European Commission

State of Health in the EU

ICELAND

Country Health Profile 2025

OECD
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European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles 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 knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

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 Observatory's 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, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS), 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 2025, based on data that was accessible as of the first half of September 2025.

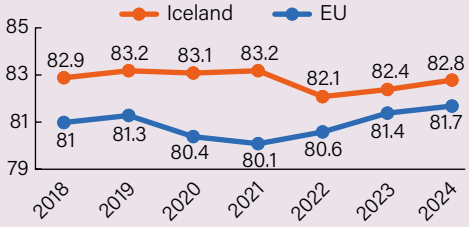
Demographic and socioeconomic context in ICELAND, 2024

Demographic factors	Iceland	EU
Population size	383 567	449 306 184
Share of population over age 65	16 %	22 %
Fertility rate 2023[1]	1.6	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	52 295	39 675
At risk of poverty or social exclusion rate[3]	11.7 %	20.9 %

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. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

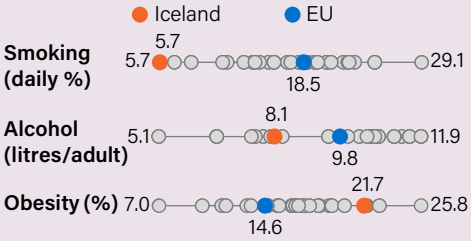
1 Highlights



Life expectancy at birth

Health Status

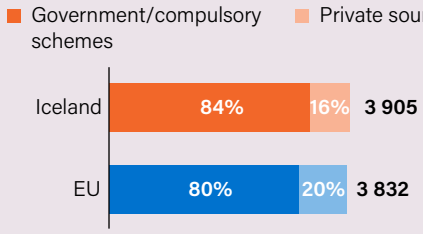
Iceland's life expectancy at birth reached 82.8 years in 2024, over one year above the EU average. After remaining stable during the first two years of the pandemic, life expectancy fell by more than a year in 2022 due to a surge in COVID-19 deaths. It has recovered partly since then, but in 2024 it still remained below its pre-pandemic level.



Adults, 2022 (or nearest year)

Risk Factors

Iceland has achieved the lowest adult smoking rate in Europe, with less than 6 % of adults smoking daily in 2023, though e-cigarette use among adolescents is rising. Alcohol consumption is also well below the EU average, supported by strict alcohol control policies. However, overweight and obesity among adults and adolescents is a growing public health concern, and obesity rate among adults is well above the EU average.



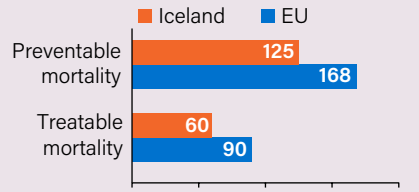
Health spending per capita (EUR PPP), 2023

The Health System

In 2023, Iceland's health spending per capita was EUR 3 905, about 2 % above the EU average, but accounted for only 8.7 % of GDP compared to the EU average of 10 %. Public sources funded 84 % of total health expenditure, resulting in relatively low out-of-pocket payments. Voluntary health insurance played a marginal role, accounting for just 2 % of total spending.

Health System Performance

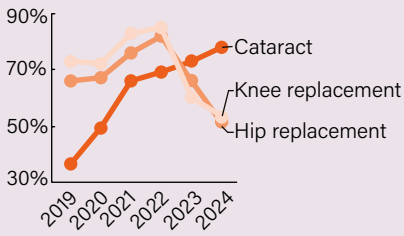
Effectiveness



Age-standardised rate per 100 000 population, 2022

Mortality rates from treatable and preventable causes in Iceland are over 25 % below the EU average, reflecting strong performance in prevention and managing life-threatening conditions. However, preventable mortality rates are about two times greater than mortality from treatable causes, indicating significant scope to further reduce premature deaths.

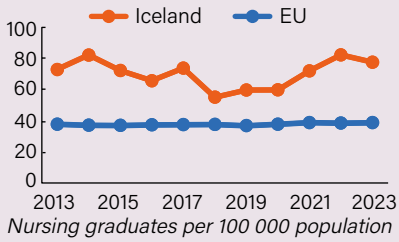
Accessibility



% of people waiting more than 3 months

Iceland's universal public health insurance provides extensive coverage for a wide range of services. Waiting times for elective surgery are a long-standing issue which worsened during the pandemic. While waits for hip and knee replacements have decreased following the peak in 2022, waits for cataract surgery have continued to worsen.

Resilience



Nursing graduates per 100 000 population

The supply of a sufficient number of health workers is key to the resilience of health systems. The number of doctors and nurses per population in Iceland is higher than the EU average, although there are issues with the composition and distribution. The number of new nurse graduates exceeds the EU average, but this figure includes both registered and practical nurses.

Spotlight: pharmaceuticals

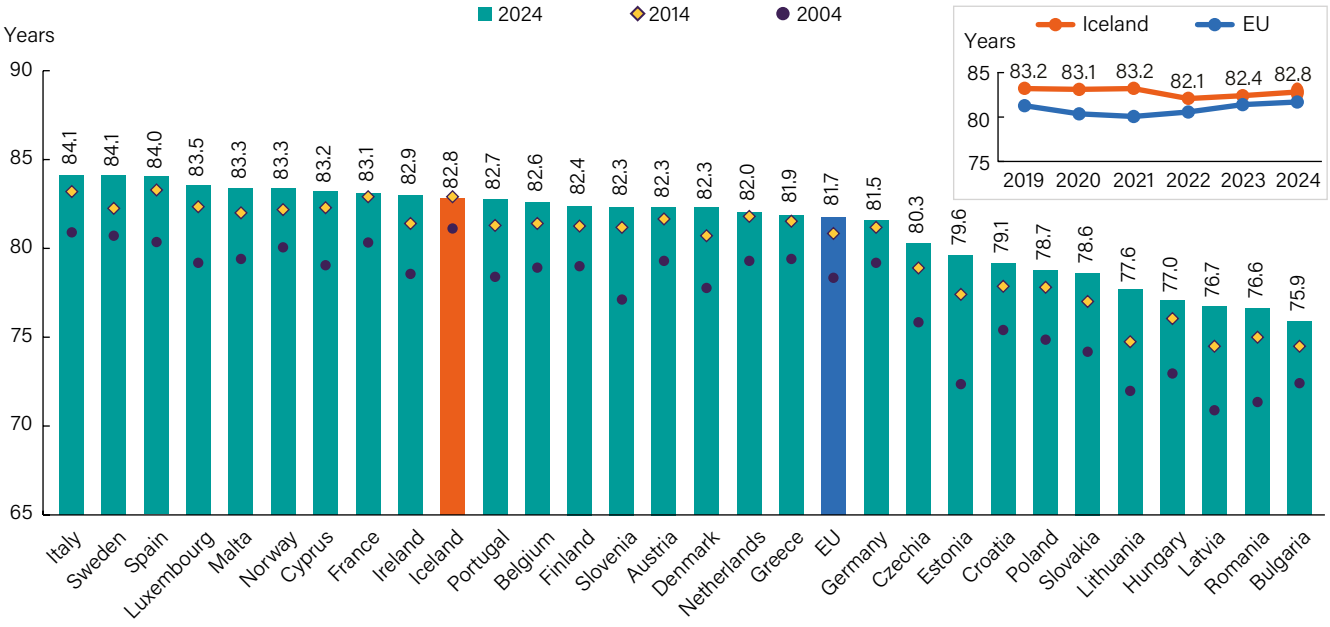
Iceland channels most pharmaceutical spending through retail pharmacies, with only 7 % procured via hospitals, far below the EU average. Retail pharmaceutical spending per capita is 6 % below the EU average, but out-of-pocket costs are relatively high due to a tiered co-payment system. Public coverage accounts for just 41 % of retail pharmaceutical expenditure compared to an EU average of 62 %. The country uses Nordic reference pricing and managed-entry agreements to control costs, while market size limits access to new medicines. Generic medicines account for about half of the market by volume, in line with the EU average.

2 Health in Iceland

Life expectancy at birth in 2024 was one year above the EU average, but below pre-pandemic level

Iceland's population enjoys a relatively high life expectancy in Europe, reaching 82.8 years in 2024 - more than one year above the EU average (Figure 1). Life expectancy remained stable in 2020 and 2021, reflecting the limited early mortality impact of COVID-19, but a sharp rise in COVID-19 deaths in 2022 led to an unprecedented 1.1-year decline. By 2024, life expectancy had partly recovered, though it remained 0.4 years below its 2019 level. As elsewhere in Europe, men have shorter life expectancies than women, but Iceland's gender gap is among the smallest in the EU: in 2024, women lived on average 3.3 years longer than men compared with a 5.2-year gap across the EU.

Figure 1. Following a large reduction in 2022, life expectancy continued to recover in 2024



Notes: The EU average is weighted. 2024 data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

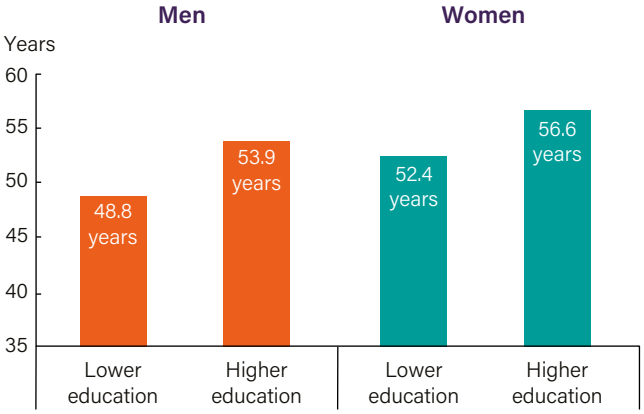
Disparities in life expectancy by educational level are substantial

Socioeconomic inequalities remain a significant driver of longevity gaps in Iceland, with educational attainment standing out as a key marker. In 2024, a 30-year-old Icelandic man without a secondary education could expect to live 5.1 years less than a peer with a university degree, while the gap among women of the same age was 4.2 years (Figure 2). These disparities reflect, in part, differences in exposure to behavioural and environmental risk factors (see Section 3).

Cardiovascular diseases and cancer are responsible for most deaths in Iceland

Chronic diseases remain the leading cause of death in Iceland, with cardiovascular diseases (CVDs) - including ischaemic heart disease and stroke - and cancer together accounting for nearly 54 % of all deaths in 2023 (Figure 3). After decades of substantial reductions in cardiovascular mortality through prevention and improved treatment, progress has recently slowed, reflecting the combined

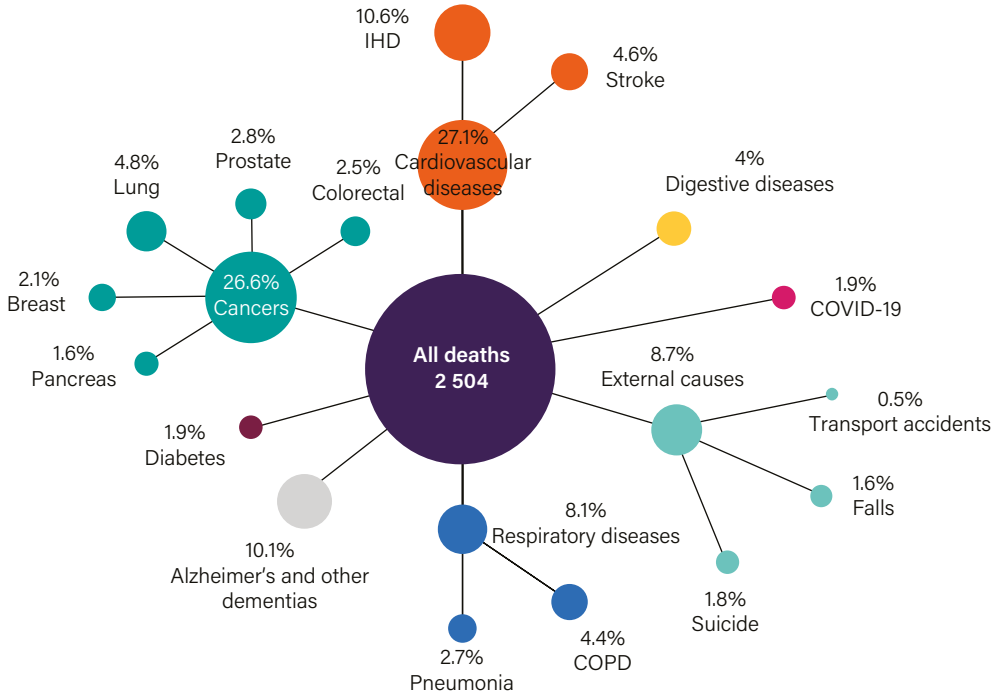
Figure 2. The life expectancy gap by educational attainment is wider among Icelandic men



Notes: Low education is defined as people who have not completed secondary education (ISCED levels 0-2), whereas high education is defined as people who have completed tertiary education (ISCED levels 5-8).
Source: Statistics Iceland, 2025. Data pertain to 2024.

effects of population ageing and adverse lifestyle trends. Neurodegenerative conditions also represent a growing burden: Alzheimer's disease and other dementias accounted for 10 % of all deaths in 2023, one percentage point below their 2020 level. By contrast, the mortality impact of COVID-19 has diminished sharply; following a major wave in 2022, when it caused over 8 % of all deaths, its share fell to less than 2 % in 2023.

