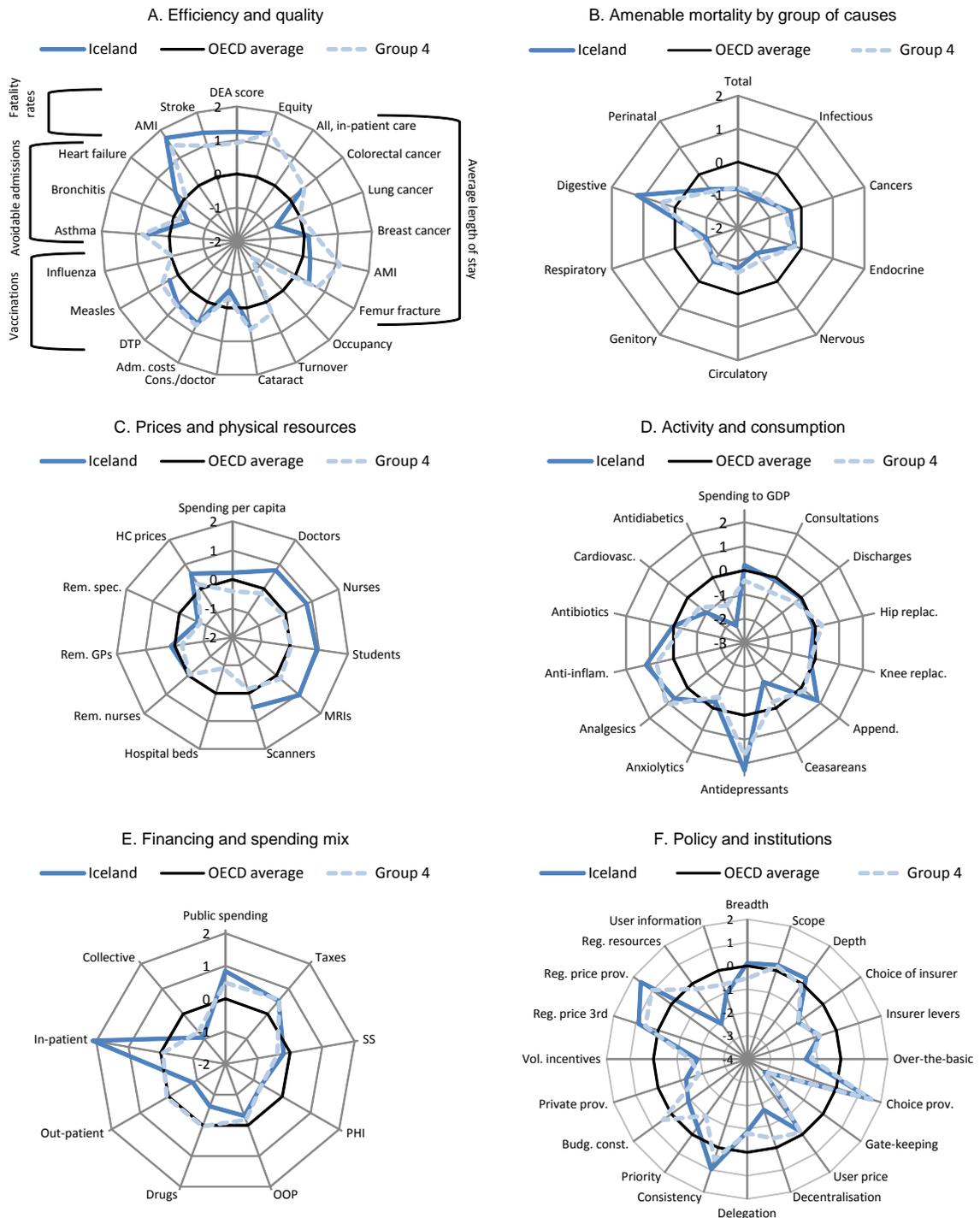


## Iceland: health care indicators

### Group 4: Iceland, Sweden, Turkey



*Note:* Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country). In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area). In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations. In Panel F, data shown are simple deviations from the OECD average.

*Source:* OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

## ICELAND

**GROUP 4:** Mostly public insurance. Users are given ample choice of providers but private supply is limited and prices tightly regulated. Gate-keeping is virtually inexistent.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score, low amenable mortality rate and low inequalities in health status	Rather high spending to GDP ratio and <i>per capita</i>		Higher public share, largely tax-financed and low out-of-pocket share	Generous basic insurance coverage	In containing public spending on health, the focus should be on the in-patient care sector. Hospital budgets are largely independent on the level of activity. There are few regulations which apply to the level of human resources and equipment, which is high by OECD standards. Two alternative strategies may be envisaged: <i>i)</i> tightening both hospital budgets and controls on resources; <i>ii)</i> linking hospital budgets to their level of activity. The first approach will help better controlling health care spending and could be reinforced <i>via</i> a tougher budget constraint while the second approach would promote efficiency gains though with uncertain impact on public spending
	More doctors, nurses, medical students, MRIs and scanners <i>per capita</i>	About average number of consultations and hospital discharges <i>per capita</i>	Very high in-patient share	Ample user choice of providers and no gate-keeping with little information on prices and quality	Introducing gate-keeping could contribute to mitigate spending pressures in the in-patient care sector
Rather high quality of out-patient and preventive care				Little private provision and provider incentives, with heavy regulation of prices. Less regulations of resources	The high number of health professionals and low number of consultations per doctor is striking. Achieving the same quality of health care services with fewer human resources could be an objective. Incorporating an activity-based component to the existing salary system for health professionals could be considered
	High relative income of (salaried) GPs but low relative income of specialists			Little decentralisation and rather soft constraint on public spending <i>via</i> the budget process	