Advance readings for October 29, 2015 Foreign Affairs discussion at the Burlington Public Library. The topic is “Health Care Systems Around the World.”


**Innovations in Diabetes Care Around the World: Case Studies of Care Transformation Through Accountable Care Reform**

Lessons from case studies of diabetes care innovations in Mexico, India, and the U.S.

The adoption of new diabetes care models are hindered by financial barriers

**Synopsis**

The rising rate of diabetes worldwide has in recent years spurred a number of innovative prevention and treatment programs focused on community-based care and information technology. Scaling up these interventions has proved difficult, however. Based on case studies conducted in the United States, Mexico, and India, researchers identified financial, organizational, and regulatory barriers to broader adoption that program leaders and policymakers are struggling to address. The authors believe a combination of new funding approaches, institutional reforms, and performance measures are necessary to spread effective advances in care and reduce the burden of diabetes and other chronic diseases.

**The Issue**

Diabetes affects 380 million adults, approximately 8.3 percent of the world’s population. Recognizing that widespread improvements in health will likely require disruptive innovations in prevention and treatment, a number of programs have emerged to combat diabetes through nontraditional pathways. These efforts include bundling care with nonhealth services, providing treatment in community settings, and using technology to reach isolated or homebound patients. Scaling up or extending these new care models has proved difficult, however, owing to a host of institutional, regulatory, and financial hurdles. Writing in *Health Affairs,* Commonwealth Fund–supported researchers examined transformative innovations in diabetes care, using case studies from Mexico, India, and the U.S., countries where diabetes prevalence is higher than the global average.

**Diabetes Care Innovations in Mexico, India, and the United States**

"Disruptive innovation for diabetes care is not easy, but it is essential to reducing the rising health and cost impact."

- Pro Mujer, in Mexico, integrates health and financial services for low-income women. For instance, it provides diabetes screenings, education, and other health services at reduced cost to women who attend monthly microloan repayment meetings.
- ClickMedix, which operates in all three countries, provides virtual medical consultations to vulnerable and rural patient populations. The electronic platform enables health workers to serve more patients while lowering costs.
The YMCA Diabetes Prevention Program uses existing community-based centers to reach patients, coordinating exercise and providing health education, nutritional support, and individual counseling at YMCA sites across the U.S. It has been expanded through results-based, add-on payments made by UnitedHealthcare and Medicaid. Depending on an individual’s attainment of weight-loss goals and class attendance, the program receives $175 per person per session on average. These payments have allowed the YMCA to offer the program to people who otherwise could not afford it or who are not covered by a participating insurer.

Policy Reforms to Reduce Barriers

The authors identified financial, institutional, and regulatory policy barriers that have hindered the diffusion of these and other successful care innovations:

Financial barriers. Across the three case study examples, financial barriers proved to be most critical. “There was a poor fit between the new models of care and many existing payment policies,” the authors note. For instance, in the U.S., estimates from the Diabetes Prevention Program suggest that scaling the intervention could delay 885,000 new cases of diabetes and save $5.7 billion over 25 years. Yet large agencies like the Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs are currently unable to redirect funding to adopt this model. Thus far, only a limited set of private payers have done so.

Institutional barriers. Pro Mujer in Mexico is dealing with issues related to health services regulation under the finance ministry, as its diabetes program is operated in conjunction with financial services outside the traditional health system. In the U.S., the fragmentation of public financing across different agencies, such as CMS for diabetes care and the Centers for Disease Control and Prevention for community initiatives, is a complicating factor. In India, meanwhile, the state-based nature of regulation and financing complicates the nationwide adoption of new care models, the authors say. Program leaders have responded by developing collaborations with physician groups and other providers, public health and patient advocates, and business and insurance leaders, as well staff members in key government agencies. Based on their research, the authors say that innovation usually begins and is scaled up in the private sector, because partnerships with the public sector can take time to develop.

Regulatory barriers. In Mexico, the Pro Mujer program found a lack of clarity about which agency had jurisdiction over the program. In the U.S., differing state laws created challenges related to licensing and practicing medicine across state lines. Regulatory barriers were relatively low in India.

