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UPDATE

# 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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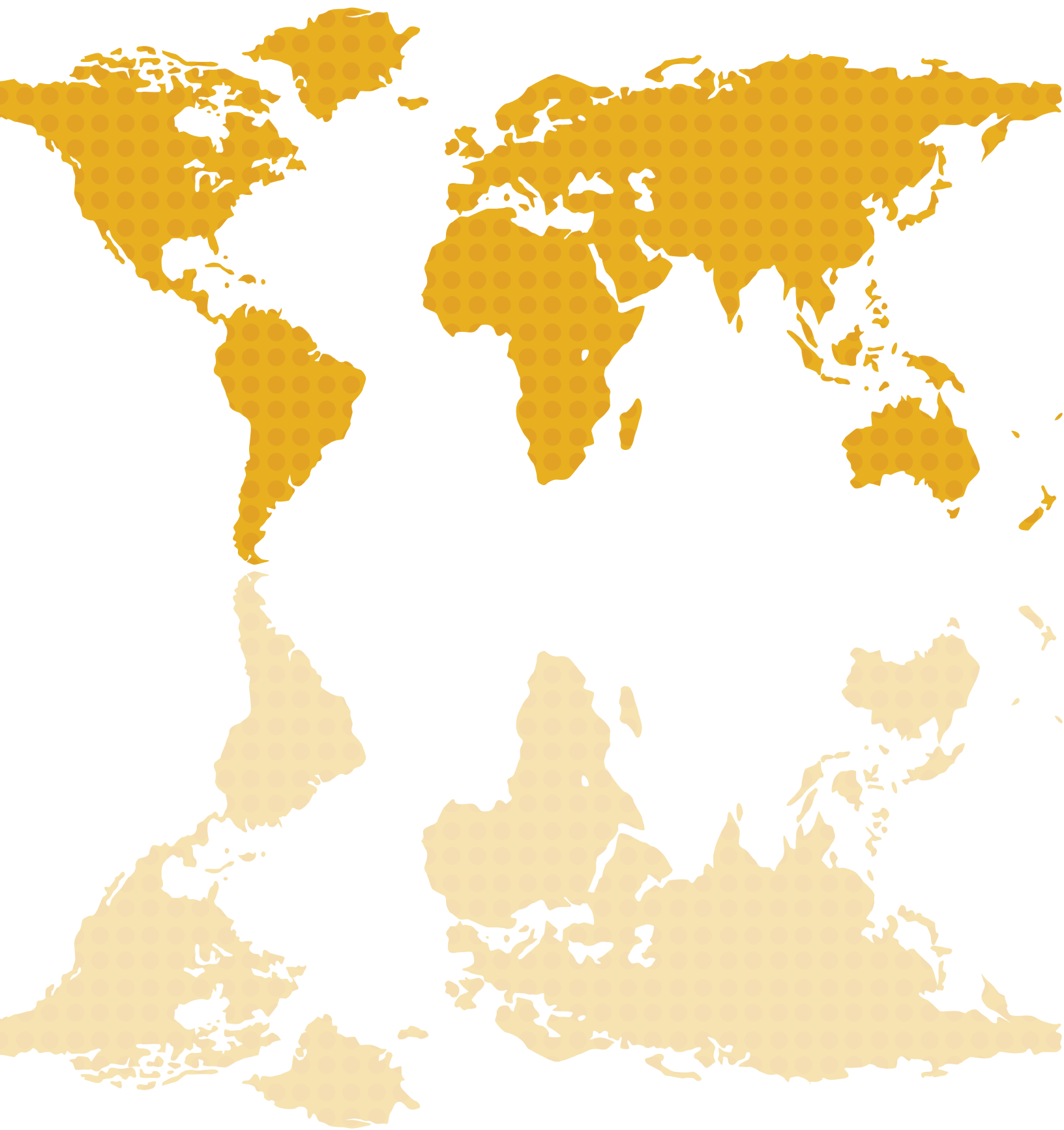
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## ABSTRACT

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.

# MIRROR, MIRROR ON THE WALL

## How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update

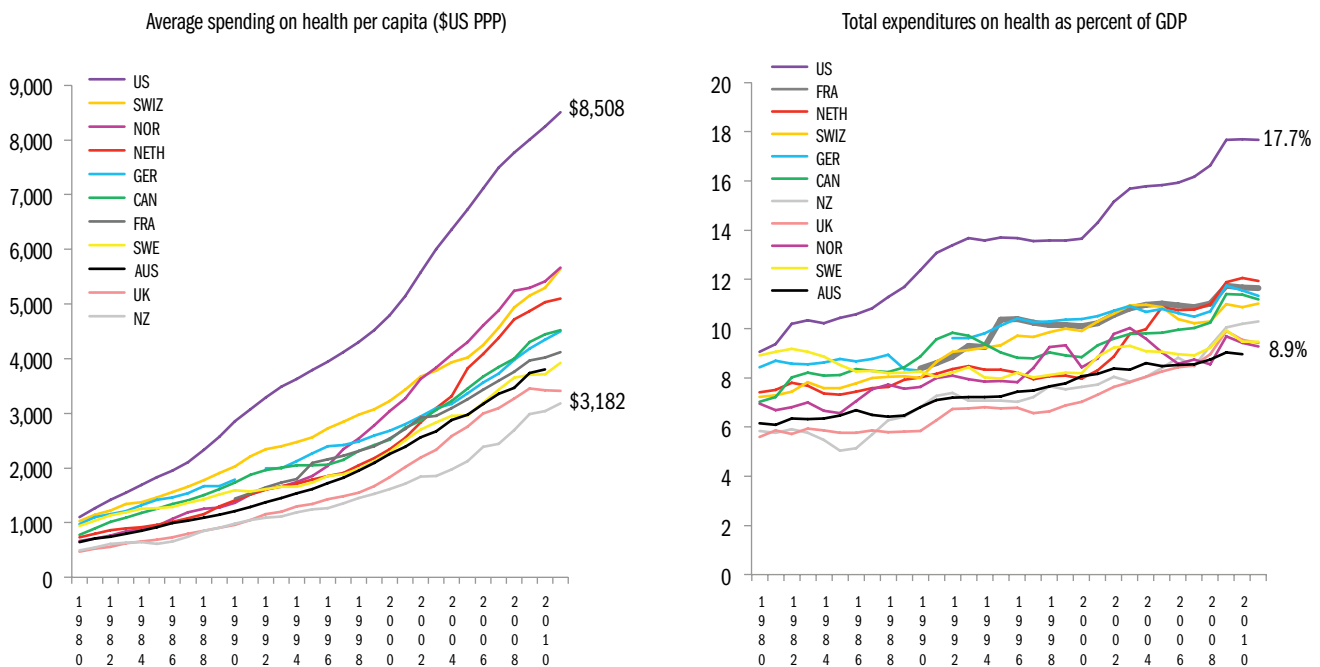
### INTRODUCTION

Over the past decade, leaders in the United States have begun to recognize that the nation’s health care system is far more costly than any other system in the world (Exhibit 1) and does not produce demonstrably better results. The claim that the United States has “the best health care system in the world”<sup>8</sup> is clearly not true. To reduce cost and improve outcomes, the U.S. must adopt and adapt lessons from effective health care systems both at home and around the world.