Figure 3. Cardiovascular diseases and cancer were responsible for more than half the deaths in Iceland in 2023

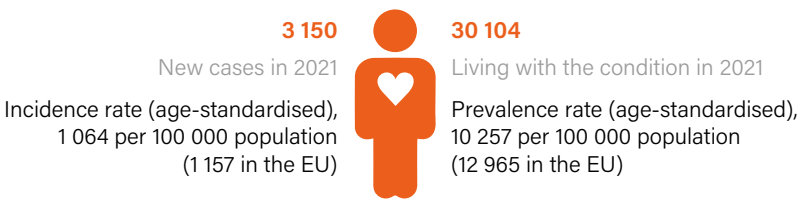


Note: IHD = ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro). Data refer to 2023.

Strong prevention keeps Iceland's cardiovascular disease burden below EU levels

CVDs and cancer are not only the leading causes of death in Iceland but also major drivers of morbidity and disability. CVDs remain the foremost cause of death and disability, but they impose a comparatively lower burden than in most other European countries. According to data from the Institute for Health Metrics and Evaluation (IHME), in 2021 Iceland's age-standardised incidence rate was 8 % below the EU average and prevalence 20 % lower, indicating effective population-level prevention consistent with very low adult smoking and decades of risk-factor control (Figure 4). The burden nevertheless remains substantial, with over 3 000 new CVD cases annually and more than 30 000 people living with these conditions in 2021. Ischaemic heart disease is the most frequent CVD, accounting for 35 % of all new cases; a pronounced gender gap can be observed, with men experiencing a 40 % higher incidence and a 25 % higher prevalence than women. Looking ahead, the buildout of national CVD and diabetes registries,[1] scheduled for completion in 2027, will strengthen surveillance and help sustain Iceland's advantage as demographic pressures intensify.

Figure 4. Iceland has lower CVD incidence and prevalence rates than the EU average



Source: IHME, Global Health Data Exchange (estimates refer to 2021).

[1] The initiative is part of the Joint Action on Cardiovascular Disease and Diabetes (JACARDI), a European collaboration project aimed at reducing the impact of these diseases on individuals and healthcare systems.

Despite today's favourable outcomes, rapidly rising future cancer caseload will test services

Cancer, the second leading cause of death, also presents a profile that underscores strong system performance: incidence and mortality are comparatively low relative to most EU countries, and mortality has fallen markedly over the past decade, indicating effective detection and treatment capacity. Estimates from European Cancer Information System (ECIS) show incidence slightly below the EU average in 2022, while prevalence in 2020 was about 7 % higher, a reflection of high survival keeping more people alive with a prior diagnosis (Figure 5). Gender disparities are smaller than in most other European countries, with prostate cancer in men and breast cancer in women being the most common types. Despite currently favourable outcomes, population ageing is expected to drive a sharp rise of over 50 % in cancer incidence by 2040, while the survivor population expected to expand to up to 31 000, with implications for workforce planning, survivorship care and management of chronic comorbidities.

Figure 5. Iceland's above-average cancer prevalence reflects higher survival rates

1 663
New cases in 2022
Incidence rate (age-standardised), 547 per 100 000 population (572 in the EU)

15 164
Living with the condition in 2020
Prevalence rate (age-standardised), 5 108 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (estimates refer to 2022 for incidence and 2020 for prevalence).

3 Risk factors

One quarter of deaths in Iceland are attributable to behavioural risk factors

Behavioural and environmental risks remain significant contributors to mortality in Iceland, though their overall impact is slightly lower than the EU average. IHME estimates attribute 25 % of all deaths in 2021 to behavioural factors such as tobacco use, unhealthy diets, alcohol consumption and physical inactivity, with air pollution from fine particulate matter ($PM_{2.5}$) and ozone responsible for an additional 1 %. Combined, these factors accounted for 26 % of all deaths compared with 29 % across the EU.

Smoking rates have declined drastically, but this has been accompanied with rising popularity of alternative products

Since the Tobacco Control Act was introduced in 2002, Iceland has steadily strengthened tobacco regulation through measures such as high excise duties, advertising bans, mandatory health warnings on packaging and a ban on vending machine sales. These sustained efforts have driven one of the sharpest declines in smoking rates in Europe, with the share of adults smoking daily falling from 22 % in 2003 to below 6 % in 2023, the lowest rate in Europe.

Adolescent smoking is also the lowest in Europe, with fewer than 4 % of 15-year-olds reporting tobacco use in 2022. However, mirroring trends elsewhere in the EU, e-cigarette use among adolescents is rising, with 14 % reporting use in the past month in 2022. As of May 2025, updated labelling and packaging rules are in force, and from January 2028, tobacco products with characteristic flavours will be prohibited.

Alcohol consumption of adults and adolescents in Iceland is well below the EU average

Alcohol consumption in Iceland is among the lowest in Europe, reflecting both cultural norms and long-standing alcohol control policy measures. In 2022, only 8 % of adolescents reported having been drunk more than once in their lifetime, compared with an EU average of 23 %, while adult consumption stood at 8.1 litres per capita, well below the EU average of 9.8 litres. This relatively low consumption has been supported by strict policies, including advertising bans, high excise duties and a legal drinking age of 20. Until 2022, sales of beverages exceeding 2.25 % alcohol by volume were limited to the state-run monopoly *Vínbúðin*. Recent legislative changes now allow breweries to sell directly to customers, and private retail sales appear to be expanding, albeit still operating in a legal grey area.

Rising obesity across ages is prompting Iceland to scale up prevention

Iceland faces a growing public health challenge related to overweight and obesity, with prevalence rates among both adults and adolescents exceeding EU averages. In 2019, 22 % of Icelandic adults were obese compared with 15 % across the EU. Among adolescents, 22 % of 15-year-olds were

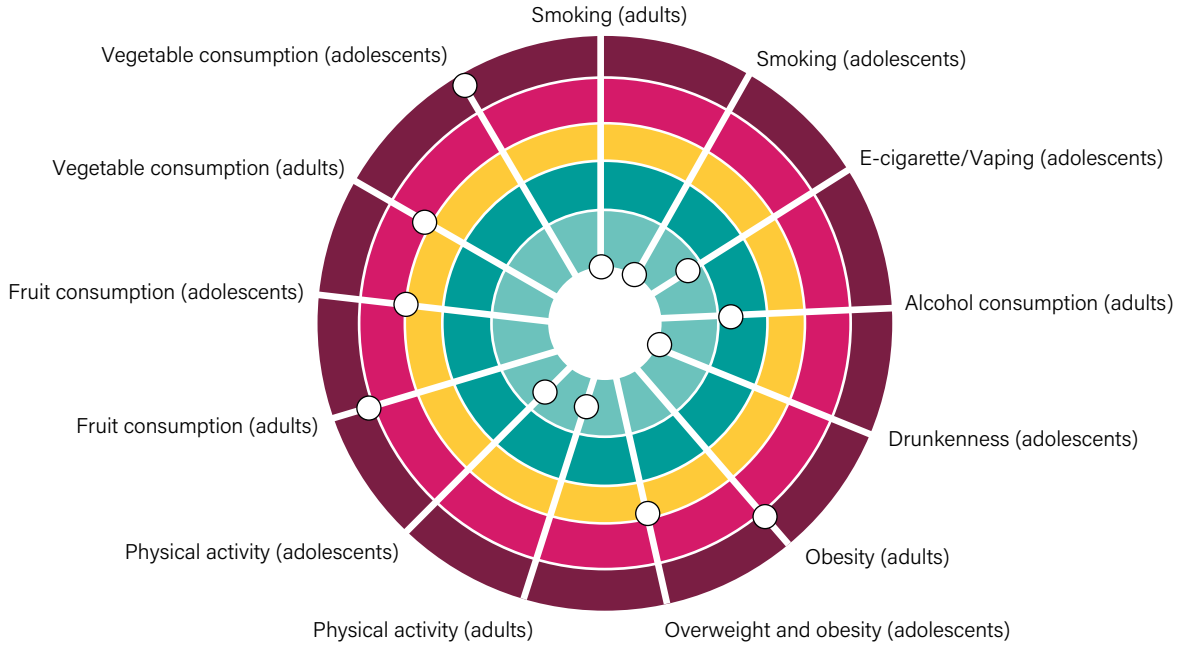
overweight or obese in 2022, slightly above the EU average of 21 %. Unhealthy dietary patterns contribute significantly to these trends: in 2022, only 47 % of Icelandic adults reported eating fruit daily, 14 percentage points below the EU average, while 51 % ate vegetables daily, 9 points lower than their EU counterparts. Adolescent diets have also worsened, with daily fruit and vegetable consumption dropping by 12 percentage points between 2014 and 2022.

To address these challenges, Iceland has implemented foundational public health measures, including nutritional standards in schools, restrictions on food advertising, and the adoption of the Nordic Keyhole food labelling system to promote healthier choices. Policy efforts have intensified in recent years: in 2024, the government proposed an ambitious long-term strategy to combat obesity, and since January 2025, primary-school lunches have been provided free nationwide. Treatment policy has evolved in parallel; national adult obesity management guidelines were introduced in 2020, and in late 2023, co-payment for semaglutide for weight management was introduced under strict criteria, reflecting the need to balance access with rapidly rising expenditure on novel therapies.

Iceland's population is more physically active than in most EU countries

Iceland presents a notable paradox regarding behavioural risks: despite a high and rising prevalence of overweight and obesity, its population boasts some of Europe's highest levels of physical activity (Figure 6). Among adults, 56 % reported engaging in at least 150 minutes of non-work-related physical activity per week in 2019 (latest year available) - a rate far exceeding the EU average of under 33 %. This pattern extends to teenagers, with 19 % of Icelandic 15-year-olds in 2022 reporting daily activity of at least 60 minutes - 4 percentage points above the EU average. However, these overall gains mask a growing gender divide among adolescents: while both boys and girls remain more active than their European peers, between 2018 and 2022 the share of girls meeting the daily activity threshold fell by 5 percentage points, whereas the rate for boys rose by 3 points.

Figure 6. The high prevalence of overweight and obesity is a public health concern in Iceland

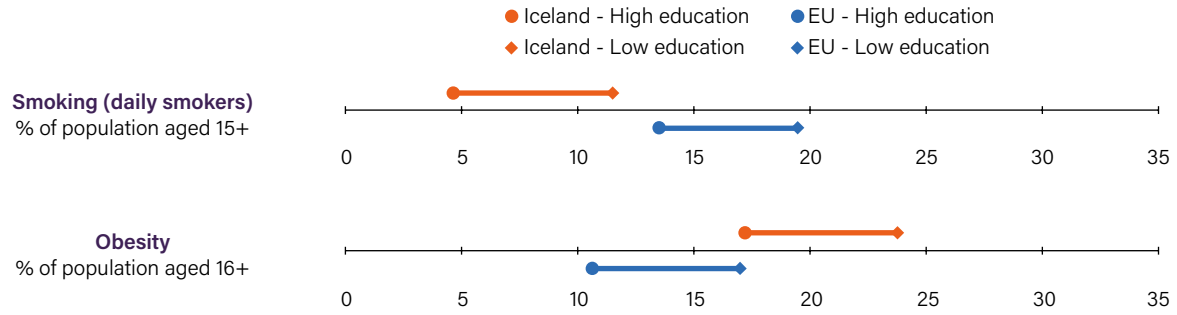


Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; OECD Data Explorer for adult smoking and alcohol consumption (2022 or nearest year) and EHIS survey 2019 for adult physical activity and obesity.

People with lower education are more likely to smoke and be obese as in most EU countries

As in other EU countries, socioeconomic status is a key determinant of exposure to behavioural risks in Iceland, with significant disparities emerging along educational lines. This pattern is evident in both obesity and smoking rates where a clear educational gradient exists. In 2019, 24 % of adults with lower education levels were obese compared to 17 % among their counterparts with higher education, a gap similar to the EU average (Figure 7). Smoking shows a comparable pattern: in 2019, daily smoking was more than twice as common among people without secondary education (11.4 %) as among those with a tertiary degree (4.5 %). These socioeconomic inequalities in health behaviours explain at least partly the inequalities in health status and life expectancy.

