To: Alma Möller, Minister of Health in Iceland
Subject: Call for the Abolition of User Fees and Improved Physical Access to Opioid Agonist Treatment (OAT)

Reykjavík, 20 February 2026

Dear Minister of Health, Alma Möller,

Rótin hereby calls on the Ministry to urgently review the current arrangements for opioid agonist treatment (OAT), both with regard to user fees and the physical accessibility of the service.

In Iceland, individuals receiving medication-assisted treatment for opioid dependence (e.g., Buvidal or Suboxone) are required to pay for physician consultations. A portion of this group lacks the financial means to do so and therefore drops out of treatment, increasing the risk of relapse, overdose, infections, and personal-social deterioration. In addition, the location of the service on the outskirts of the city creates further barriers to physical access.

1. User Fees and Financial Accessibility

It is clear that access to harm-reduction-oriented maintenance treatment provided by SÁÁ does not meet the standards of the low-threshold, harm-reduction service it is intended to be. Too often, individuals are forced out of treatment because they cannot afford consultation fees or due to limited physical access. The consequences are serious and foreseeable, including an increased risk of overdose and death.

Staff members of Rótin, at Konukot, have observed this issue directly, and staff from other services for homeless individuals have also contacted the organization regarding this concern.

Article 65 of the Constitution of the Republic of Iceland guarantees equality before the law. However, equality does not require identical fees for all; rather, different circumstances must be treated in a reasonable and just manner. If fee arrangements have exclusionary effects on a marginalized group, there is a risk that formal equality may result in substantive discrimination.

Under Article 76 of the Constitution and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the State is obligated to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." General Comment No. 14 (2000)[1] specifies that health services must be accessible without discrimination and economically accessible (para. 12(b)(iii) and para. 18), with particular emphasis on protecting marginalized populations.

In the 2024 report of the UN Special Rapporteur on the right to health (A/79/177)[2], harm reduction is defined as part of the normative content of the right to health. States are required to ensure that harm-reduction services are accessible without exclusionary barriers and that substantive equality requires targeted measures to secure real access for vulnerable groups.

Opioid agonist treatment is an evidence-based, life-saving health service. Under Article 2 of the European Convention on Human Rights (cf. Act No. 62/1994)[3], the State has a positive obligation to take reasonable measures to protect life where a foreseeable risk exists. Arrangements that lead to treatment dropout due to financial barriers may engage these obligations.

For these reasons, user fees in opioid agonist treatment are incompatible with the requirements of substantive equality and real access to health care.

[1] https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf
[2] https://docs.un.org/en/A/79/177
[3] https://www.althingi.is/lagas/nuna/1994062.html

2. Physical Accessibility and Low-Threshold Services

The current location of OAT services at Vogur, on the outskirts of Reykjavík, creates significant access barriers. According to General Comment No. 14, the right to health also includes physical accessibility (para. 12(b))[4], meaning that services must be within safe and reasonable reach for all, particularly marginalized groups.

International best practice in harm reduction and opioid treatment (WHO, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*)[5] emphasizes community-based and integrated services located close to where need is greatest, in order to ensure continuity of care and minimize barriers such as long travel distances.

The current arrangement also results in Reykjavík City's VoR outreach team spending considerable time transporting individuals to treatment. This reduces the team's capacity for other necessary outreach work and underscores that the service is not organized according to low-threshold harm-reduction principles, whereby the system adapts to people's circumstances—not the other way around.

This reflects what Thomas Kattau, in his review of the Icelandic treatment system, refers to as a "programme-centred model,"[6] in which users must adapt to the service offered, rather than a "patient-centred or patient-led model," which promotes long-term treatment outcomes and broader societal benefits.

3. Recommendations

In light of the above legal and human rights considerations, we recommend that:

1. User fees for opioid agonist treatment be abolished without delay.
2. The location and organization of the service be reviewed to ensure genuine physical accessibility and alignment with international standards for low-threshold harm-reduction services and the right to the highest attainable standard of health.
3. Since OAT is already available for a narrowly defined group at the outpatient clinic for psychiatric and addiction services at Landspítali National University Hospital (LSH), a straightforward solution would be to expand that service to a broader group and abolish user fees, as has been done within the Laufey Community Service outreach services for people with severe mental illness and/or long-term substance use disorders.

The current arrangement does not meet the requirements of substantive equality, financial and physical accessibility, or the State's positive obligations under the Constitution and Iceland's international human rights commitments. Nor is it consistent with the overarching goal of Iceland's health policy to provide the right service in the right place.

Respectfully,
On behalf of Rótin,

Kristín I. Pálsdóttir
Spokeswomen

[4] https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf
[5] https://www.who.int/publications/i/item/9789241547543
[6] https://www.stjornarradid.is/library/04-Raduneytin/Heilbrigdisraduneytid/ymsar-skrar/Review%20of%20treatment%20services-%20T%20Kattau.pdf

Appendix – Financial Barriers in Opioid Agonist Treatment (OAT): European Examples[7]

Other European countries have organized OAT in ways that reduce treatment dropout due to financial barriers:

1. Norway – No User Fees in Specialist Services

- OAT is part of the public specialist health service.
- Substance use treatment is generally provided without user fees.
- Low-threshold outpatient clinics (e.g., LASSO)[8] are specifically designed to retain marginalized groups in treatment.

Lesson: When consultations and follow-up are free of charge, the risk of dropout due to financial hardship decreases.

2. Finland – OAT Free of Charge in Specialized Units

- OAT is provided without direct user fees within public OAT units.
- Long-acting buprenorphine (comparable to Buvidal) is included.

Lesson: Systematic implementation within public services ensures that ability to pay does not determine access.

3. United Kingdom – NHS Model ("Free at the Point of Use")

- OAT is part of NHS health services.
- Treatment is generally not subject to direct payment for physician consultations.
- Emphasis is placed on accessibility and continuity of care.

Lesson: When treatment is integrated into a tax-funded health system, prescriptions and monitoring do not become financial barriers.

4. France – General Practitioner Model + Full Reimbursement

- General practitioners play a central role in buprenorphine treatment.
- Opioid dependence is classified as a chronic illness eligible for 100% reimbursement.
- Broad access reduces marginalization.

Lesson: When treatment is both decentralized (GP model) and financially secured, dropout decreases.

Conclusion

In these countries, systems are designed so that:

- Access to prescriptions and monitoring is not dependent on ability to pay.
- OAT is defined as essential health care.
- Low-threshold services are integrated into the funding structure.

If the goal is to reduce dropout from harm-reduction treatment in Iceland, comparative evidence suggests that key measures include:

- Abolishing user fees for OAT-related physician consultations; or
- Ensuring full public reimbursement for this defined group; or
- Establishing a dedicated, inclusive low-threshold service without financial barriers.

[7] https://www.tandfonline.com/doi/full/10.1080/17425247.2024.2369756#abstract
[8] https://pubmed.ncbi.nlm.nih.gov/30466108/