

*The Icelandic
National Health Plan
to the year 2010*



The Ministry of Health and Social Security
Reykjavík 2004

The Icelandic National Health Plan to the year 2010

Carried at the Althing, 20 May, 2001

Abridged version

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Introduction

During the years 1996-2000 a committee appointed by Iceland's Minister for Health and Social Security worked on the revision of a health plan which had been in effect since 1991. This revision has taken into account the policy of WHO on Health for All and the health plans of other countries on the one hand, and the public policy and revising of many aspects of health matters in Iceland on the other.

The preliminary draft for a National Health Plan until 2010 was presented at the Icelandic National Health Care Convention in March 1999, after which it was referred for comments to health care centre directors, professionals, interest groups and other parties. Their notes and various other issues which emerged at the convention have since been incorporated into the National Health Plan.

The Committee which worked on drafting the Health Plan chose to emphasise long-term health targets aimed at improving the general state of health of the populace, and the Institute of Economic Studies was contracted to perform a cost and profit analysis of the Plan. Its main findings were that, if the Health Plan targets are attained, it should be possible to reduce the annual cost to society at large by about 7.5-15 billion Icelandic crowns. In order to achieve these targets, it is necessary in some instances to incur expenses, while in other cases the reorganisation of the system is very likely sufficient in order to attain them.

The National Health Plan will apply until 2010, but a special revision will be performed of its main targets in 2005. The Ministry of Health and Social Security will conduct the administrative implementation and revision of the targets of the Plan, and the Directorate of Health will make provisions for the collection and processing of information and professional monitoring. District physicians, health care employees and boards, as well as directors of institutions, will work towards reaching the set targets and ensure the monitoring of the implementation of the plan at a local level.

A review or report on the status and progress of the projects covered by the National Health Plan will be published annually.

History

For a variety of reasons, general policy-making in health care matters has met with difficulties in Iceland. This applies both to the drafting of long-term overall policy and to policy relating to specific parts of the health care services, such as the structure of the hospital service sector and the organisation of preventive actions and health promotion efforts. The exception to this, however, was the orientation in health care that was adopted with the Health Act in 1973.

In 1980, a draft was compiled for a comprehensive health plan covering the next few years. At the time, though, the necessary prerequisites for the implementation of this plan were not present. It was not until early 1986 that the decision was made to prepare a national plan for health care matters taking account of Icelandic circumstances and the policy of WHO on Health For All in 2000 (HFA 2000).

A proposal for a parliamentary resolution for Icelandic health policy was presented to the Icelandic parliament, the Althing, in 1987. This was subsequently revised and presented at the Health Care Convention of February 1988, presented again to parliament in the winter of 1990-1991 and finally adopted on 19 March 1991 in an altered and shortened form. The plan was intended to cover the period up to the year 2000 but was to be revised after three years.

In the late 1970s and early 1980s, most countries in Europe drew up special national plans aimed at reaching the 38 health targets set forth in Europe in 1984 in accordance with the WHO Health For All 2000 policy and the Alma Ata declaration. In 1985, Sweden became the first Nordic country to launch such a plan, followed by Finland in 1987, Norway in 1988, Denmark in 1989 and finally Iceland in 1991.

Principal aspects of the National Health Plan

The World Health Organisation revised its policy on Health for All in the year 2000. A framework for the policy regarding Health for All in the 21st century was adopted during the 51st World Health Assembly in May 1998. This framework puts strong emphasis on the assumption that health is a basic right of every individual, and in addition defines specific targets which are to remain in place until 2020. The regional boards of WHO and the governments of its member states are to elaborate on the policy, each in its respective region.

In the autumn of 1998, the regional committee of WHO in Europe adopted a health plan which in most areas covers the period until 2020, with its emphasis on 21 health targets instead of the previous 38. Its targets are better defined and more emphasis placed on statistical criteria than in the 2000 plan. The main target of the Health for All policy framework for the WHO European Region is to promote health in all the member countries to the furthest extent possible.

The two main targets of the policy framework are:

- To promote and protect the health of people during their entire lifespan.
- To reduce the incidence rate of diseases and accidents and alleviate the pain and suffering caused by them.

Three basic values form the moral foundation of the WHO European plan.

- Health as a basic human right.
- Equity to health and active collective responsibility.
- Participation and responsibility with regard to health care activities.

The four major types of activities regarding the implementation of the European plan are:

- Multidisciplinary measures
- Performance management
- Coordinated solutions
- Social participation

During the revision of the Icelandic Health Plan a decision was taken to specifically define seven priority targets until the year 2010. Apart from this, its basis is formed by the 21 targets of the WHO European plan.

The National Health Plan describes all the European targets, circumstances in Europe and in Iceland, and the specific Icelandic targets up until 2010. It also covers fields where the situation is unsatisfactory, or less clear. Furthermore, the Plan uses the appropriate type of statistical measurement tools, thereby endeavouring to present a reasonably accurate picture of the development of health care matters and of the effectiveness of the country's health care services.

The Plan covers specific factors which influence the making and implementation of health plans. Among these are trends in population growth, age composition, lifestyle and environment, the economic situation, state fiscal status, quality of health care services, social services, technological development, progress in medicine and other health care sciences, as well as a description of the general health situation and future vision for health care affairs.