International health outcome measures that are comparable across nations are limited, but cross-national surveys of patients and their physicians provide another method to compare health care system performance. Focusing on access to care, costs, and quality, these surveys allow assessments of important dimensions of health system performance. When such surveys include a common set of questions, they can overcome differences among national data systems and definitions that often frustrate cross-national comparisons. Since 1998, The Commonwealth Fund has supported annual international surveys about patients’ and health professionals’ experiences with their health care systems.<sup>9</sup>

Patients are clearly a key source of information about access and affordability—with surveys enabling comparisons of their experiences. Yet, survey results do have limitations. In addition to lacking clinical data on effectiveness of care and including data from a limited number of countries, the surveys focus on only part of

**EXHIBIT 1. INTERNATIONAL COMPARISON OF SPENDING ON HEALTH, 1980–2011**



Note: \$US PPP = purchasing power parity.  
 Source: Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

the health care quality picture—patient and primary care physician perceptions of the care they received and administered.

This report includes 80 indicators, grouped into five dimensions of performance: quality, access, efficiency, equity, and healthy lives. These categories mirror those used in The Commonwealth Fund’s *State Scorecard* and *National Scorecard* series.<sup>10</sup> The indicators are drawn heavily from the Fund’s international surveys—specifically, the 2011 survey of “sicker” adults, the 2012 survey of primary care physicians, and the 2013 survey of the general population. Additional indicators also are drawn from the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD) on costs and health outcomes. The analysis ranks each indicator within each dimension to determine dimension ranks, and averages dimensions to determine the overall country rank. We tested several other ranking methodologies to confirm the stability of our rankings. A complete [methodology](#) is included in the appendix.

While each of the 11 industrialized countries in this study has a unique health system, they all face cost and quality challenges. Comparing patient- and physician-reported experiences in these countries can inform the ongoing debate over how to make the U.S. health care system more effective and responsive to patient needs, and also may help other nations improve their own health care systems.

## RESULTS

The U.S. ranks last overall, and last or close to last on four of the five dimensions of a high performance health system, including health outcomes. Exhibit 2 displays how each country ranked overall and provides a snapshot of how the 11 nations rank on the domains of quality, access, efficiency, equity, and healthy lives. The United Kingdom ranks first overall, scoring highest on quality, access, and efficiency. Switzerland, which ranks second overall, is among the leading countries on equity, timeliness of care, and patient-centered care. France ranks highest on healthy lives; Canada and the U.S. rank tenth and eleventh, respectively.

The high- and low-performing countries have been relatively stable over time (Exhibit 3), with the U.S. ranked last among countries included in each edition. However, some caution is warranted when examining trends in rankings. Some indicators and domains have undergone minor variations between editions of the report, and a number of new countries have been added to the analysis, including four since the last

**EXHIBIT 2. 11-NATION SUMMARY SCORES ON HEALTH SYSTEM PERFORMANCE**

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING</b>	<b>4</b>	<b>10</b>	<b>9</b>	<b>5</b>	<b>5</b>	<b>7</b>	<b>7</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>11</b>
<b>Quality Care</b>	<b>2</b>	<b>9</b>	<b>8</b>	<b>7</b>	<b>5</b>	<b>4</b>	<b>11</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>5</b>
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>	<b>8</b>	<b>9</b>	<b>11</b>	<b>2</b>	<b>4</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>9</b>
Cost-Related Access Problems	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>	<b>4</b>	<b>10</b>	<b>8</b>	<b>9</b>	<b>7</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>6</b>	<b>1</b>	<b>11</b>
<b>Equity</b>	<b>5</b>	<b>9</b>	<b>7</b>	<b>4</b>	<b>8</b>	<b>10</b>	<b>6</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>11</b>
<b>Healthy Lives</b>	<b>4</b>	<b>8</b>	<b>1</b>	<b>7</b>	<b>5</b>	<b>9</b>	<b>6</b>	<b>2</b>	<b>3</b>	<b>10</b>	<b>11</b>

### EXHIBIT 3. HISTORICAL RANKING

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING (2014 EDITION)</b>	<b>4</b>	<b>10</b>	<b>9</b>	<b>5</b>	<b>5</b>	<b>7</b>	<b>7</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>11</b>
Overall Ranking (2010 edition)	3	6	n/a	4	1	5	n/a	n/a	n/a	2	7
Overall Ranking (2007 edition)	3	5	n/a	2	n/a	3	n/a	n/a	n/a	1	6
Overall Ranking (2006 edition)	4	5	n/a	1	n/a	2	n/a	n/a	n/a	3	6
Overall Ranking (2004 edition)	2	4	n/a	n/a	n/a	1	n/a	n/a	n/a	3	5
Health Expenditures per Capita, 2011*	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

\* Expenditures shown in \$US PPP (purchasing power parity); data for Australia from 2010.

Data: OECD, *OECD Health Data, 2013* (Nov. 2013).

edition. Second, while in 2014 the top two and bottom two countries are clear outliers, the scores for many of the countries grouped in the middle are quite close, and so their rankings are sensitive to small variations in the data (for more on this, see the [methodology](#) appendix). 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. For this purpose, raw scores are included in the tables and discussed in relevant sections of the report.

## QUALITY

High-quality care is defined in the Fund's *National Scorecard* as care that is effective, safe, coordinated, and patient-centered. The United Kingdom ranks first and Norway last on quality, based on averages of the scores in these four areas (Exhibit 2). The U.S. falls in the midrange on this domain of performance.

### Effective Care

An important indicator of quality is the degree to which patients receive “services that are effective and appropriate for preventing or treating a given condition and controlling chronic illness.”<sup>11</sup> In this report, the indicators used to define effective care are grouped into two categories: prevention and chronic care (Exhibit 4a).

