

## HEALTH POLICY 101

# International Comparison of Health Systems

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[Health Care Costs and Affordability](#)

[The Regulation of Private Health Insurance](#)

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# Introduction

Every health system aims to provide accessible, high-quality care that improves health outcomes at an affordable cost. One way to assess the performance of the United States' health system is to benchmark it against health systems in similar countries.

Comparing health system performance internationally is complicated, though, as each country has unique political, economic, and social conditions. Because health spending and health outcomes are often correlated with a country's wealth, this chapter focuses on comparisons of the U.S. to other large and wealthy OECD nations: Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the United Kingdom.

Despite spending far more money than any peer nation, Americans live shorter lives and often face more barriers to care. Some of this disparity can be attributed to aspects of the U.S. health system, but socioeconomic and other factors also play a role.

## How Do Health Insurance Systems and Coverage in the U.S. Compare to Other Countries?

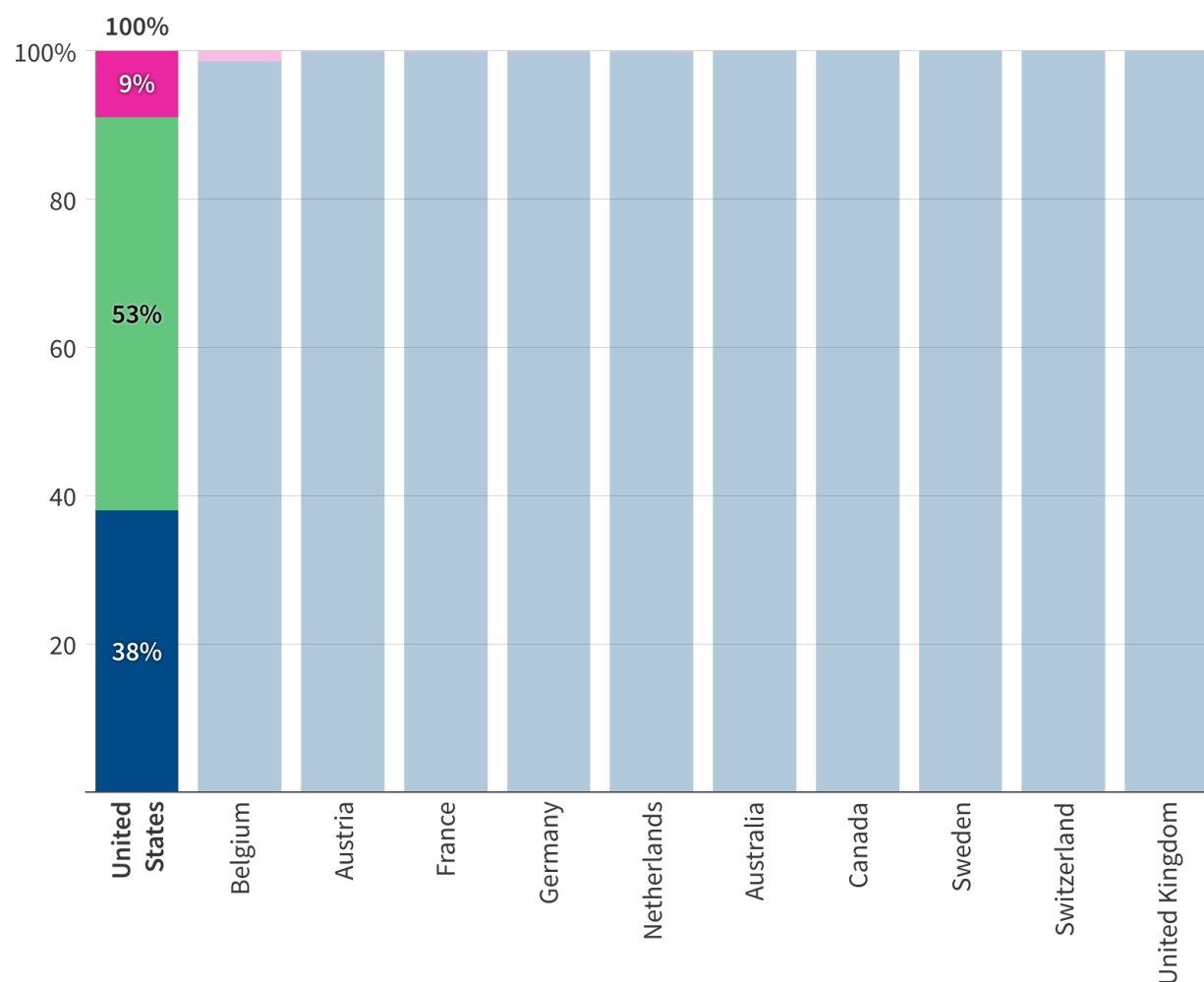
From the late nineteenth to mid-twentieth centuries, many nations created health insurance systems that aimed to make health care accessible and affordable to all residents. Some countries, like the United Kingdom, have health systems that are largely publicly funded and operated, while other countries, like Switzerland, have a compulsory private insurance system. Many countries' health systems include a mix of private and public insurance. Regardless of the financing mechanism, the health systems in all countries that are similarly large and wealthy as the U.S. are largely compulsory, resulting in universal or near-universal health coverage.

During this same period, the United States took a different approach, relying on a largely *voluntary* private insurance system that resulted in a substantial share of the population being uninsured. Despite decades of calls for a national public health insurance program, it was not until 1965 that two major public insurance programs were created – Medicare for adults age 65 or older and Medicaid for low-income people – and it was not until the Affordable Care Act passed in 2010 that the U.S. health system was overhauled to create near-universal eligibility for health insurance coverage for lawfully present residents. Even so, the U.S. health system is still largely voluntary and millions of people continue to go without insurance, often [citing cost as a barrier](#).

Figure 1

## Population by Health Insurance Coverage Status and Coverage Type, 2021

■ Compulsory health insurance coverage ■ Primary voluntary health insurance (VHI) coverage ■ No Coverage



Note: "Primary voluntary" indicates that private voluntary insurance is an individual's only source of coverage. Totals may not sum to exactly 100% due to rounding.

Source: Organisation for Economic Co-Operation and Development

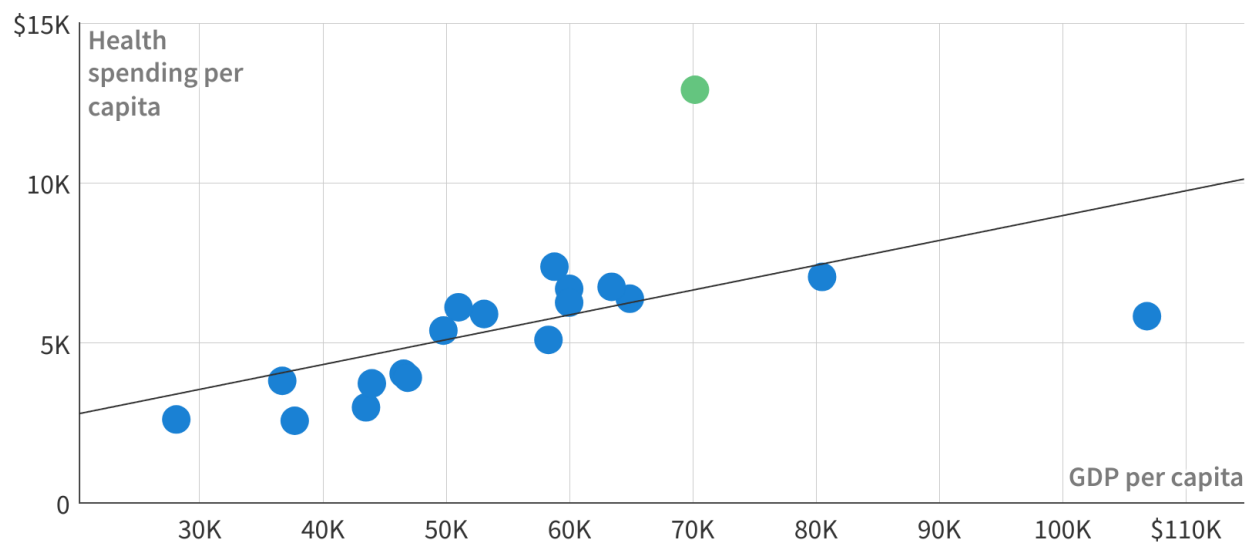
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# How Does Health Spending in the U.S. Compare to Other Countries?