During the 20th century, the organisation of health care services in Iceland was influenced by the fact that for decades there had been different legislation for two of its main components, health care and hospital services i.e. legislation regarding districts and legislation regarding hospitals. For a long time, these fields had developed in different directions, and it was not until 1973 that coordinated national legislation was passed on health care

services. This latest Health Care Plan is an effort to try and coordinate all the main fields of the health care services and ensure that their activities are aimed at common targets.

When coordinated legislation on health care services in Iceland came into force on January 1, 1974, it replaced older legislation regarding districts and hospitals. Since then, the administrative system of health care matters has been divided into three bodies; central administration, local administration and boards of institutions. In spite of a variety of alterations to health care legislation, this tripartite administration system has remained more or less unchanged.

It is considered important that health care, prevention efforts and health promotion receive appropriate status within the health care services and that the emphasis is placed on improving health and preventing disease. In order to achieve this, a coordinated effort is required on the part of the government, health care service administrators, health care professionals, special-interest organisations and non-governmental organisations. At the same time, it is important that the country's population is provided as far as possible with the appropriate diagnosis, treatment and rehabilitation services due to illness and other health-related problems.

The National Health Plan described here is based on rules on priority ranking, based on the proposals of a committee assigned with evaluating how best to rank priorities within the health care services. The Minister for Health and Social Security adopted these proposals in 1998, and has assigned the ministry and other parties within the health care system with the task of implementing them in systematic stages. Ranking will cover both the moral aspects and main targets of the health care services, as well as their organisation and policy formulation.

Priority projects of the Health Plan until 2010 cover the following seven sectors:

- Prevention of alcohol, drug, and tobacco use
- Children and adolescents
- Senior citizens
- Mental health
- Heart and brain disease prevention
- Cancer prevention
- Prevention of accidents

A special cost and profit analysis was performed on the Health Plan and the main findings were that, by attaining the targets it sets, costs to society would be reduced by approximately 7.5-15 billion Icelandic crowns per year.

The indicators by which the development of health matters is evaluated are chosen primarily in order to attain a better understanding of the status of health matters, as well as evaluating the efficiency of the health care services. This has been done because it is important not to use too many criteria at the same time in order to prevent less important items from overshadowing what is most important.

Many of the targets will require re-evaluation in the coming years, but as a whole they should provide information, or at least strong clues, as to the health status of the nation and how it is likely to develop. In endeavouring to obtain a successful outcome, a decision was made to concentrate on a few major fields, since experience shows that there is a higher probability of implementing measures in fields which have caught the attention of the public and created debate. Other related health care features and projects would then be implemented simultaneously or later on.

Implementation

The Health Plan will be in effect until the year 2010, and the supervision of its implementation rests with the Ministry of Health and Social Security in cooperation with the Directorate of Health.

Several experts, collaboration boards and health care authority committees will assist in the implementation of various aspects of the Plan, and a number of work groups appointed to work on plans for its implementation. It is imperative that close cooperation is established with hospitals, health centres, health care professionals and other relevant parties within the health care system.

Furthermore, it is important that the Health Plan is adhered to at all levels of the health care services and that it has the support of community councils, regional organisations, non-governmental organisations, professional and special-interest organisations, private companies, economic and social partner organisations, families and individuals. It must also be ensured that the policy of the state, communities and social partners in various areas of society promotes improved health in Iceland.

The establishment of the National Health Plan is not intended to reduce work on strategy or planning in various sectors of the health care system, and large projects on the status and future of institutions, specialised medicine and individuals will be continued.

It is intended to evaluate the progress of the Plan's implementation at the beginning of each year using statistical measures, or, where applicable, special evaluation. During its lifespan, reports will be published annually on its status and implementation and a thorough revision of its main aspects performed every three years.

The country's health care authorities emphasise that health institutions, health care employees and other parties within the health care services focus their operations at obtaining the targets laid out in the Plan. Increased independence and responsibility have been placed on boards and directors in the health care services, who have also been instructed to monitor the work and ensure that professional procedures based on health care and medical legislation and other instructions from the authorities are followed. Concrete measures will be taken to ensure that all these parties organise and coordinate their operations better, in order to achieve the main targets of the plan in the next few years.

