United States

The Commonwealth Fund

International Health Care System Profiles

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Overview

In the United States, health care coverage is available through a mix of private insurance and public programs financed by general taxation, payroll taxes, premiums, and out-of-pocket payments. Public programs such as Medicare and Medicaid provide broad coverage to older adults, low-income families, military veterans, and Indigenous populations. However, health care access and outcomes vary across the country due to affordability barriers, workforce shortages, and state- and local-level differences in health care infrastructure, funding, and public policy.[1]

Health care spending in the United States, as a proportion of gross domestic product, is significantly higher than in other high-income countries, yet health outcomes are far worse. For example, average life expectancy is lower than in peer countries, while avoidable death rates are higher. Affordable health care coverage is not guaranteed. A significant portion of the population is uninsured or underinsured, facing high out-of-pocket costs that limit access to needed care. Systemic inequities lead to pronounced disparities in care and outcomes for many racial and ethnic minority groups, low-income families, and rural populations.

Health system challenges include rapidly rising costs caused in part by market consolidation, inconsistent access to primary and specialty care, and administrative complexity.

HEALTH SYSTEM BY THE NUMBERS

18%

Health care spending as a percent of GDP

78.5 years

Life expectancy at birth

36%

Public insurance coverage

Coverage and Access

Background and History

The U.S. health system evolved through the private market. In the 1930s, nonprofit Blue Cross and Blue Shield plans introduced the concept of prepaid health insurance that offered hospital and physician coverage. Plans were initially community-based and targeted individuals rather than employers. In the 1940s, employer-sponsored plans became the dominant form of coverage, incentivized by policies that enabled companies to offer health benefits as a tax-free form of compensation.[2]

In 1965, two major public insurance programs were established to address gaps in coverage under the employer-based system: Medicaid, which provides coverage for low-income families, and Medicare, which covers the elderly and individuals with disabilities. At the time, racial segregation was widespread in many hospitals. The introduction of Medicare played a vital role in incentivizing desegregation by making federal funding contingent on compliance with civil rights laws.[3]

In the 1980s and 1990s, rapidly rising health care costs prompted a shift toward managed care models, which gave insurers greater capacity to control costs and maximize efficiency. Common managed care models include health maintenance organizations and preferred provider organizations.[4]

However, gaps remained. Between 1978 and 1990, the percentage of the population that was uninsured increased from 12 to 17 percent.[5] States set their own individual eligibility criteria, and insurers could deny or limit coverage or charge higher premiums, based on factors such as health status, age, and gender.[6]

In 2010, the Patient Protection and Affordable Care Act (ACA) expanded health coverage, primarily by: 1) enrolling individuals in health plans sold on state health insurance marketplaces, assisted by income-based subsidies, and 2) expanding Medicaid eligibility in participating states to nearly all adults with incomes up to 138 percent of the federal poverty level (FPL).[7] The law also implemented consumer protections, such as prohibiting coverage denials for preexisting health conditions and allowing young adults to remain on their parents' insurance until age 26.[8]

The ACA reduced the nation's uninsured rate from about 16 percent in 2010 to about 9 percent by 2016, although during this period a 2012 Supreme Court ruling made Medicaid expansion optional; as of 2025, 10 states have not yet adopted expansion (*see Addressing Health Inequities*). Coverage gains have plateaued, with roughly 7.4 percent of Americans still lacking insurance in 2023.[9] A consumer survey found that 7.3 percent of the population did not access needed medical care in 2024 due to cost, while 7.7 percent did not take medication as prescribed during the same period to save money.[10]

The Role of Public Health Insurance

Public programs cover about 36 percent of the U.S. population.[11] The two main public programs are Medicaid and Medicare.

Medicaid

Medicaid is a joint federal and state program that provides health coverage to people with low incomes and limited resources. Unlike Medicare, Medicaid is a means-tested program, where eligibility is determined by specific income limits (set by each state) based on the FPL. Medicaid is mandated to cover certain groups, including low-income children, pregnant women, and the elderly/disabled who meet financial thresholds.

