HEALTH POLICY 101

International Comparison of Health Systems

October 2025

This publication is available at kff.org/health-policy-101

KFF

This is one chapter of KFF's Health Policy 101, a resource for students and educators of health policy. View its other chapters at the links below or at: kff.org/health-policy-101

Medicare 101

Medicaid 101

The Affordable Care Act 101

Employer-Sponsored Health Insurance 101

The Uninsured Population and Health Coverage

Health Care Costs and Affordability

The Regulation of Private Health Insurance

Health Policy Issues in Women's Health

Race, Inequality, and Health

LGBTQ+ Health Policy

U.S. Public Health 101

International Comparison of Health Systems

The U.S. Government and Global Health

The Role of Public Opinion Polls in Health Policy

Congress, the Executive Branch, and Health Policy

The Politics of Health Care and Elections

Table of Contents

Introduction 1

Health Insurance Systems and Coverage 1

Health Spending 2

- Spending Growth 2
- Drivers of Health Spending 2

Health Outcomes 3

- Life Expectancy 3
- Years of Life Lost 4

Quality of Care 4

- Hospital Mortality Rates 5
- Maternal Health 5
- Hospital Admissions 5
- Post-Operative Complications 6

Access to Care 6

- Out-of-Pocket Costs 6
- Appointment Availability 6
- Physicians 7

Future Outlook 7

Resources 8

Introduction

Health systems aim 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 those 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 between the U.S. and 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, health and other factors also play a role.

Health Insurance Systems and Coverage

From the late nineteenth to mid-twentieth centuries, many nations created health insurance systems that aimed to make health care accessible and affordable to their population. 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 financing mechanism, the health systems in many 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 people 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 expanded 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 in the U.S. continue to go without insurance, often citing cost as a barrier.

Health Spending

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.

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, which was 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.

The United States spends more per capita on total health expenditures, including government spending and household payments. In 2020, the U.S. spent 19.5% of its GDP on health consumption (up from 17.5% in 2019), largely due to the increased spending during the COVID-19 pandemic, along with the economic downturn. By 2023, health spending as a share of GDP had declined to 17.6% 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, which includes 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 $8,353 per person on inpatient and outpatient care, compared to $3,636 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).

The cost of prescription drugs is another factor that partially explains the U.S.'s higher health spending. Many of the same medications cost more in the U.S. than they do in other comparable nations. In 2022, the U.S. spent $1,765 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. were closer to that of comparable countries, that would make only a small dent in closing the gap on health spending.

Spending on health administration is similarly much higher in the U.S. than in comparable countries: $1,078 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 per capita on preventive care than peer nations. Activities captured in this spending category vary among 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. In the U.S., preventive care spending more than doubled between 2019 and 2020, from $343 to $741 per capita, but subsequently declined to $649 by 2022.

Meanwhile, the only category of spending in which the U.S. spends less than most comparable countries on a per-person basis is long-term care. Long-term care spending includes health and social services provided in long-term care institutions such as nursing homes as well as home- and community-based settings. After an increase from 2019 to 2020 at the onset of the COVID-19 pandemic, U.S. spending on long-term care declined by 4.9% between 2020 and 2021 but increased again by 5.4% between 2021 and 2022. Long-term care spending was already lower in the U.S. than in peer countries before the pandemic.

Health Outcomes

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. That 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 nations (78.8 vs. 82.7 years).

This plateau and four-year gap were already highly concerning, but the health crisis brought on by the COVID-19 pandemic made the situation in the U.S. much worse. For the first time ever recorded, life expectancy dropped by almost two years, from 78.8 in 2019 to 77.0 in 2020. 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). By 2023, life expectancy rebounded to 78.4 years, still a full 1.3 years below pre-pandemic levels and over four years below the average among peer nations.

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 persisted 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 factors which are decreasing life expectancy.

The United States had the highest rate of years of life lost per 100,000 population aged 75 years old in 2021, by a large margin. However, by examining the cause of these years of life lost, it is possible to notice where the U.S. underperforms. 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).

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. 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 doctors' offices or hospitals. Life expectancy, mortality rates, and disease burden can also be influenced by factors outside 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.

Quality of Care

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

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) are similar in the U.S. and the average of comparable countries. However, the 30-day mortality rates for ischemic strokes (caused by blood clots) were 4.5 deaths per 100 patients in the U.S. in 2022, compared to an average of 6.9 deaths per 100 patients in similar countries. Rates of mortality after hemorrhagic stroke (caused by bleeding) are also lower in the U.S. While the U.S. has lower rates of mortality 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

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 (18.6 deaths per 100,000 live births in 2023) when compared to similar countries (5.1 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 3 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.

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 2022, 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 2022, on the lower end among comparable countries with available data.

Hospital Admissions

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 may be avoided through primary care.

Post-Operative Complications

Rates of post-operative complications are an important measure of hospital safety. Pulmonary embolisms and deep vein thromboses 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.

Sepsis is a life-threatening complication of infection that can lead to organ failure, shock, or death. 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, among 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.

Access to Care

Out-of-Pocket Costs

Universal coverage means all residents have health insurance, but it does not mean health care is free. In many countries people contribute to health care costs through both out-of-pocket expenses—such as copays, coinsurance, and deductibles—as well as insurance premiums. 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 ($1,425) per capita.

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 21% 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.

Appointment Availability

Cost is not the only reason why a person may miss or delay needed medical care. The availability of physicians can also impact access to care. 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%).

Physicians

The U.S. has just 2.7 practicing physicians per 1,000 residents, compared to an average of 3.8 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 all 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 general physicians, including primary care physicians.

The U.S. faces this physician shortage and high rates of specialization in part 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 with a significant amount of debt. Because primary care generally comes with a lower salary, some new physicians may pursue a higher-paid specialty, even if they would rather work in primary care.

Additionally, the U.S. has only 0.15 psychiatrists per 1,000 residents, the 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.

Future Outlook

The 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, and it is not yet clear whether life expectancy and other measures will recover as quickly in the U.S. as in peer nations. In addition to the pandemic recovery, both the U.S. and peer countries face the challenge of aging populations and increases in chronic conditions, leading to increased demand for health care services and long-term care.

Access to Care: Unlike the U.S., other large and wealthy nations have long achieved universal or near-universal health coverage and offer more robust access to care. While the U.S. recently reached a record-high insurance coverage rate, the tax and spending legislation signed by President Trump includes the biggest reduction ever in federal spending on Medicaid and the Affordable Care Act Marketplaces—changes that are projected to increase the number of people uninsured by millions in the coming years. Moreover, even those with insurance in the U.S. often face high out-of-pocket costs, leading many to forgo needed care or incur medical debt.

Quality of Care: The adoption of new technologies will shape care delivery in both the United States and in other countries. 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. In the U.S., by contrast, the federal and state governments less directly control commercial health insurance prices. However, with the passage of the Inflation Reduction Act, Medicare has negotiated drug prices for a selection of high cost drugs. There will likely be ongoing debate about further actions the federal government can take to lower drug prices, as well as taking other steps to restrain prices 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.

Citation

Wager, E. & Cox, C., International Comparison of Health Systems. In Altman, Drew (Editor), Health Policy 101, (KFF, October 2025) https://www.kff.org/health-policy-101-international-comparison-of-health-systems/ (date accessed).

KFF

The independent source for health policy research, polling, and news.

Headquarters
185 Berry Street, Suite 2000
San Francisco, CA 94107
650.854.9400

Washington Office &
Barbara Jordan Conference Center
1330 G Street NW
Washington, DC 20005
202.347.5270

This publication is available at kff.org/health-policy-101