Wealthy countries, including the U.S., tend to spend more per person on health care and related expenses than lower-income countries. However, even among higher-income countries, the U.S. spends far more per person on health.

Figure 2

## GDP Per Capita and Health Consumption Spending Per Capita, 2021 (U.S. Dollars, PPP Adjusted)



Note: U.S. value obtained from National Health Expenditure data. For all other countries except the United States, health spending per capita is provisional. GDP per capita data for France, Germany, Korea, Netherlands, and Portugal are all provisional. Data from Canada represents a difference in methodology from the prior year. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of National Health Expenditure (NHE) and OECD data

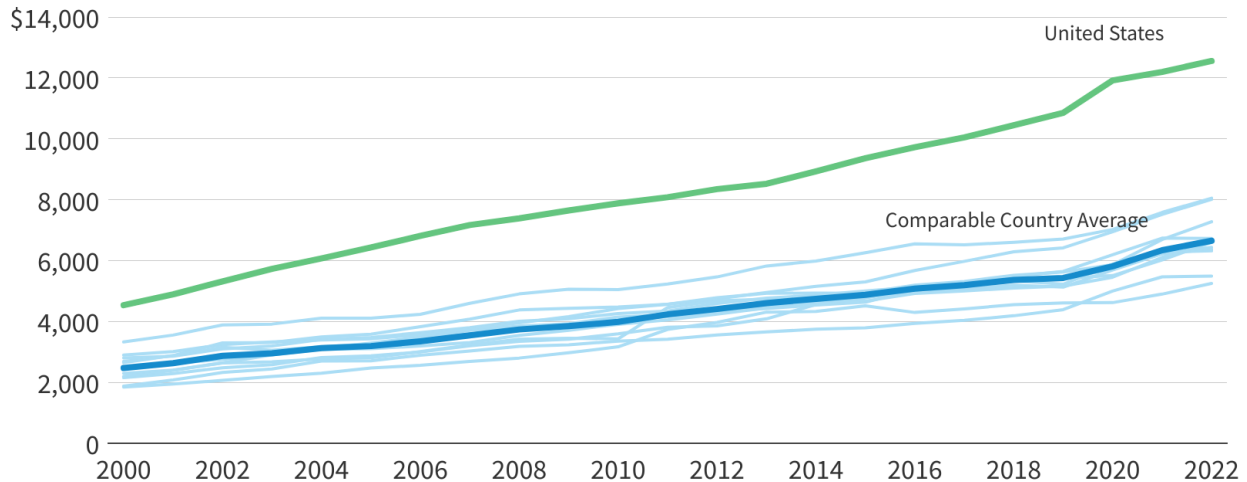
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## Spending Growth

Over the past five decades, the health spending gap between the U.S. and peer nations has widened. In 1970, the U.S. spent about 7% of its GDP on health, similar to spending in several comparable countries (the average of comparably wealthy countries was about 5% of GDP in 1970). The U.S. was relatively on pace with other countries until the 1980s, when health spending in the U.S. grew at a significantly faster rate relative to its GDP.

Figure 3

### Total Health Spending Per Capita, U.S. and Peer Nations, 2000-2022



Source: Organisation for Economic Co-operation and Development

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The COVID-19 pandemic led to both an increase in health spending and an economic downturn resulting in higher health spending as a share of the GDP in the U.S. and every comparable country between 2019 and 2020. In 2020, the U.S. spent 19.7% of its GDP on health consumption (up from 17.6% in 2019). In 2021, health spending as a share of GDP declined to 18.3% in the U.S.—but remains substantially higher than in peer countries.

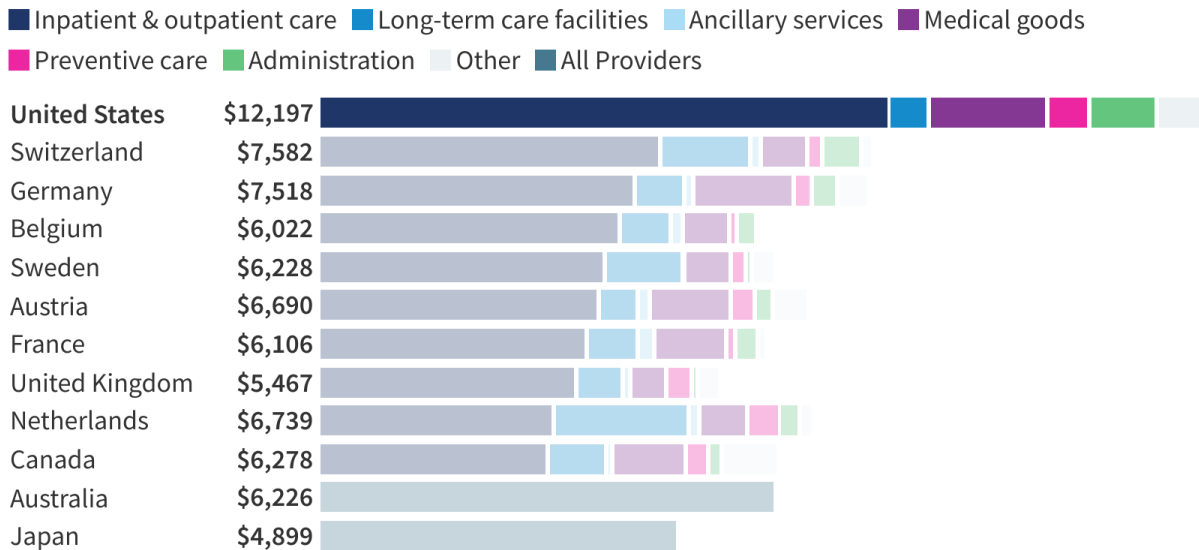
## Drivers of Health Spending

The largest category of health spending in both the U.S. and comparable countries is spending on inpatient and outpatient care, including payments to hospitals, clinics, and physicians for services and fees such as primary care or specialist visits, surgical care, provider-administered medications, and facility fees. Americans spent \$7,500 per person on inpatient and outpatient care, compared to \$3,851 in peer countries, on average. The U.S.'s higher spending on providers is driven more by higher prices than higher utilization of care. Patients in the U.S. have [shorter average](#) hospital stays and [fewer physician visits](#) per capita, while many [hospital procedures](#) have been shown to have higher prices in the U.S. Higher spending on inpatient and outpatient care drives most of the difference in health spending between the U.S. and its peers. In fact, the U.S. spends more on inpatient and outpatient care than most peer nations spend on their entire health systems (including long-term care, prescription drugs, administration, prevention, and other services).



Figure 4

## Health Spending Per Capita, U.S. Dollars, 2021



Note: Total per capita spending for Australia and Japan is not broken out by service due to lack of available data. Countries have varying definitions and methods for identifying and categorizing health care spending, which reduces comparability across countries, particularly for spending within the specific categories.

