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EXECUTIVE SUMMARY

# MIRROR, MIRROR ON THE WALL

How the Performance of the U.S. Health Care System Compares Internationally

Karen Davis, Kristof Stremikis, David Squires, and Cathy Schoen

June 2014

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## ABSTRACT

The United States health care system is the most expensive in the world, but comparative analyses consistently show the U.S. underperforms relative to other countries on most dimensions of performance. Among the 11 nations studied in this report—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—the U.S. ranks last, as it did in prior editions of *Mirror, Mirror*. The United Kingdom ranks first, followed closely by Switzerland. Since the data in this study were collected, the U.S. has made significant strides adopting health information technology and undertaking payment and delivery system reforms spurred by the Affordable Care Act. Continued implementation of the law could further encourage more affordable access and more efficient organization and delivery of health care, and allow investment in preventive and population health measures that could improve the performance of the U.S. health care system.

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## EXECUTIVE SUMMARY

The United States health care system is the most expensive in the world, but this report and prior editions consistently show the U.S. underperforms relative to other countries on most dimensions of performance.<sup>1</sup> Among the 11 nations studied in this report—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—the U.S. ranks last, as it did in the 2010, 2007, 2006, and 2004 editions of *Mirror, Mirror*.<sup>2</sup> Most troubling, the U.S. fails to achieve better health outcomes than the other countries, and as shown in the earlier editions, the U.S. is last or near last on dimensions of access, efficiency, and equity. In this edition of *Mirror, Mirror*, the United Kingdom ranks first, followed closely by Switzerland (Exhibit ES-1).

Expanding from the seven countries included in 2010, the 2014 edition includes data from 11 countries. It incorporates patients' and physicians' survey results on care experiences and ratings on various dimensions of care.<sup>3</sup> It includes information from the most recent three Commonwealth Fund international surveys of patients and primary care physicians about medical practices and views of their countries' health systems (2011–2013). It also includes information on health care outcomes featured in The Commonwealth Fund's most recent (2011) national health system scorecard, and from the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD).<sup>4</sup>

### EXHIBIT ES-1. OVERALL RANKING

#### COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*



	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING (2013)</b>	4	10	9	5	5	7	7	3	2	1	11
<b>Quality Care</b>	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
<b>Access</b>	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
<b>Efficiency</b>	4	10	8	9	7	3	4	2	6	1	11
<b>Equity</b>	5	9	7	4	8	10	6	1	2	2	11
<b>Healthy Lives</b>	4	8	1	7	5	9	6	2	3	10	11
<b>Health Expenditures/Capita, 2011**</b>	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: \* Includes ties. \*\* Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

The most notable way the U.S. differs from other industrialized countries is the absence of universal health insurance coverage.<sup>5</sup> Other nations ensure the accessibility of care through universal health systems and through better ties between patients and the physician practices that serve as their medical homes. The Affordable Care Act is increasing the number of Americans with coverage and improving access to care, though the data in this report are from years prior to the full implementation of the law.<sup>6</sup> Thus, it is not surprising that the U.S. underperforms on measures of access and equity between populations with above-average and below-average incomes.

The U.S. also ranks behind most countries on many measures of health outcomes, quality, and efficiency. U.S. physicians face particular difficulties receiving timely information, coordinating care, and dealing with administrative hassles. Other countries have led in the adoption of modern health information systems, but U.S. physicians and hospitals are catching up as they respond to significant financial incentives to adopt and make meaningful use of health information technology systems. Additional provisions in the Affordable Care Act will further encourage the efficient organization and delivery of health care, as well as investment in important preventive and population health measures.<sup>7</sup>

For all countries, responses indicate room for improvement. Yet, the other 10 countries spend considerably less on health care per person and as a percent of gross domestic product than does the United States. These findings indicate that, from the perspectives of both physicians and patients, the U.S. health care system could do much better in achieving value for the nation's substantial investment in health.