Priority areas

I. Alcohol, Other Drugs and Tobacco

Main objectives

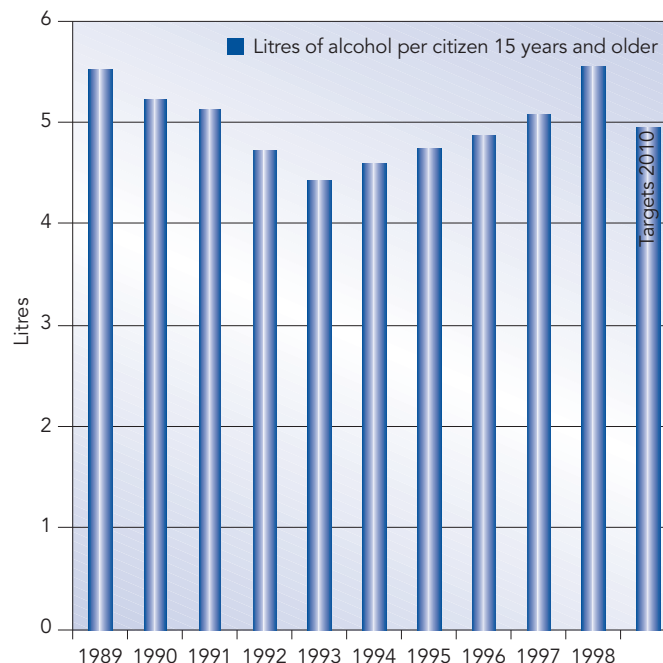
- 1.a Reduced alcohol consumption of inhabitants 15 years and older to an annual average of no more than 5,0 liter of pure alcohol and almost none under that age.
(Baseline: In 1998 the alcohol consumption was 5.56 litres per inhabitant 15 years and older).
- 1.b Reduced consumption of alcohol and other drugs of those who are under age by 25% (under 18 years).
(Baseline: According to studies from 1998 20% of pupils in the 10th grade said they had been drinking 3 - 6 times in the last 30 days before these studies were carried out and that year 16% of the pupils in same grade said they had smoked hash).
- 1.c Reduced smoking among people 18 - 69 years of age to a prevalence less than 20%.
(Baseline: In 1998 27% of males and 28% of females smoked daily)
- 1.d Reduced smoking among children and adolescents 12 - 17 years to a prevalence less than 5%.
(Baseline: In 1997 5 - 21% of adolescents 14 - 16 years smoked).

Current situation

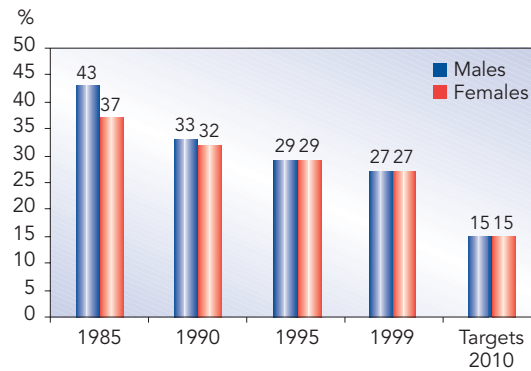
Approximately 90% of the Icelandic population over the age of 20 uses alcohol. The frequency of alcoholism in Iceland has been estimated to be in the range of 3.5-6.3%. In 1998 per capita alcohol consumption among those aged 15 years and above was 5.56 litres of pure alcohol. According to research, around 16% of pupils in the 10th grade have used cannabis. Information on the use of other illegal substances is limited.

Smoking is the main cause of several diseases and one of the major public health problems of modern-day life. Any kind of tobacco use is detrimental to health. The more a person smokes and the earlier a person starts smoking increases the harmful effects of smoking. Smoking is the main cause of 18-19% of deaths in Iceland each year. Women smoke more than men, and in some age groups the mortality rate of women due to smoking related diseases has increased in recent years. According to surveys conducted by the Tobacco Control Task Force of Iceland (TCTFI), 27% of adults in the age group 18-69 smoke on a daily basis. Smoking among children and adolescents increased again in the mid-1980s, but has decreased slightly in recent years.

Consumption of pure alcohol per capita among Icelanders aged 15 years and above

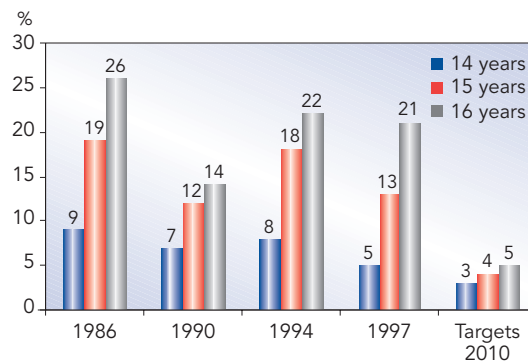


Ratio of people who smoke daily (18-69 years)



Source: Hagvangur for TCTFI 1998

Ratio of 14-16 year-olds who smoke daily



Source: Research Institute of Paedagogy and Education, Health Directorate

Methods

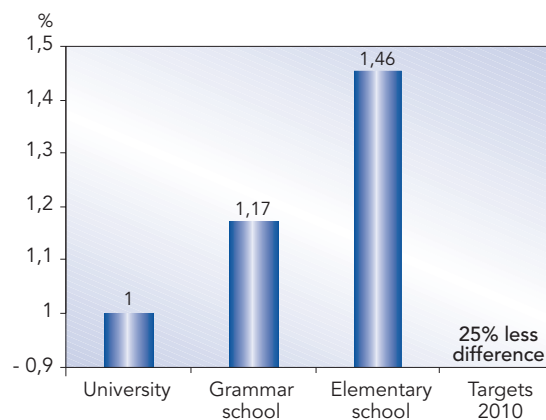
1. Education and preventive measures aimed at children, adolescents and adults.
2. Follow-up on prohibition of alcohol and tobacco advertisements, subsidising of nicotine medication and price regulation.
3. Access to treatment options for alcohol, drug and tobacco addicts should be facilitated.
4. Provide smoke-free environments as widely as possible.
5. Increase control on sale of tobacco to adolescents.
6. Systematic collection and processing of statistics on alcohol, drug and tobacco consumption among the Icelandic population as a whole, as well as specific social groups.