Figure 7. People with lower education are more likely to be obese and smoke



Note: 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). Low physical activity is defined as people doing physical activity 3 times or less per week.
Source: Eurostat based on EHIS 2019 (hlth_ehis_sk1e and hlth_ehis_bm1e)

4 The health system

Iceland's tax-funded healthcare system offers near-universal coverage

Iceland's healthcare system is founded on the principles of universal, tax-funded coverage and highly centralised governance. Eligibility is based on residence, with *Icelandic Health Insurance* (*Sjúkratryggingar Íslands - SÍ*) providing near-universal coverage and acting as the single national purchaser of services. Service delivery operates across seven health districts within a predominantly public framework, where state-owned primary care centres and hospitals create a highly integrated model with the state serving as both principal owner and payer. Within this public structure, SÍ has increasingly contracted private outpatient specialist clinics in recent years, supported by temporary regulations extended through May 2026 that permit reimbursement for self-employed specialists to ensure care continuity and reduce treatment backlogs (see Section 5.2).

The patient pathway has undergone significant structural reform to strengthen primary care coordination: prior to 2024, Iceland operated without formal referral-based access mechanisms, allowing patients direct access to specialist services. However, 'soft gatekeeping' (referral guidance) introduced in 2024 now establish the expectation that specialist care should typically commence with family doctor referrals to receive reimbursement for the appointment. This policy reinforces primary care's coordinating function while being supported by financial incentives that reduce patient co-payments for referred specialist services. To protect against high costs, the system applied monthly caps on co-payments for covered services and a stepwise cost-sharing scheme for medicines (see Section 6). As of 2025, the system of referrals to specialists is being abolished for children, eliminating the obligation to pay up to 30 % of the bill when there is no referral.

Health spending per capita is in line with the EU average

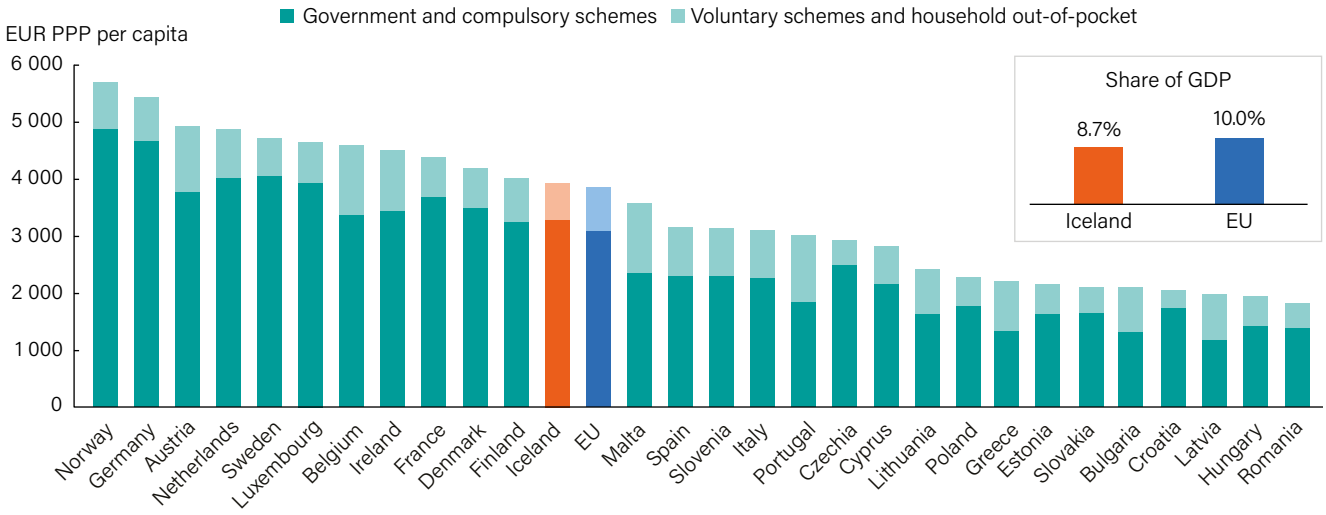
Health expenditure in Iceland is broadly in line with the EU average in per capita terms, but lower as a share of GDP. In 2023, expenditure reached EUR 3 905 per person - 1.9 % above the EU average, yet accounted for only 8.7 % of GDP compared with 10.0 % across the EU (Figure 8). Public funding covered 83.6 % of current health expenditure, above the EU average of 80.0 %, resulting in comparatively low out-of-pocket (OOP) payments at 14.7 % of total spending, nearly one percentage point below the EU average. These OOP costs are mainly co-payments for primary and specialist outpatient care and pharmaceuticals, with exemptions or reductions for vulnerable groups. Voluntary health insurance (VHI) remains marginal (covering less than 2 % of total spending), used mainly by new residents temporarily ineligible for public coverage.

Since 2019, real per capita health spending has risen by 7 %, driven almost entirely by public expenditure. The limited impact on individuals is clear: between 2019 and 2023, OOP spending per capita grew by only 1.8 %. In contrast, while VHI recorded the fastest relative growth at 10 %, its impact on the overall financing landscape remains negligible due to its very small base. This trend of increased spending appears set to continue, as preliminary 2024 data indicate further year-on-year total health spending growth per capita of nearly 5 %.

Most spending is allocated to inpatient and outpatient care

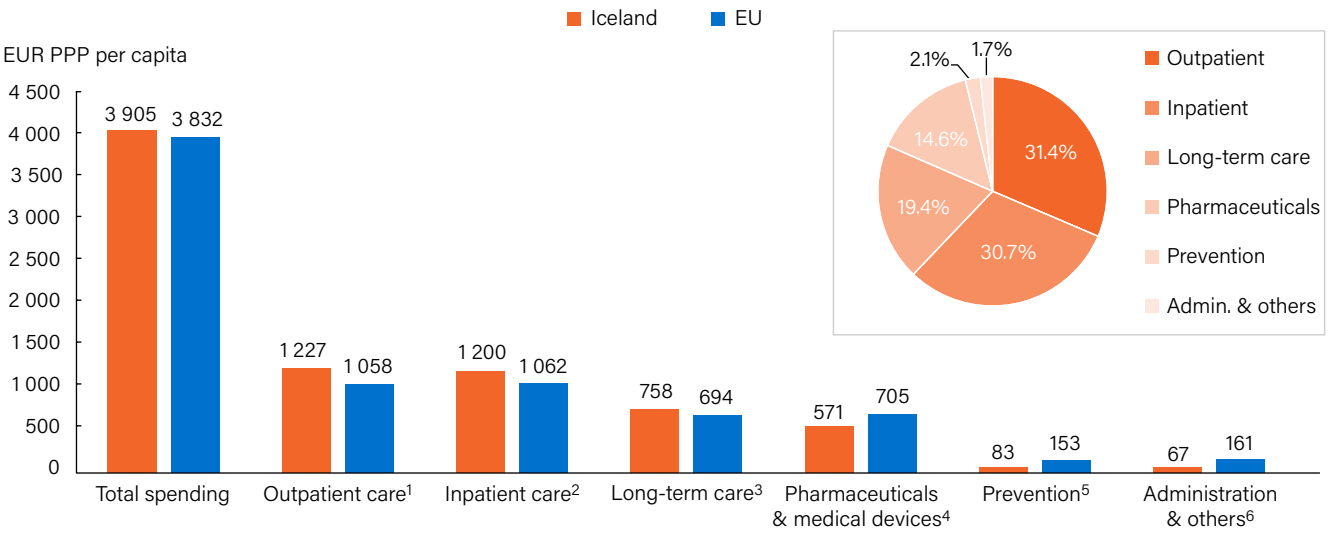
In 2023, Iceland's health spending was concentrated on inpatient and outpatient care, which together accounted for over 60 % of total expenditure, with each consuming roughly 31 % of the budget, exceeding EU averages by around 3 percentage points (Figure 9).

Figure 8. Iceland spends more on health per capita than most EU countries, but less as a share of GDP



Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Figure 9. Per capita spending on inpatient, outpatient and long-term care is comparatively high



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 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. The EU average is weighted (calculated by OECD).
Source: OECD Data Explorer (DF_SHA). Data refer to 2023.

Long-term care also represented a significant share, absorbing nearly one fifth of health spending (19 %), slightly above the EU average of 18 %. By contrast, spending on pharmaceuticals and medical devices was comparatively low at under 15 % of total expenditure, below the EU average of 18 %, reflecting the impact of wide-ranging cost-control measures (see Section 6). Preventive care received the smallest allocation at just 2 % of total spending - half the EU average, underscoring a relatively limited investment in prevention compared to treatment and care services.

Iceland is investing in major infrastructure upgrades to tackle capacity shortages

Iceland is divided into seven state-run health districts that organise services across primary care, hospitals and nursing homes. Care remains highly centralised around Reykjavík, with the most complex inpatient activities concentrated at Landspítali, which also anchors the bulk of private specialist capacity in the capital region. While Iceland is undertaking major, long-term capital investments to modernise its hospital infrastructure, the healthcare system faces significant near-term capacity constraints (see Section 5.3). The cornerstone of this modernisation strategy is the new campus (*Hringbraut*) for the Landspítali in Reykjavík, a flagship project designed

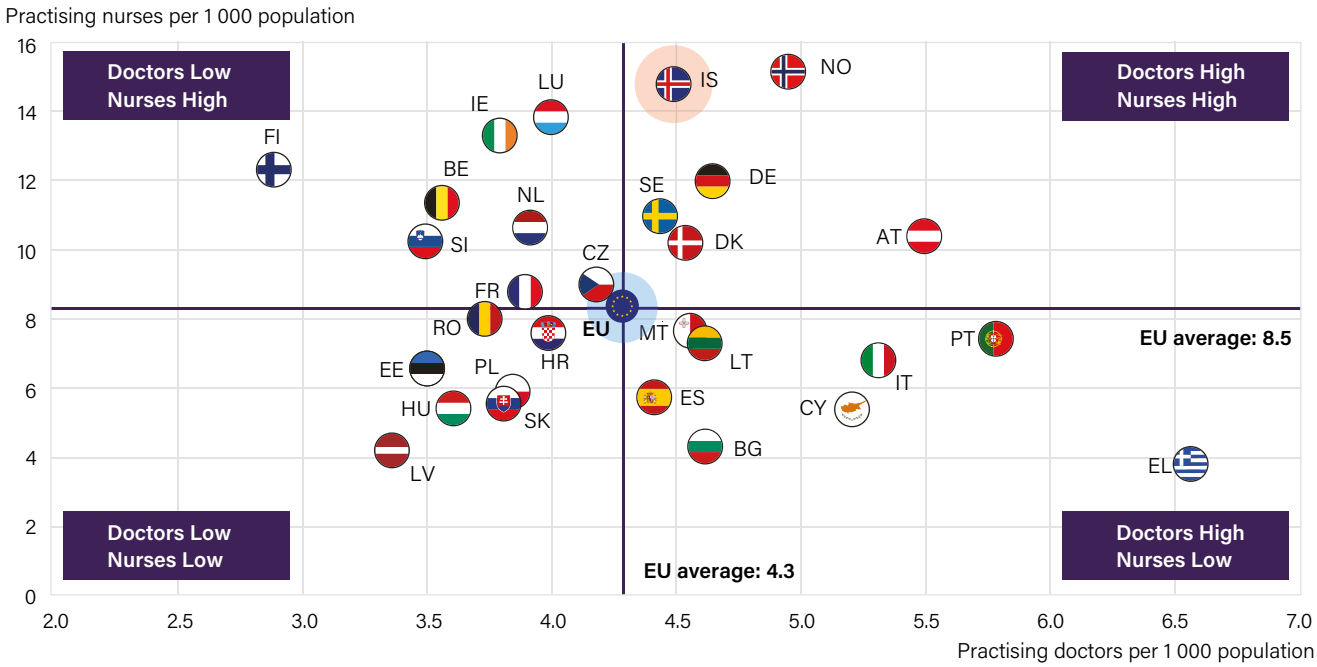
to consolidate critical services. With the building enclosure finished in late 2024 and interior work commencing in June 2025, major construction is scheduled for completion around end-2027. This is complemented by a planned expansion at Akureyri Hospital in the north, with groundwork expected in summer 2026.

Despite high workforce densities, misaligned skills and geography drive operational shortages

Iceland's health workforce presents a paradox of high aggregate supply alongside persistent operational shortages driven by mismatches in skill, specialty and geographic distribution that impact care delivery. Nurse availability is the second highest in Europe at 15.2 per 1 000 population in 2023 (including registered nurses and licensed practical nurses), and the doctor-to-population ratio also exceeds the EU average (Figure 10). Yet, these headline statistics conceal critical gaps in workforce deployment, particularly in hospitals and long-term care settings.

