaceuticals in Iceland is comparatively low



Notes: The EU averages are weighted. 1. Includes curative-rehabilitative care in hospitals and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the health component; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending.

Source: OECD Health Statistics 2023 (data refer to 2021).

Healthcare governance is decentralised across seven districts

Iceland is divided into seven districts, each tasked with organising and delivering health services at all levels. Along with primary care, nursing home services and other healthcare, each region has at least one main hospital, the size and main function of which may vary. Most private specialised clinics, on the other hand, are located in the area of the capital, where around two thirds of the country's

population live. Hospital capacity is comparatively low, with bed occupancy rates consistently above 90 % (see Section 5.3). In March 2020, capacity in intensive care units (ICUs) was increased to accommodate potential surges in demand due to COVID-19.

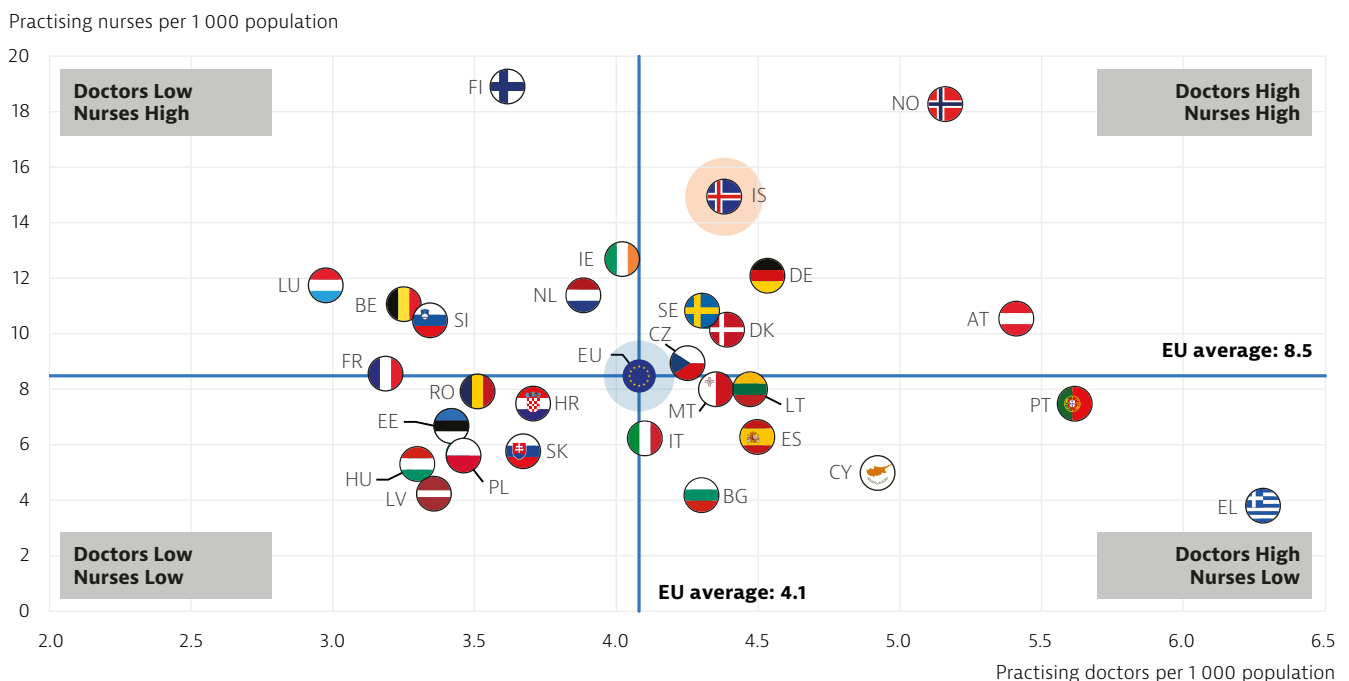
Iceland has a high number of doctors compared to most European countries, but a low proportion work in general practice

In 2021, only 12.9 % of doctors in Iceland worked as general practitioners (GPs), which was far below the EU average of 20.4 %. GPs do not perform a gatekeeping and referral function, allowing patients to seek care directly from private specialists. The overall number of doctors in Iceland in 2021 (4.4 per 1 000 population) was slightly above the EU average (4.1 per 1 000). The number of nurses in 2021 was much higher (15 per 1 000 population) than the average across the

EU (8.5 per 1 000), but this number includes both nurses with high level of qualifications and licensed practical nurses who have lower qualifications (Figure 12).

Recruitment, training and retention have posed a challenge, and a shortage of nursing professionals has been a longstanding problem. The number of nursing graduates has declined in recent years, from a recent peak of 82 nursing graduates per 100 000 population in 2014 to 60 per 100 000 in 2021. The Ministry of Health has recognised this challenge, and aims to increase their number.

Figure 12. Iceland has a higher density of doctors and nurses than most European countries



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.

Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

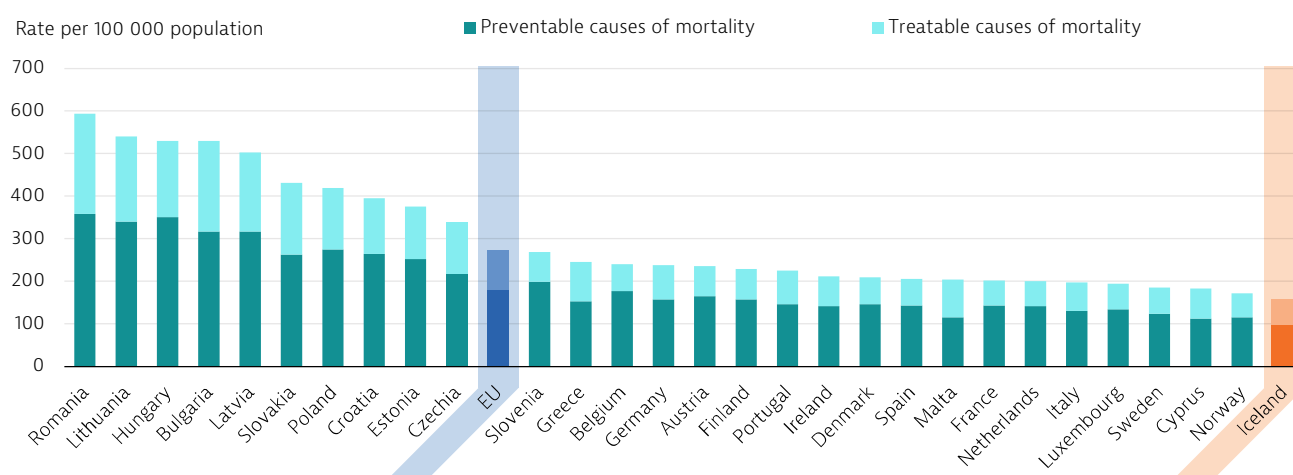
5.1 Effectiveness

Iceland's potentially avoidable mortality rates are the lowest in Europe

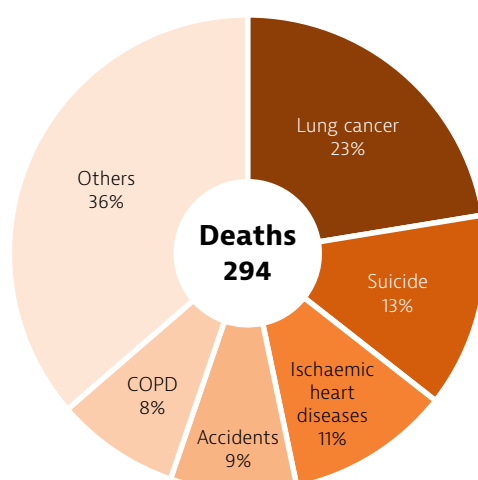
In 2020, mortality rates from causes deemed to be generally preventable and treatable were 45 % and 37 % lower than the EU averages. Against the trend of a nearly 17 % increase in preventable mortality across the EU between 2019 and 2020, Iceland's rate declined by over 6 %, reflecting its

extremely low mortality rate due to COVID-19 in 2020. In line with most other EU countries, lung cancer was the primary cause of preventable mortality, accounting for nearly a quarter of all preventable deaths in 2020 (Figure 13). However, the standardised mortality rate due to lung cancer among individuals below age 65 was nearly half the EU average.

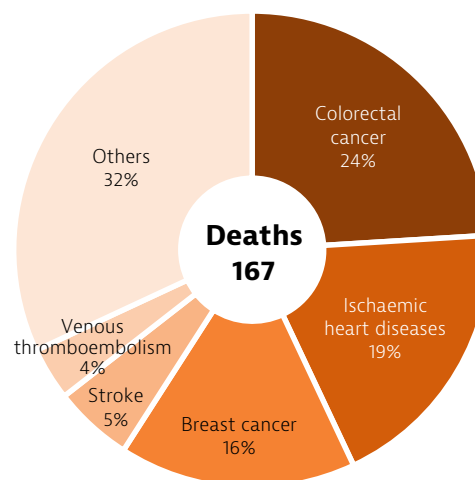
Figure 13. Iceland had notably low rates of avoidable mortality in 2020



Preventable causes of mortality



Treatable causes of mortality



Iceland

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

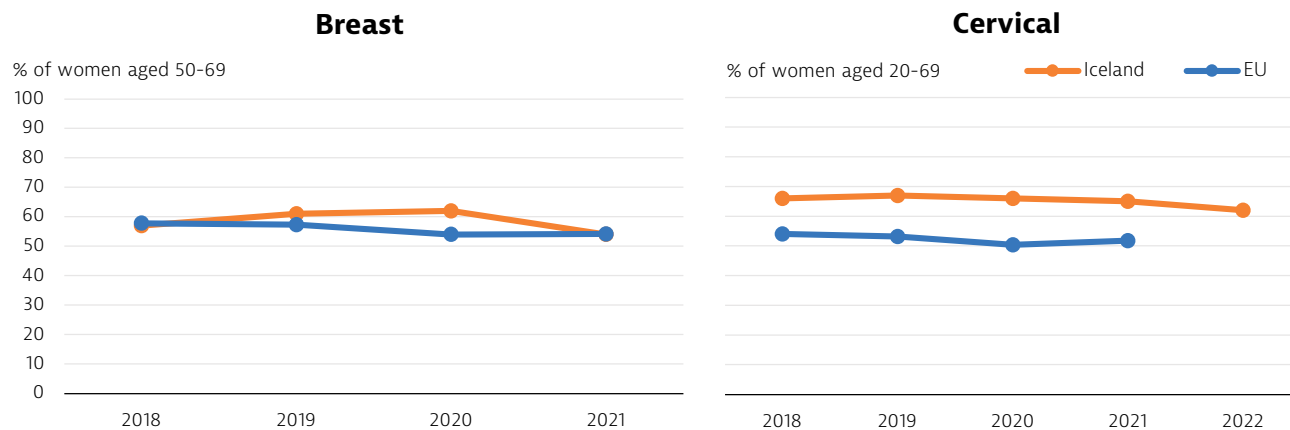
Although Iceland's treatable mortality rate was below the EU average in 2010, between 2010 and 2020 it declined by an average of 1.2 % per year – slightly below the EU average annual decline in the same period. The improvements were primarily attributable to a decline in mortality from ischaemic heart diseases. Nevertheless, colorectal cancer and ischaemic heart disease remained the leading causes of potentially treatable deaths in 2020, accounting for over 40 % of the total.

Iceland runs two of the three recommended cancer screening programmes

Infrastructure supporting high-quality cancer care in Iceland is largely in place, including a comprehensive cancer registry covering virtually all diagnoses in the country run by the Directorate

of Health in collaboration with the Icelandic Cancer Society – a not-for-profit organisation. In 2021, the breast cancer screening programme reached 54 % of eligible women within the past two years, a share equal to the EU average. However, this marked a decline from the peak of 62 % achieved in 2020. This decrease can primarily be attributed to implementation challenges experienced in the first half of the year as part of a comprehensive reorganisation of all cancer screening activities and procedures that came into effect at the beginning of 2021 (Directorate of Health, 2023a). The notable resurgence of COVID-19 cases in 2022 contributed to a further slight decline in the breast cancer screening rate (Figure 14).

Figure 14. Cancer screening rates in Iceland are on a par with or higher than the EU averages for the country's two screening programmes



Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years.

Source: OECD Health Statistics 2023 (based on national programme data).