Source: Organisation for Economic Co-Operation and Development

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Prescription drugs are another factor partially explaining the U.S.'s higher health spending. Many prescription drugs [cost more](#) in the U.S. than the same drugs do in other comparable nations. In 2021, the U.S. spent \$1,635 per capita on prescription drugs and other medical goods (including over-the-counter and clinically delivered pharmaceuticals as well as durable and non-durable medical equipment). However, because prescription drugs represent a relatively small share of total health spending, even if per capita prescription drug spending in the U.S. was lowered to be closer to that of comparable countries, that would make only a small dent in the overall difference in health spending.

Spending on health administration is similarly much higher in the U.S. than in comparable countries: \$925 per capita. Administrative costs include spending on running governmental health programs and overhead from insurers, but exclude administrative expenditures from health care providers. This includes administrative [spending](#) for private health insurance, governmental health programs (such as Medicaid and Medicare) as well as other third-party payers and programs.

The U.S. also spends more on preventive care than peer nations. Activities captured in this spending category vary amongst countries, but in the U.S., it generally consists of public health activities, including preventive health programs and education for immunizations, disease detection, emergency preparedness, and more. The



growth in preventive care spending between 2019 and 2021 is notable, considering the 2020 emergence of the COVID-19 pandemic. In the U.S., preventive care spending more than doubled between 2019 and 2020, from \$343 to \$741 per capita, but subsequently declined to \$589 in 2021.

## **How Do Health Outcomes in the U.S. Compare to Other Countries?**

### **Life Expectancy**

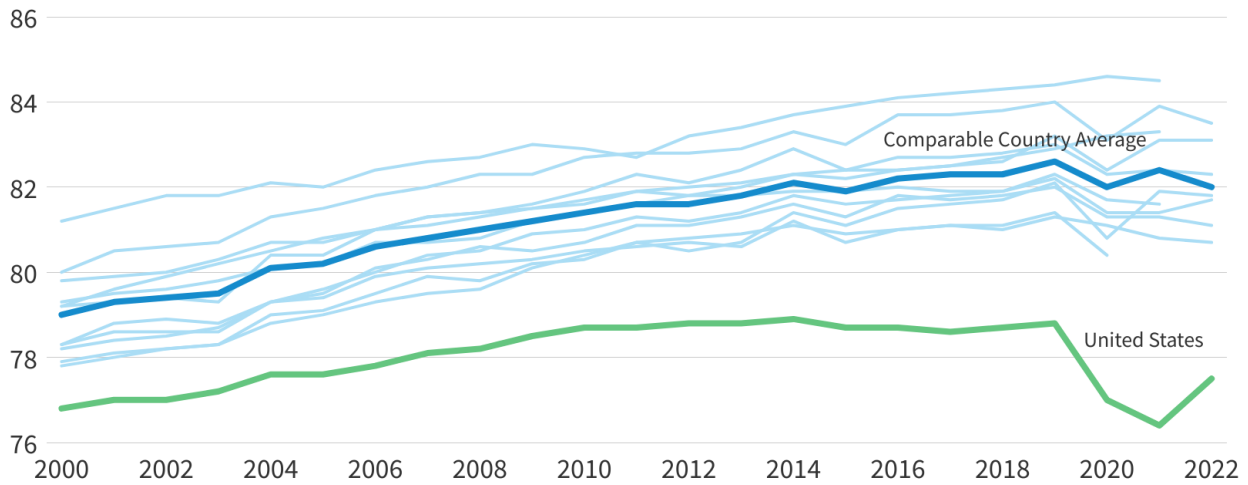
Life expectancy is one of the most common measures of health outcomes. In 1980, the average American could expect to live 73.7 years—a similar life expectancy to residents of most wealthy countries. However, in subsequent years, life expectancy continued growing in most other nations at a pace far beyond that of the U.S.

In 1996, Japan became the first nation to report an average life expectancy of 80 years among its population. By 2012, all peer countries had also achieved this milestone. This same year, life expectancy in the U.S. was 78.5 years and began a decade-long plateau. By 2019, the life of the average U.S. resident would be almost four years shorter than the life of the average resident of these comparable wealthy nations (78.8 vs. 82.7 years).

This plateau and four-year gap was already highly concerning, but the health crisis brought on by the COVID-19 pandemic made the situation in the U.S. much worse. Life expectancy dropped, by nearly two years from 78.8 in 2019 to 77.0 in 2020, for the first time ever recorded. The pandemic was not unique to the United States, but this stunning life expectancy drop was – the average comparable nation saw a decline of less than half a year (82.7 to 82.3). In 2021, the situation became even more extreme. Life expectancy in comparable nations saw a small rebound to 82.5 years, but the U.S. saw another drastic decrease to 76.1 years. In 2022, life expectancy rebounded to 77.5 years, still 1.3 years below pre-pandemic levels and almost five years below the average among peer nations.

Figure 5

## Total Life Expectancy at Birth, U.S. and Peer Nations, 2000-2022



Source: Organisation for Economic Co-operation and Development

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The life expectancy data presented here are period life expectancy estimates based on excess mortality observed in each year. Period life expectancy at birth represents the mortality experience of a hypothetical cohort if current conditions persist into the future and not the mortality experience of a birth cohort.

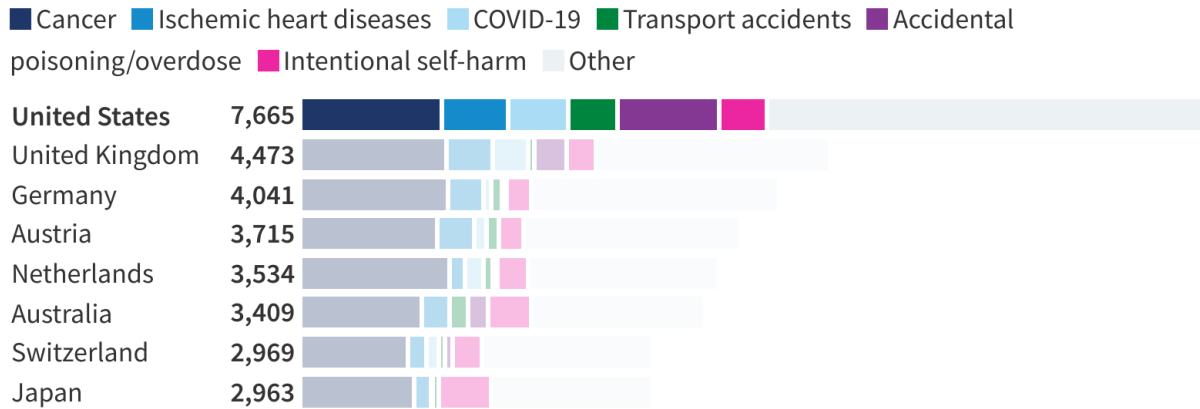
## Years of Life Lost

The causes of this decrease in life expectancy are multifaceted. When people die before a certain age, the difference between their age at death and the specified age is recorded as life years lost. For example, when looking at years of life lost before age 75, a person who dies at age 60 would be considered to have lost 15 years of life. Examining the causes of these years of life lost can point to the specific factors driving life expectancy down.

The United States has the highest rate of years of life lost by a large margin per 100,000 population aged 75 years old in 2020. However, examining the cause of these years of life lost makes it possible to notice where the U.S. underperforms compared to these other countries. For example, the U.S. has a significantly higher rate of years of life lost due to heart disease, transport accidents, and accidental poisoning (a category that includes drug overdose) than these other nations.

Figure 6

## Years of Life Lost per 100,000 Population Age 75 Years Old, 2020



Source: Organisation for Economic Co-Operation and Development

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While cancer is a common cause of premature years of life lost in the United States, most other countries have a similar rate of years of life lost due to cancer in the same population. This indicates that cancer is not a main cause of the discrepancy between the U.S. and peer nations.