The 2024 transition of doctors and pharmacists to a 36-hour workweek, conditional on maintained productivity, has coincided with mounting workforce pressures. A 2025 audit of *Landspítali*, Iceland's main hospital, revealed that the facility was unable to meet its 2024 staffing plan, with 50 registered nurse positions and 379 licensed practical nurse positions unfilled, an operational deficit which constrained surgical capacity and aggravated pressures in high-dependency wards and emergency rooms (National Audit Office, 2025). Skill mix is a further constraint: no nursing home meets the safe-staffing benchmark of at least 60 % registered nurses, partly due to funding limits on hiring and training. In 2024, the government and unions agreed measures to ease workloads and finance interim solutions into 2025 (Efling, 2024).

Figure 10. The number of nurses and doctors per population in Iceland is greater than the EU average



Note: The EU average is unweighted. 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 practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

A similar imbalance is evident among physicians: although doctor density has risen sharply from 3.3 per 1 000 population in 2013 to 4.5 in 2023, this growth has been heavily concentrated in specialties. Family medicine has simultaneously eroded, with GP density declining by 0.3 % annually over the past decade, contrasting sharply with an average EU increase of over 1 % annually. As a result, only 13 % of Icelandic doctors work as GPs, well below the EU average of 19 %, translating to just 0.6 GPs per 1 000 population compared with 0.8 across the EU. This shortage has tangible consequences for access, with an estimated half of all residents lacking a fixed family doctor (*fastur heimilislæknir*) in late 2023 (BSRB, 2023). To alleviate this imbalance, the Icelandic government has expanded family medicine training and raised the maximum working age of non-hospital doctors from 70 to 75 years.

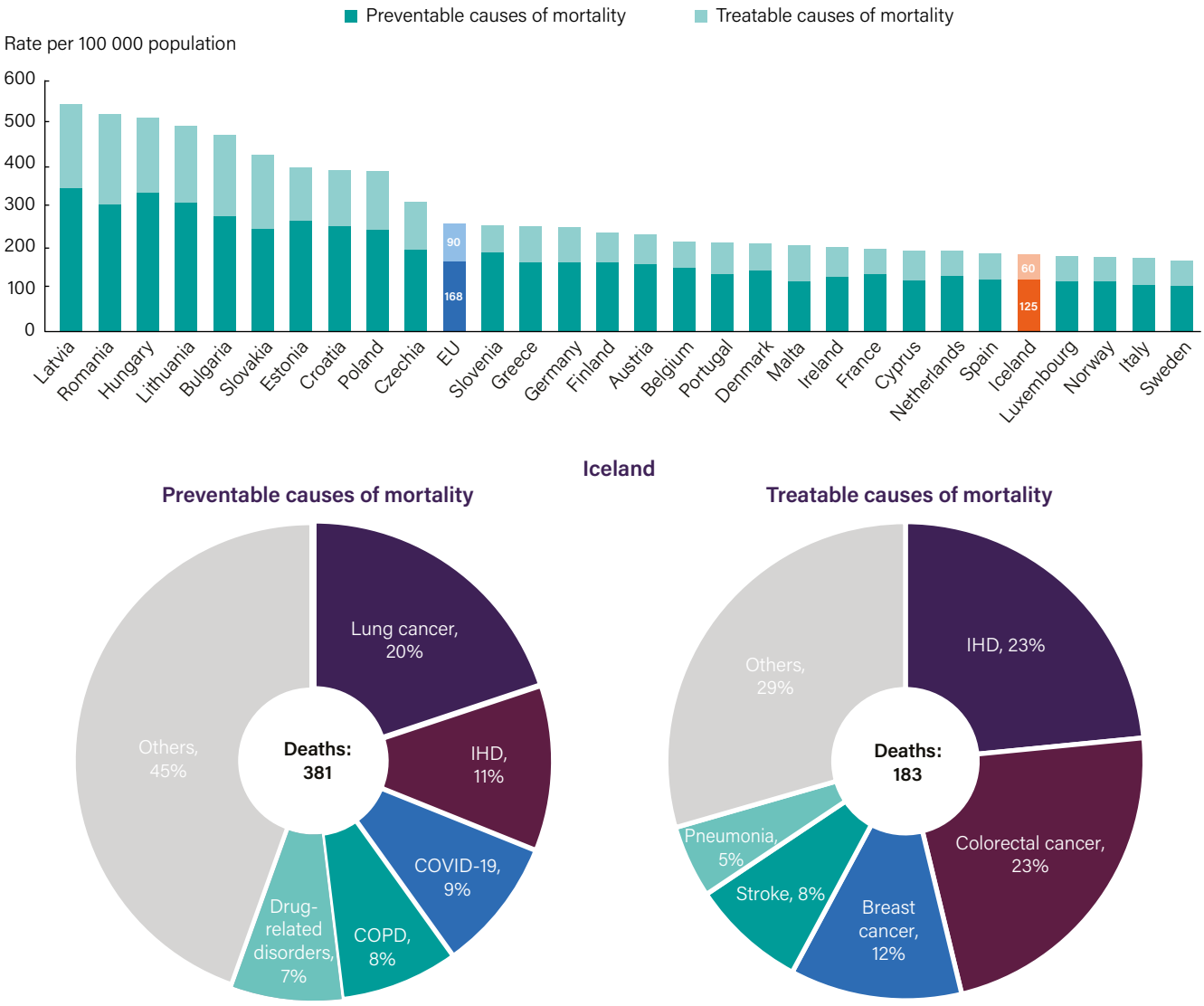
5 Performance of the health system

5.1 Effectiveness

Low preventable and treatable mortality underscore strong prevention and high-quality care

Iceland records some of the lowest avoidable mortality rates in Europe, underscoring the effectiveness of its public health and healthcare systems. In 2022, the rate of potentially preventable mortality stood at 125 deaths per 100 000 population - 26 % below the EU average. Lung cancer remained the leading cause of preventable mortality in 2022, accounting for 20 % of all such deaths, followed by ischaemic heart disease and COVID-19, each accounting for around one tenth (Figure 11). Treatable mortality has also remained consistently low, indicating strong performance in managing life-threatening conditions. Over the past decade, treatable mortality has held at roughly 60 deaths per 100 000, about one third below the EU average. In 2022, ischaemic heart disease accounted for one quarter of treatable deaths, while colorectal and breast cancers together represented over one third.

Figure 11. Avoidable mortality rates in Iceland are well below the EU average

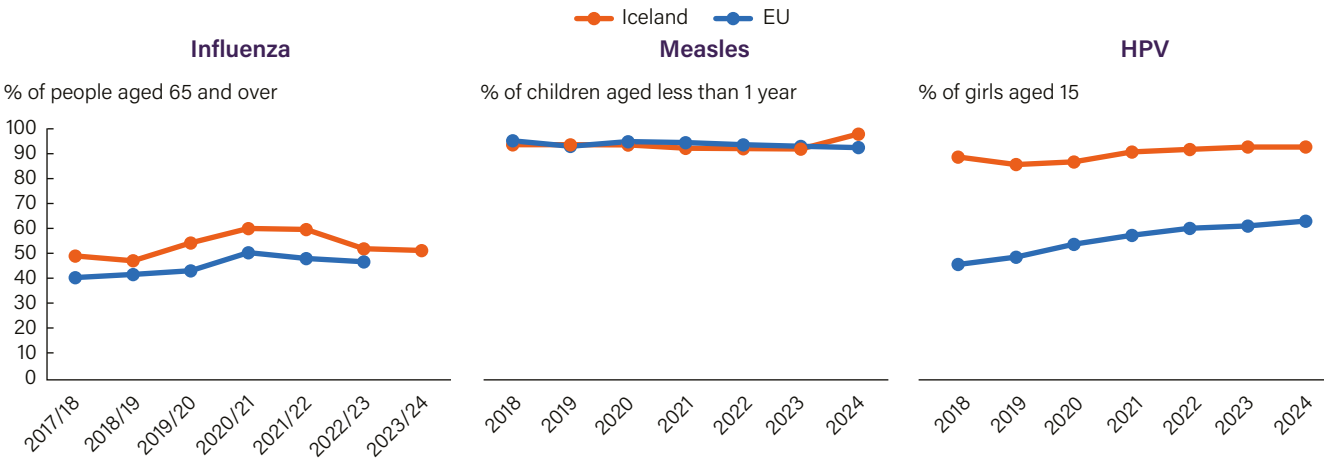


Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths for some diseases (e.g. ischaemic heart diseases, 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 (hlth_cd_apr) (data refer to 2022).

Immunisation rates against infectious diseases in Iceland are higher than the EU average

Iceland's vaccination programmes consistently achieve high coverage, reflecting strong public health infrastructure and sustained public trust. Seasonal influenza vaccination is offered free to people aged 60 and over; coverage rose to 60 % in 2020/21 and 2021/22 in response to COVID-19, then moderated to just over 50 % in 2022/23 and 2023/24 - still slightly above the EU average (Figure 12). Childhood immunisation is a particular strength: in 2024, 97 % of young children received a first measles dose compared with 92 % in the EU. Human papillomavirus (HPV) vaccination performance is especially strong: coverage among 15-year-old girls has remained near 90 % since 2018 and reached 93 % in 2024, the second highest in Europe and roughly 30 percentage points above the EU average. Building on this, a gender-neutral policy introduced in autumn 2023 extended free HPV vaccination to boys.

Figure 12. Immunisation rates against influenza and HPV in Iceland are higher than the EU average



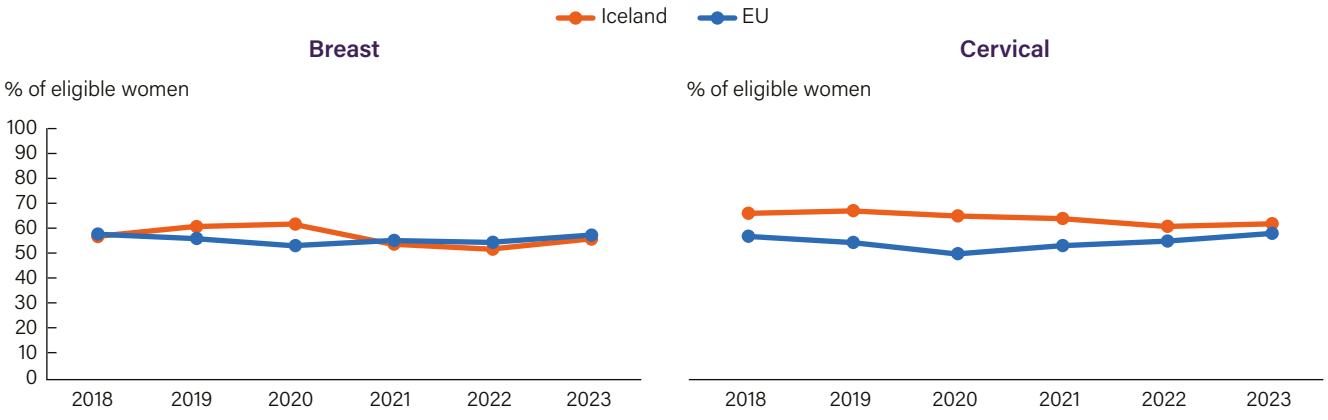
Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: OECD Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Iceland is strengthening cancer prevention and early detection through strategic screening reforms

To reduce the burden of cancer, Iceland is systematically strengthening its prevention and early detection activities, guided by its first National Cancer Plan 2019-2030, which is aligned with Europe's Beating Cancer Plan. After a brief implementation pause during the first year of the COVID-19 pandemic, efforts resumed in 2021. A cornerstone of this strategy was the 2021 transfer of screening oversight from the Icelandic Cancer Society to the public sector. This reform established a national screening centre to coordinate programmes on a unified, guideline-based foundation and shifted delivery to public providers. This structural overhaul has been accompanied by clinical protocol updates, most notably the adoption of HPV-DNA as the primary test for cervical screening in 2024, in line with the 2022 EU Council recommendations on cancer.