Services that all states are required to offer under Medicaid include:[12]

- Primary care at Federally Qualified Health Centers (including routine health checkups, management of chronic diseases, mental health care, and access to pharmacy services)
- Inpatient and outpatient hospital care
- Nurse-midwife services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Transportation services
- Inpatient psychiatric care for people under age 21
- Vision, dental, and hearing services for children.

Medicaid may also cover the following services, though this varies by state:

- Prescription drugs
- Vision, dental, and hearing services for children
- Long-term nursing home care (this is a significant difference from Medicare)
- Physical therapy and occupational therapy.

While Medicaid eligibility varies by state, there are federally mandated limits on the amount that states may charge enrollees. For instance, no charges can be applied to Medicaid enrollees whose incomes are below the 150 percent FPL, while total out-of-pocket costs cannot exceed 5 percent of a family's income.

Enacted in 2010, the ACA expanded health insurance coverage and affordability for more people. Despite numerous studies demonstrating the ACA's positive impact on health outcomes, health equity, and state economies, the One Big Beautiful Bill Act, signed into law in July 2025, includes cuts of USD 793 billion to Medicaid. In 2025, the Congressional Budget Office predicted that this would result in an increase of 7.8 million in the number of uninsured people.[13]

Medicare

Medicare is a federal social insurance program primarily for people age 65 and over. However, individuals under age 65 may also be eligible if they have received Social Security Disability Insurance for 24 months or have specific medical conditions, particularly life-limiting conditions such as end-stage renal disease and ALS.[14] Eligibility is generally based on whether an individual (or their spouse) has worked and paid Medicare taxes for at least 10 years (40 quarters). Because Medicare is an earned entitlement, it is not means-tested, meaning a person's income level does not affect eligibility.[15]

Medicare is divided into four parts:[16]

- **Part A (hospital insurance)** covers inpatient hospital stays, skilled nursing facility care, hospice, and some home health care.
- **Part B (medical insurance)** covers outpatient services, including doctor visits, preventive services, and some home health care.
- **Part C, or Medicare Advantage** is an alternative to traditional fee-for-service (FFS) Medicare that is administered by Medicare-approved private insurance companies instead of the government. Medicare Advantage plans bundle Part A and Part B coverage and often provide additional benefits, such as vision, dental, and prescription drug coverage. Over the years, Medicare Advantage has become the predominant form of Medicare coverage.
- **Part D (prescription drug coverage)** offers outpatient drug coverage through private plans approved by Medicare and is available to those enrolled in either traditional Medicare or Medicare Advantage.

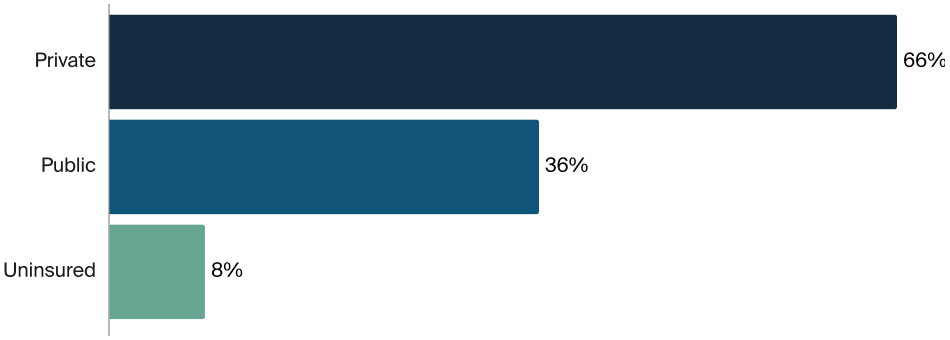
Unlike Medicaid enrollees, Medicare enrollees typically pay additional premiums. While Part A is usually premium-free, beneficiaries typically face monthly premiums (for Parts B and D), deductibles, and copays, and Original Medicare does not cover long-term custodial care.[17]

People can be dual eligible for Medicare and Medicaid. When this applies, Medicaid tends to help cover the out-of-pocket costs incurred under Medicare.[18]

In addition to the Medicare and Medicaid programs, the Children's Health Insurance Program (CHIP) provides low-cost coverage for children and pregnant women in low- to middle-income families who don't qualify for Medicaid.[19] Additional coverage is available through the Veterans Health Administration and the Indian Health Service.[20]

In 2024, 19 percent of the population was covered by Medicare, while 17 percent was covered by Medicaid or CHIP.[21]

Insurance Coverage (Percentage of Population), 2024



Source: Lisa N Bunch and Halelujha Ketema, "Health insurance coverage in the United States: 2024," United States Census Bureau, September 9, 2025.