Overall, the United States' higher rates of [premature death](#) and [disease burden](#) do not necessarily reflect entirely on the quality of care that patients receive in doctor's offices or hospitals. Life expectancy, mortality rates, and disease burden can also be influenced by factors that are largely outside of the control of the health system, like [socioeconomic conditions](#) (e.g. income inequality, structural racism) and differences in health-related behaviors (e.g. diet, exercise, drug use). Children and teens in the U.S. are less likely to make it to adulthood than in peer countries, with the U.S. having higher rates of motor vehicle accidents, firearm deaths, and suicide deaths among children and teens.

## How Does Quality of Care in the U.S. Compare to Other Countries?

Another, more direct way to measure the performance of the health system is to examine the quality of care provided in a hospital or clinical setting. However, inconsistent and imperfect quality metrics make it difficult to compare quality of care in the U.S. and its peers.

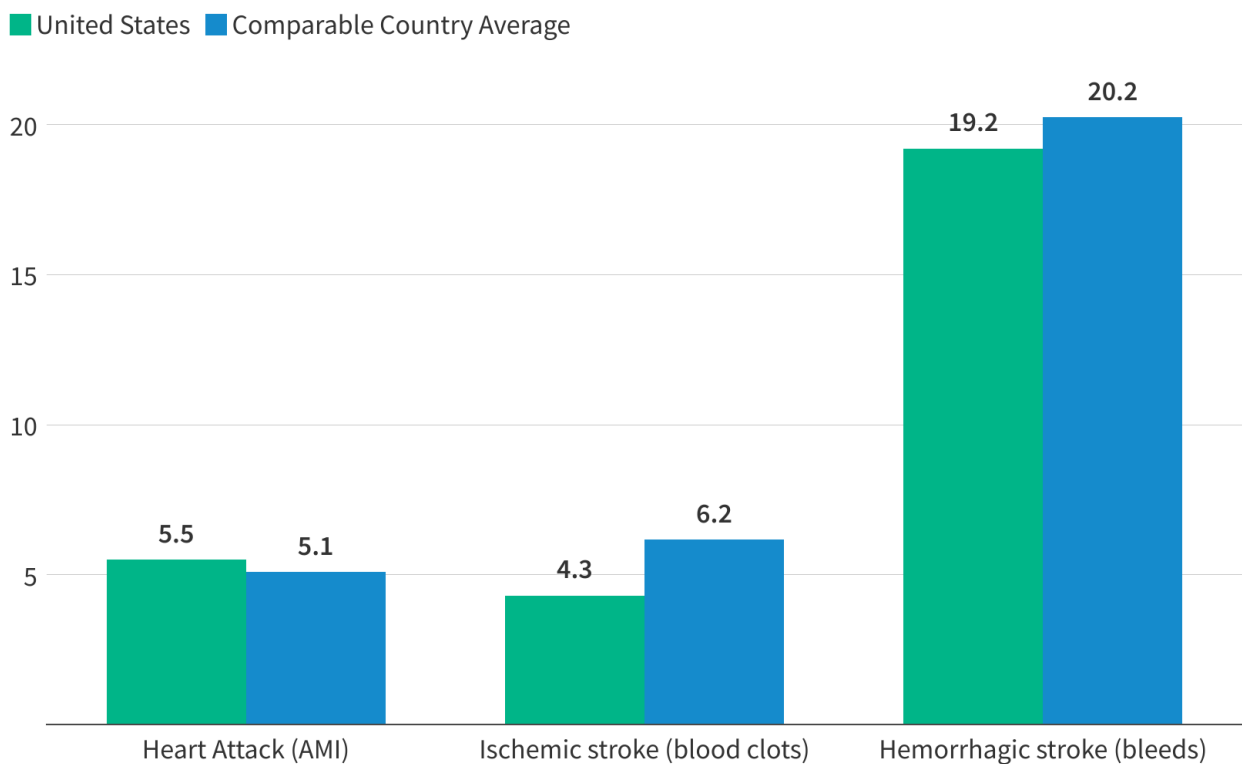
In comparison to peer nations, across the limited measures available internationally, the U.S. performs better on some and worse on other indicators of quality of care. For example, the U.S. performs worse on certain measures of treatment outcomes (such as maternal mortality) and some patient safety measures (such as

obstetric trauma with instrument and medication or treatment errors). The U.S. performs similarly to or better than peer nations in other measures of treatment outcomes (such as mortality rates within 30 days of acute hospital treatment) and patient safety (such as rates of post-operative sepsis).

## Hospital Mortality Rates

Figure 7

### Age-Standardized 30-Day Mortality Rate per 100 Patients After Admission to the Hospital for Acute Myocardial Infarction, Ischemic Stroke, and Hemorrhagic Stroke, Ages 45 and Older, 2020



Note: Comparable countries include Australia, Austria, Belgium, Canada, Japan, the Netherlands, Sweden, and the U.K. Data for France, Germany, and Switzerland are not available. AMI stands for acute myocardial infarction. Data is unlinked.

Source: KFF analysis of OECD data

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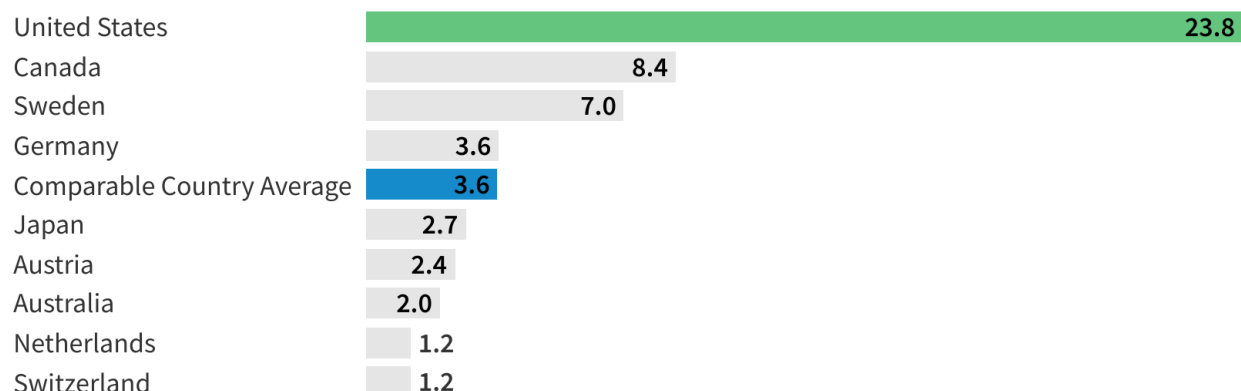
Mortality within 30 days of being admitted to a hospital is not entirely preventable, but high quality of care can reduce the mortality rate for certain diagnoses. The 30-day mortality rates after hospital admissions for heart attacks (acute myocardial infarction) and hemorrhagic stroke (caused by bleeding) are similar in the U.S. and comparable countries average. The 30-day mortality rate for ischemic strokes (caused by blood clots) was 4.3

deaths per 100 patients in the U.S. in 2020, compared to an average of 6.2 deaths per 100 patients in similar countries. While the U.S. has lower mortality rates due to these conditions than the average across peer nations, it is important to note that several peer nations have lower rates than the U.S.

## Maternal Health

Figure 8

### Maternal Mortality Rate per 100,000 Live Births, 2020



Note: Data for Belgium, France, and the U.K. are not available.