## Key Findings

- **Quality:** The indicators of quality were grouped into four categories: effective care, safe care, coordinated care, and patient-centered care. Compared with the other 10 countries, the U.S. fares best on provision and receipt of preventive and patient-centered care. While there has been some improvement in recent years, lower scores on safe and coordinated care pull the overall U.S. quality score down. Continued adoption of health information technology should enhance the ability of U.S. physicians to identify, monitor, and coordinate care for their patients, particularly those with chronic conditions.
- **Access:** Not surprisingly—given the absence of universal coverage—people in the U.S. go without needed health care because of cost more often than people do in the other countries. Americans were the most likely to say they had access problems related to cost. Patients in the U.S. have rapid access to specialized health care services; however, they are less likely to report rapid access to primary care than people in leading countries in the study. In other countries, like Canada, patients have little to no financial burden, but experience wait times for such specialized services. There is a frequent misperception that trade-offs between universal coverage and timely access to specialized services are inevitable; however, the Netherlands, U.K., and Germany provide universal coverage with low out-of-pocket costs while maintaining quick access to specialty services.
- **Efficiency:** On indicators of efficiency, the U.S. ranks last among the 11 countries, with the U.K. and Sweden ranking first and second, respectively. The U.S. has poor performance on measures of national

health expenditures and administrative costs as well as on measures of administrative hassles, avoidable emergency room use, and duplicative medical testing. Sicker survey respondents in the U.K. and France are less likely to visit the emergency room for a condition that could have been treated by a regular doctor, had one been available.

- **Equity:** The U.S. ranks a clear last on measures of equity. Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick; not getting a recommended test, treatment, or follow-up care; or not filling a prescription or skipping doses when needed because of costs. On each of these indicators, one-third or more lower-income adults in the U.S. said they went without needed care because of costs in the past year.
- **Healthy lives:** The U.S. ranks last overall with poor scores on all three indicators of healthy lives—mortality amenable to medical care, infant mortality, and healthy life expectancy at age 60. The U.S. and U.K. had much higher death rates in 2007 from conditions amenable to medical care than some of the other countries, e.g., rates 25 percent to 50 percent higher than Australia and Sweden. Overall, France, Sweden, and Switzerland rank highest on healthy lives.

## Summary and Implications

The U.S. ranks last of 11 nations overall. Findings in this report confirm many of those in the earlier four editions of *Mirror, Mirror*, with the U.S. still ranking last on indicators of efficiency, equity, and outcomes. The U.K. continues to demonstrate strong performance and ranked first overall, though lagging notably on health outcomes. Switzerland, which was included for the first time in this edition, ranked second overall. In the subcategories, the U.S. ranks higher on preventive care, and is strong on waiting times for specialist care, but weak on access to needed services and ability to obtain prompt attention from primary care physicians.

Any attempt to assess the relative performance of countries has inherent limitations. These rankings summarize evidence on measures of high performance based on national mortality data and the perceptions and experiences of patients and physicians. They do not capture important dimensions of effectiveness or efficiency that might be obtained from medical records or administrative data. Patients' and physicians' assessments might be affected by their experiences and expectations, which could differ by country and culture.

Disparities in access to services signal the need to expand insurance to cover the uninsured and to ensure that all Americans have an accessible medical home. Under the Affordable Care Act, low- to moderate-income families are now eligible for financial assistance in obtaining coverage. Meanwhile, the U.S. has significantly accelerated the adoption of health information technology following the enactment of the American Recovery and Reinvestment Act, and is beginning to close the gap with other countries that have led on adoption of health information technology. Significant incentives now encourage U.S. providers to utilize integrated medical records and information systems that are accessible to providers and patients. Those efforts will likely help clinicians deliver more effective and efficient care.

Many U.S. hospitals and health systems are dedicated to improving the process of care to achieve better safety and quality, but the U.S. can also learn from innovations in other countries—including public

reporting of quality data, payment systems that reward high-quality care, and a team approach to management of chronic conditions. Based on these patient and physician reports, and with the enactment of health reform, the United States should be able to make significant strides in improving the delivery, coordination, and equity of the health care system in coming years.