**Prevention.** Preventive care is crucial to an effective health care delivery system. When utilized appropriately, lists of patients who are due or overdue for tests or preventive care, reminders for preventive care visits, and discussions of lifestyle issues can increase the effectiveness of care through the early diagnosis or prevention of illness. Consistent with previous editions of *Mirror, Mirror*, the U.S. does well in providing preventive care for its population. Respondents in the U.S. were more likely than those in most other countries to receive preventive care reminders and advice from their doctors on diet and exercise.

**Chronic care.** Carefully managing the care of patients with chronic illnesses is another sign of an effective health care system. Overall, the U.K. outperforms all countries on each of the seven chronic care management indicators. Different countries, however, were successful on different aspects of chronic care. Australia performs well in delivering recommended services to patients with diabetes, as well as providing written instructions to chronically ill patients. A relatively large percentage of primary care physicians in the Netherlands

report that it is easy to print out lists of patients by diagnosis and lists of all medications taken by individual patients. Meanwhile, a very low percentage of chronically ill patients in Sweden did not follow recommended care or treatment plan because of cost.

The U.S. is third on effective care overall, performing relatively well on prevention but average in comparison to other industrialized nations on quality of chronic care management. The U.K and New Zealand scored first and second, respectively, in terms of effective care. The widespread and effective use of health information technology (HIT) in the U.K. plays a large role in the country's high score on the chronic care management indicators, as well as its performance on system aspects of preventive care delivery. All countries, however, have room for improvement to ensure patients uniformly receive effective care.

### EXHIBIT 4A. EFFECTIVE CARE MEASURES

	Source	Raw Scores (Percent)											Ranking Scores										
		AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL BENCHMARK RANKING</b>													<b>4</b>	<b>7</b>	<b>9</b>	<b>6</b>	<b>5</b>	<b>2</b>	<b>11</b>	<b>10</b>	<b>8</b>	<b>1</b>	<b>3</b>
<b>Prevention</b>																							
Physicians reporting it is easy to print out a list of patients who are due or overdue for tests or preventive care	2012	65	23	34	40	72	81	5	16	28	88	30	4	9	6	5	3	2	11	10	8	1	7
Patients receive reminders for preventive care	2013	38	39	40	47	58	56	24	32	33	46	49	8	7	6	4	1	2	11	10	9	5	3
Patients routinely sent computerized reminder notices for preventive or follow-up care	2012	76	35	64	35	80	95	17	55	48	95	52	4	9	5	9	3	1	11	6	8	1	7
Doctor or other clinical staff talked with patient about a healthy diet and healthy eating	2013	55	51	39	39	41	47	30	30	38	54	67	2	4	7	7	6	5	10	10	9	3	1
Doctor or other clinical staff talked about exercise or physical activity	2013	54	54	50	47	44	51	39	43	40	51	70	2	2	6	7	8	4	11	9	10	4	1
Doctor or other clinical staff talked with patient about health risks and ways to quit (base: smokers)	2013	61	69	54	59	58	86	45	49	47	67	77	5	3	8	6	7	1	11	9	10	4	2
<b>Chronic Care</b>																							
Patients with diabetes receiving all four recommended services†	2011	56	40	26	39	49	53	33	41	34	76	50	2	7	11	8	5	3	10	6	9	1	4
Patients with hypertension who have had cholesterol checked in past year	2011	82	84	82	90	78	84	85	69	89	93	85	8	6	8	2	10	6	4	11	3	1	4
Has chronic condition and did not receive recommended test, treatment, or follow-up care because of cost	2011	20	8	10	12	8	17	8	5	11	4	33	10	3	6	8	3	9	3	2	7	1	11
Primary care practices that routinely provide written instructions to patients with chronic diseases	2012	41	21	15	34	34	25	14	13	26	61	39	2	8	9	4	4	7	10	11	6	1	3
Physicians reporting it is easy to print out a list of patients by diagnosis	2012	72	39	27	53	77	74	38	45	25	96	49	4	8	10	5	2	3	9	7	11	1	6
Physicians reporting it is easy to print out a list of all medications taken by individual patients, including those prescribed by other doctors	2012	78	42	39	61	78	74	59	52	46	98	56	2	10	11	5	2	4	6	8	9	1	7
Pharmacist or doctor did not review and discuss all medications patient uses in the past year (base: taking 2 or more prescriptions regularly)	2011	34	28	58	29	41	31	62	55	25	16	28	7	3	10	5	8	6	11	9	2	1	3

† Recommended services include hemoglobin A1c checked in past six months, and feet examined, eyes examined, and cholesterol checked in past year.

## Safe Care

The Institute of Medicine describes safe care as “avoiding injuries to patients from the care that is intended to help them.”<sup>12</sup> Sicker adults in Norway and New Zealand reported the highest rates of medical errors (Exhibit 4b). Among those who had a lab test in the previous two years, sicker adults in Canada were the most likely to experience delays in being notified about abnormal results. Norway, Switzerland, Germany, and Canada lag in terms of using HIT to receive computerized alerts or prompts about potential problems with drug doses or interactions, with scores markedly below international leaders. Only 22 percent of physicians in Norway reported receiving such alerts compared with 93 percent in the Netherlands.

The U.S. ranks seventh of the 11 countries on safe care overall, while the United Kingdom ranks first. Differences in education, cultural norms, and media attention, as well as the subjective nature of communication between doctors and patients might influence patients’ perceptions of error. Therefore, caution must be used in relying only on patients’ perceptions to rank safety. Nevertheless, these findings indicate that the United States has improved on safety indicators since the publication of the last edition of *Mirror, Mirror*, when the country ranked last. For example, the U.S. now leads all nations with a relatively low number of sicker patients reporting an infection during a hospital stay or shortly after. Such progress could be indicative of the numerous safety initiatives under way throughout the country and recent imposition of financial penalties for hospitals with high rates of hospital-acquired conditions.<sup>13</sup>