Source: KFF analysis of OECD data

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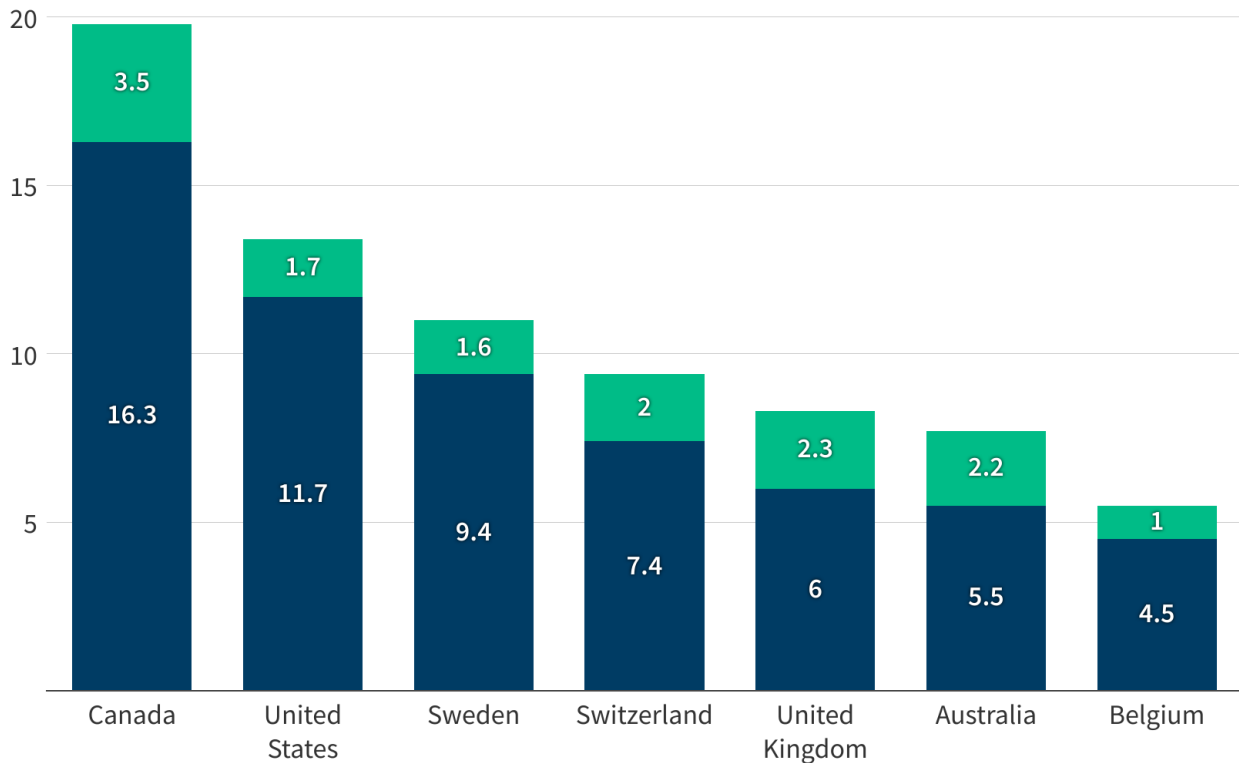
While wealth and economic prosperity are highly correlated with lower maternal mortality rates, the U.S. is an outlier with the highest rate of pregnancy-related deaths (23.8 deaths per 100,000 live births in 2020) when compared to similar countries (3.6 deaths per 100,000 live births).

Within the U.S., there are significant racial disparities in maternal mortality rates. The maternal mortality rate for Black mothers is about three times the rate for White mothers — a disparity that persists across age and socioeconomic groups. Every race and ethnicity, socioeconomic, and age group in the United States sees higher maternal mortality rates than the average in comparable countries. Maternal mortality in the U.S. has risen in recent years, sparking concern from the medical community and policymakers.

Figure 9

### Crude Rate per 100 Vaginal Deliveries for Obstetric Trauma During Vaginal Delivery, With and Without an Instrument, Ages 15 and Older, 2020

■ Obstetric trauma vaginal delivery with instrument ■ Obstetric trauma vaginal delivery without instrument



Note: Data for Austria, France, Germany, Japan, and the Netherlands are not available.

Source: KFF analysis of OECD data

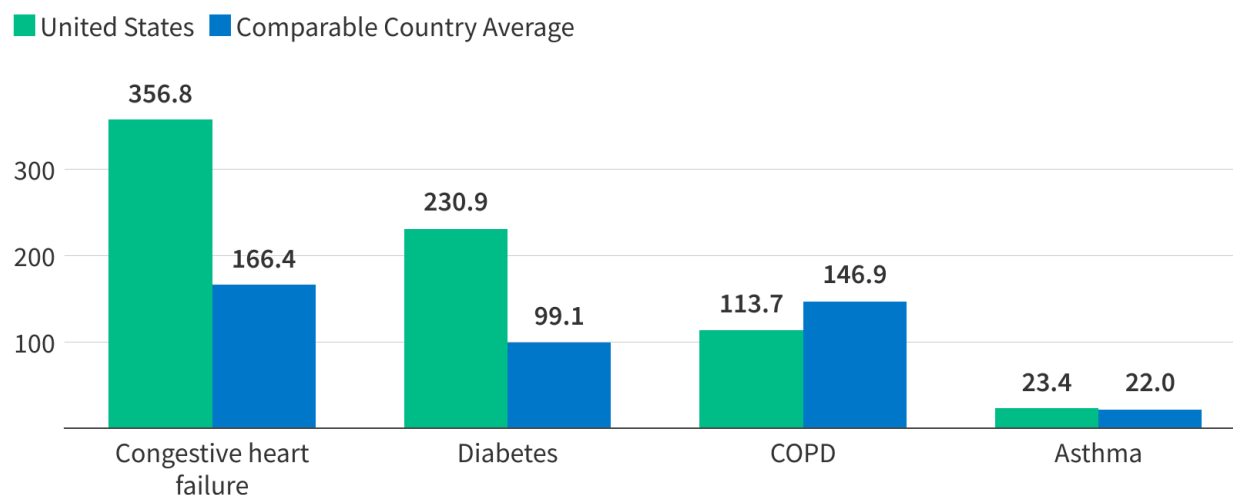
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Obstetric trauma is more likely to occur in deliveries where instruments are utilized (i.e., forceps). The rate of obstetric trauma during deliveries with an instrument in the U.S. was 11.7 per 100 vaginal deliveries in 2020, higher than most comparable countries with available data. The rate of obstetric trauma during deliveries without an instrument in the U.S. was 1.7 per 100 vaginal deliveries in 2020, on the lower end among comparable countries with available data.

## Hospital Admissions

Figure 10

### Age-Standardized Hospital Admission Rate per 100,000 Population, Ages 15 and Over, 2020



Note: Comparable countries include Australia, Austria, Belgium, Canada, the Netherlands, Switzerland, and the U.K. Data for France, Germany, Japan, and Sweden are not available. COPD stands for chronic obstructive pulmonary disease.

Source: KFF analysis of OECD data

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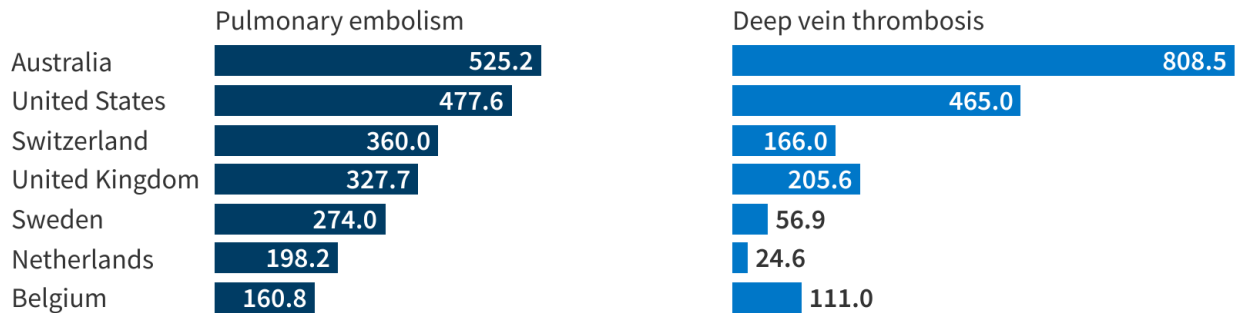
Hospital admissions for certain chronic diseases, such as cardiac conditions, chronic obstructive pulmonary diseases (COPD), asthma, and diabetes, can arise for a variety of reasons, but preventive services — or lack thereof — play a large role. Hospital admission rates in the U.S. are higher than in comparable countries for congestive heart failure and complications due to diabetes, and some admissions for these chronic conditions could be minimized with adequate primary care. Admission rates in 2020 are likely impacted by the COVID-19 pandemic—patients were less likely to seek hospital treatment, and hospitals were at times overwhelmed and unable to admit patients who would have been admitted in a different year.