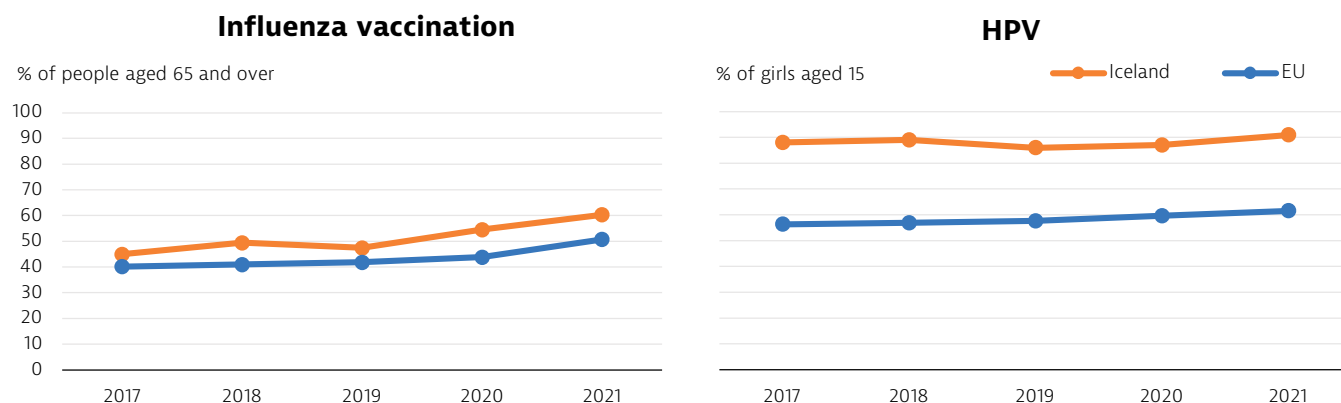
In contrast, in recent years Iceland has consistently maintained a higher cervical cancer screening rate than the EU average. In 2021, Iceland's screening rate was 52 %, exceeding the EU average by more than 15 percentage points. However, from the start of the pandemic the cervical cancer screening rate saw a gradual but consistent decline: by 2022, it had dropped by five percentage points from its 2019 level. To a large extent, these declines reflect the disruptive impact of COVID-19 on screening activities and operational difficulties associated with the major reorganisation of cancer screening services mentioned above (Directorate of Health, 2023b).

As of 2023, Iceland has not yet introduced a population-based screening programme for colorectal cancer, but preparations are under way for its forthcoming implementation. The programme will initially target individuals aged 50-69, with subsequent expansion in line with the European Commission's recommendation for individuals aged 50-74.

Immunisation rates are high in Iceland

Iceland's immunisation rates for influenza and human papillomavirus (HPV) consistently surpass those of most other European countries. In 2021, 60.4 % of Icelanders aged 65 and over received the influenza vaccine – a proportion approximately 10 percentage points higher than the EU average. The increased awareness triggered by the COVID-19 pandemic played a significant role in boosting influenza vaccine uptake among this age group, resulting in a notable increase of nearly 13 percentage points between 2019 and 2021. However, this rate still falls below the recommended WHO coverage target of 75 % (Figure 15). Iceland's HPV vaccination programme stands out as particularly robust compared to the rest of Europe. In 2022, a remarkable 94 % of 15-year-old girls were vaccinated for HPV – one of the highest coverage rates in Europe. This rate exceeds the WHO 2030 target as outlined in its global strategy for the elimination of cervical cancer.

Figure 15. Iceland has been approaching universal distribution of the human papillomavirus vaccine



Sources: OECD Health Statistics 2023, Eurostat Database (influenza) and WHO Immunisation Database (HPV).

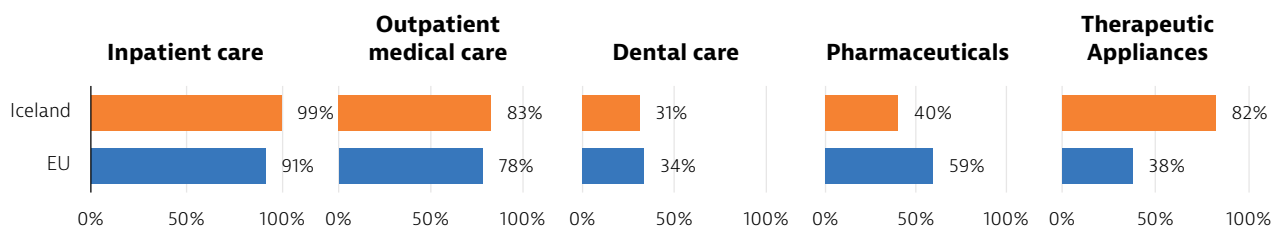
5.2 Accessibility

Public coverage is very high for all services except dental care and pharmaceuticals

While Iceland's publicly funded share of health expenditure slightly exceeds the EU average (see Section 4), a closer examination of the shares for specific health system functions provides additional insight into the scope of financial protection provided by the healthcare system. In

2021, Iceland's public health insurance system guaranteed near-complete coverage for the costs of inpatient care and over 80 % coverage for outpatient care (Figure 16). Similarly, public coverage therapeutic appliances – including vision and hearing aids – was above 80 %, exceeding the EU average by a significant margin. In contrast, public coverage rates for dental care and for outpatient pharmaceuticals in particular were comparatively low and below the EU averages.

Figure 16. Public health insurance in Iceland covers virtually all inpatient care costs but only 40 % of outpatient pharmaceuticals



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.

Source: OECD Health Statistics 2023.

In recent years, Iceland has taken measures to increase the affordability of dental care for vulnerable groups. As of 2023, health insurance covered 69 % of general dental care expenses for pensioners and those with chronic conditions, marking an increase from the 63 % that applied to pensioners until 2022. Additionally, children under 18 enjoy full coverage for oral check-ups, preventive measures, fillings and essential repairs for a minimal yearly charge of ISK 2 500 (EUR 16.53). This system encourages access to dental care through registration with a family dentist – a requirement for benefiting from these services. However, an estimated 5 000 children did not register for free dental care in 2022, possibly due to a lack of awareness of the programme (Iceland Monitor, 2022).

Iceland provides healthcare to an increasingly diverse population

Immigration rates to Iceland have been rising in recent years. In 2022, first- and second-generation immigrants accounted for 18 % of the population, compared to around 8 % in 2012 (Statistics Iceland, 2022b). Everyone with legal residency in Iceland for six consecutive months is covered by the national health insurance. Nevertheless, delivering healthcare to a progressively diverse population presents inherent challenges. Finding effective ways to overcome language barriers and provide culturally sensitive health services remains a central topic of discussion and consideration.