**EXHIBIT 4B. SAFE CARE MEASURES**

	Raw Scores (Percent)											Ranking Scores											
	Source	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL BENCHMARK RANKING</b>													<b>3</b>	<b>10</b>	<b>2</b>	<b>6</b>	<b>7</b>	<b>9</b>	<b>11</b>	<b>5</b>	<b>4</b>	<b>1</b>	<b>7</b>
Patient believed a medical mistake was made in treatment or care in past 2 years	2011	10	11	6	8	11	13	17	11	4	4	11	5	6	3	4	6	10	11	6	1	1	6
Patient given wrong medication or wrong dose at a pharmacy or while hospitalized in past 2 years	2011	4	5	6	8	6	7	8	5	2	2	8	3	4	6	9	6	8	9	4	1	1	9
Patient given incorrect results for a diagnostic or lab test in past 2 years (base: had a lab test ordered)	2011	4	5	3	2	6	5	4	3	3	2	5	6	8	3	1	11	8	6	3	3	1	8
Patient experienced delays in being notified about abnormal test results in past 2 years (base: had a lab test ordered)	2011	7	11	3	5	5	8	10	9	5	4	10	6	11	1	3	3	7	9	8	3	2	9
Hospitalized patients reporting infection in hospital or shortly after	2011	9	11	8	10	12	12	10	8	10	12	5	4	8	2	5	9	9	5	2	5	9	1
Doctor routinely receives a computerized alert or prompt about a potential problem with drug dose or interaction	2012	88	30	41	26	93	89	22	70	25	85	58	3	8	7	9	1	2	11	5	10	4	6
Doctor routinely receives reminders for guideline-based interventions and/or tests	2012	58	34	53	16	18	53	10	14	32	78	49	2	6	3	9	8	3	11	10	7	1	5

## Coordinated Care

In its discussion of coordinated care, The Commonwealth Fund's first *National Scorecard* report states, "Coordination of patient care throughout the course of treatment and across various sites of care helps to ensure appropriate follow-up treatment, minimize the risk of error, and prevent complications. Failure to properly coordinate and integrate care raises the costs of treatment, undermines delivery of appropriate, effective care, and puts patients' safety at risk."<sup>14</sup>

The United Kingdom ranks first on coordinated care measures, while Sweden ranks last and Germany next-to-last (Exhibit 4c). The United States ranks sixth. Sicker adults in the U.S. are least likely to report having a regular doctor (91%) while those in the Netherlands are most likely to have this connection (100%). Virtually all primary care physicians in France, New Zealand, and Switzerland report they always or often receive relevant information back from specialists, compared with just 59 percent in Sweden, 74 percent in the U.S., and 82 percent in Germany.

Effective communication among patients, physicians, and hospitals is essential for high-quality care. Among sicker adults who had been hospitalized within the past two years, American patients were the most likely to receive a written plan for care after discharge and to know whom to contact for questions about their condition or treatment when leaving the hospital. Eighty-three percent of American patients had arrangements for follow-up visits with a doctor or other health care professional made for them when leaving the hospital, second only to the United Kingdom (87%). Physicians in Germany and New Zealand reported the highest rates of receiving information from the hospital needed to manage a patient's care within two days of discharge.



## EXHIBIT 4C. COORDINATED CARE MEASURES

	Raw Scores (Percent)												Ranking Scores										
	Source	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL BENCHMARK RANKING</b>													<b>4</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>5</b>	<b>2</b>	<b>7</b>	<b>11</b>	<b>3</b>	<b>1</b>	<b>6</b>
Have a regular doctor or place	2011	97	96	99	97	100	99	99	95	99	99	91	7	9	2	7	1	2	2	10	2	2	11
Regular doctor or place always or often helps coordinate and arrange care from other doctors or places	2011	45	66	39	43	41	56	58	44	72	73	67	7	4	11	9	10	6	5	8	2	1	3
Specialist did not have information about medical history	2011	18	18	38	33	16	10	24	22	10	6	18	5	5	11	10	4	2	9	8	2	1	5
When primary care physicians refer a patient to a specialist, they always or often receive a report back with all relevant health information	2012	91	85	96	82	89	96	92	59	96	87	74	5	8	1	9	6	1	4	11	1	7	10
When primary care physicians refer a patient to a specialist, they always or often receive information about changes to a patients medication or care plan	2012	89	79	94	75	59	95	88	63	87	88	69	3	7	2	8	11	1	4	10	6	4	9
When primary care physicians refer a patient to a specialist, they always or often receive information that is timely and available when needed	2012	71	64	86	62	62	78	69	52	83	63	60	4	6	1	8	8	3	5	11	2	7	10
Doctor receives alert or prompt to provide patients with test results	2012	71	39	41	28	18	45	35	27	52	70	57	1	7	6	9	11	5	8	10	4	2	3
Know whom to contact for questions about condition or treatment (base: those hospitalized or having surgery within past 2 years)	2011	87	88	79	89	90	88	87	83	90	93	93	8	6	11	5	3	6	8	10	3	1	1
Receive written plan for care after discharge (base: those hospitalized or having surgery within past 2 years)	2011	68	70	62	69	54	66	54	48	69	80	92	6	3	8	4	9	7	9	11	4	2	1
Hospital made arrangements for follow-up visits with a doctor or other health care professional when leaving the hospital (base: those hospitalized or having surgery within past 2 years)	2011	67	72	51	47	77	67	61	62	65	87	83	5	4	10	11	3	5	9	8	7	1	2
Primary care physician always or often receives notification that patient has been seen in emergency room	2012	72	61	49	66	97	94	75	43	73	86	60	6	8	10	7	1	2	4	11	5	3	9
Primary care physician always or often receives notification that patient is being discharged from hospital	2012	75	55	75	71	96	89	74	45	67	79	60	4	10	4	7	1	2	6	11	8	3	9
Primary care physicians receive the information needed to manage a patient's care within 2 days after they were discharged from the hospital	2012	36	15	10	67	42	56	14	21	40	21	45	6	9	11	1	4	2	10	7	5	7	3

## Patient-Centeredness

The Fund's *National Scorecard* defines patient-centeredness as “care delivered with the patient’s needs and preferences in mind.”<sup>15</sup> The surveys explored issues related to provider–patient communication, physician continuity and feedback, and engagement and patient preferences. The United Kingdom ranks first and Switzerland second among the 11 countries with respect to these measures. The U.S. ranks fourth (Exhibit 4d). All countries could improve substantially in this area.

**Communication.** Communication measures included whether patients reported they always or often got an answer to their question by telephone from their doctor on the same day they called, and whether their doctor always or often explains things in a way they can understand. Patients who had been hospitalized were asked whether they had received clear instructions about what to watch for or when to seek further care. Norway and France scored relatively poorly on the three measures, while Germany and the U.K. were leaders. The U.S. was average in terms of the percentage of respondents who were able to contact the doctor’s office by phone and reported their doctors explain things in an understandable way. The U.S. had the highest number of patients who reported receiving clear instructions after hospital discharge.

**Continuity and feedback.** The U.S. scored in the midrange on measures of continuity and feedback. Only slightly more than half (57%) of U.S. respondents had been with the same doctor for five years or more, compared with more than three-quarters (80%) of respondents in the Netherlands and France. The U.S. ranks third among the 11 countries in terms of physicians routinely receiving data on patient satisfaction and experiences with care: 60 percent of American physicians receive such data. As in previous editions of this report, the U.K. continues to lead most other nations in feedback: 84 percent of physicians in the U.K. receive patient satisfaction data.