## Post-Operative Complications

Figure 11

### Crude Rate per 100,000 Hospital Discharges for Post-Operative Pulmonary Embolism and Deep Vein Thrombosis After Hip or Knee Surgery, Ages 15 and Older, 2018



Note: Data is unlinked.

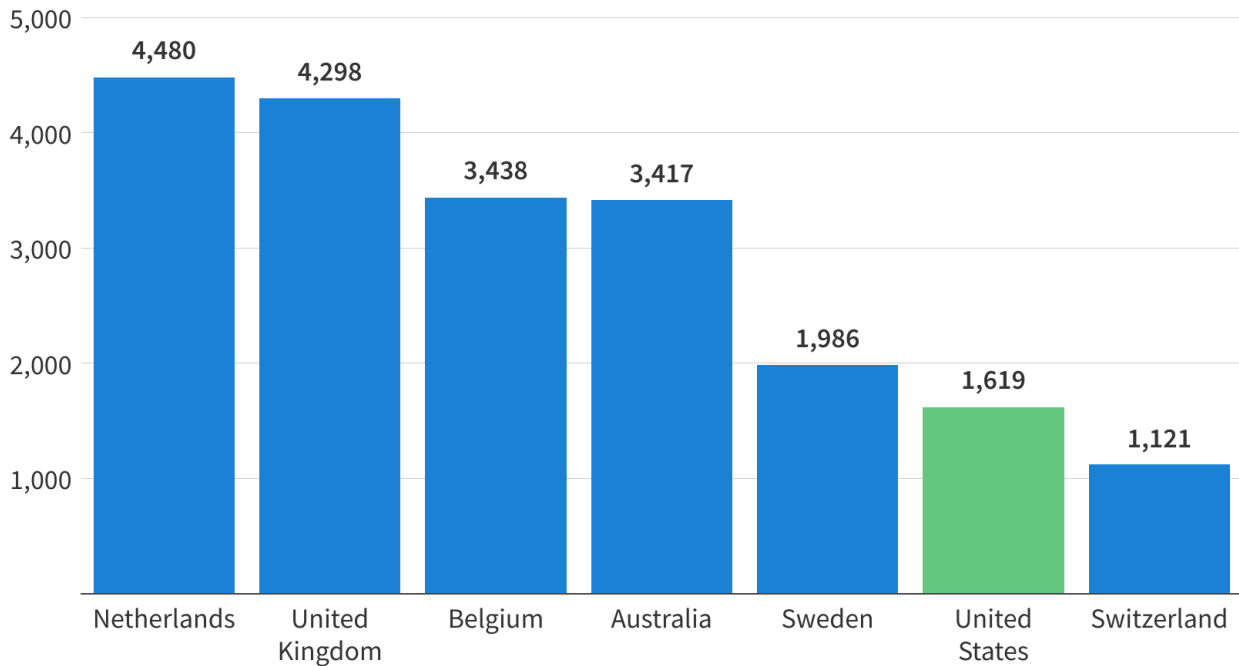
Source: KFF analysis of OECD data

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Rates of post-operative complications are an important measure of hospital safety. Pulmonary embolisms and deep vein thrombosis are common complications after major surgeries, such as hip or knee replacement. The prevalence of post-operative clots for these procedures is higher in the U.S. than in the U.K., Sweden, Belgium, and the Netherlands, but lower than in Australia.

Figure 12

### Crude Rate per 100,000 Hospital Discharges for Post-Operative Sepsis After Abdominal Surgery, Ages 15 and Older, 2020



Note: Hospital discharges are for a surgical episode-related method. Data is unlinked. Data for Austria, Canada, France, Germany, and Japan are not available.

Source: KFF analysis of OECD data

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Sepsis is a serious complication for patients with infections, and effects can range from organ failure and shock to death in severe cases. Rates of post-operative infections and sepsis are an important marker of care quality for patients undergoing surgery, because this is a major source of morbidity and mortality that can sometimes be prevented. Prevention is multifactorial and can involve proper operative techniques and training, hygiene and safety protocols, and antibiotic utilization, amongst other things. The rate of post-operative sepsis following abdominal surgery is just under 2% in the U.S., lower than in most peer countries that report data.

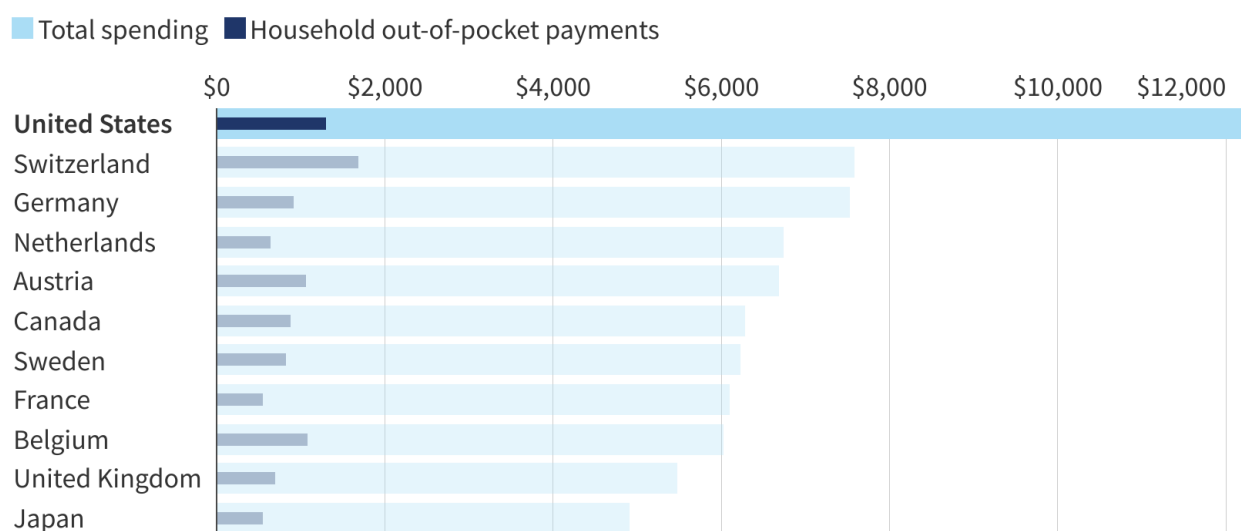
# How Does Access to Care in the U.S. Compare to Other Countries?

## Out-of-Pocket Costs

Universal coverage means all residents have health insurance, but it does not mean health care is free. Even in countries with universal coverage, residents often have at least nominal out-of-pocket costs. In fact, people in Switzerland pay more out-of-pocket on health care (\$1,688), on average, than Americans do (\$1,305) per capita.