Overcoming Barriers to Diffusion

The authors identified policy reforms that would provide health care innovations with a clearer pathway to sustainability. Most important are financing reforms, such as linking provider payment to scores on meaningful, outcome-oriented performance measures, offering add-on payments to providers, or making subsidies available to patients. Other recommendations include forming partnerships between health care payers and community organizations.

About This Study
The authors conducted a literature review to identify diabetes care innovations in different countries. Once selected, they interviewed some of the organization leaders (i.e., of ClickMedix and Pro Mujer) regarding barriers and challenges to adopting and disseminating their programs.

**The Bottom Line**

Disruptive innovation in diabetes care is essential in the fight against this costly global disease, but financial and other policy barriers must be overcome if the most promising programs are to reach those populations most likely to benefit.

**International Health Policy Surveys**

The Commonwealth Fund and its partners conduct a cross-national survey of health care system performance annually.

*International Survey of Older Adults Finds Shortcomings in Access, Coordination, and Patient-Centered Care*
November 21, 2014
Compared with their counterparts in 10 other industrialized countries, older adults in the U.S. are sicker and more likely to have problems paying their medical bills and getting needed health care.

*Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries*
November 13, 2013
The 2013 international survey finds that adults in the United States are far more likely than those in 10 other high-income industrialized nations to go without health care because of the cost, encounter difficulties paying medical bills, and deal with time-consuming health insurance paperwork or disputes, including claims that were unexpectedly not paid.

*A Survey of Primary Care Doctors in Ten Countries Shows Progress in Use of Health Information Technology, Less in Other Areas*
November 15, 2012
More than two-thirds of U.S. primary care physicians were using electronic medical records in 2012, a substantial increase from 2009, when less than half had adopted the technology, a new Commonwealth Fund survey finds. But results also depict the U.S. as an outlier when it comes to affordability of health care.

*Survey of Patients with Complex Care Needs in Eleven Countries Finds That Care Is Often Poorly Coordinated*
November 9, 2011
Adults with complex medical conditions, including those with serious or chronic illness, injury, or disability, benefit from receiving their care from a medical home, The Commonwealth Fund's latest international health policy survey finds.
U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries

High U.S. health care spending due to greater use of medical technology, health care prices

U.S. spends more on health care than other high-income countries but has worse outcomes

Abstract

This analysis draws upon data from the Organization for Economic Cooperation and Development and other cross-national analyses to compare health care spending, supply, utilization, prices, and health outcomes across 13 high-income countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. These data predate the major insurance provisions of the Affordable Care Act. In 2013, the U.S. spent far more on health care than these other countries. Higher spending appeared to be largely driven by greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions. In contrast, U.S. spending on social services made up a relatively small share of the economy relative to other countries. Despite spending more on health care, Americans had poor health outcomes, including shorter life expectancy and greater prevalence of chronic conditions.

"Maybe We Could Have Bought Him a Good Pair of Shoes": Why Peer Nations Spend Less on Health Care but Stay Healthier

OVERVIEW

Cross-national comparisons allow us to track the performance of the U.S. health care system, highlight areas of strength and weakness, and identify factors that may impede or accelerate improvement. This analysis is the latest in a series of Commonwealth Fund cross-national comparisons that use health data from the Organization for Economic Cooperation and Development (OECD), as well as from other sources, to assess U.S. health care system spending, supply, utilization, and prices relative to other countries, as well as a limited set of health outcomes. Thirteen high-income countries are included: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. On measures where data are widely available, the value for the median OECD country is also shown. Almost all data are for years prior to the major insurance provisions of the Affordable Care Act; most are for 2013.

Health care spending in the U.S. far exceeds that of other high-income countries, though spending growth has slowed in the U.S. and in most other countries in recent years. Even though the U.S. is the only country without a publicly financed universal health system, it still spends more public dollars on health care than all but two of the other countries. Americans have relatively few hospital admissions and physician visits, but are greater users of expensive technologies like magnetic resonance imaging (MRI) machines. Available cross-national pricing data suggest that prices for health care are notably higher in the U.S., potentially explaining a large part of the higher health spending. In contrast, the U.S. devotes a relatively small share of its economy to social services, such as housing assistance, employment programs, disability benefits, and food security. Finally, despite
its heavy investment in health care, the U.S. sees poorer results on several key health outcome measures such as life expectancy and the prevalence of chronic conditions. Mortality rates from cancer are low and have fallen more quickly in the U.S. than in other countries, but the reverse is true for mortality from ischemic heart disease.