**Engagement and patient preferences.** The surveys measured patient engagement by asking respondents whether their doctor always tells them about their options for care and asks their opinions, discusses goals and encourages them to ask questions, and gives clear instructions about symptoms to watch for and when to seek treatment. Overall, Switzerland and the United Kingdom scored highly on measures of patient engagement, while Norway, Sweden, and France performed poorly. The United States did well on most indicators.

## EXHIBIT 4D. PATIENT-CENTERED CARE MEASURES

		Raw Scores (Percent)											Ranking Scores										
Source	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	
<b>OVERALL BENCHMARK RANKING</b>																							
<b>Communication</b>																							
Patients reporting always or often getting telephone answer from doctor the same day (base: have a regular doctor and tried to contact by phone)	2013	79	67	63	90	84	80	78	84	82	75	73	6	10	11	1	2	5	7	2	4	8	9
Doctor always or often explains things in a way that is easy to understand	2013	88	88	88	94	90	91	88	86	88	94	88	5	5	5	1	4	3	5	11	5	1	5
Received clear instructions about symptoms to watch for and when to seek further care after surgery or when leaving the hospital (base: those who had surgery or been hospitalized)	2011	82	83	65	70	77	80	69	70	85	88	92	5	4	11	8	7	6	10	8	3	2	1
<b>Continuity and Feedback</b>																							
With same doctor 5 years or more	2011	64	64	80	72	80	69	70	47	65	59	57	7	7	1	3	1	5	4	11	6	9	10
Doctor routinely receives and reviews data on patient satisfaction and experiences with care	2012	56	15	1	35	39	51	7	90	15	84	60	4	8	11	7	6	5	10	1	8	2	3
Regular doctor always or often knows important information about patient's medical history	2011	84	80	88	91	79	89	76	66	96	94	84	6	8	5	3	9	4	10	11	1	2	6
<b>Engagement and Patient Preferences</b>																							
Specialist always or often involves patient as much as they want in decisions about care and treatment (base: saw or needed to see specialist in past 2 years)	2011	77	77	61	63	79	75	65	67	85	87	71	4	4	11	10	3	6	9	8	2	1	7
Doctor or health care professional discussed patient's main goals or priorities in caring for condition (base: has chronic condition)	2011	63	67	42	59	67	62	51	36	81	78	76	6	4	10	8	4	7	9	11	1	2	3
Specialist always or often tells you about treatment choices (base: saw or needed to see specialist in past 2 years)	2011	72	72	49	70	82	78	52	61	92	85	80	6	6	11	8	3	5	10	9	1	2	4
Regular doctor always or often encouraged you to ask questions	2011	71	62	55	66	59	70	33	44	79	80	75	4	7	9	6	8	5	11	10	2	1	3
Doctor or health care professional gives clear instructions about symptoms, when to seek further care (base: has chronic condition)	2011	66	66	56	64	64	63	44	49	84	80	75	4	4	9	6	6	8	11	10	1	2	3

## ACCESS

Patients have good access to health care when they can obtain affordable care and receive attention in a timely manner. The 2013 survey included questions about whether patients were able to afford needed care (Exhibit 5). The survey also asked whether patients had serious problems paying medical bills and assessed out-of-pocket costs in each of the 11 countries.

### Cost-Related Access Problems

A higher percentage of people in the U.S. go without needed care because of cost than in any other surveyed nation. Americans were the most likely to say they had access problems because of cost. Thirty-seven percent said they did not get recommended care, fill a prescription, or visit a doctor or clinic when they had a medical problem because of cost. In the next-highest country, the Netherlands, the comparable percentage was 22. Patients in the United Kingdom and Sweden were the least likely to report having these cost-related access concerns (4% and 6%, respectively). Americans also reported negative insurance surprises and the highest rates of serious problems paying medical bills. Physicians in the U.S. acknowledge their patients have difficulty paying for care, with 59 percent believing affordability is a problem.

### Timeliness of Care

While Switzerland and the U.K. rank highly on all measures of timeliness, different patterns surface for the other countries in the study, depending on the particular health care service. Patients in the U.S. face financial burdens, and were far less likely than patients in Switzerland and the U.K. to have rapid access (same or next day) to primary care when they needed medication attention. However, U.S. patients report relatively rapid access to specialized health care services.

It is a common mistake to associate universal or near-universal coverage with long waiting times for specialized care. The U.K. has short waiting times for basic medical care and nonemergency access to services after hours. The U.K. also has improved waiting times to see a specialist and now rates fourth on this dimension with the U.S. ranking third. Patients in the Netherlands, Germany, France, and Switzerland have rapid access to elective or nonemergency surgery compared with patients in the U.S. Canada ranks last or near-to-last on most measures of timeliness of care.

## EXHIBIT 5. ACCESS MEASURES

		Raw Scores (Percent)												Ranking Scores											
Source		AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US		
<b>OVERALL BENCHMARK RANKING</b>													<b>8</b>	<b>9</b>	<b>11</b>	<b>2</b>	<b>4</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>9</b>		
<b>Cost-Related Access Problems</b>													<b>9</b>	<b>5</b>	<b>10</b>	<b>4</b>	<b>8</b>	<b>6</b>	<b>3</b>	<b>1</b>	<b>7</b>	<b>1</b>	<b>11</b>		
Did not fill a prescription; skipped recommended medical test, treatment, or follow-up; or had a medical problem but did not visit doctor or clinic in the past year because of cost	2013	16	13	18	15	22	21	10	6	13	4	37	7	4	8	6	10	9	3	2	4	1	11		
Patient's insurance denied payment for medical care or did not pay as much as expected	2013	15	14	17	14	13	6	3	3	16	3	28	8	6	10	6	5	4	1	1	9	1	11		
Patient had serious problems paying or was unable to pay medical bills	2013	8	7	13	7	9	10	6	4	10	1	23	6	4	10	4	7	8	3	2	8	1	11		
Physicians think their patients often have difficulty paying for medications or out-of-pocket costs	2012	25	26	29	21	42	26	4	6	16	13	59	6	7	9	5	10	7	1	2	4	3	11		
Out-of-pocket expenses for medical bills more than \$1,000 in the past year, US\$ equivalent	2013	25	14	7	11	7	9	17	2	24	3	41	10	7	3	6	3	5	8	1	9	2	11		
<b>Timeliness of Care</b>													<b>6</b>	<b>11</b>	<b>10</b>	<b>4</b>	<b>2</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>1</b>	<b>3</b>	<b>5</b>		
Last time needed medical attention, was able to see doctor or nurse the same or next day	2011	63	51	75	59	70	75	59	50	79	79	59	6	10	3	7	5	3	7	11	1	1	7		
Very or somewhat difficult to get medical care in the evening, weekend, or on a holiday without going to the emergency room (base: sought after-hours care)	2013	54	62	64	44	44	46	42	65	51	31	61	7	9	10	3	3	5	2	11	6	1	8		
Waiting time for emergency care was 2 hours or more (base: used an emergency room in past 2 years)	2013	25	48	36	23	17	14	34	32	18	16	28	6	11	10	5	3	1	9	8	4	2	7		
Doctors report patients often experience difficulty getting specialized tests (e.g., CT, MRI)	2012	16	38	41	27	7	59	10	15	3	14	23	6	9	10	8	2	11	3	5	1	4	7		
Doctors report patients often experience long wait times to receive treatment after diagnosis	2012	20	23	59	25	20	34	29	21	2	21	8	3	7	11	8	3	10	9	5	1	5	2		
Waiting time to see a specialist was 2 months or more (base: saw or needed to see a specialist in past 2 years)	2013	18	29	18	10	3	19	26	17	3	7	6	7	11	7	5	1	9	10	6	1	4	3		
Waiting time of 4 months or more for elective/nonemergency surgery (base: those needing elective surgery in past year)	2013	10	18	4	3	1	15	22	6	4	*	7	7	9	3	2	1	8	10	5	3	*	6		