Figure 13

### Total Health Spending and Household Out-of-Pocket Spending, Per Capita, U.S. Dollars, 2021



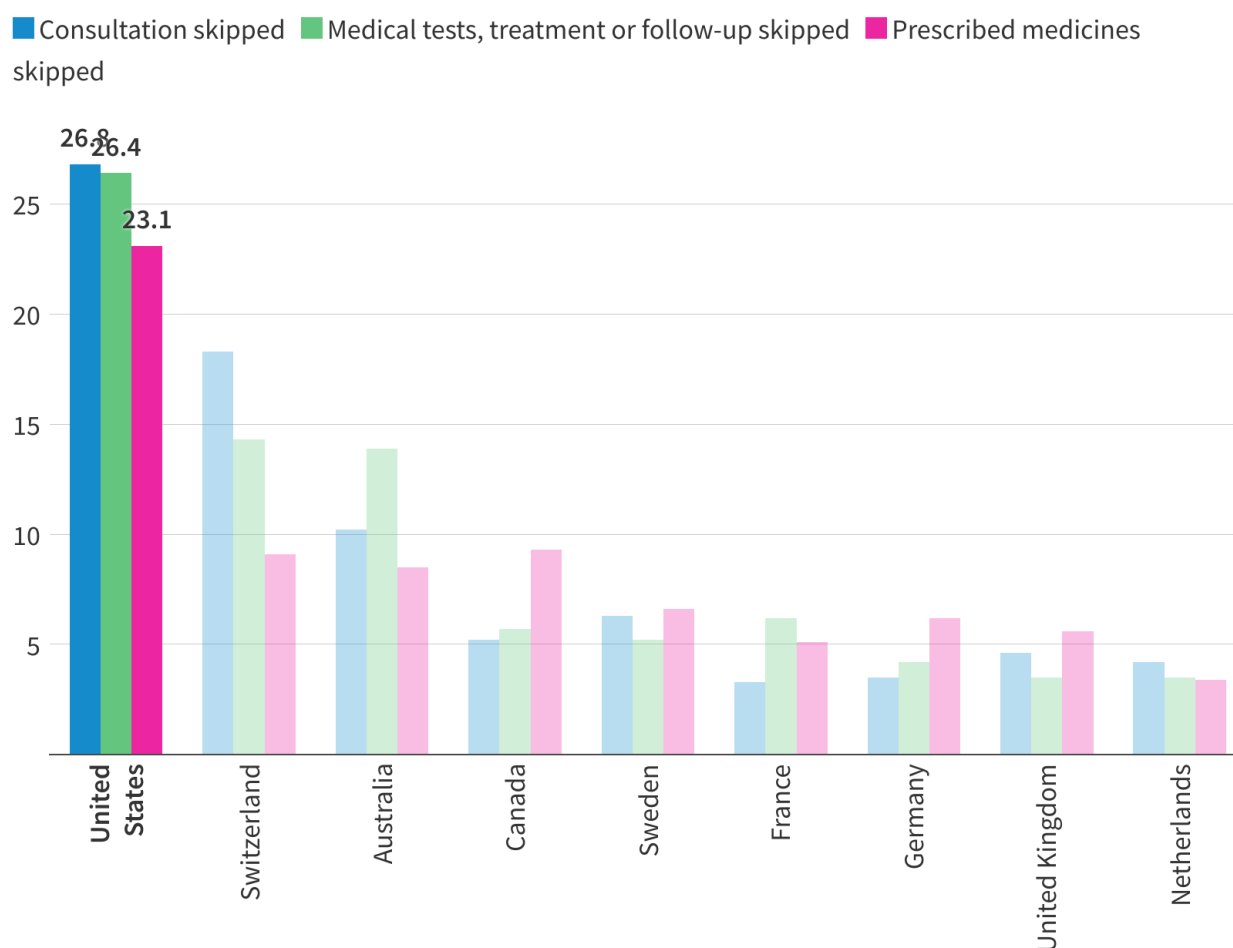
Source: Organisation for Economic Co-Operation and Development

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Costs are a common barrier to accessing health care in the U.S. More than 1 in 4 Americans report skipping consultations, tests, treatment, or follow-up, and 23% report skipping medication. Only 9.2% of the United States population is uninsured, so these numbers include individuals who have health insurance, but still find medical care unaffordable. While cost-related access barriers are particularly prevalent in the U.S., residents of other countries with universal coverage also report skipping care due to costs.

Figure 14

## Patients who report skipping care due to costs, crude rate per 100 patients age 16+, 2020



Source: Organisation for Economic Co-Operation and Development

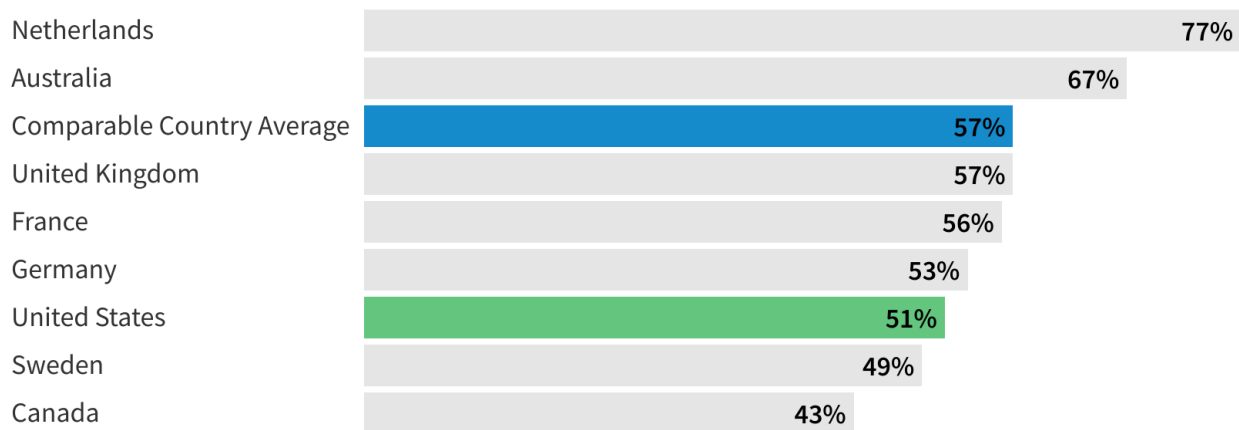
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## Appointment Availability

Among people who needed same or next-day medical care, about half (51%) of Americans were able to make a timely appointment, which is somewhat below the average of peer nations (57%).

Figure 15

### Percent of Adults Who Made a Same-Day or Next Day Appointment When Needed Care, 2016



Source: KFF analysis of Commonwealth Fund International Health Policy Survey of Eleven Countries

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## Physicians

Cost is not the only reason why a person may miss or delay needed medical care. Physician availability can also impact access to care. The U.S. has just 2.7 practicing physicians per 1,000 residents, compared to an average of 3.9 among peer nations.