Participation rates in cancer screening programmes are in line with the EU average. Uptake rates in 2023 were 62 % for cervical and 56 % for breast screening compared with the EU averages of 58 % (Figure 13). However, these national figures mask marked disparities, as uptake is significantly lower

Figure 13. Cancer screening rates in Iceland are in line with the EU average



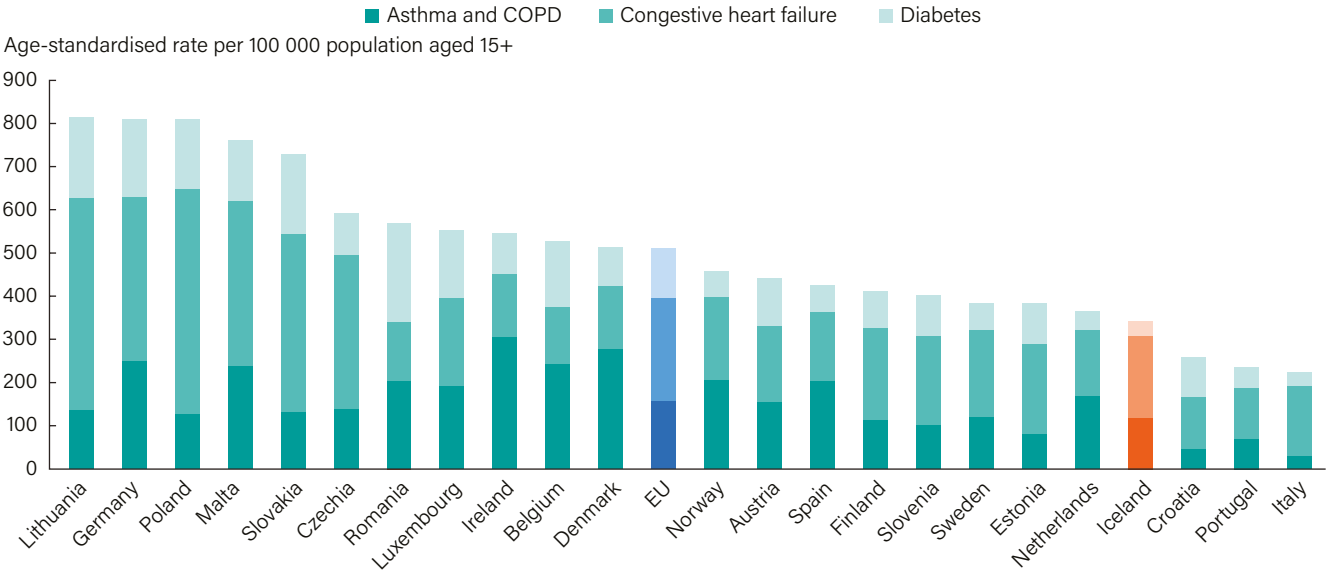
Notes: All data refer to programme data. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat database (hlth_ps_prev).

among foreign-born women (OECD/European Commission, 2025). A major step towards more comprehensive screening programmes was achieved in 2025 with the landmark launch of a population-based colorectal cancer screening programme. This programme, which invites people aged 60 to 74 to biennial faecal immunochemical testing (FIT) with results delivered via the *Heilsuvera* health portal, brings Iceland's screening framework into closer alignment with EU recommendations.

Iceland's hospital admission rates for chronic conditions are relatively low

Iceland demonstrates exceptional performance in preventing hospitalisations for chronic conditions, with a combined admission rate one third below the EU average in 2023 (Figure 14). This success is most striking for diabetes, where the hospitalisation rate is a remarkable 71 % lower than the EU average. While Iceland benefits from a lower population prevalence of the disease, this outcome is primarily driven by a robust, nurse-led primary care model. The effectiveness of this approach is confirmed by both clinical practice and long-term outcomes, with a recent evaluation of nurse-led diabetes clinics in Iceland finding that 70 % of patients achieved treatment outcomes aligned with guideline targets (Birgisdóttir et al, 2025). This strong primary care management translates directly to superior long-term health, evidenced by Iceland having one of Europe's lowest rates of diabetes-related amputations.

Figure 14. Avoidable hospital admissions for chronic conditions in Iceland are below the EU average



Note: Admission rates are not adjusted for differences in disease prevalence across countries. The data pertain to 2023 or latest available year.
Source: OECD Data Explorer (DF_HCQO).

Icelandic chronic patients report weaker care experiences than European peers

Despite strong system-level indicators, Icelanders with chronic conditions report a significant gap in their care experience compared to their European peers. According to the 2023-24 OECD PaRIS survey, only about one third of patients feel confident in managing their health or report good care coordination - far below the 60 % EU average. This low confidence is also reflected in their overall trust in the healthcare system, which is similarly below the average of the other 15 EU countries participating in the survey (Figure 15). This disconnect persists even though Icelandic primary care has notable structural strengths, including longer consultation times and widespread involvement of non-physician staff. However, a critical gap in care processes appears to undermine these strengths: fewer than half of patients with three or more conditions received a medication review in the past year, a rate well below the EU average. This specific failure in coordinating care for the most complex patients is a likely driver of the poor overall patient-reported experience (OECD, 2025).

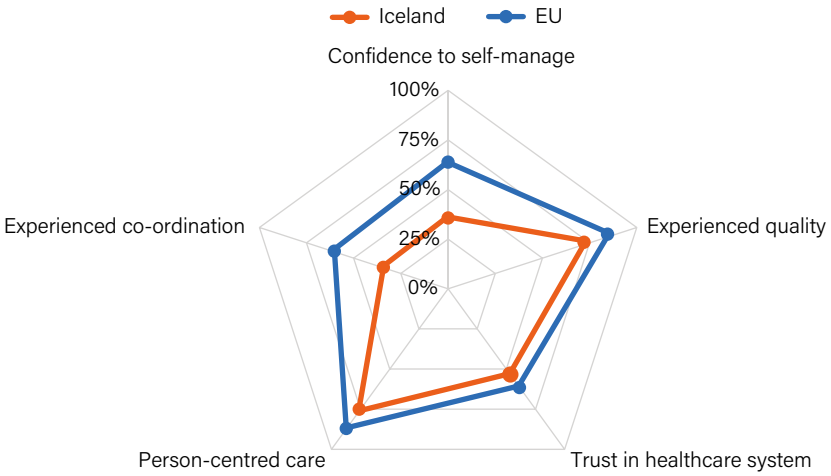
5.2 Accessibility

Public coverage is above average for inpatient and outpatient care, but relatively low for pharmaceuticals and dental care

Iceland achieves universal health coverage through broad eligibility and comprehensive benefits, supported by strong public financing. Virtually the entire population is covered, with financial protection mechanisms that include monthly caps on user charges for covered services and a tiered co-payment ('ladder') system for outpatient medicines, capped annually and with lower thresholds for children, pensioners and people with disabilities (see Section 6).

This high level of public commitment is reflected in the extent of public coverage: 99 % of hospital costs are publicly covered, and public sources fund 84 % of outpatient care spending - above the EU average. However, pharmaceuticals are less generously covered, with public financing rates almost 20 percentage points below the EU average, reflecting the system's tiered cost-sharing design. Dental care remains

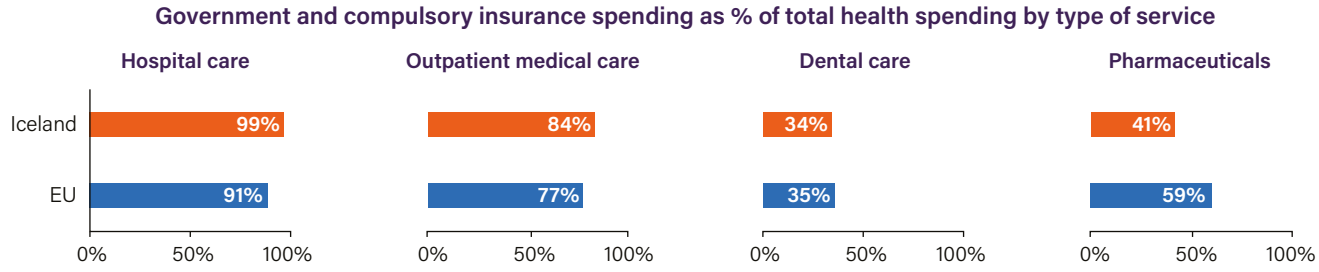
Figure 15. Only one third of Icelandic chronic disease patients feel confident managing their health



Note: Values refer to the percentage of people reporting positive experiences. Experienced co-ordination is measured through response to five questions on care co-ordination (care joined up, single named contact, overall care plan, support to self-manage, information to self-manage). Experienced quality is measured through response to a question on how people rate the care they received in the past 12 months from a primary care centre. Person-centred care is measured through response to eight questions (e.g. involved in decisions, considered "whole person", support to self-manage).
Source: OECD PaRIS 2024 Database.

the main area of limited coverage, as in most other European countries. Only 34 % of dental spending is publicly financed, broadly in line with the EU average (Figure 16). Nonetheless, coverage is more generous for certain groups: children under 18 benefit from full coverage of basic dental services for a small annual fee of ISK 3 500 (EUR 24.2), while pensioners and people with chronic conditions had approximately 69 % of general dental costs covered in 2023.

Figure 16. Public health insurance in Iceland covers virtually all inpatient care, but a much smaller share of pharmaceuticals and dental care



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 as well as medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

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

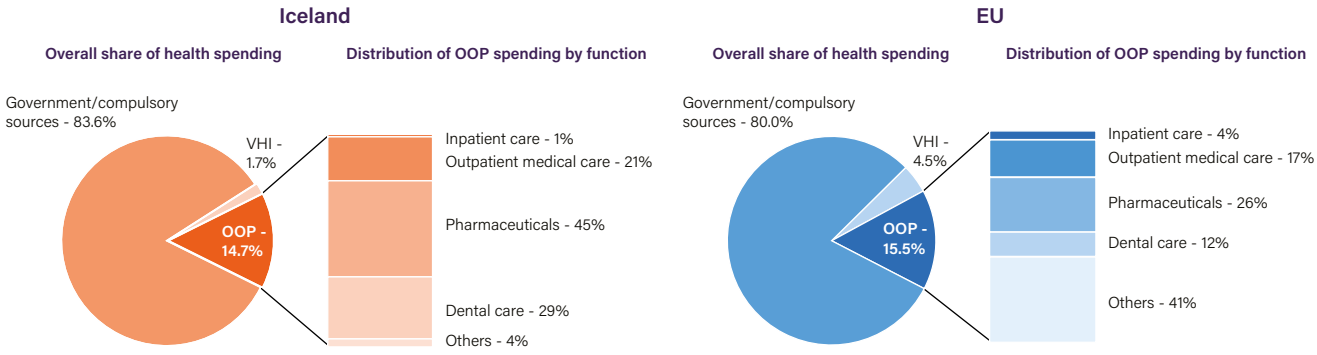
While the overall share of private health expenditure in Iceland is modest, its composition reveals a highly concentrated financial burden on households for specific services. At 16.4 % of total health spending in 2023, the private share is below the EU average of 20 %. However, most of this (14.7 %) consists of direct out-of-pocket (OOP) payments, while voluntary insurance amounted to only 1.7 % (Figure 17).

Nearly 45 % of OOP expenditure in Iceland went to outpatient pharmaceuticals, well above the EU average, reflecting the tiered co-payment system and comparatively limited public financing (see Section 6). Dental care absorbed a further 30 % of OOP payments, again a larger share than the EU average due to limited public coverage for adult services. Financial protection has been recently strengthened: since July 2025, specialist visits for children are free at the point of use even without referral, a reform expected to slightly reduce OOP spending on outpatient care (Government of Iceland, 2025).

Near-universal 30-minute access is reinforced by new facilities, air-ambulance coverage and a strong digital front door

Geographical accessibility to healthcare in Iceland is high: with approximately 64 % of residents living in the Reykjavík region, the vast majority of the population has rapid access to a dense network of services. According to 2020 data, this translates to over 91 % of residents reaching a hospital with 24/7 surgical and overnight care within 30 minutes by car. When considering the full network of facilities, including 47 primary care centres and 22 part-time sites, 99.5 % of Icelanders are within a 30-minute drive of a health service

Figure 17. Out-of-pocket expenditures in Iceland are close to the EU average



Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

(Wang, 2020). This strong baseline is being actively reinforced through ongoing infrastructure investments, as evidenced by the opening of new primary care facilities in Akureyri in 2024 and Suðurnesjabær in 2025. Beyond physical infrastructure, Iceland's accessibility strategy incorporates two crucial dimensions: emergency coverage for remote areas and a robust digital front door. Iceland currently has one official helicopter emergency medical services base (Akureyri), which can cover up to 66 % of demand within 60 minutes (Nordic Co-operation, 2025). Digital tools such as *Heilsuvera*, Iceland's national health portal, have also fundamentally extended access by mitigating the need for physical travel (Box 1).

Box 1. *Heilsuvera*: Iceland's national e-health portal is improving healthcare access and efficiency

A central pillar of Iceland's digital health strategy is Heilsuvera, the national health portal that functions as a unified digital front door to the healthcare system. Developed in phases since 2014, it is fully integrated with the national electronic health record system. Residents can securely access their medical information using a national e-ID and use the platform to book appointments, view test results, request prescription renewals and engage in secure video consultations.