\* U.K. sample size too small.

Note: The overall benchmark rating equally weights country performance on cost-related access problems and timeliness of care.

## EFFICIENCY

In the first *National Scorecard* report, efficiency is described in the following way: “An efficient, high-value health care system seeks to maximize the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time.”<sup>16</sup> To measure efficiency, this report examines total national expenditures on health as a percent of gross domestic product (GDP), as well as at the percentage spent on health administration and insurance. An important indicator from the 2013 survey of adults includes how much time patients spent on paperwork or disputes related to medical bills or health insurance. To get at administrative costs from a practice perspective, the 2012 survey asked primary care doctors about staff time spent on administrative issues related to claims or time spent getting their patient needed care because of coverage restrictions.

Exhibit 6 also shows data from the 2011 survey of adults with health problems who visited the emergency department for a condition that could have been treated by a regular doctor had one been available, those whose medical records did not reach the doctor’s office in time for an appointment, and those who were sent for duplicate tests. It also reports on the incidence of recently hospitalized adults who went to the emergency department during recovery or were rehospitalized for complications. Efficiency indicators from the 2012 survey include whether or not primary care practices have “multifunctional clinical information technology.” To be defined as a primary care practice with multifunctional IT functionality, the practice must have an electronic medical record (EMR) system with two or more functions for ordering, patient information, panel information, and decision support.

On indicators of efficiency, the U.S. scores last overall with poor performance on the two measures of national health expenditures, as well as on measures of administrative hassles, timely access to records and test results, duplicative tests, and rehospitalization. Among sicker respondents, those in Canada and the U.S. were most likely to visit the emergency department for a condition that could have been treated by a regular doctor had one been available, with rates twice as high as that of the United Kingdom and France. In the summary ranking, the U.K. and Sweden score first and second, respectively.

## EXHIBIT 6. EFFICIENCY MEASURES

	Source	Raw Scores (Percent)											Ranking Scores										
		AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL BENCHMARK RANKING</b>													<b>4</b>	<b>10</b>	<b>8</b>	<b>9</b>	<b>7</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>6</b>	<b>1</b>	<b>11</b>
Total expenditures on health as a percent of GDP*	2011	8.9	11.2	11.6	11.3	11.9	10.3	9.3	9.5	11.0	9.4	17.7	1	7	9	8	10	5	2	4	6	3	11
Percentage of national health expenditures spent on health administration and insurance*	2011	1.8	3.3	6.7	5.3	3.9	4.0	0.6	1.4	4.7	3.4	7.1	3	4	10	9	6	7	1	2	8	5	11
Patient spent a lot of time on paperwork or disputes related to medical bills	2013	6	5	10	8	9	4	7	2	16	2	18	5	4	9	7	8	3	6	1	10	1	11
Doctors report time spent on administrative issues related to insurance or claims is a major problem	2012	31	21	39	52	48	33	15	35	54	17	51	4	3	7	10	8	5	1	6	11	2	9
Doctors report time spent getting patients needed medications or treatment because of coverage restrictions is a major problem	2012	10	21	17	37	26	17	11	10	23	9	52	2	7	5	10	9	5	4	2	8	1	11
Visited ED for a condition that could have been treated by a regular doctor, had he/she been available (base: visited ED in past 2 years)	2011	31	41	21	28	26	22	28	28	25	16	40	9	11	2	6	5	3	6	6	4	1	10
Medical records/test results did not reach doctor's office in time for appointment, in past 2 years	2011	13	19	12	9	13	12	19	12	7	10	17	7	10	4	2	7	4	10	4	1	3	9
Sent for duplicate tests in past 2 years	2011	9	9	12	10	7	6	5	5	8	6	17	7	7	10	9	5	3	1	1	6	3	11
Hospitalized patients went to ER or rehospitalized for complication after discharge	2011	8	12	6	5	11	11	11	10	11	12	11	3	10	2	1	5	5	5	4	5	10	5
Practice with multifunctional clinical information technology**	2012	60	10	6	7	33	59	4	19	11	68	27	2	8	10	9	4	3	11	6	7	1	5
Practice can electronically exchange patient clinical summaries and laboratory and diagnostic tests with doctors outside practice	2012	27	14	39	22	49	55	45	52	49	38	31	9	11	6	10	3	1	5	2	3	7	8

\* Data: OECD, *OECD Health Data, 2013* (Nov. 2013); Australia is 2010, U.K. is 1999.

\*\* Primary care practice has EMR and 2+ functions for: ordering, patient info, panel info, decision support.

## EQUITY

The Institute of Medicine defines equity as “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.”<sup>17</sup> We grouped adults by two income categories: those who reported their incomes as above the country median and those who reported their incomes as below the country median. In all 11 countries, adults reporting below-average incomes were more likely to report chronic health problems (not shown). Thus, reports from these lower-income adults provide particularly sensitive measures for how well each country performs in terms of meeting the needs of its most vulnerable population.