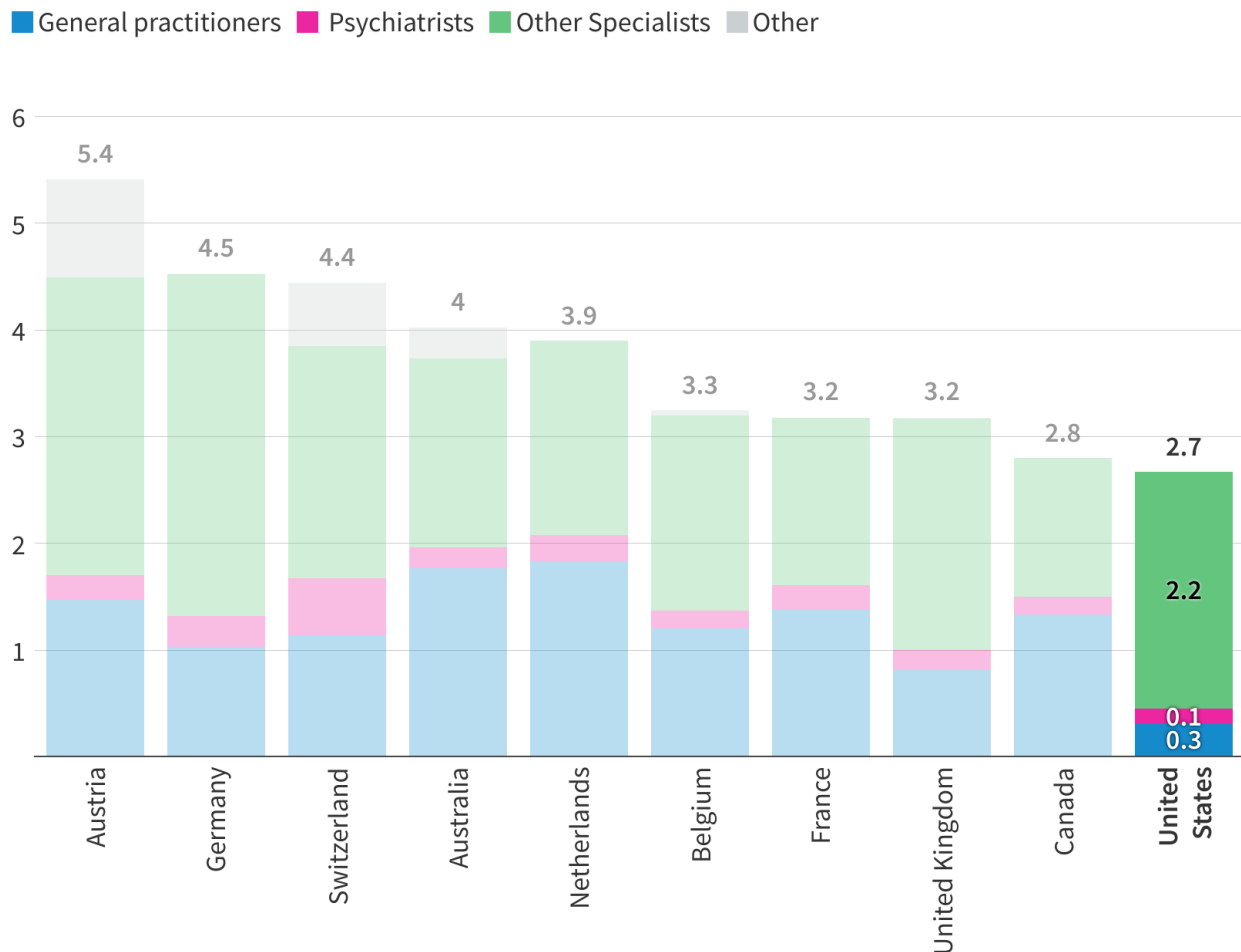
Also of concern in the U.S. is the ratio of primary to specialty care providers. Most other nations have somewhere between one-quarter and one-half of physicians employed in primary care. Primary care is an integral part of the health system in many nations—a patient sees a primary care physician for most illnesses or injuries and only goes to a specialist or hospital if their primary care doctor decides it is necessary. In the United States, however, only 12% of doctors are primary care physicians (PCPs). Specialist care is more expensive than primary care, driving costs up for patients and health systems.

The U.S. faces this [physician shortage](#) and high rates of specialization partly due to how medical education is structured. The U.S. has kept a tight lid on the number of medical schools, as well as the number of training spots available to new doctors. Furthermore, the higher education system in the U.S. places the burden of financing an education on the student, and university tuition is [more expensive](#) than in many peer countries. As a result, students borrow money, and most graduate from medical school in [significant debt](#). Because primary care generally comes with a lower salary, some new physicians pursue a higher-paid specialty, even if they would rather work in primary care.

Additionally, the U.S. has only 0.14 psychiatrists per 1,000 residents, the second lowest of all peer nations. Although the U.S. has a high number of specialist providers, only 6% are psychiatrists, compared to an average of 10% of specialists in other countries examined. Despite clear and increasing demand for mental health treatment, psychiatry remains one of the [lowest-paid](#) physician specialties in the United States.

Figure 16

### Physicians per 1,000 residents, by specialty, 2021



Source: Organisation for Economic Co-Operation and Development

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## Future Outlook

The future outlook of health systems will be shaped by various factors, including political and policy changes, technological advancements, economic and demographic shifts, social factors, and unforeseen events – as the COVID-19 pandemic demonstrated. Here are some issues to watch:

**Health Outcomes:** The United States was already performing worse than its peers across a wide range of health outcomes, but the COVID pandemic widened the gap further and it is not yet clear whether life expectancy and other measures of long-term health outcomes will recover as quickly in the U.S. as in peer nations. The pandemic has underscored the importance of robust health care system capacity, though countries will likely continue to differ in their responses to COVID and preparations for future pandemics. In addition to the pandemic recovery, both the U.S. and peer countries face the challenge of aging populations, leading to increased demand for health care services and long-term care.

**Access to Care:** Unlike the U.S., similarly large and wealthy nations have long had universal or near-universal health coverage and more robust access to health care. Although the U.S. has recently reached an all-time high rate of insurance coverage, it still lags behind its peers and the ongoing [disenrollments from Medicaid](#) may cause the uninsured rate to rise. Additionally, even people who are insured in the U.S. often face such high out-of-pocket costs for medical care that they go without needed care or incur medical debt. Future policymaking in the U.S. may continue to focus on improving insurance coverage rates and addressing cost-related and other barriers to care.

**Quality of Care:** The adoption of new technologies will shape care delivery in both the United States and its peers. Electronic health records, telemedicine, artificial intelligence, and other digital health tools are becoming more prevalent globally. However, many digital health tools are new, untested, and have unknown implications for quality of care.

**Health Spending:** Most peer nations place a strong emphasis on cost containment and efficiency and achieve this through regulation of and negotiation with health providers to lower costs. In the U.S., by contrast, the federal and state governments are much more hands-off. However, with the recent passage of the Inflation Reduction Act, the U.S. will start to negotiate certain drug prices. Medicare recently announced the first 10 drugs selected for [negotiation](#) under its new drug price negotiation program, which is projected to lower Medicare spending on those drugs. There will likely be ongoing debate over extending drug price negotiation by the federal government outside of Medicare, as well as taking other steps to restrain the price of health care generally.



# Resources

## Health Costs:

- [How does health spending in the U.S. compare to other countries? - Peterson-KFF Health System Tracker](#)
- [How do healthcare prices and use in the U.S. compare to other countries? - Peterson-KFF Health System Tracker](#)
- [What drives health spending in the U.S. compared to other countries - Peterson-KFF Health System Tracker](#)
- [How do prices of drugs for weight loss in the U.S. compare to peer nations' prices? - Peterson-KFF Health System Tracker](#)
- [How do prescription drug costs in the United States compare to other countries? - Peterson-KFF Health System Tracker](#)

## Health Outcomes:

- [How does U.S. life expectancy compare to other countries? - Peterson-KFF Health System Tracker](#)
- [Premature mortality during COVID-19 in the U.S. and peer countries - Peterson-KFF Health System Tracker](#)
- [What do we know about social determinants of health in the U.S. and comparable countries? - Peterson-KFF Health System Tracker](#)

## Access and Quality of Care

- [How does the quality of the U.S. health system compare to other countries? - Peterson-KFF Health System Tracker](#)
- [How do U.S. healthcare resources compare to other countries? - Peterson-KFF Health System Tracker](#)
- [Percent of adults who made a same-day or next day appointment when needed care](#)

This chapter was prepared by Emma Wager and Cynthia Cox and draws on existing KFF products.

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