## NOTES

- <sup>1</sup> Institute of Medicine, *U.S. Health in International Perspective: Shorter Lives, Poorer Health* (Washington, D.C.: National Academies Press, Jan. 2013); K. Davis, C. Schoen, and K. Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update* (New York: The Commonwealth Fund, June 2010); and World Health Organization, *World Health Report, 2000* (Geneva: WHO, 2000).
- <sup>2</sup> Davis, Schoen, and Stremikis, *Mirror, Mirror on the Wall*, 2010; K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (New York: The Commonwealth Fund, May 2007); K. Davis, C. Schoen, S. C. Schoenbaum, A.-M. J. Audet, M. M. Doty, A. L. Holmgren, and J. L. Kriss, *Mirror, Mirror on the Wall: An Update on the Quality of American Health Care Through the Patient's Lens* (New York: The Commonwealth Fund, April 2006); and K. Davis, C. Schoen, S. C. Schoenbaum, A.-M. J. Audet, M. M. Doty, and K. Tenney, *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens* (New York: The Commonwealth Fund, Jan. 2004).
- <sup>3</sup> In each of the past 15 years, The Commonwealth Fund has performed a survey in five countries: Australia, Canada, New Zealand, the United Kingdom, and the United States. The Fund added Germany to the survey in 2006, the Netherlands in 2007, France in 2008, Norway and Sweden in 2009, and Switzerland in 2010. In each year the ministers of health have met to review the findings. The specific surveys used in this report are: C. Schoen, R. Osborn, D. Squires, and M. M. Doty, "Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries," *Health Affairs* Web First, published online Nov. 13, 2013; C. Schoen, R. Osborn, D. Squires, M. M. Doty, P. W. Rasmussen, R. Pierson, and S. Applebaum, "A Survey of Primary Care Doctors in Ten Countries Shows Progress in Use of Health Information Technology, Less in Other Areas," *Health Affairs* Web First, published online Nov. 15, 2012; and C. Schoen, R. Osborn, D. Squires, M. M. Doty, R. Pierson, and S. Applebaum, "New 2011 Survey of Patients with Complex Care Needs in 11 Countries Finds That Care Is Often Poorly Coordinated," *Health Affairs* Web First, Nov. 9, 2011.
- <sup>4</sup> The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (New York: The Commonwealth Fund, Oct. 2011).
- <sup>5</sup> K. Davis, "Uninsured in America: Problems and Possible Solutions," *BMJ*, Feb. 17, 2007 334(7589):346–48.
- <sup>6</sup> D. Blumenthal and S. Collins, "Health Care Coverage Under the Affordable Care Act: A Progress Report," *New England Journal of Medicine* (forthcoming).
- <sup>7</sup> K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate* (New York: The Commonwealth Fund, Dec. 2009).

## METHODOLOGY APPENDIX

Data are drawn from the Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults; the Commonwealth Fund 2012 International Health Policy Survey of Primary Care Physicians; and the Commonwealth Fund 2013 International Health Policy Survey. The 2011 survey targets a representative sample of “sicker adults,” defined as those who rated their health status as fair or poor; received medical care for a serious chronic illness, serious injury, or disability in the past year; or were hospitalized or underwent major surgery in the previous two years. The 2012 survey looks at the experiences of primary care physicians. The 2013 survey focuses on the experiences of nationally representative samples of adults age 18 and older. Exhibit 9 presents the number of respondents for each survey.

The 2011 and 2013 surveys examine patients’ views of the health care system, quality of care, care coordination, medical errors, patient–physician communication, waiting times, and access problems. The 2012 survey looks at primary care physicians’ experiences providing care to patients, as well as the use of information technology and teamwork in the provision of care. Further details of the survey methodology are described elsewhere.<sup>20</sup>

For this report, we selected and grouped indicators from these three surveys using the *National Scorecard’s* dimensions of quality. Quality was measured by 44 indicators, broken down into four areas (13 effective care measures, seven safe care measures, 13 coordinated care measures, and 11 patient-centered care measures). There are 12 access indicators (five for cost-related access problems, and seven indicators of timeliness of care), and 11 efficiency indicators. For the equity measure, we compared experiences of adults with incomes above or below national median income to examine low-income experiences across countries and differences between those with lower and higher incomes for each of 10 indicators. For the healthy lives dimension, we compiled three indicators from the OECD and the WHO.<sup>21</sup>

In all, 80 indicators of performance are included. We ranked countries by calculating means and ranking scores from highest to lowest (where 1 equals the highest score) across the 11 countries. For ties, the tied observations were both assigned the score that would be assigned if no tie had occurred. For each *Scorecard* domain of quality and access, a summary ranking was calculated by averaging the individual ranked scores within each country and ranking these averages from highest (value=1) to lowest (value=11) score.

In order to gauge the stability of our rankings, we experimented with several different ranking methodologies to see if they yielded the same or similar results. These methodologies included one approach that scored countries based on standard deviation and one approach that scored countries only if they were well above or well below the average range. We found that these alternative methods tended to consistently yield the same top-performing countries (the U.K. and Switzerland) and worst-performing countries (the U.S. and Canada). However, there was a fair amount of fluidity among the countries in the middle of the performance range, whose rankings were sensitive to relatively small changes in data or methodology. For this reason, overall rankings may overshadow important absolute differences in performance, warranting closer examination of the data when describing a particular country’s performance.



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