## EXHIBIT 7. EQUITY MEASURES

	Raw Scores (Percent): Below-Average Income												Raw Scores (Percent): Above-Average Income											
	Source	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	
	<b>OVERALL BENCHMARK RANKING</b>																							
Rated doctor fair/poor	2013	5	12	9	11	5	8	14	17	3	11	15	5	6	6	6	6	2	12	12	1	6	6	
Rated quality of care fair/poor	2011	12	17	12	19	16	10	21	11	6	5	27	7	9	8	15	17	5	14	10	4	6	7	
Had medical problem but did not visit doctor because of cost in the past year	2013	14	7	11	11	16	23	7	5	11	1	39	5	3	3	4	8	15	3	2	4	3	17	
Did not get recommended test, treatment, or follow-up because of cost in the past year	2013	10	14	10	12	11	9	9	7	9	1	31	6	4	2	5	5	2	2	2	4	2	11	
Did not fill prescription or skipped doses because of cost in the past year	2013	14	8	11	8	20	18	7	4	11	4	30	8	4	6	3	14	9	4	1	6	2	12	
Last time needed medical attention was able to see doctor or nurse the same or next day	2011	64	45	73	61	66	71	55	46	79	78	55	67	53	71	59	78	82	64	54	82	82	61	
Somewhat or very difficult to get care in the evenings, on weekends, or holidays (base: sought after-hours care)	2013	58	67	64	44	53	64	48	67	56	40	70	58	59	62	47	35	42	37	63	52	30	53	
Waited 2 months or longer for specialist appointment (base: needed to see specialist in past 2 years)	2013	22	29	19	12	3	29	29	16	3	6	9	22	30	16	8	3	12	29	17	1	7	4	
Waited 2 hours or more in ER (base: those going to ER)	2013	28	48	34	20	22	15	33	37	20	24	36	20	43	39	21	13	10	27	29	15	11	16	
Unnecessary duplication of medical tests in past 2 years	2011	8	10	13	9	6	7	7	6	8	4	19	11	9	10	15	6	6	7	6	8	3	14	

In Exhibit 7, we compare how adults reporting their incomes as below average rate their access to care compared with those reporting their incomes as above average. The rankings are based on the percentage-point difference between the responses of below-average-income respondents to above-average-income respondents, with a higher percentage gap indicating greater access problems for those with below-average incomes. We used survey measures expected to be sensitive to financial barriers to care, such as not getting needed or recommended care because of costs and difficulty getting care when needed.

The U.S. ranks low on access to care measures, with low-income adults particularly at risk. As a result, it does poorly on all 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 of lower-income adults in the U.S. said they went without needed care because of costs in the past year.

Sweden, Switzerland, and the U.K. score highest on overall equity, with small differences between lower- and higher-income adults on most measures. The United States and New Zealand are last and second-to-last, respectively, on the equity domain.



## EXHIBIT 7. EQUITY MEASURES (continued)

Percentage-Point Difference Between Below-Average and Above-Average Income											Ranking Scores										
AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
											<b>5</b>	<b>9</b>	<b>7</b>	<b>4</b>	<b>8</b>	<b>10</b>	<b>6</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>11</b>
0	6	3	5	-1	6	2	5	2	5	9	2	9	5	6	1	9	3	6	3	6	11
5	8	4	4	-1	5	7	1	2	-1	20	7	10	5	5	1	7	9	3	4	1	11
9	4	8	7	8	8	4	3	7	-2	22	10	3	7	5	7	7	3	2	5	1	11
4	10	8	7	6	7	7	5	5	-1	20	2	10	9	6	5	6	6	3	3	1	11
6	4	5	5	6	9	3	3	5	2	18	8	4	5	5	8	10	2	2	5	1	11
3	8	-2	-2	12	11	9	8	3	4	6	3	7	1	1	11	10	9	7	3	5	6
0	8	2	-3	18	22	11	4	4	10	17	2	6	3	1	10	11	8	4	4	7	9
0	-1	3	4	0	17	0	-1	2	-1	5	4	1	8	9	4	11	4	1	7	1	10
8	5	-5	-1	9	5	6	8	5	13	20	7	3	1	2	9	3	6	7	3	10	11
-3	1	3	-6	0	1	0	0	0	1	5	2	7	10	1	3	7	3	3	3	7	11

## HEALTHY LIVES

The goal of a well-functioning health care system is to ensure that people lead long, healthy, and productive lives. To measure this dimension, Exhibit 8 includes three outcome indicators, including mortality amenable to health care—that is, deaths that could have been prevented with timely and effective care; infant mortality; and healthy life expectancy.

On the three healthy lives indicators, France ranks highest overall—scoring among the top three countries on each indicator—and Sweden ranks second. The U.S. ranks last on mortality amenable to health care, last on infant mortality, and second-to-last on healthy life expectancy at age 60. Notably, countries’ performance on these three outcomes indicators did not necessarily align with their ranks on the other dimensions of health system performance. France ranks near the bottom overall, whereas the U.K., which ranks first or second on every other dimension, ranks near the bottom of healthy lives. Unfortunately, scarce cross-nationally comparable data on health outcomes limit this dimension to only three indicators. However, the indicators that are available demonstrate the health care system to be just one of many factors, including social and economic well-being, that influence the health of a nation.

The finding that the U.S. lags in health outcomes despite spending so much more than other countries on health care echoes the findings in the Institute of Medicine’s 2013 report on the health of the U.S. population, which found the U.S. has worse health and premature death rates in all age groups and at all income levels.<sup>18</sup> The wealth of data amassed by the IOM underscores a clear need to focus on improving population health along with the performance of the health care delivery system.

## EXHIBIT 8. HEALTHY LIVES MEASURES

	Raw Scores											Ranking Scores										
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL BENCHMARK RANKING</b>												4	8	1	7	5	9	6	2	3	10	11
Mortality amenable to health care (deaths per 100,000) <sup>a</sup>	57	77	55	76	66	79	64	61	*	83	96	2	7	1	6	5	8	4	3	*	9	10
Infant mortality (deaths per 1,000 live births) <sup>b</sup>	3.8	4.9	3.5	3.6	3.6	5.5	2.4	2.1	3.8	4.3	6.1	6	9	3	4	4	10	2	1	6	8	11
Healthy life expectancy at age 60 (average of women and men) <sup>c</sup>	18.7	18.3	18.8	17.8	17.8	18.2	17.4	18.2	19.0	17.7	17.5	3	4	2	8	7	5	11	6	1	9	10

<sup>a</sup> 2006–07 World Health Organization (WHO) mortality data; Canada data from 2002–03. \* Data not available for Switzerland. For more details on sources see the [methodology](#) appendix.