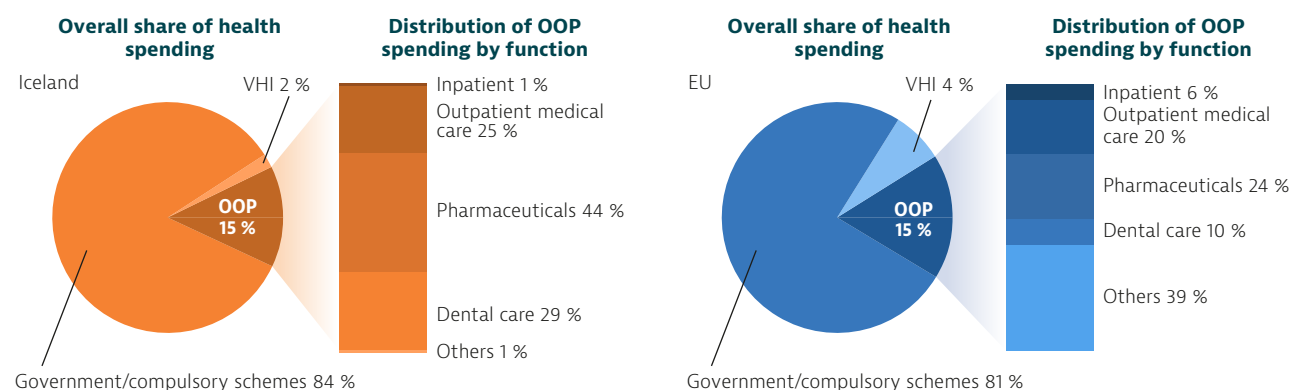
Out-of-pocket expenditure is concentrated on pharmaceuticals and dental care

In 2021 OOP spending in Iceland accounted for 14.6 % of total health expenditure – a figure nearly equal to the EU average (Figure 17). However, its composition diverged significantly from the EU averages, with the vast majority directed towards health services less comprehensively covered by public health insurance. Notably, nearly 73 % of OOP spending was allocated to retail pharmaceuticals and dental care – a much larger share than the EU average of 34 %.

Iceland's OOP spending on pharmaceuticals reflects the tiered design of its copayment system for medicines, which is aimed at protecting individuals with high medication needs from financial strain. Under this scheme, individuals pay an initial deductible of ISK 22 000 (EUR 150) per year, and subsequently pay an increasingly low proportion of total costs as their medication expenses rise, up to an annual threshold of ISK 62 000 per person (EUR 430).

As part of a plan developed in 2019 to alleviate financial barriers, in 2021 patient fees to access GP care during working hours were reduced by nearly a third to ISK 500 (EUR 3.50), and remained unchanged at ISK 3 400 (EUR 23) for specialist visits, despite inflation (Ministry of Health, 2021).

Figure 17. Nearly three quarters of out-of-pocket health spending is on retail pharmaceuticals and dental care



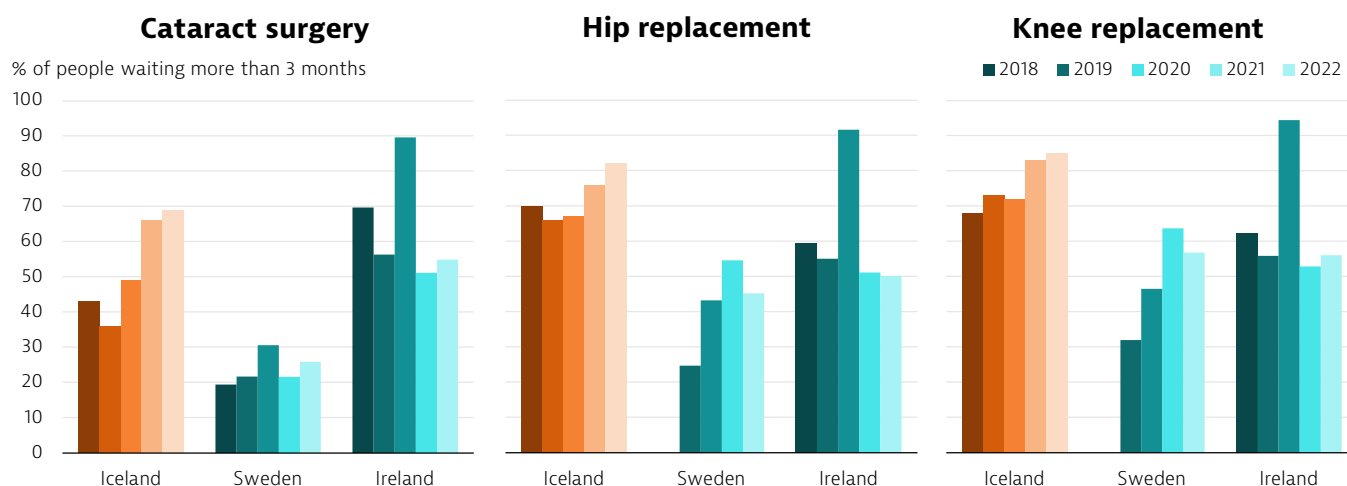
Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

The pandemic aggravated historically long waiting times for hospital care

Reducing the persistently long waiting times in the Icelandic hospital sector remains a policy priority for the government. In 2016, the Ministry of Health introduced a plan to reduce waiting times for 18 elective surgical procedures, and set a maximum acceptable threshold of 90 days for 80 % of patients. While waiting times have decreased since the plan's launch, as many as 50-75 % of patients still found themselves waiting longer than three months for selected elective surgical procedures in 2019. The disruptions caused by the COVID-19

pandemic (see Section 5.3) and related redirection of resources to pandemic-related care aggravated waiting times for elective care. The percentage of patients waiting longer than three months for hip and knee replacement surgery rose by about 20 % between 2019 and 2022 (Figure 18), to over 1 700 people, and the average waiting time for knee replacement surgery at the National University Hospital was 49 weeks (Directorate of Health, 2022). In response, ISK 750 million (ca. EUR 5.2 million) of additional funding was approved in 2023 to reduce waiting lists for joint replacement surgery.

Figure 18. Waiting times for elective surgical procedures lengthened in the wake of the pandemic



Source: OECD Health Statistics 2023.

Insufficient treatment capacity in Icelandic hospitals also affects admissions from emergency care. In 2019, between 20 and 40 patients a day waited more than 24 hours for a hospital bed after accessing the emergency department of Landspítali, Iceland's leading hospital. To tackle

this problem, in 2020 the government established a dedicated task force, which identified increasing ICU bed capacity, creating personalised patient transfer plans and enhancing the presence of senior clinicians as essential measures to alleviate waiting times (Castegren & Permert, 2020).