The Commonwealth Fund has supported a series of publications using OECD Health Data since 1998

What’s new in this update?
Health care spending growth has slowed in recent years, both in the U.S. and internationally.

What remains the same?
Americans continue to far outspend other wealthy nations on health care but do not have better health outcomes.

KEY FINDINGS

The United States is the highest spender on health care. [Exhibits 1, 2]

Data from the OECD show that the U.S. spent 17.1 percent of its gross domestic product (GDP) on health care in 2013. This was almost 50 percent more than the next-highest spender (France, 11.6% of GDP) and almost double what was spent in the U.K. (8.8%). U.S. spending per person was equivalent to $9,086 (not adjusted for inflation).

Since 2009, health care spending growth has slowed in the U.S. and most other countries. The real growth rate per capita in the U.S. declined from 2.47 percent between 2003 and 2009 to 1.50 percent between 2009 and 2013. In Denmark and the United Kingdom, the growth rate actually became negative. The timing and cross-national nature of the slowdown suggest a connection to the 2007–2009 global financial crisis and its aftereffects, though additional factors also may be at play.\(^5\)
Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

*2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.
Private spending on health care is highest in the U.S. [Exhibit 2]

In 2013, the average U.S. resident spent $1,074 out-of-pocket on health care, for things like copayments for doctor’s office visits and prescription drugs and health insurance deductibles. Only the Swiss spent more at $1,630, while France and the Netherlands spent less than one-fourth as much ($277 and $270, respectively). As for other private health spending, including on private insurance premiums, U.S. spending towered over that of the other countries at $3,442 per capita—more than five times what was spent in Canada ($654), the second-highest spending country.²

U.S. public spending on health care is high, despite covering fewer residents. [Exhibit 2]

Public spending on health care amounted to $4,197 per capita in the U.S. in 2013, more than in any other country except Norway ($4,981) and the Netherlands ($4,495), despite the fact that the U.S. was the only country studied that did not have a universal health care system. In the U.S., about 34 percent of residents were covered by public programs in 2013, including Medicare and Medicaid.³ By comparison, every resident in the United Kingdom is covered by the public system and spending was $2,802 per capita. Public spending on health care would be even greater in the U.S. if the tax exclusion for employer-sponsored health insurance (amounting to about $250 billion each year) was counted as a public expenditure.⁴
Despite spending more on health care, Americans have fewer hospital and physician visits. [Exhibit 3, 4]

The U.S. had fewer practicing physicians in 2013 than in the median OECD country (2.6 versus 3.2 physicians per 1,000 population). With only four per year, Americans also had fewer physician visits than the OECD median (6.5 visits). In contrast, the average Canadian had 7.7 physician visits and the average Japanese resident had 12.9 visits in 2012.

In the U.S., there were also fewer hospital beds and fewer discharges per capita than in the median OECD country.
Exhibit 3. Physician Supply and Use, 2013 or Nearest Year

Practicing physicians per 1,000 population

<table>
<thead>
<tr>
<th>Country</th>
<th>NOR</th>
<th>GER</th>
<th>SWE</th>
<th>SWZ</th>
<th>DEN</th>
<th>AUS</th>
<th>OECD median</th>
<th>FR</th>
<th>NZ</th>
<th>US</th>
<th>CAN</th>
<th>JAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>4.3</td>
<td>4.1</td>
<td>4.0</td>
<td>4.0</td>
<td>3.6</td>
<td>3.4</td>
<td>3.2</td>
<td>3.1</td>
<td>2.8</td>
<td>2.6</td>
<td>2.5</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Annual physician visits per capita