II. Children and Adolescents

Main objectives

- 2.a Measures should be taken to reduce by 25% health differences among children linked to social position of parents.
(Baseline: In 1991 - 1995 an index of long-term diseases among children linked to the education of the father was as follows: university education 1, secondary education 1.17 and primary education 1.47).
- 2.b Extend the psychiatric service to reach on an annual basis to at least 2% of all children and adolescents in the age group 0 - 18 years.
(Baseline: In 1997 psychiatric service covered 0,4 - 0,5% of the age group 0 - 18 years).
- 2.c Reduced by 25% accidents and accidental deaths among children.
(Baseline: In the period 1991 - 1995, 35 or 60 per 100,000 boys in the age group 1 - 14 years died an accidental death and comparable figure for girls in the same age group were 30 or 56,7 per 100,000).
- 2.d Reduced prevalence of dental caries (DMF) among 12 years old to 1,0.
(Baseline: In 1996 the DMF among 12 years old was 1,5).

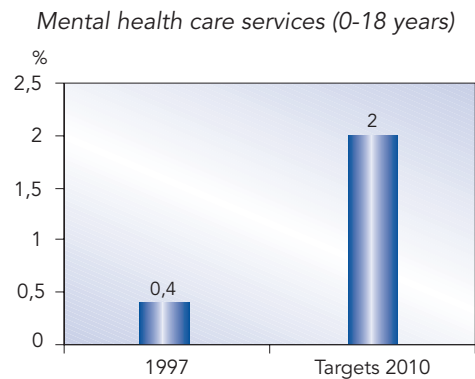
Probability of chronic diseases with regard to father's education



Source: Matthías Halldórsson, unpublished study 1998

Current situation

Icelandic society has undergone a series of fundamental changes in the last few decades which have affected the status of the family within society. Research has shown that there is a correlation between the social status of parents and the health of their children. At every school level, pupils, teachers and parents, supported by the health care services, should work systematically towards preventing substance use and promoting health. Health promotion in schools aims at turning the school into a healthy environment which encourages positive interpersonal relations. At the same time, it is also necessary to improve the ability of families to fulfil their needs and obligations. It is estimated that around 0.4-0.5% of children aged 0-18 years come under the care of the mental health services each year. Compatible figures for the other Nordic countries are up to 2%, and it is only natural that equally good services are made available in Iceland.



Source: Ministry of Health and Social Security 1997

Methods

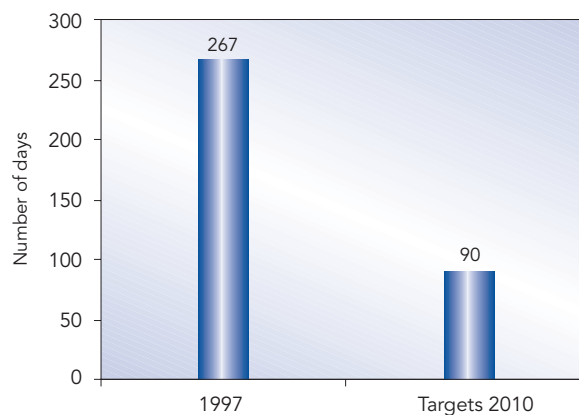
1. Provide support for families, particularly those at the lower end of the social scale.
2. Encourage schools to adopt methods of promoting health.
3. Increase the availability of mental health care services for children in general, as well as those from lower social levels.
4. Improve links between health care and mental health care services.
5. Education and measures aimed at encouraging a healthier lifestyle among children, parents and teachers.
6. Increase links between schools and mental health care services through, for instance, increased psychological services in schools.
7. Promote research on the relation between disease and social status.
8. Facilitate access for children and adolescents to dental services.

III. Older Adults

Main objectives

- 3.a Reduced waiting time for people in great need for a place in a nursing home to maximum of 90 days.
(Baseline: In 1997 the average waiting time in Reykjavík was 267 days).
- 3.b Over 75% of people 80 years and older should be in so good health that they can with an appropriate support live in their own home.
(Baseline: In 1997 28,1% of people 80 years and older were living at nursing homes and other health institutions).
- 3.c Reduced prevalence of breaking coxal and back bones by 25%.
(Baseline: In 1990 - 1992 the prevalence of beaking coxal bones was as follows (standardized by age): Females 50 years and older 327.2; Males 50 years and older 169.6).
- 3.d Over 50% of people 65 years and older should have at least 20 healthy teeth in a bite.
(Baseline: In 1990 41,6% of those in age group 45 - 54 had 10 or more upper teeth and in 1995 this proportion had risen to 58,9%).

Waiting time for available room at a nursing home in Reykjavik



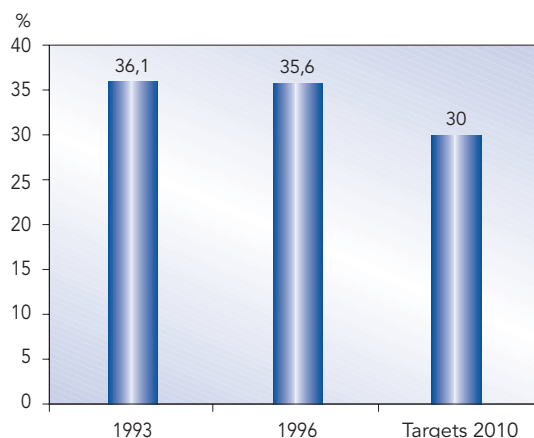
Source: Ministry of Health and Social Security and City of Reykjavik report on available nursing care measures for the senior citizens of Reykjavik, 1998

Current situation

Considerable changes are taking place in the age composition of Icelanders. It is estimated that from the mid-1990s until 2010, the overall population will grow by around 11%. At the same time, the number of people aged 65 years and over is expected to increase by 23%, and those aged 85 years and older by 45%. Around 35% of those over 80 years old currently live in facilities for senior citizens.