The platform has played a transformative role in improving access, particularly in overcoming Iceland's geographical barriers. By 2024, more than half of the adult population actively used the platform, with strong uptake across all regions. Its value became especially clear during the COVID-19 pandemic, when it enabled remote booking of tests, issuance of quarantine certificates and continued access to care, reducing reliance on in-person services.

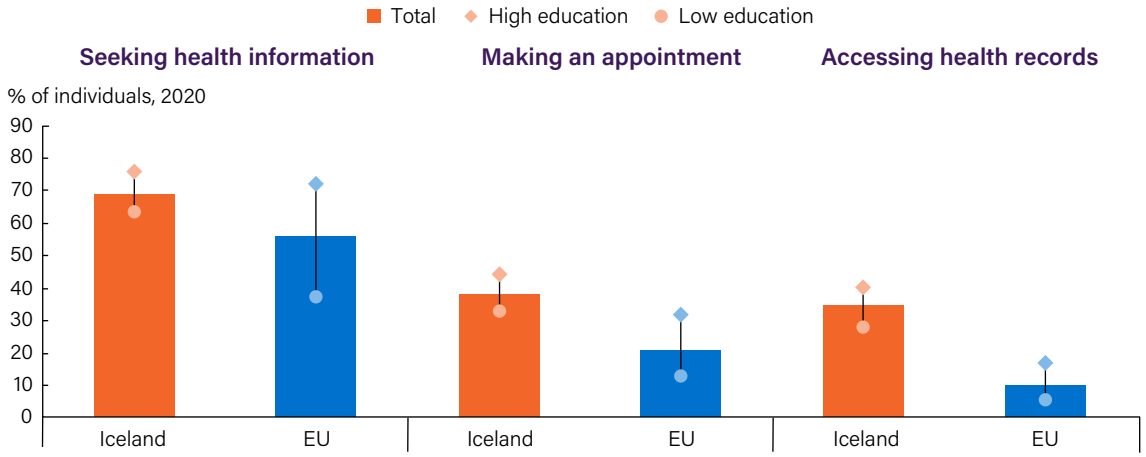
Beyond access, Heilsuvera has delivered efficiency gains and helped reshape the patient-provider relationship. By automating routine administrative tasks like appointment scheduling and prescription requests, Heilsuvera has reduced the workload on clinical staff, while secure messaging and online consultations increasingly substitute for in-person visits in non-urgent cases. The Icelandic experience highlights how a well-designed national e-health platform anchored in secure digital ID infrastructure and broad service integration can promote equity, system efficiency and patient empowerment.

A strong digital infrastructure underpins high and relatively equitable patient uptake

Iceland has established itself as a leader in digital health adoption. During the first year of the COVID-19 pandemic, public uptake of digital health tools in Iceland was above the EU average, with a significantly larger share of Icelanders using online services to seek health information, book appointments and access health records compared with EU peers. While adoption was greater among people with higher education, the gap was notably smaller than the EU average, suggesting more equitable digital health access across socioeconomic groups (Figure 18).

This foundation has continued to strengthen. A longitudinal study covering 2019-2022 reported substantial growth in citizens' use of digital channels for personalised communication with healthcare professionals, alongside marked improvements in perceived readiness to adopt health technologies (Pálsdóttir, 2024). This high public engagement is supported by advancing digital infrastructure: 61 % of patients are now managed in practices able to exchange medical records electronically, slightly above the OECD PaRIS average of 57 % (OECD, 2025). Recent innovations, including the Meðvera e-communication portal for real-time symptom monitoring for cancer patients and Iceland's participation in the EU4Health cross-border data exchange for patient summaries and ePrescriptions, demonstrate continued momentum to leverage digital tools for improving patient outcomes.

Figure 18. Icelanders are more likely to use digital health tools than the EU average



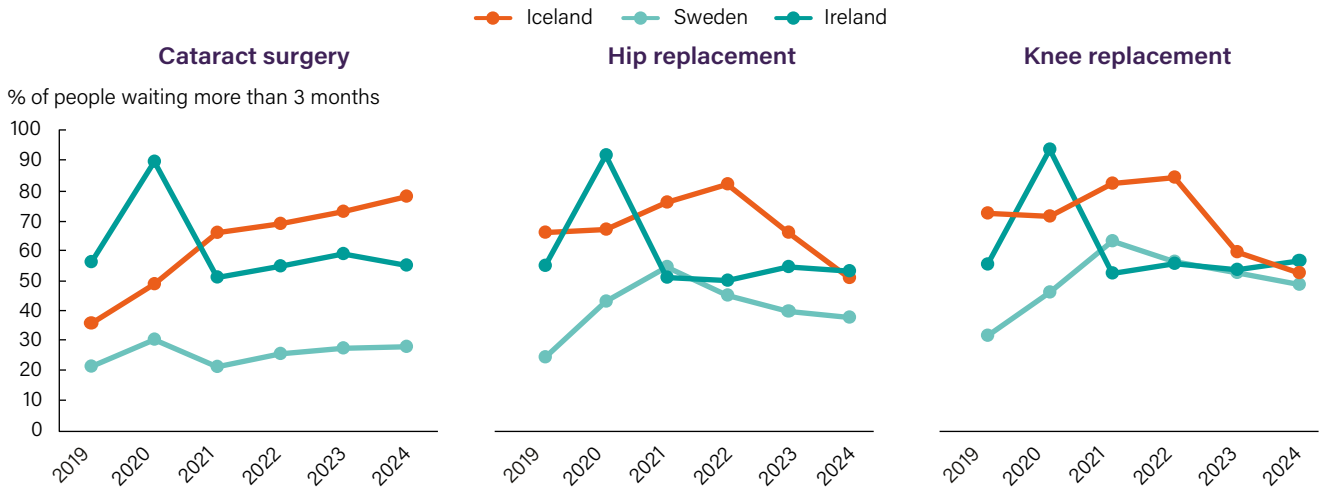
Source: Eurostat database (isoc_ci_ac_i). The data refer to 2020.

A multi-year procurement plan aims to clear elective ophthalmology backlogs

Reducing long waits for elective surgery remains a central policy challenge in Iceland, with recent trends showing a sharp divergence across procedures. Although a 2016 plan set a benchmark for 80 % of patients to be treated within 90 days, backlogs persisted and were exacerbated by the COVID-19 pandemic: in 2022, over 80 % of joint-replacement patients and 69 % of cataract patients waited more than 90 days. Since 2023, performance has diverged sharply between procedures. Hip and knee replacements have improved dramatically, supported by targeted funding, pay-per-case incentives, and the purchase of 700 additional procedures from private providers.

This strategy yielded a record 2 138 operations in 2023, with median waiting times at Landspítali falling from 9.5 to 4.6 months (Government of Iceland, 2024). By contrast, cataract surgery has steadily worsened: the waiting list at Landspítali swelled to 3 000 people by August 2023, with 1 000 waiting over a year. By 2024, 78 % of patients were waiting longer than 90 days, the highest level on record. This performance compares unfavourably with countries facing similar hospital capacity constraints, such as Sweden and Ireland (Figure 19).

Figure 19. While hip and knee replacement backlogs have decreased markedly, cataract surgery backlogs have worsened



Source: OECD Data Explorer (DF_WAITING).

This divergence reflects the mix of policy levers and delivery constraints. Orthopaedics benefited from targeted purchasing, performance-linked funding, and focused managerial attention following the introduction of a national waiting-times dashboard. Ophthalmology, by contrast, faced tighter constraints in specialist staffing and theatre time. To relieve pressures, the government announced a multi-year strategy in August 2025 to secure roughly 1 000 additional elective procedures annually through long-term contracts (Government of Iceland, 2025). While this should help consolidate gains in orthopaedics, similar structural arrangements will likely be required to clear the ophthalmology backlog.

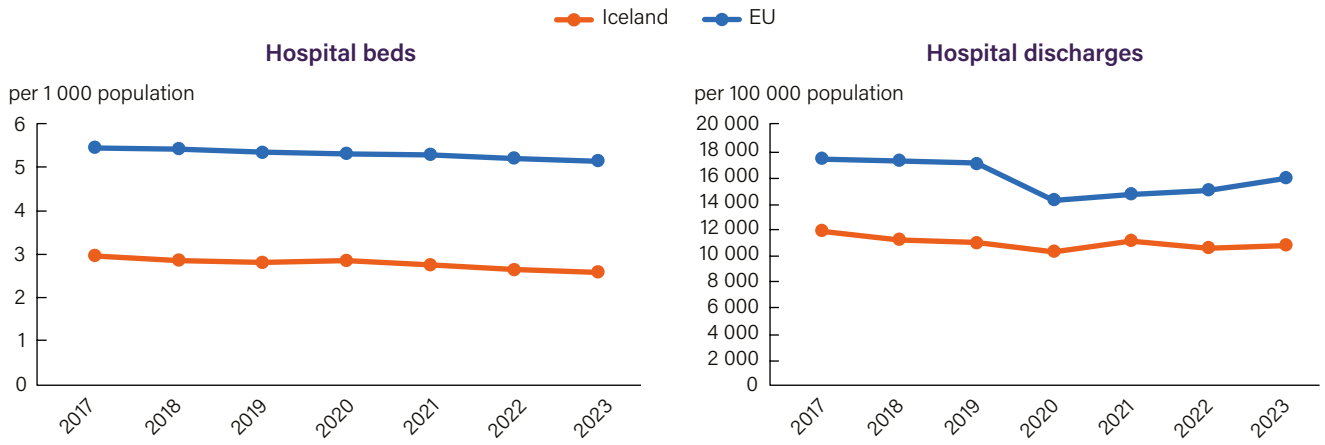
5.3 Resilience

Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

Iceland's efforts to expand its limited hospital bed capacity are constrained by staff shortages and long waiting times for long-term care beds for the elderly

Iceland's hospital sector operates under structural capacity constraints stemming from a long-term policy to maintain lean inpatient capacity that has become increasingly misaligned with rising demand. In 2023, Iceland had 2.6 hospital beds per 1 000 population - about half the EU average, and hospital discharge rates were 32 % below the EU average (Figure 20).

Figure 20. Iceland's hospital bed density is half the EU average and discharge rates are one third below it



Note: The EU averages are weighted.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

While this approach supports the National Health Policy 2030 objective of shifting care toward community settings, the emphasis on operational efficiency has created vulnerabilities. Bed-occupancy rates routinely exceed the 85 % safety threshold, and staffing shortages, identified by the National Audit Office as the principal bottleneck, are driving emergency department overcrowding, postponement of elective procedures (see Section 5.2) and reductions in operational bed capacity (National Audit Office, 2025). Although major infrastructure projects are underway (see Section 4), Ministry of Health projections indicate that by 2040 the hospital system will require roughly 50 % more beds than the configuration planned for 2026 (Ministry of Health, 2021). Interim measures such as expanding emergency departments and contracting external providers for elective surgery help manage acute pressures but do not obviate the need for near-term expansion of inpatient capacity.

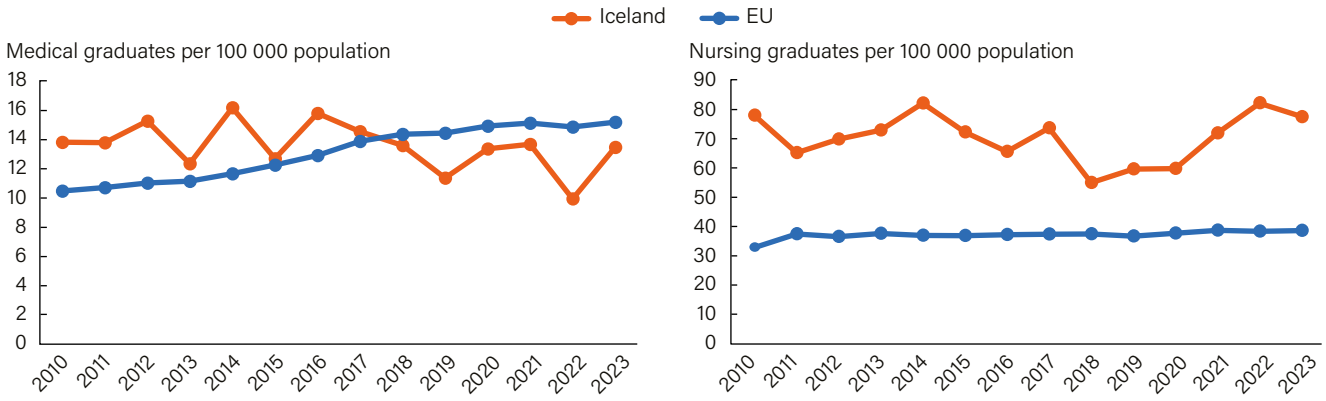
A further structural constraint is the shortage of long-term care (LTC) capacity, which impedes timely discharge and generates downstream congestion. At end-2023 Iceland had about 2 800 nursing-home beds; meeting projected demand will require roughly 100 additional places per year to 2040. With a waiting list of 677 people in June 2025, discharge delays are directly slowing patient flow through hospitals (National Audit Office, 2025). The construction of 1 041 additional nursing-home beds is planned for 2025-2029.