<table>
<thead>
<tr>
<th>Country</th>
<th>JAP</th>
<th>GER</th>
<th>CAN</th>
<th>AUS</th>
<th>OECD median</th>
<th>FR</th>
<th>NETH</th>
<th>DEN</th>
<th>NOR</th>
<th>US</th>
<th>SWZ</th>
<th>NZ</th>
<th>SWE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>12.9</td>
<td>9.9</td>
<td>7.7</td>
<td>7.1</td>
<td>6.5</td>
<td>6.4</td>
<td>6.2</td>
<td>4.6</td>
<td>4.2</td>
<td>4.0</td>
<td>3.9</td>
<td>3.7</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Note: Data from 2012 in Canada, Denmark, Japan, and Sweden.

Note: Data from 2012 in Canada, Japan, Sweden, and Switzerland; and 2010 in the U.S.

Source: OECD Health Data 2015.
Americans appear to be greater consumers of medical technology, including diagnostic imaging and pharmaceuticals. [Exhibit 5, 6]

The U.S. stood out as a top consumer of sophisticated diagnostic imaging technology. Americans had the highest per capita rates of MRI, computed tomography (CT), and positron emission tomography (PET) exams among the countries where data were available. The U.S. and Japan were among the countries with the highest number of these imaging machines.9

In addition, Americans were top consumers of prescription drugs. Based on findings from the 2013 Commonwealth Fund International Surveys, adults in the U.S. and New Zealand on average take more prescription drugs (2.2 per adult) than adults in other countries.
### Exhibit 5. Diagnostic Imaging Supply and Use, 2013

<table>
<thead>
<tr>
<th></th>
<th>Magnetic resonance imaging</th>
<th>Computed tomography</th>
<th>Positron emission tomography</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MRI machines per million pop.</td>
<td>MRI exams per 1,000 pop.</td>
<td>CT scanners per million pop.</td>
</tr>
<tr>
<td>Australia</td>
<td>13.1</td>
<td>27.6</td>
<td>53.7</td>
</tr>
<tr>
<td>Canada</td>
<td>8.8</td>
<td>52.8</td>
<td>14.7</td>
</tr>
<tr>
<td>Denmark</td>
<td>–</td>
<td>60.3</td>
<td>37.8</td>
</tr>
<tr>
<td>France</td>
<td>9.4</td>
<td>90.9</td>
<td>14.5</td>
</tr>
<tr>
<td>Japan</td>
<td>46.9&lt;sup&gt;b&lt;/sup&gt;</td>
<td>–</td>
<td>101.3&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Netherlands</td>
<td>11.5</td>
<td>50.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>11.5</td>
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<tr>
<td>New Zealand</td>
<td>11.2</td>
<td>–</td>
<td>16.6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>–</td>
<td>–</td>
<td>36.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6.1</td>
<td>–</td>
<td>7.9</td>
</tr>
<tr>
<td>United States</td>
<td>35.5</td>
<td>106.9</td>
<td>43.5</td>
</tr>
<tr>
<td>OECD median</td>
<td>11.4</td>
<td>50.6</td>
<td>17.6</td>
</tr>
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</table>

<sup>a</sup> 2012. <sup>b</sup> 2011. <sup>c</sup> 2010.

Source: OECD Health Data 2015.
Health care prices are higher in the U.S. compared with other countries. [Exhibit 7]

Data published by the International Federation of Health Plans suggest that hospital and physician prices for procedures were highest in the U.S. in 2013.\textsuperscript{10} The average price of bypass surgery was $75,345 in the U.S. This is more than $30,000 higher than in the second-highest country, Australia, where the procedure costs $42,130. According to the same data source, MRI and CT scans were also most expensive in the U.S. While these pricing data are subject to significant methodological limitations, they illustrate a pattern of significantly higher prices in many areas of U.S. health care.

Other studies have observed high U.S. prices for pharmaceuticals. A 2013 investigation by Kanavos and colleagues created a cross-national price index for a basket of widely used in-patent pharmaceuticals. In 2010, all countries studied had lower prices than the U.S. In Australia, Canada, and the United Kingdom, prices were about 50 percent lower.\textsuperscript{11}
A 2013 study by Bradley and Taylor found that the U.S. spent the least on social services such as retirement and disability benefits, employment programs, and supportive housing among the countries studied in this report, at just 9 percent of GDP. Canada, Australia and New Zealand had similarly low rates of spending, while France, Sweden, Switzerland, and Germany devoted roughly twice as large a share of their economy to social services as did the U.S.