With the appropriate services and support it is fair to assume that more people would be able to stay longer at home. Research shows that the mean waiting time for nursing home vacancies was 267 days in Reykjavik in 1997, but the aim is to shorten it to no longer than 90 days. It is important to emphasise the need to maintain and enhance physical and mental abilities, in order for senior citizens to be able to stay as long as possible in their own homes.

Ratio of residents aged 80 years and above in institutions for senior citizens



Source: Statistics Iceland

Methods

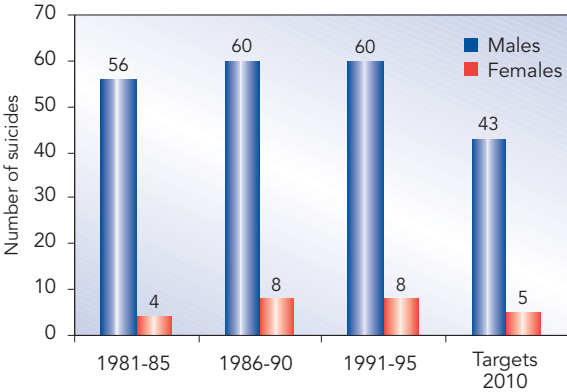
1. Health-promoting actions and increased physiotherapy and occupational therapy for senior citizens.
2. Strengthen and increase cooperation and coordination of home help, health centre home services, hospital senior citizen services, and nursing and retirement homes for elderly persons, with special emphasis on team work.
3. Coordinated evaluation of the needs of senior citizens (cf. RAI evaluation) and of the quality of service at every level will be utilised as a means of further developing treatment.
4. Increase the availability of day care, health centre home services, in which the emphasis should be on round- the-clock, 7-day service and short-term hospitalisation.
5. Good access to hospital services for senior citizens and other extra-institutional treatment options.
6. Draft clinical directions for senior citizen service teams pertaining to the specialised care of senior citizens.
7. Strive to create an equilibrium between supply and demand for nursing home vacancies.
8. Draft clinical instructions for health care services for middle-aged and younger senior citizens which would contribute to their improved health, for instance with regard to osteoporosis.
9. Strengthen dental health care for adults and senior citizens.

IV. Mental Health

Main objectives

- 4.a Reduce the prevalence of suicides by 25%.
(Baseline: In 1991 - 1995, 60 males younger than 35 years of age committed suicide and 8 females in same age group).
- 4.b Reduce the prevalence of mental disorders by 10%.
(Baseline: In 1994 was the total prevalence of mental disorders was estimated 22%).

Number of suicides among those younger than 35 years

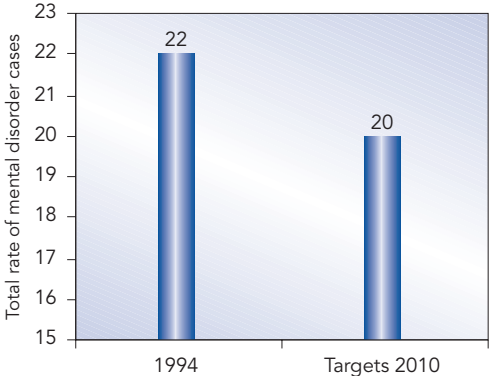


Source: Directorate for Health, 1997

Current situation

Mental illnesses and mental disorders are among the most common diseases in Iceland, resulting in more lost working hours and higher costs to society than most other disease groups. This is revealed, for instance, by the fact that more than a quarter of all those receiving full disability pensions do so due to mental disorders. The prevalence of mental disorders in Iceland is estimated at 22%. In the light of this figure it is fair to assume that around 50,000 Icelanders aged five years or older suffer from some form of mental disorder at any given time. In addition, the suicide rate among young men has been rising.

Overall ratio of mental disorders among people aged 20-59 years



Source: Directorate for Health 1998

Methods

1. The registration of mental disorders shall adhere to the same rules as the registration of other diseases.
2. Improved education, information and special training of staff with regard to mental health problems and preventive measures.
3. Public provision of information on mental health problems.

4. Access to mental health services should be facilitated and more forms of treatment made available.
5. Harmonisation of school activity and mental health care services.
6. Strengthening of preventive measures against mental disorders, in particular with regard to suicide.
7. Drafting of clinical directions pertaining to the diagnosis and treatment of mental illnesses.