Recent reforms are tackling Iceland's health workforce imbalances

Iceland is implementing comprehensive reforms to its health-related education and training programmes to address deep-seated structural imbalances in physician and nursing capacity. For physicians, the central challenge has been a domestic training capacity that has struggled to keep pace with population growth. Annual medical graduate output in Iceland has fluctuated over the past decade, with around 50 medical students graduating in 2023, equivalent to 13.5 per 100 000 population - about 10 % below the EU average (Figure 21). This gap is partly offset by Icelandic students trained abroad, some of whom return after graduation. Intake has been progressively expanded from 48 in 2019 to 75 in 2024, alongside initiatives to attract internationally trained Icelandic doctors back to practice. Structural reforms include the 2023 introduction of a mandatory one-year foundation internship (*sérnámsgrunnur*) for all new doctors to ensure broad clinical experience before specialisation.

In contrast, Iceland's number of nurse graduates has expanded rapidly in recent years, supported by targeted government investment. Annual nursing graduate output is double the EU average, including students graduating from registered nurse programmes and lower-level licensed practical nurses programmes. This substantial growth is the direct result of concerted government initiatives: higher student quotas, expanded bachelor-level slots, and bridging courses for licensed practical and foreign-trained nurses. The expansion has been further accelerated by strategic improvements in wages, working conditions, and specialised

Figure 21. Iceland's nursing graduate output is double the EU average, while the medical graduate output is slightly below average



Note: The EU average is weighted (calculated by the OECD). Data include graduates from all nursing education programmes, not limited to those meeting the EU Directive for general nurses.
Source: OECD Data Explorer (DF_GRAD).

postgraduate programmes that have enhanced nursing's appeal as a career path and attracted more students to the profession. Despite this domestic expansion, Iceland continues to rely on active international recruitment to fill immediate workforce needs. This is most evident in the significant presence of Filipino nurses, who now comprise the majority of the foreign nursing workforce at Landspítali. This dual strategy reflects the reality that even rapid training growth cannot fully offset the scale and urgency of current staffing pressure.

Iceland is modernising its health data infrastructure

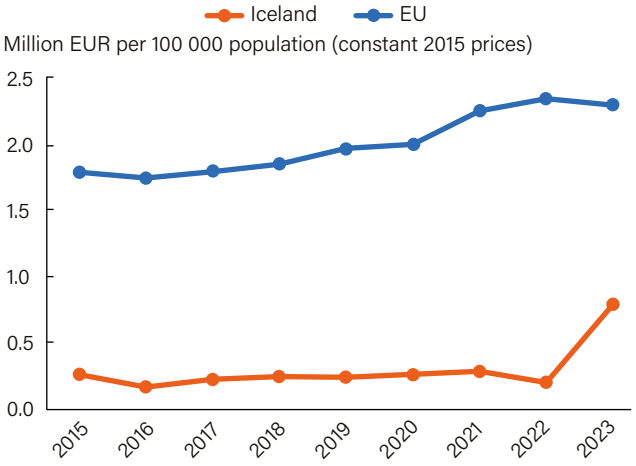
Despite its status as an advanced digital society, Iceland has a legacy of chronic underinvestment in health ICT, a gap reflecting governance constraints rather than lack of ambition. In 2023, investment quadrupled, yet the resulting EUR 0.8 million per 100 000 population remained 65 % below the EU average (Figure 22). This long-standing underinvestment stemmed from a fragmented governance model in which agencies funded their own IT from operating budgets, combined with the absence of dedicated capital expenditure for digital projects and competing priorities, notably large physical infrastructure upgrades (Alþingi, 2024).

A strategic shift is now under way. Building on post-pandemic momentum and the Digital Healthcare Policy (2021), Iceland is prioritising advanced, interoperable systems, including adoption of the HL7-FHIR standard to overcome legacy constraints and enable true data exchange (Alþingi, 2024). Complementary clinical deployments are emerging, such as Landspítali's 2024 introduction of AI-assisted cervical cancer screening as screening services are reintegrated into the public system.

Careful antibiotic consumption drives Iceland's strong AMR performance

Iceland has emerged as a European leader in antimicrobial resistance (AMR) control, anchored by its systematic approach to reducing antibiotic consumption. In 2023,

Figure 22. Capital investment in health ICT in Iceland surged in 2023 but remains low compared to the EU average



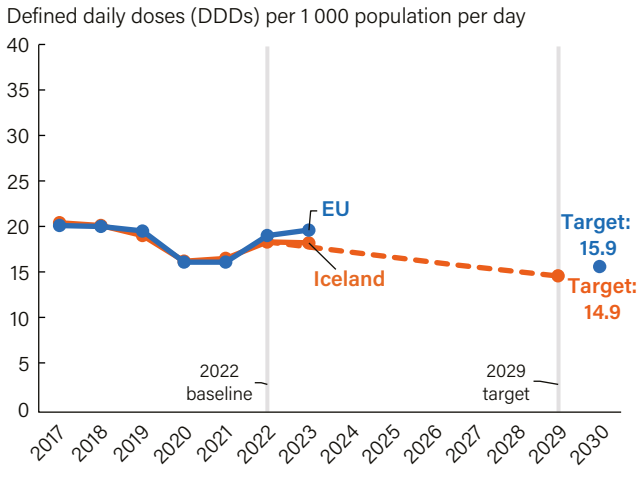
Note: Values refer to gross expenditure and include ICT equipment and computer software and databases. Data refer to human health and social work activities (Q).
Source: Eurostat database (nama_10_a63_p5).

the country recorded 18.5 defined daily doses (DDDs) per 1 000 population, 7 % below the EU average and 4 % below its own pre-pandemic level (Figure 23). This achievement reflects decades of sustained policy efforts, particularly the 2017 introduction of stewardship guidelines that significantly curtailed broad-spectrum antibiotic use (Gunnlaugsdottir et al., 2021).

Building on this strong foundation, the *National Action Plan on AMR 2025-2029* sets an ambitious goal to reduce antibiotic consumption by a further 20 % from 2022 baseline levels by 2029. This domestic target broadly aligns with the EU Council's 2030 recommendation[2] for a 20 % reduction by 2030 compared with 2019 levels while establishing a faster timeline reflecting Iceland's leadership in this area. To achieve this, the strategy dedicates ISK 1.8 billion (EUR 12.7 million) to

[2] Council of the European Union (2023) - Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach.

Figure 23. Iceland is on track to meet its 2030 antibiotic consumption reduction target



Note: The EU average is weighted. The data show antibiotic consumption in hospital and in the community. The dashed line from 2019 to 2029 illustrates the national policy target reduction pathway by 2029.
Source: ECDC ESAC-Net.

digital innovation, including enhanced ePrescription analytics, expanded whole-genome sequencing and environmental surveillance systems - all consistent with the EU One Health guidance to further strengthen Iceland's AMR control framework (Ministry of Health, 2024).

This strong performance is underpinned by high prescribing quality and long-standing stewardship policies. Over 80 % of antibiotics prescribed fall within the WHO 'Access' group, far exceeding the 65 % target. This success is rooted in systematic efforts, such as the 2017 introduction of stewardship guidelines in the capital region inspired by Sweden's AMR programme that led to notable reductions in broad-spectrum antibiotic. Consequently, Iceland ranks among the best in Europe on the ECDC's composite AMR index, which measures resistance to first-line treatments, reflecting the effectiveness of its prudent consumption patterns (ECDC, 2024).

6 Spotlight on pharmaceuticals

Iceland channels most pharmaceutical spending through retail pharmacies

Although total health spending per capita in Iceland is slightly above the EU average, retail pharmaceutical expenditure was EUR 480 per capita in 2023, 6 % below the EU average (Figure 24). However, Iceland records the highest level of retail pharmaceutical spending among Nordic countries, with per capita outlays approximately 16 % above the Nordic average. At the same time, only 7 % of total pharmaceutical expenditure in Iceland is channelled through hospitals, a figure far below the EU average of 41 % and much lower than in Sweden (35 %) and Finland (22 %).

This retail-focused model has proven stable, with real per capita spending in the hospital channel growing at the same rate (about 16 %) between 2013 and 2023 as the retail channel (Figure 25). A central driver of this distribution is Iceland's approach to high-cost therapies: while specialty care high-cost medicines follow a separate procurement pathway, many therapies that are typically provided through hospitals in other European countries, such as oral oncology drugs and treatments for autoimmune conditions, are mostly channelled through pharmacies in Iceland.

Centralised reimbursement leverages Nordic HTA and joint negotiations to balance access and affordability in Iceland

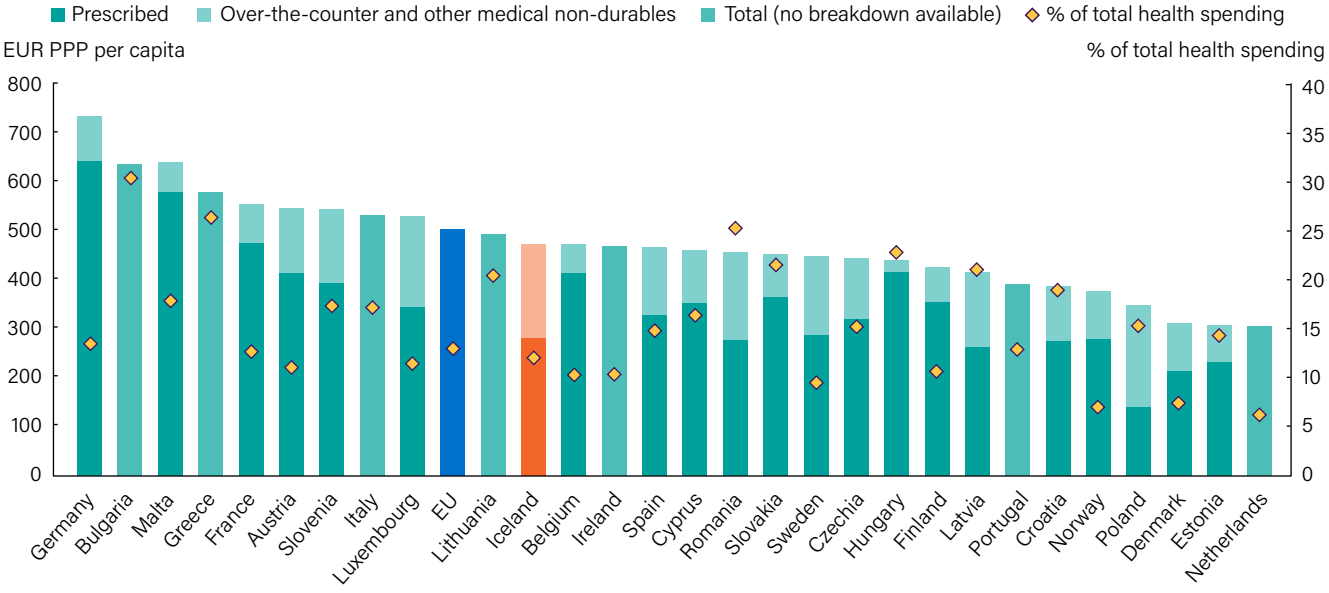
Reimbursement decisions are managed by the Icelandic Medicines Agency (IMA), which bases its assessments on an expert review by the Landspítali Medicine Committee (LMC). The LMC evaluates each product's clinical benefit, cost-effectiveness and likely budget impact. While Iceland does not conduct its own health technology assessments (HTAs), the IMA incorporates evaluations from other Nordic countries - an approach reinforced since 2024 through Iceland's participation in the Joint Nordic HTA project (formerly FINOSE), which aims to harmonise HTA methodologies and share knowledge on new medicines. Final reimbursement decisions consider the LMC's evaluation alongside other key criteria, including expected patient numbers and reimbursement practices in reference countries. Approved medicines are listed on an official reimbursement register published once a month[3]. In order to improve access and affordability of new and expensive medicines, Iceland also participates in the Nordic Pharmaceutical Forum, which facilitates joint price negotiation and collaboration across the Nordic countries.