The U.S. was also the only country studied where health care spending accounted for a greater share of GDP than social services spending. In aggregate, U.S. health and social services spending rank
near the middle of the pack.

**Exhibit 8. Health and Social Care Spending as a Percentage of GDP**

Despite its high spending on health care, the U.S. has poor population health. [Exhibit 9]

On several measures of population health, Americans had worse outcomes than their international peers. The U.S. had the lowest life expectancy at birth of the countries studied, at 78.8 years in 2013, compared with the OECD median of 81.2 years. Additionally, the U.S. had the highest infant mortality rate among the countries studied, at 6.1 deaths per 1,000 live births in 2011; the rate in the OECD median country was 3.5 deaths.

The prevalence of chronic diseases also appeared to be higher in the U.S. The 2014 Commonwealth Fund International Health Policy Survey found that 68 percent of U.S. adults age 65 or older had at least two chronic conditions. In other countries, this figure ranged from 33 percent (U.K.) to 56 percent (Canada).\(^{13}\)

A 2013 report from the Institute of Medicine reviewed the literature about the health disadvantages of Americans relative to residents of other high-income countries. It found the U.S. performed poorly on several important determinants of health.\(^{14}\) More than a third of adults in the U.S. were obese in 2012, a rate that was about 15 percent higher than the next-highest country, New Zealand. The U.S. had one of the lowest smoking rates in 2013, but one of the highest rates of tobacco consumption in the 1960s and 1970s. This earlier period of heavy tobacco use may still be contributing to relatively worse health outcomes among older U.S. adults.\(^{15}\) Other potential contributors to the United States’ health
disadvantage include the large number of uninsured, as well as differences in lifestyle, environment, and rates of accidents and violence.

The Institute of Medicine found that poorer health in the U.S. was not simply the result of economic, social, or racial and ethnic disadvantages—even well-off, nonsmoking, nonobese Americans appear in worse health than their counterparts abroad.

The U.S. performs well on cancer care but has high rates of mortality from heart disease and amputations as a result of diabetes. [Exhibits 10, 11, 12]

One area where the U.S. appeared to have comparatively good health outcomes was cancer care. A 2015 study by Stevens et al. found that mortality rates from cancer in the U.S. were lower and had declined faster between 1995 and 2007 than in most industrialized countries. Other research based on survival rates also suggests that U.S. cancer care is above average, though these studies are disputed on methodological grounds.

The opposite trend appears for ischemic heart disease, where the U.S. had among the highest mortality rates in 2013. 128 per 100,000 population compared with 95 in the median OECD country. Since 1995, mortality rates have fallen significantly in all countries as a result of improved treatment and changes in risk factors. However, this decline was less pronounced in the U.S., where rates declined from 225 to 128 deaths per 100,000 population considerably less than countries like Denmark, where rates declined from 242 to 71 deaths per 100,000 population.

<table>
<thead>
<tr>
<th>Exhibit 9. Select Population Health Outcomes and Risk Factors</th>
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<td>OECD median</td>
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*a Source: OECD Health Data 2015.
*b Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014
*c DEN, FR, NET, NOR, SWE, and SWI based on self-reported data; all other countries based on measured data.
The U.S. also had high rates of adverse outcomes from diabetes, with 17.1 lower extremity amputations per 100,000 population in 2011. Rates in Sweden, Australia and the U.K. were less than one-third as high.

**Exhibit 10. Mortality as a Result of Cancer, 1995 to 2007**

*Deaths per 100,000 population (adjusted)*

* Mortality rates are adjusted for likelihood of death from other causes.
Exhibit 11. Mortality as a Result of Ischemic Heart Disease, 1995 to 2013

Deaths per 100,000 population

* Data from 2012 for Denmark and Switzerland, 2011 for France, Canada, Australia, and New Zealand, and 2010 for the U.S.  
Source: OECD Health Data 2015.