V. Cardiovascular Disease and Stroke

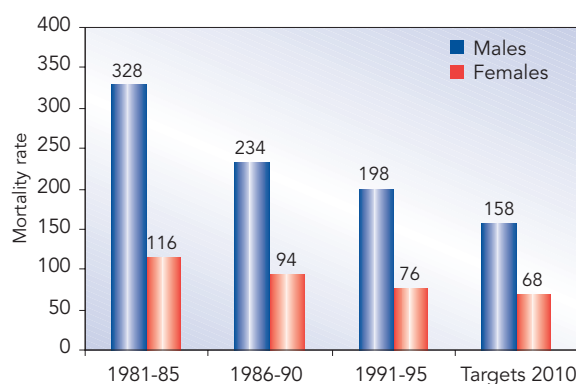
Main objectives

- 5.a Reduce cardiovascular disease deaths in the age group 25 - 74 years, men by 20% and women by 10%.
(Age-adjusted baseline: Annually in 1991 - 1995, males: 131 deaths per 100,000, and females: 76 deaths per 100,000).
- 5.b Reduce stroke events by 25%.
(Age-adjusted baseline: Annually in 1991 - 1995, males: 44,1 deaths per 100,000, and females: 30.4 deaths per 100,000).

Current situation

Over 60% of all deaths in Iceland are caused by chronic diseases, of which around 35% are cardiovascular disease. The incidence rate of cardiovascular diseases has been reduced significantly during the last two decades, both among men and women. It is not only the mortality rate which has decreased, but also new incidence rates and recurrent cases. A further decrease in mortality rates due to coronary diseases cannot be expected in the coming years, however, as the growing age of the populace weighs as much as the lowered risk factor. However, the mortality rate among people younger than 65 years can be reduced, and the incidence rate of cardiovascular diseases by the age of 70 can be reduced by 30%.

Mortality rate due to heart and cardiovascular diseases per 100,000 Icelanders aged 25-74 years



Source: Statistics Iceland

Methods

1. Education regarding healthy food, exercise and risk factors of cardiovascular diseases.
2. Actions aimed at encouraging a healthier lifestyle.
3. Regular monitoring of risk factors, such as blood pressure, blood fat levels and weight.
4. Drafting of clinical directions relating to the diagnosis and treatment of cardiovascular diseases, as well as preventive measures, particularly those regarding the treatment of high blood pressure and increased blood fat levels.

VI. Cancer

Main objectives

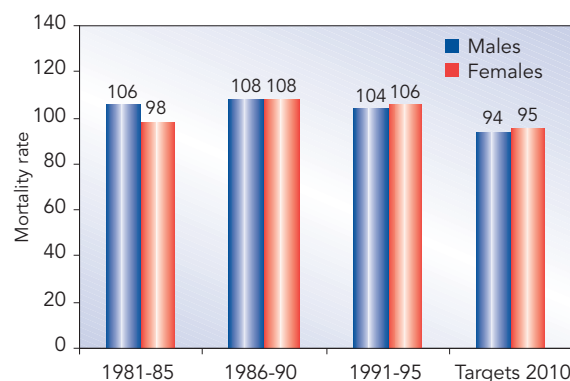
Cancer mortality rate among people younger than 75 years of age should be reduced by 10%.

(Age-adjusted baseline: Annually in 1991 - 1995, males: 104 deaths per 100,000 younger than 75 years, and females 106 deaths per 100,000).

Current situation

About one-third of Icelanders get cancer and almost a quarter die as a result. The incidence of the disease increases up to a certain age, and research indicates a relationship between lifestyle and cancer. There are also diverse carcinogenic materials in the environment. Given that the present trend continues, a rise can be expected in both the incidence rate and mortality rate of cancer exceeding the normal rise in age. There has been considerable progress in the treatment of several cancer types, so that many patients now recover fully and others are capable of living longer with the disease than before.

Mortality rate due to cancer per 100,000 Icelanders aged 75 years and below



Source: Statistics Iceland

Methods

1. Information on cancer risk factors.
2. Actions aimed at encouraging a healthier lifestyle.
3. Drafting of clinical directions pertaining to the diagnosis and treatment of cancer.
4. Systematic search for cancers and monitoring of risk factors.
5. Increase research on the relation between cancer and social status, and environmental factors.

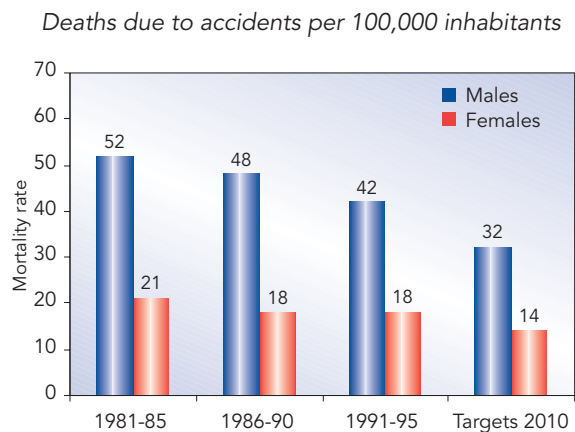
VII. Accidents

Main objectives

- 7.a Reduce accidents by 25%.
(Base line: In 1997 the total number of accidents was estimated at 60,000).
- 7.b Reduced deaths by accident by 25%.
(Baseline: Annually in 1991 - 1995, males: 42 deaths per 100,000, and females: 21 deaths per 100,000).