The COVID-19 pandemic prompted an expansion of digital healthcare

Even prior to the pandemic, telephone and web-based consultations with clinicians were common in Iceland. Nevertheless, during March and April 2020 telephone consultations for primary healthcare surged by 69 % and web-based consultations by 213 % compared to the same months in 2018 and 2019. This expansion improved access to healthcare professionals significantly when in-person visits were limited, and the total number of consultations increased by 35 % (Sigurdsson et al., 2020).

Even before the onset of the pandemic, Iceland's online platform, Heilsuvera, provided health information, appointment scheduling, prescription renewals and access to healthcare professionals via phone and online chat (Directorate of Health, 2020). During the first months of the pandemic, platform use – measured by total number of logins – nearly tripled, and the number of enrollees increased to nearly 70 % of the population. The platform facilitated checking COVID-19 test results and monitoring quarantine progress. As Iceland looks to the future of digital healthcare, promoting patient self-monitoring through Heilsuvera remains a focus, alongside enhancing health system compatibility and supporting healthcare technology innovation and research (Ministry of Health, 2021b).

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges in countries' emergency preparedness strategies and on their ability to provide healthcare to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like Russia's war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,² improve critical areas of the health sector, and fortify their preparedness for future shocks.

Efforts are under way to expand the capacity of hospital care in Iceland

Iceland's hospital capacity falls below that of many European countries. The hospital network includes Landspítali and Akureyri – the largest hospitals, which contribute over 75 % of total beds – alongside

21 smaller hospitals dispersed across the country. In line with the general EU trend, Iceland saw a gradual decline in hospital bed density in the last decade, from 3.6 beds per 1 000 population in 2010 to 2.8 per 1 000 in 2021 – significantly lower than the EU average of 4.8 per 1 000. Hospital admission rates in Iceland are among the lowest in Europe, and below the averages of other Nordic countries.

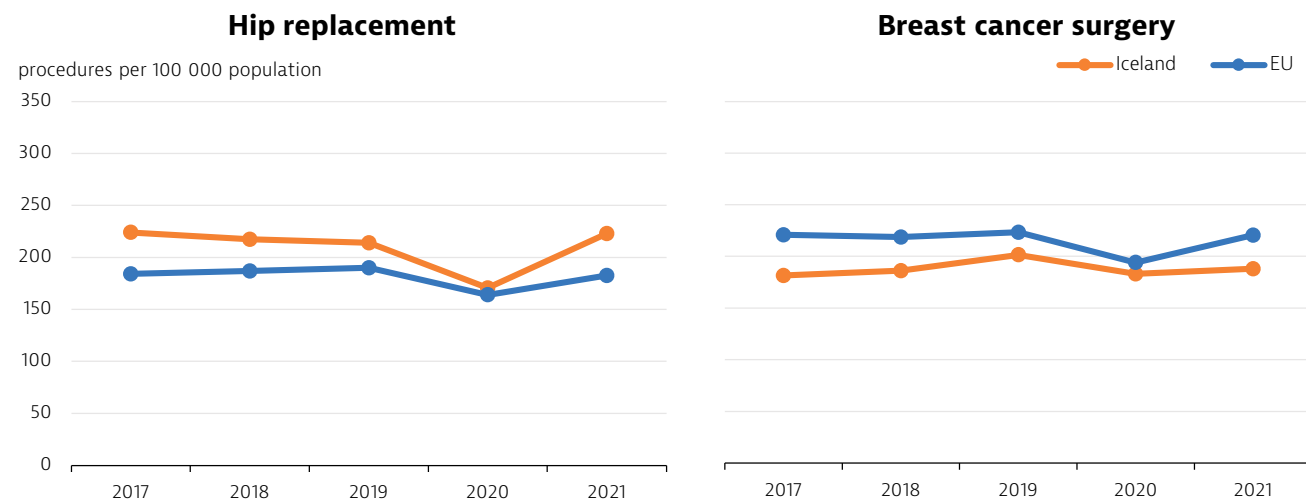
At the same time, bed occupancy rates consistently surpass the 85 % often considered a threshold to maintain an adequate buffer for emergency situations, indicating a structural undercapacity problem. In response, in 2020 Iceland began construction of a new hospital building next to Landspítali, which is set to be operational by 2026. According to projections by the Ministry of Health, expected demographic shifts and associated changes in burden of disease until 2040 will require Landspítali to expand its bed capacity by an additional 50 % (Ministry of Health, 2021c).

Iceland experienced pandemic-related disruptions to elective care, but impacts on essential care were limited

Elective surgical procedures experienced the greatest disruptions in Iceland during the COVID-19 pandemic. Between 2019 and 2020, numbers of hip replacements decreased by 18 % - more than the EU average reduction of 14 %, while rates of cataract surgery only decreased by 4 %, considerably less than the EU average reduction of 23 % (OECD/EU, 2022). Breast surgery, including total mastectomy and partial mammillary gland excision, decreased by over 7 %, slightly less than the EU average reduction of 10 %. In 2021, volumes of hip replacement and breast surgery procedures rebounded, and hip replacements slightly surpassed 2019 numbers, indicating at least a partial catch-up of the backlog accumulated in 2020 (Figure 19).

On the other hand, hospital stays for mental disorders and cancer-related surgery decreased only modestly between 2019 and 2020, suggesting moderate disruptions in these areas. Childhood vaccination rates, senior influenza vaccination rates, breast and cervical cancer screening rates, and diagnostic computerised tomography (CT) and magnetic resonance imaging (MRI) exams experienced small or no disruptions or in 2020. Inpatient cancer care was also relatively unchanged during the pandemic (OECD/EU, 2022).

² In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt, and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).