Safety Nets

The health care safety net is a patchwork of public hospitals, federally qualified health centers, and community health centers that provide essential care regardless of ability to pay.[22] Federally qualified health centers alone are estimated to serve over 30 million patients annually, many of whom have low incomes or are uninsured.[23]

Medicaid and CHIP coverage reinforce the safety net by reducing costs and improving access to care for roughly 90 million low-income individuals and families, including children and pregnant women.[24] As of May 2025, 70.8 million people were enrolled in Medicaid, and 7.2 million people were enrolled in CHIP.[25]

Although prescription coverage is not required under federal Medicaid law, all states currently provide coverage for outpatient prescription drugs to enrollees. Medicaid may also cover non-prescription medications (i.e., over-the-counter drugs) when prescribed by a physician or other authorized prescriber.[26] In addition, nonprofit organizations and free clinics offer medical services, dental care, and free or discounted medications.[27]

Beyond Medicaid and CHIP, health care insurance marketplace plans (*see The Role of Private Health Insurance*) also offer safety nets. Under the ACA, people who buy marketplace health plans may be eligible for premium tax credits (PTCs) and cost-sharing reductions (CSRs). PTCs offer lower premium costs, with more than 90 percent of enrollees receiving them. The amount saved varies based on factors such as age, location, and income level. CSRs, which lower the portion of health care service costs that enrollees have to pay, are less common. They are available only to people with income between 100 and 250 percent of the FPL.[28]

Underfunding and restrictive eligibility criteria, however, limit the safety net's reach, particularly in rural areas.[29]

The Role of Private Health Insurance

Private health insurance is accessed primarily through employer-sponsored plans or the individual market. It is the most common form of health insurance, with 66 percent of the population enrolled in private programs in 2024. Insurance premiums for employer-based plans, which cover about half of the population, are typically shared between firms and their employees.[30]

People who are not offered employer-sponsored health benefits can purchase coverage directly from insurers or through ACA marketplaces, where plans vary in price, benefits, and cost-sharing requirements.[31] In 2024, about 11 percent of the population relied solely on direct-purchase coverage.[32]

Private insurance typically covers a broad range of services, including inpatient and outpatient care, emergency services, prescription drugs, and preventive care.[33]

Private insurers also administer Medicare Advantage plans, a bundled alternative to traditional Medicare that covers more than half of Medicare beneficiaries and usually offers additional benefits such as vision or dental care.[34] Private insurance can also supplement public coverage through Medigap plans, which help cover out-of-pocket costs under traditional Medicare or employer-sponsored retiree plans. Medicaid enrollees can also access private managed care or limited supplementary plans.[35]

The Role of Government

Although health care in the U.S. is largely market-driven, federal and state governments set the legal and operational framework for the delivery of most care, particularly for the elderly, people with disabilities, and low-income families (*see Safety Nets*).[36]

The federal government finances major public insurance programs, such as Medicare, Medicaid, and CHIP, and provides care directly through agencies such as the Veterans Health Administration and the Indian Health Service.[37] The main federal agencies are as follows:

- **The Department of Health and Human Services** oversees national health policy and coordinates federal health programs.
- **The Centers for Medicare and Medicaid Services** administers Medicare, Medicaid, and CHIP.
- **The Food and Drug Administration** regulates food, pharmaceuticals, vaccines, and other biologics, and medical devices.
- **The Centers for Disease Control and Prevention** leads public health surveillance, infectious disease control, and emergency preparedness.
- **The Health Resources and Services Administration** supports health care delivery in underserved and rural communities.
- **The National Institutes of Health** funds biomedical and public health research.
- **The Agency for Healthcare Research and Quality** develops evidence to improve the quality, safety, and efficiency of health care services.[38]

State and local agencies manage disease prevention, environmental health, and preparedness activities in collaboration with nonprofit providers, health systems, and communities.[39]

Integration and Care Coordination

Care coordination is promoted through a mixture of federally supported models and community-based initiatives. Federally qualified health centers and community health centers are playing a growing role in the integration of primary and long-term care, particularly for low-income and aging populations. From 2019 to 2023, the number of patients age 65 and over served by these centers grew by nearly 30 percent.[40] Partnerships with hospitals, home health providers, and long-term care facilities help ensure continuity across care settings.