Current situation

Each year, approximately 60,000 accidents occur in Iceland. This is equivalent to a quarter of the populace being injured, and around 30,000 of victims require secondary treatment. Men are much more prone to accidents than women, and Iceland stands out from other countries in terms of the number of accidents in private homes. The overall cost is enormous, with traffic accidents alone accounting for an estimated 14-18 billion Icelandic crowns each year. Medical and care costs form only a fraction of this expenditure, with property, income and accident benefits the largest items. The consequences of accidents are not only loss of worktime and the financial cost to society, but also a loss of life-years, disability and human suffering. From the period 1981-1985 to the period 1991-1995 the accident-related mortality rate among men fell from 52 per 100,000 to 42 per 100,000. At the same time, fatal accidents among women decreased from 21 per 100,000 to 18 per 100,000, and experts claim that even better results can be achieved.



Source: Statistics Iceland

Methods

1. Campaigning against speeding and drink-driving, education and increasing police surveillance.
2. Improvements in driver training and facilities for practice and training.
3. Prevention of accidents to children - strive towards child environment safety.
4. Accident prevention at sea - information and security equipment.
5. Improved and coordinated registration of accidents.

Main aspects of National Health Plan until 2010

A. Collective responsibility and equity.

Target 1 - Solidarity for health in the European region

European targets

By the year 2020, the present gap in health status between Member States of the European region should be reduced by at least one third.

Icelandic targets until 2010

1. Iceland is to remain among the top five nations with the best health care services in the world, according to United Nations quality standards.
2. An amount equal to 1% of health care expenditure will be used to assist other countries in creating and developing health care services.
3. Promoting an increase in health care technology industry turnover to one-third of public expenditure on health care services.

Target 2 - Equity in health

European targets

By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups.

Icelandic targets until 2010

1. Reduce the difference in life expectancy of different social groups by at least 25%.
2. Reduce the difference in accessibility for citizens in different areas of the country to health care services.
3. Ensure that persons who have difficulties in preserving their rights due to youth, disability or old age enjoy the same rights as others.

B. Improved health

Target 3 - Healthy start in life

European targets

By the year 2020, all newborn babies, infants and pre-school children in the Region should have better health, ensuring a healthy start in life.

Icelandic targets until 2010

1. Infant mortality shall be less than 3 per 1,000 births.
2. Reduce accidents and accidental deaths among children by 25%.
3. Adhere to the instructions of the Directorate for Health regarding regular evaluation of the mental, physical and social development of children aged 0-6 years.

Target 4 - Health of young people

European targets

By the year 2020, young people in the Region should be healthier and better able to fulfil their roles in society.

Icelandic targets until 2010

1. Reduce alcohol and narcotic use among young people by 25%.
2. Reduce smoking among young people by 50%.
3. Reduce injuries and fatal accidents among young people by 25% .
4. Reduce unwanted pregnancies among girls aged 19 years of age or less by around 50%.

Target 5 - Healthy aging

European targets

By the year 2020, people over 65 should have the opportunity of enjoying their full health potential and playing an active social role.

Icelandic targets until 2010

1. More than 70% of citizens over the age of 80 will retain their health to the extent that they can with the appropriate support services, continue to live in their homes and participate in daily life.
2. At least 85% of senior citizens will be inoculated every year against influenza and every 10 years against the pneumonia bacteria.
3. Regular health inspections and monitoring of citizens 65 years and older and assessments of how they evaluate their own health.
4. Waiting time for nursing homes for people in dire need will be no longer than 90 days.

C. Preventive measures and health care

Target 6 - Improving mental health

European targets

By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems.

Icelandic targets until 2010

1. Reduce the frequency of mental disorders by 10%.
2. Reduce the frequency of suicides by 25%.
3. Mental health services shall reach 2% of children and adolescents in the age group 0-18 years, regardless of domicile.
4. Access to mental health services should be facilitated and more treatment options made available.

Target 7 - Reducing communicable diseases

European targets

By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance.

Icelandic targets until 2010

1. Maintain powerful preventive measures against communicable diseases through immunisation efforts.
2. Rubella and mumps will be eradicated.
3. Reduce the incidence of chlamydia by 50%.
4. Improve and increase surveillance of communicable diseases through systematic registration, concrete measures and cooperation with foreign parties.
5. Reduce bacteria immunity against antibiotics.
6. Increase information and education efforts aimed at the general population and professionals on epidemics and the containment of such diseases.

Target 8 - Reducing non-communicable diseases

European targets

By the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the Region.

Icelandic targets until 2010

1. Cardiovascular mortality rate in the age-group 25-74 will be reduced by 20% in men and 10% in women.
2. Cancer mortality rate of people younger than 75 years will be reduced by 10%.
3. Systematically reduce by one-third illnesses, disability and mortality rate due to respiratory system diseases.

Target 9 - Reducing injury from violence and accidents

European targets

By the year 2020 there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the Region.

Icelandic targets until 2010

1. Mortality rate and disabilities due to traffic accidents will be reduced by at least 25%.
2. Mortality rate and disabilities due to workplace, domestic and school accidents will be reduced by 25%.
3. Reduce the incidence and mortality rate due to domestic violence, sexually related violence and other types of violence by 25%.

D. Multidisciplinary measures

Target 10 - A healthy and safe physical environment

European targets

By the year 2015, people in the Region should live in a safer physical environment, with exposure to contaminants hazardous to health at levels not exceeding internationally agreed standards.