Figure 19. Hip replacement procedures declined in 2020 but rebounded strongly in 2021

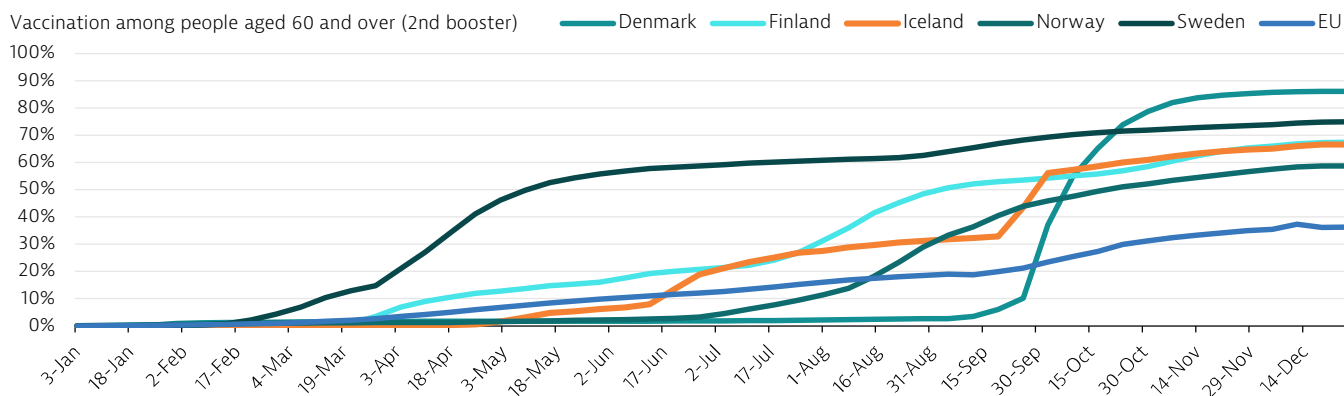
Source: OECD Health Statistics 2023.

COVID-19 vaccination rates waned somewhat with the booster shots

Iceland began distributing COVID-19 vaccinations at the end of December 2020. By August 2021, more than 80 % of the total population had received the full dosage (two doses or equivalent) – a much higher rate than the EU average of less than 60 %.

In mid-2022, booster doses became available in Iceland, with overall steady uptake punctuated

by a large push in dosage distribution around September of that year (Figure 20). As of December 2022, 67 % of people aged 60 and over had received their second booster vaccination – a rate much higher than the EU average of 36 %. However, compared to its Nordic neighbours, Iceland trailed Denmark (86 %) and Sweden (75 %), was on a par with Finland, and surged ahead only of Norway (59 %).

Figure 20. While exceeding the EU average, Iceland's COVID-19 booster take-up lagged behind that of Denmark and Sweden

Notes: Data refer to 2022.

Source: ECDC.

Iceland's antibiotic consumption surpasses that of other Nordic countries

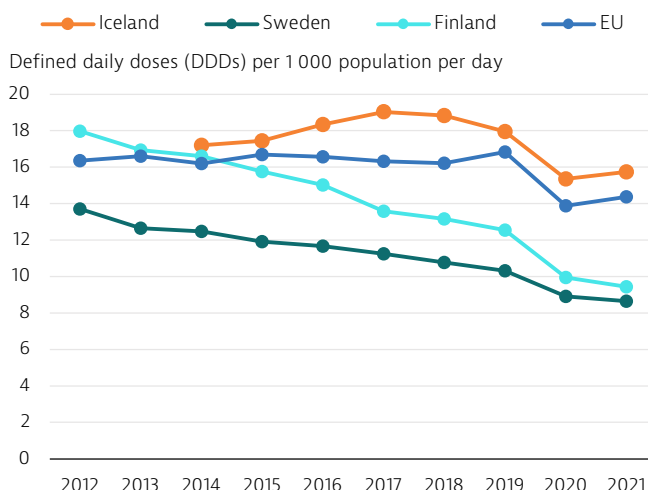
Antimicrobial resistance (AMR) is a major public health concern in Europe, with estimates of about 35 000 deaths and healthcare-associated costs of around EUR 1.1 billion per year in the EU and European Economic Area (EEA) due to antibiotic-resistant infections (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in

humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

In this context, between 2017 and 2021 total antibiotic consumption in Iceland decreased at an average rate of 5.1 % per year, slightly outpacing the EU average trend and resulting in a total

consumption rate 2.4 % above the EU average. This decline was driven by decreased prescriptions in community settings, which account for over 93 % of Iceland's total antibiotic consumption. The COVID-19 pandemic played a significant role in reducing antibiotic consumption in the community, as Iceland experienced a decline of nearly 13 % between 2019 and 2021 (Figure 21). This result was partly attributable to pandemic containment measures leading to fewer infections. Although Iceland's overall antibiotic consumption is slightly higher than the EU average, less than 20 % of it consists of second-line broad-spectrum antibiotics categorised under the WHO's 'watch' category, which pose a higher risk of accelerating the development of AMR. This percentage is significantly lower than the EU average of 40 %.

Figure 21. The pandemic led to a substantial decrease in the use of antibiotics in the community



Notes: The EU average is unweighted. The data only cover consumption in the community (outpatient).
Source: ECDC ESAC-Net.

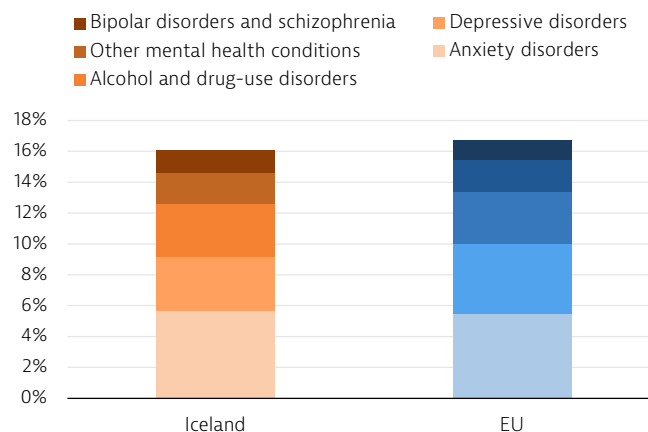
6 Spotlight on mental health

Despite being one of the “happiest” countries in the world, Iceland experiences average rates of mental health disorders

According to the World happiness report 2023, Iceland was ranked the third happiest country in the world during 2020-22 (Helliwell et al., 2023). This achievement can be attributed to Iceland's high GDP per capita and robust social support, along with other positive factors such as extended healthy life expectancy, strong perceptions of freedom and generosity, and low levels of perceived corruption. Despite this, mental health problems impose meaningful costs. In 2015, the combined direct expenses for health and social services and the indirect costs of productivity loss due to mental health issues were estimated at 4.9 % of GDP (OECD/EU, 2018) – above the EU average of 4.1 %.

Compared to other European countries, Iceland experiences an average prevalence of mental health disorders. In 2019, 16 % of Icelanders were diagnosed with a mental health condition, compared to the EU average of 17 % (Figure 22). The prevalence rates of broad types of disorders were also close to the EU averages: 6 % of the Icelandic population experienced anxiety disorders – the same as the EU average; 4 % depressive disorders – compared to 5 % across the EU; 3 % alcohol and drug-use disorders, and 1 % bipolar disorders and schizophrenia – both the same as the EU averages.