Iceland's co-payment design places a comparatively high financial burden on households

Retail pharmaceutical coverage in Iceland is governed by a graduated co-payment structure where individuals pay proportionately less as their medication costs increase within a 12-month rolling period. Under this scheme, individuals pay the full price of medicines until reaching ISK 22 800 (EUR 160), after which they pay 15 % until ISK 32 430, then 7.5 % until ISK 62 000 (EUR 433), above which public insurance covers all remaining costs. Importantly, the system incorporates protections for vulnerable groups, including

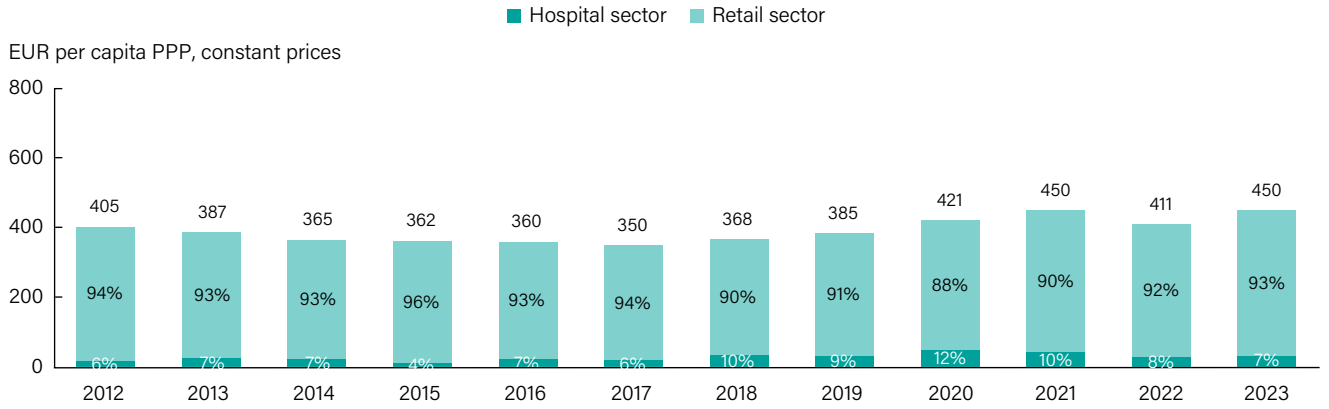
[3] Icelandic Medicines Agency, https://www.lyfjastofnun.is/verd-og-greidsluthatttaka/lyfjaverdskra/

Figure 24. Expenditure on retail pharmaceuticals per capita is lower in Iceland than the EU average



Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

Figure 25. Less than 10 % of pharmaceutical spending in Iceland is procured through hospitals



Source: OECD Data Explorer (DF_SHA).

children, pensioners, and people with disabilities, who benefit from reduced co-payments and lower annual caps. Despite these safeguards, these high initial deductibles place a relatively heavier burden on households than in most European countries. In 2023, public insurance covered just 41 % of retail pharmaceutical expenditure, below the EU average of 62 % (Figure 26). Pharmaceuticals consequently represent 45 % of all direct OOP spending in Iceland, nearly twice the EU average of 25 % (see Figure 17 in Section 5.2).

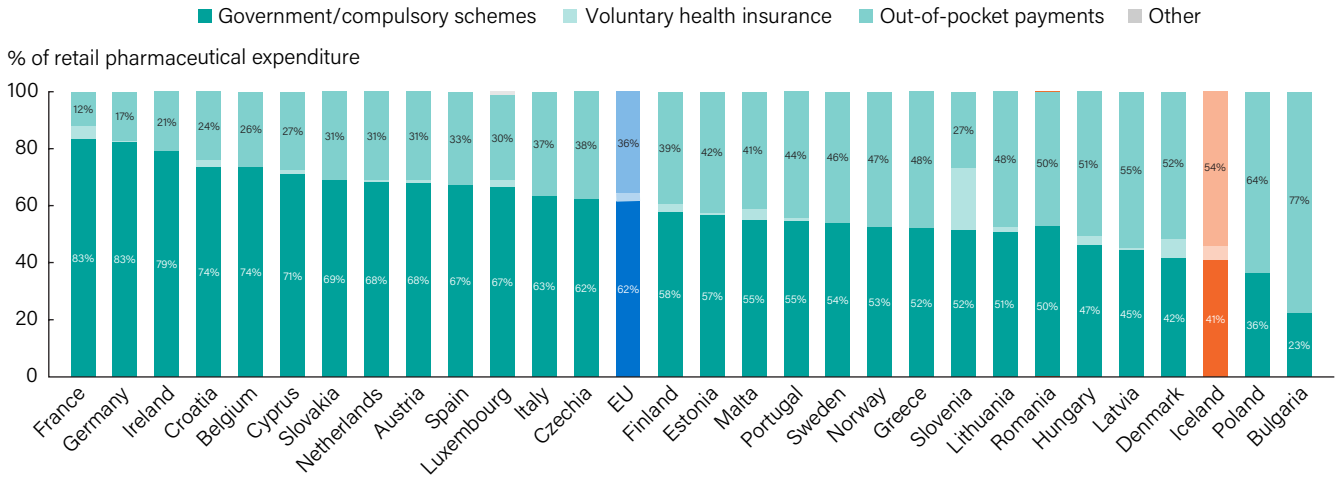
Nordic-referenced price caps, reinforced by tenders and contracts, keep Iceland's medicine costs down while preserving access

Iceland employs a multi-layered strategy to contain pharmaceutical expenditure, anchored by a system of external reference pricing (ERP) that uses Denmark, Finland, Norway and Sweden as reference countries. For most general prescription medicines, the maximum wholesale price cannot exceed the average price across these Nordic countries; the rules are stricter for specialty care high-cost medicines, which are benchmarked against the single lowest price in the region.

To secure patient access while managing the budget impact of these high-cost therapies, this formal price-setting is supplemented by a system functionally equivalent to managed-entry agreements.[4] Iceland's framework explicitly allows for tendering and contractual agreements, most notably with Landspítali: the Icelandic Medicines Agency (IMA) may approve a higher official list price for a product, provided the hospital has secured a contract that guarantees its actual net purchase price remains below this

[4] Managed entry agreements (MEAs) are confidential contracts between a manufacturer and a public payer that grant coverage for a medicine under specified conditions to manage clinical or budget uncertainty. They are usually grouped into: i) financial-based agreements (e.g. confidential discounts, price/volume deals, expenditure caps or paybacks), and ii) performance/outcome-based agreements that tie payment to real-world results.

Figure 26. More than half of Iceland's spending on outpatient medicines is borne out-of-pocket



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

Nordic-lowest benchmark. This pricing framework extends to other categories to maximize cost-effectiveness: generic medicines are capped at the average of generic prices in the reference countries, while biosimilars are capped at or below the lowest average biosimilar price. Parallel imports, in turn, must always be priced lower than the corresponding product already on the Icelandic market (Icelandic Medicines Agency, 2023). The IMA is legally obliged to reassess pricing at least every two years, and holds the authority to implement price freezes.

Reference pricing and aligned incentives for pharmacists drive strong generic uptake in Iceland

Iceland has established a robust framework to promote the uptake of generic medicines, leveraging both pharmacy and patient financial incentives. At the core of this system is the use of reference price categories (*viðmiðunarverðflokkar*), which group together generics and medicines with comparable therapeutic effect on the official exchange list (*skiptiskrá*). Pharmacists are financially motivated to substitute within these groups, receiving additional payments for dispensing either the cheapest product or one priced within 5 % of the lowest-cost option. This supply-side strategy is complemented by patient cost-sharing rules that anchor out-of-pocket payments to the reference price: if patients opt for a more expensive alternative, they must cover the full price difference, with this extra payment excluded from their annual co-payment cap. These mechanisms have delivered substantial results: the IMA reports that in 2021, generics accounted for 49 % of the total pharmaceutical market by volume in Iceland, a share comparable to the EU average, notably higher than Sweden's 37 % but below Denmark's 69 % (Icelandic Medicines Agency, 2023).

Iceland combines rapid assessment with selective listing, prioritising value-based access over broad medicine availability

Medicine availability in Iceland is shaped less by appraisal delays than by selective listing of new products. The country's median time to market for new medicines between 2020 and 2023 was 513 days after EU market authorisation, closely aligned with the EU median of 518 days. However, this average conceals a substantial availability gap: as of January 2025, only 31 % of approved medicines were available to patients in Iceland compared with 46 % on average across the EU. The shortfall is particularly pronounced for oncology medicines, with only 34 % of authorised products listed compared with 50 % in the EU (Newton et al., 2025). This approach is a deliberate strategic choice reflecting both the realities of a small market and a focus on value-based reimbursement decisions made by the national authorities. Iceland's participation in joint Nordic HTA supports clinical assessment, but the final listing decisions remain national, explaining how speed can coexist with a narrow scope. Crucially, interpreting these availability figures requires caution: standard metrics like the W.A.I.T. indicator measure inclusion on a reimbursement list, not actual clinical uptake or alternative access routes. A lower 'availability' rate may therefore reflect a successful value-based selection process rather than a failure of access.

7 Key findings

- Iceland maintains a relatively high life expectancy at 82.8 years in 2024, over a year above the EU average, though still 0.4 years below its pre-pandemic level. The gender gap is small, yet longevity differs markedly by education, with men without secondary schooling living 5.1 years less than university graduates. Cardiovascular diseases and cancer caused 54 % of deaths in 2023, while COVID-19 fell below 2 %. Strong prevention keeps CVD incidence and prevalence below EU levels, but population ageing will lift cancer incidence by over 50 % by 2040, straining capacity and survivorship care.
- Behavioural and environmental risks account for 26 % of deaths in Iceland, below the EU average but still substantial. Daily smoking has fallen to the lowest level in Europe, yet adolescent e-cigarette use is rising; in response, strengthened labelling rules took effect in 2025 and flavour bans start in 2028. While alcohol use remains low, obesity is high and increasing, driven by poor diets despite high physical activity. Policy responses include a 2024 obesity strategy, free primary-school lunches from 2025 and targeted treatment measures.
- Iceland's tax-funded, residence-based system delivers universal coverage through a single purchaser and predominantly public providers. Per-capita spending aligns with the EU average but takes a smaller GDP share; the public share is high and out-of-pocket payments relatively low. Referral guidance introduced in 2024 strengthens primary care coordination, with children exempt from referral requirements from 2025. Despite major hospital investments, capacity is constrained by staffing gaps and skill-mix imbalances, especially GP shortages and nursing deficits, driving high occupancy and pressure on emergency and surgical services.
- Iceland combines very low preventable and treatable mortality with strong prevention and primary care. Preventable deaths were 26 % below the EU average in 2022, and treatable mortality about one third lower. Vaccination coverage is high, with gender-neutral HPV vaccination since 2023. Cancer screening has been consolidated under a national centre, with HPV-DNA testing and a 2025 rollout of population colorectal screening. Avoidable hospitalisations are low, especially for diabetes, reflecting the effective implementation of nurse-led primary care.
- Near-universal public coverage and high financial protection underpin access in Iceland, with hospital and outpatient care largely publicly financed. Coverage is comparatively weaker for pharmaceuticals and adult dental care, concentrating out-of-pocket spending on these items despite recent protections for children. Performance on waiting times is mixed: targeted purchasing has cut hip and knee replacement waits, but cataract surgery backlogs have worsened, prompting multi-year contracting to expand elective capacity.
- Iceland's hospital capacity and patient flow are increasingly constrained. Bed density is low at about half the EU average, while occupancy routinely exceeds 85 %, with shortages of long-term care places further delaying discharge and contributing to emergency department crowding. Workforce reforms are under way: nursing graduation rates are well above the EU average, but medical graduate output remains slightly below, with a new foundation year introduced to broaden clinical experience. Digital investment has accelerated, yet remains substantially below EU levels. By contrast, antimicrobial stewardship is exemplary: antibiotic consumption is low, and a 2025 plan targets a further 20 % reduction by 2029.
- Iceland channels most pharmaceutical spending through retail pharmacies, with per capita outlays 6 % below the EU average but 16 % above the Nordic average. The country uses a graduated co-payment system placing relatively high household burdens, with public insurance covering only 41 % of retail pharmaceutical expenditure compared to the EU average of 62 %. Centralised reimbursement leverages Nordic HTA and joint negotiations, strict external reference pricing, tenders and strong generic-substitution incentives. While market entry timelines are rapid, Iceland's selective listing approach results in a narrower reimbursed medicine portfolio than in the EU on average, particularly for oncology medicines, reflecting a deliberate value-based strategy.

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Country abbreviations

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

State of Health in the EU
Country Health Profiles 2025

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 2025 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;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

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

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