Exhibit 12. Lower Extremity Amputations as a Result of Diabetes, 2011

Amputations per 100,000 population

* Data from 2010 for the Netherlands, Switzerland, and the U.S.; and 2009 for Denmark  
Source: OECD Health Data 2015.
DISCUSSION

Health care spending in the U.S. far exceeds that in other countries, despite a global slowdown in spending growth in recent years. At 17.1 percent of GDP, the U.S. devotes at least 50 percent more of its economy to health care than do other countries. Even public spending on health care, on a per capita basis, is higher in the U.S. than in most other countries with universal public coverage.

How can we explain the higher U.S. spending? In line with previous studies, the results of this analysis suggest that the excess is likely driven by greater utilization of medical technology and higher prices, rather than use of routine services, such as more frequent visits to physicians and hospitals.

High health care spending has far-reaching consequences in the U.S. economy, contributing to wage stagnation, personal bankruptcy, and budget deficits, and creating a competitive disadvantage relative to other nations. One potential consequence of high health spending is that it may crowd out other forms of social spending that support health. In the U.S., health care spending substantially outweighs spending on social services. This imbalance may contribute to the country’s poor health outcomes. A growing body of evidence suggests that social services play an important role in shaping health trajectories and mitigating health disparities. Additional cross-national research is needed to better understand the relationship between social services and health, as well as other health determinants like lifestyle and environment.

New care models that reward health care providers based on their patient population’s health outcomes (e.g., accountable care organizations) are an interesting development. Such accountability could create a business case for health care providers to invest in certain social services or other nonclinical interventions, if doing so would be a cost-effective way to improve patients’ health. Over the long term, such a strategy could potentially alter the current balance between health and social services spending.

METHODS

The Organization for Economic Cooperation and Development (OECD) annually tracks and reports on a wide range of health system measures across 34 high-income countries, from population health status to health care spending and utilization. This analysis examined 2015 OECD health data for 13 countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. This brief presents OECD data for the year 2013 or, if not available, for 2012 or 2011. The median for all available OECD countries is included in Exhibits 2, 3, 4, 5, 9, and 11; it is excluded for some indicators because of incompleteness of data. All currency amounts are listed in U.S. dollars (USD) and adjusted for national differences in cost of living.

Data are also included from a report by the International Federation of Health Plans (2013) on prices of hospital procedures and diagnostic tests; an analysis by Kanavos and colleagues (2013) on branded drug prices and spending, originally published in *Health Affairs*; results from the Commonwealth Fund 2013 and 2014 International Health Policy Surveys, which were published in *Health Affairs*; an analysis by Stevens and colleagues (2015) on cancer mortality, originally published in *Health Affairs*;

Notes


6 Because of data limitations in several countries, the breakdown of health spending by source of financing is for current spending only, meaning it excludes capital formation of health care providers. In most countries, those amounts range between 2 percent and 7 percent of total health spending.


9 It should be noted that, despite the comparatively high levels of use in the U.S., growth in medical imaging appears to have leveled off in recent years after surging through much of the 2000s. The slowdown has been attributed to patient cost-sharing, prior authorization, best-practice guidelines, and other strategies to reduce potentially unnecessary utilization. See D. W. Lee and F. Levy, “The Sharp Slowdown in Growth of Medical Imaging: An Early Analysis Suggests...


13 Chronic conditions included hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. See Commonwealth Fund 2014 International Health Policy Survey of Older Adults.


**Publication Details**

**Publication Date:**
October 8, 2015

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**Editor:**
Deborah Lorber

**Citation:**

**Related Publications**

October 8, 2015

**US Spends More on Health Care Than Other High-Income Nations But Has Lower Life Expectancy, Worse Health**

September 9, 2015

**Innovations in Diabetes Care Around the World: Case Studies of Care Transformation Through Accountable Care Reforms**
Annual physician visits per person (2013 or nearest year available)

4.0
U.S.

6.5
Median of 34 high-income countries*

* Includes 34 member countries of the Organisation for Economic Cooperation and Development: http://www.oecd.org/about/membersandpartners/