Figure 22. The prevalence of mental health disorders is in line with the EU average



Source: IHME (data refer to 2019).

The COVID-19 pandemic exacerbated pre-existing mental health issues

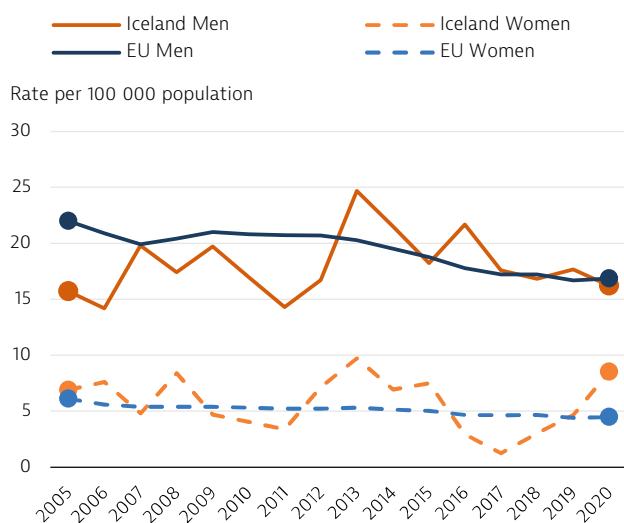
As in other countries, the pandemic had a negative impact on the mental health of the population in Iceland, particularly among individuals aged 18-29. The prevalence of depressive symptoms in this age group underwent a substantial increase, surging from less than 10 % in 2019 to nearly 40 % in 2020-21 (OECD/EU, 2022). While many European countries prioritised reinforcing psychosocial and mental health support for students during

the pandemic, Iceland did not introduce any new national measures. This could be in part because full school closures were never implemented in Iceland, unlike in many EU countries.

Iceland's suicide mortality rate is higher than the EU average

Suicide constitutes a public health concern in Iceland, and was responsible for approximately 2 % of all deaths in 2020 – a mortality rate about 20 % higher than the EU average. Although the causes of suicide are complex, extensive research and clinical experience have identified mental health issues as significant risk factors. As in other European countries, suicide rates in Iceland reveal a marked gender disparity, with a significantly higher incidence among men. Between 2016 and 2020, the average annual suicide rate among Icelandic men was more than four times that among women. Against the backdrop of a gradual decline in the suicide rate among Icelandic men over the past decade, the rate among women has increased gradually since 2017 (Figure 23).

Figure 23. The suicide mortality rate among Icelandic women has increased in recent years

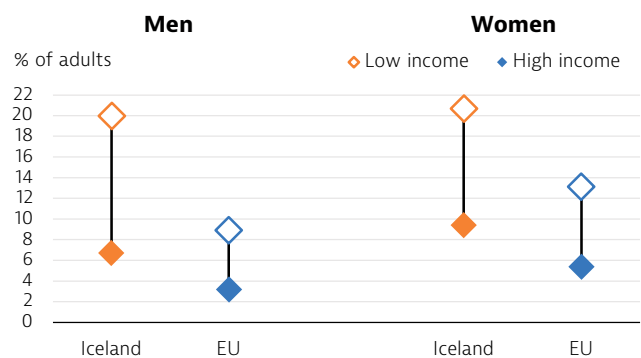


Source: Eurostat Database.

Icelanders on low incomes are more likely to report depression

The prevalence of mental health disorders in Iceland demonstrates a notable socioeconomic divide. In 2019, approximately 20 % of men and women in the lowest income quintile reported suffering from depression, compared to only 6.7 % of men and 9.4 % of women in the highest quintile (Figure 24). These differences amounted to 13.3 percentage points among men and 11.3 percentage points among women, which were larger than the

Figure 24. The gaps in prevalence of depression across income groups are significantly wider in Iceland than the EU averages



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

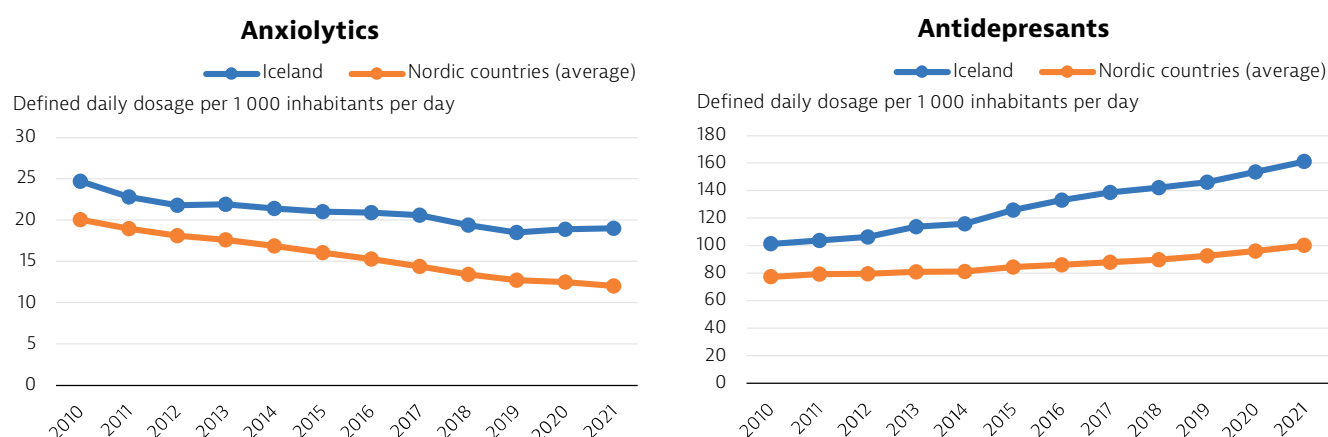
EU average gaps of 5.7 percentage points among men and 7.7 percentage points among women.

Iceland reports the highest rate of antidepressant consumption in Europe

Over the past decade, consumption of psychoactive medications has generally increased across European countries, including Iceland. The country has witnessed a consistent surge in antidepressant use, growing at a rate nearly double the average annual increase across Nordic countries, which in turn report higher consumption rates than those in most EU countries. In 2021, Iceland's antidepressant consumption peaked at 161 defined daily doses per 1 000 inhabitants per day – the highest in Europe and approximately 61 % above the Nordic average (Figure 25). In the same year, about 57 900 people in Iceland received at least one antidepressant prescription – equivalent to 15.7 % of the population (Nomesco, 2023).