<sup>b</sup> OECD, *OECD Health Data, 2013* (Nov. 2013). Data are from 2011, except Canada (2009).

<sup>c</sup> WHO Global Health Observatory Data Repository. Data from 2011.

## DISCUSSION

This examination provides evidence of deficiencies in quality of care in the U.S. health system, as reflected by patients' and physicians' experiences. Although the U.S. spends more on health care than any other country and has the highest proportion of specialist physicians, survey findings indicate that from the patients' perspective, and based on outcome indicators, the performance of American health care is severely lacking. The nation's substantial investment in health care is not yielding returns in terms of public satisfaction or health outcomes.

Based on the indicators measured in the surveys, the U.S. rarely outperforms the other nations. While its quality scores have improved somewhat since the last edition of the report, the U.S. is still only average on the key subdomains of effective, safe, coordinated, and patient-centered care. It is apparent that many primary care physicians struggle to receive relevant clinical information from specialists and hospitals, complicating efforts to provide seamless, coordinated care. Among the 11 countries, the U.S. performed particularly poorly on measures of access; efficiency; equity; and healthy lives.

It is difficult to disentangle the effects of health insurance coverage from the quality of care experiences reported by U.S. patients. Comprehensiveness of insurance and stability of coverage are likely to play a role in patients' access to care and interactions with physicians. We found that insured Americans and higher-income Americans were more likely than their counterparts in other countries to report problems such as not getting recommended tests, treatments, or prescription drugs. This is undoubtedly a reflection of the lack of comprehensive health insurance coverage and the high out-of-pocket costs for care in the U.S., even among the insured and those with above-average incomes. Fragmented coverage and insurance instability undermine efforts in the U.S. to improve care coordination, including the sharing of information among providers. Patients in other countries, in addition, are more likely to have a regular physician and long-time continuity with the same physician.

The Affordable Care Act is designed to ameliorate some of these problems. The establishment of health insurance marketplaces, income-related premium subsidies, minimum essential benefit packages, and new insurance market regulations in 2014 will help extend coverage to an estimated 26 million previously uninsured Americans and contribute greatly to the stability and security of coverage of those who already

have it. Closing gaps in coverage will support better disease management, greater care coordination, and superior outcomes over time.

Any international comparison of health care is subject to inherent data weaknesses, such as the absence of medical record clinical information or timely health outcomes data. The measures, methods, and data used in this analysis are far from perfect. Different measures, moreover, are given equal weight in the rankings and are not weighted based on independent evidence of what patients value most highly. That is, patients may, in fact, value a measure of effective care—whether they received a reminder for preventive care or recommended diabetic services if warranted—more than a measure of timeliness. However, for the purposes of this report, all measures are weighted equally.

One definition of “quality” care is health services that meet or exceed consumer expectations. Even if the expectations of U.S. patients were higher than patients in other countries, the U.S. health care system should be held to the standard of meeting its consumers’ needs. Thus, while patient perspectives are only one lens through which to view health systems, the overall conclusion remains: the U.S. health care system is not the “fairest of them all,” at least from the viewpoint of those who use it to stay healthy, get better, or manage their chronic illnesses, or who are vulnerable because of low income and poor health. Patients’ perceptions on issues of financial accessibility are mirrored, too, by physicians’ views.

In seeking to improve health system performance, the U.S. can look to the experiences of other countries. The U.K. ranks high in all dimensions except for healthy lives; Switzerland does well on timeliness, equity, and offering patient-centered care; and France and Sweden demonstrate superior performance on healthy lives indicators. The U.S. would benefit from analysis of promising innovations in other countries and greater investment in cross-national research as well as looking at best practices within its borders. However, examination of the raw scores shows that in many or most instances the top-ranked country is performing at less than an “ideal” level. It is likely that, as within the U.S., there is significant variation within each of the countries and all countries could improve performance by looking for best practices within and outside their borders.

These results indicate a consistent relationship between how a country performs in terms of equity and how patients rate other dimensions of performance: the lower the performance score for equity, the lower the performance on other measures. This suggests that, when a country fails to meet the needs of the most vulnerable, it also fails to meet needs for the average citizen. Rather than regarding performance on equity as a separate and lesser concern, the U.S. should devote far greater attention to building a health system that works well for all Americans. Indeed, a Commonwealth Fund *State Scorecard* comparing access, quality, and health outcomes for lower-income individuals finds that the gap between the average performance of lagging and leading states would be substantially reduced by raising standards of care and improving access for those in the bottom half of the income distribution.<sup>19</sup>

The U.S. is implementing historic legislation that could improve health insurance coverage and quality of care for low- and moderate-income families. This is an important first step, but the nation must vigilantly monitor the experiences and outcomes of vulnerable populations. In doing so, it can continue to make progress toward a high performance health system that can truly be called “the best in the world.”

## 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

**EXHIBIT 9. NUMBER OF INDIVIDUALS SURVEYED**

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US	TOTAL
2011, Survey of Sicker Adults	1,500	3,958	1,001	1,200	1,000	750	753	4,804	1,500	1,001	1,200	18,667
2012, Survey of Primary Care Physicians	500	2,124	501	909	522	500	869	1,314	1,025	500	1,012	9,776
2013, Survey of Adults	2,200	5,412	1,406	1,125	1,000	1,000	1,000	2,400	1,500	1,000	2,002	20,045

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.

## 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).
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- <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).
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- <sup>8</sup> E. J. Emanuel, "What Cannot Be Said on Television About Health Care," *Journal of the American Medical Association*, May 16, 2007 297(19):2131–33.
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- <sup>10</sup> Commonwealth Fund Commission, *Why Not the Best?* 2011; D. C. Radley, D. McCarthy, J. A. Lippa, S. L. Hayes, and C. Schoen, *Aiming Higher: Results from a Scorecard on State Health System Performance, 2014* (New York: The Commonwealth Fund, May 2014).

- <sup>11</sup> Ibid.
- <sup>12</sup> Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academies Press; 2001).
- <sup>13</sup> *National and State Healthcare Associated Infections: Progress Report* (Atlanta: Centers for Disease Control and Prevention, March 2014).
- <sup>14</sup> Commonwealth Fund Commission, *Why Not the Best?* 2011.
- <sup>15</sup> Ibid.
- <sup>16</sup> Ibid.
- <sup>17</sup> Institute of Medicine, *Crossing the Quality Chasm*, 2001.
- <sup>18</sup> Institute of Medicine, *U.S. Health in International Perspective: Shorter Lives, Poorer Health* (Washington, D.C.: National Academies Press, Jan. 2013).
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