Icelandic targets until 2010

1. Funds for health care research will be doubled.
2. A national plan will be produced for environmental and health care issues (NEHAP).
3. Systematic evaluation will be performed on a regular basis on the effect of environmental factors and working conditions on health.

Target 11 - Healthier living

European targets

By the year 2015, people across society should have adopted healthier patterns of living.

Icelandic targets until 2010

1. Promote the consumption of as varied foodstuffs as possible, where the ratio of fat consumption by adults is between 25-35% of energy, as laid out in the targets of the Icelandic Nutrition Council.
2. Promote significantly increased consumption of vegetables and fruit to bring them in line with the targets set by the Icelandic Nutrition Council, at least five portions per day.
3. The great majority of people shall be active in their leisure time, participating in appropriate physical exercise equivalent to a 30 minute walk at least five times a week.
4. Every child attending compulsory school classes shall receive health care education equivalent to one lesson per week during each school year.

Target 12 - Reducing harm from alcohol, drugs and tobacco

European targets

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States.

Icelandic targets until 2010

1. The proportion of smokers in the age group 18-69 will be less than 15% and less than 5% among children and adolescents aged 14-17.
2. Alcohol consumption shall be less than 0.5 litres of pure alcohol per year per person aged 15 years and above, and practically non-existent among those who are younger.
3. The use of illegal drugs should be reduced by at least 25% and the mortality rate due to such drugs reduced by at least 50%.

Target 13 - Settings for health

European targets

By the year 2015, people in the Region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.

Icelandic targets until 2010

1. At least 95% of schoolchildren should receive systematic education and training in health promotion.
2. At least 50% of cities, towns and other communities shall have set targets in the field of health promotion.
3. At least 20% of large and medium-sized companies shall have committed themselves to encourage health promotion among their staff.

Target 14 - Multisectoral responsibility for health

European targets

By the year 2020, all sectors should have recognised and accepted their responsibility for health.

Icelandic targets until 2010

1. Legislation shall provide for and ensure that every sector of society bears responsibility in health care matters.
2. Systematic environmental evaluation will be performed on the possible effects of every major industrial development project, work project and social action on the health of the public.
3. Projects in the fields of education, information and research shall be aimed to a greater extent towards increasing awareness among all individuals of their collective responsibilities in health matters.

E. Effective health care services

Target 15 - An integrated health sector

European targets

By the year 2010, people in the Region should have much better access to family and community-oriented primary health care, supported by a flexible and responsive hospital system.

Icelandic targets until 2010

1. Operation of the health care system will become increasingly based on teamwork and continuity of service.
2. Health care services outside as well as inside institutions will adhere to harmonised working procedures.

Target 16 - Managing for quality of care

European targets

By the year 2010, Member States should ensure that the management of the health sector, from population-based health programmes to individual patient care at the clinical level, is oriented towards health outcomes.

Icelandic targets until 2010:

1. Every health care institution should develop tools for measuring efficiency and use them or other accepted databases as a means of evaluating their work.
2. Every health care institution should establish a formal quality development procedure and follow its own plans in quality issues.
3. Over 90% of patients should be satisfied with the health care services they receive.

Target 17 - Funding health services and allocating resources

European targets

By the year 2010, Member States should have sustainable financing and resource allocation mechanisms for health care systems, based on the principles of equal access, cost-effectiveness, solidarity, and optimum quality.

Icelandic targets until 2010

1. Service contracts running for three years at a time will be concluded with all health care institutions in the country.
2. The development of expenditure for health care services will not be less than the annual growth of national income.

Target 18 - Developing human resources for health

European targets

By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health.

Icelandic targets until 2010

1. The manpower needs of the health care services shall be estimated annually for a period of 5-10 years.
2. Access to study for health care related professions shall take into account the manpower needs of the health care services.
3. Health care curriculum shall take into account the health needs of the populace and the implementation of the National Health Plan.

F. Research, cooperation and work plans

Target 19 - Research and knowledge for health

European targets

By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilisation, and dissemination of knowledge to support health for all.

Icelandic targets until 2010

1. Expenditure on research and development projects shall be at least 2% of total expenditure on health care.
2. Around 3-5% of annual health care institution expenditure will be used to purchase and update computers, medical devices and other equipment.

Target 20 - Mobilising partners for health

European targets

By the year 2005, implementation of policies for health for all should engage individuals, groups and organisations throughout the public and private sectors, and civil society, in alliances and partnerships for health.

Icelandic targets until 2010

1. Work towards widespread participation within society in the implementation of the policies of WHO and the Icelandic National Health Plan.
2. Systematically investigate the manner in which each sector of society or field of work can contribute to improving the health of the nation.

Target 21 - Policies and strategies for health for all

European targets

By the year 2010, all Member States should have and be implementing policies for health for all at country, regional and local levels, supported by appropriate institutional infrastructures, managerial processes and innovative leadership.

Icelandic targets

1. The strategic and administrative system of health care will be reviewed with regard to WHO policy making and the implementation of the National Health Plan.
2. Further short-term and long-term targets, measuring tools and priorities will be developed within the health care services, along with actions and methods of reaching set targets as laid out in the report on priority ranking.
3. Decisions shall be made as to the division of health care tasks between the state, private sector, and communities.

Carried at the Althing, 20 May, 2001.