Iceland's increased usage of antidepressants can be attributed to several factors, including better diagnosis of mental disorders, changing patient attitudes and the broadening scope of these medications, including their off-label use for various therapeutic purposes. However, it is plausible that restricted availability and public coverage of non-pharmaceutical treatments like psychotherapy may also contribute to this trend. In contrast to the prescription patterns seen for antidepressants, prescription rates for anxiolytics in Iceland have declined since 2010, aligning with the overall trend in Nordic countries.

Figure 25. Antidepressants consumption in Iceland increased by 55 % over the last decade



Source: OECD Health Statistics 2023.

Mental health services are integrated at every level of health provision

Primary healthcare centres are the points of first contact for people seeking mental healthcare, and are responsible for identification and management – typically via medication – of relatively common conditions, such as milder forms of anxiety and depression. Short-term psychological services are also available at health centres. Before the COVID-19 pandemic, waiting lists typically ranged between four and nine months. Health centres also offer referrals to mental health specialists when appropriate, wherein care and specialised diagnostic services are provided by interdisciplinary care teams. When additional support is needed, specialists refer patients to one of the two hospitals in Iceland that specialise in mental healthcare.

Icelandic psychologists also offer their services through private practices. The majority of adults seeking psychological assistance opt for the private sector to circumvent extended waiting periods. However, there are substantial financial hurdles associated with accessing these services, as the public insurance system does not contribute to covering their costs (Ægisdóttir et al., 2019).

Long waiting times undermine timely access to mental health services

As mental healthcare needs have grown in Iceland in recent years, increasingly long waiting times have begun to constitute a significant barrier to accessing mental health services. The increase in demand for mental health support during the COVID-19 pandemic exacerbated this problem. In 2021, the average waiting times for mental healthcare services were more than four months for children and nearly six months for adults (National Audit Office, 2022), although these vary

significantly by type of service sought. Reasons for this are largely attributable to a shortage of qualified staff – due in part to wages and working conditions that may need revaluation – and an undersized mental health workforce training pipeline.

Iceland has developed an ambitious strategic plan to improve mental health

Iceland developed a Mental Health Policy and Action Plan in 2016 to delineate goals and strategies for promotion, prevention and treatment related to mental health conditions to 2020. Funding was allocated for primary healthcare to increase psychological services and employ interdisciplinary teams devoted to mental healthcare. Today, most primary healthcare clinicians – including GPs, nurses and midwives – can provide counselling. The country has also been working to establish interdisciplinary community outreach teams to target people in need of mental health services. In support of this work, Iceland devoted about 12 % of its overall health budget to mental healthcare (United Nations Regional Information Centre for Western Europe, 2021).

Over the last decade, cross-sectoral programmes have become an important part of Iceland's approach to strengthening mental healthcare. The Health-promoting Schools Programme, launched in 2009 and now implemented in the majority of primary and secondary schools, stands as a prime example. This initiative engages school personnel, students, parents and local organisations to enhance psychosocial skills, mental well-being and anti-bullying measures. In 2021, the Icelandic government also allocated ISK 150 million (about EUR 1 million) to enhance mental health services in upper secondary schools, colleges and universities.

7 Key findings

- In 2022, Iceland's life expectancy at birth stood at 82.1 years. While this exceeded the EU average by around 1.5 years, it fell short of Iceland's pre-pandemic life expectancy by over 1 year. This decrease was concentrated entirely in 2022, when Iceland experienced a significant surge in mortality – primarily attributed to a notable increase in COVID-19 fatalities, which occurred after two years of minimal deviations from the pre-pandemic mortality baseline.
- In 2019, behavioural risk factors for health were associated with over a third of all fatalities in Iceland. Despite comparatively low alcohol consumption, heavy drinking is more common among Icelanders than in the rest of Europe. Additionally, overweight and obesity rates are significantly higher than the EU averages for both adults and adolescents. Although policy initiatives have been implemented to tackle these risks in recent years, their impact on population-level rates is yet to be observed. Following a large decrease over the past two decades, the prevalence of smoking in Iceland is the lowest in Europe.
- Iceland's health expenditure was slightly below the EU average in 2021, with private sources accounting for 16.3 % of health spending – a lower share than the EU average of 19 %. Health spending per person on inpatient, outpatient and long-term care nearly aligned with the EU average, while spending on retail pharmaceuticals was comparatively low. However, it constituted a larger proportion of out-of-pocket spending by households. Between 2019 and 2021, health spending per capita in Iceland increased by 8.4 % in real terms, driven primarily by increased public financing aimed at expanding care capacity to address the COVID-19 emergency.
- In 2020, Iceland had one of the lowest potentially avoidable mortality rates in Europe – a testament to the efficacy of its disease prevention efforts as well as the effectiveness of its healthcare system in treating life-threatening conditions. Screening rates for breast cancer align with the EU average, and for cervical cancer exceed the EU average, but the country has not yet implemented a colorectal cancer screening programme. Immunisation rates for influenza and human papillomavirus consistently surpass those of most other European countries.
- The pandemic exacerbated historically long waiting times for elective surgical procedures, intensifying the urgency to address this issue. Several initiatives to reduce waiting times have been undertaken since 2016, but they have achieved relatively modest results. As in most other European countries, in 2020 disruptions caused by COVID-19 caused a sizeable decline in the volume of elective surgical procedures performed, resulting in a patient backlog that was only partly cleared in 2021. Conversely, the pandemic had a negligible impact on volumes of cancer-related surgery and other critical procedures.
- Iceland has identified key healthcare infrastructure strengthening needs, particularly in terms of its hospital bed capacity, which is among the lowest in Europe. Against the backdrop of ongoing investment to expand acute care capacity in Landspítali – Iceland's primary hospital – projected demographic shifts and the associated changes in disease burden are expected to necessitate significant additional hospital capacity expansions in the medium term.
- In 2019, 16 % of Iceland's population suffered from a mental health disorder – a slightly lower proportion than the EU average. The COVID-19 pandemic had a negative impact on population mental health – particularly among young people – and on mental health services, which are facing extended waiting times and shortages of clinical staff. Iceland's suicide mortality rate exceeds the EU average by over a fifth. As in other countries, suicide is significantly more prevalent among men. Iceland leads Europe in consumption of antidepressants, with almost 16 % of its population receiving prescriptions in 2021. To enhance the mental well-being of its population, the Icelandic government has developed a comprehensive mental health plan, coupled with several cross-sectoral programmes.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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