Medicaid is a major funding source for integrated care, contributing 43 percent of health center revenue in 2023.[41]

Integration and coordination models include the following:

- **Patient-Centered Medical Homes** are team-based primary care models that emphasize accessibility, prevention, and coordinated services.[42]
- **Accountable Care Organizations** are provider groups that share financial risk and responsibility for quality and outcomes among Medicare patients.[43]
- **Care coordination programs** are initiatives that are often funded by Medicaid or Medicare and support transitions between hospitals, rehabilitation, and home care, using case managers or care navigators.[44]

Operations and Resources

Overview of the Delivery System

The health system is structured across three levels of care:[45]

- **Primary care** is the first point of contact for most patients. This includes checkups, preventive services, and the management of chronic illnesses. Providers include family physicians, internists, pediatricians, and nurse practitioners.[46]
- **Secondary care** consists of specialist services, such as cardiology, dermatology, and oncology, typically accessed through referral.
- **Tertiary care** involves advanced and highly specialized care, such as neurosurgery, intensive care, and cancer treatment. It's generally delivered in hospitals or specialized centers.

Care is delivered by a mix of public, private nonprofit, and for-profit providers. Patients typically access services through a health insurance plan, and most plans allow patients to choose their providers within a designated network.[47]

Health care providers are paid through a number of different models. Medicare, for example, primarily uses an FFS payment model to pay physicians and other clinicians.[48] Hospital care is often paid through bundled payments, such as diagnosis-related groups, which provide a fixed rate based on diagnosis.[49]

Evidence suggests that the FFS model incentivizes primary care providers (PCPs) to deliver a higher volume of clinical services while discouraging them from comprehensively assessing and addressing patients.[50] While FFS still dominates, especially in the private sector, federal programs are steadily pushing the system toward more integrated performance-based payment structures that reward coordination and cost control.[51] Value-based payment models, such as Accountable Care Organizations and Medicare's Merit-Based Incentive Payment System, tie reimbursement to outcomes, efficiency, and patient experience.[52]

Primary Care

Primary care is delivered by physicians, nurse practitioners, and physician assistants. Whether patients are required to register with a primary care provider depends on their insurance — some plans will require registration with a PCP and referrals to access specialist care.[53] Most providers are privately employed. Patients with low incomes (including those covered by Medicaid) can access care at Federally Qualified Health Centers — federally funded nonprofit clinics that provide a range of primary care services on a sliding-fee scale and treat patients regardless of their ability to pay.[54]

Urgent care centers are an important aspect of primary care. These centers, which are for-profit businesses, typically treat urgent but non-life-threatening conditions. Insurers typically require copayments for use of urgent care centers, and fees are generally higher compared with visits to a PCP. Unlike ER departments, urgent care centers are not federally mandated to provide care to uninsured individuals.[55]

Primary care physicians, or general practitioners (GPs), make up less than one-third of the physician workforce.[56] Nurse practitioners and physician assistants increasingly serve in primary care roles, especially in underserved communities.

"The current system places a disproportionate emphasis on specialty, while chronically underinvesting in primary. Payment structures heavily favor specialists, which discourages new physicians from entering primary care," explains Yashaswini Singh, a health care economist at Brown University. "That imbalance matters because many chronic conditions could be managed effectively and less expensively if patients had timely access to high-quality primary care."

Number of primary care physicians per 100,000 People, 2022–23

Source: "U.S. physician workforce data dashboard," Association of American Medical Colleges, accessed December 5, 2025; total per 100,000 population was calculated from World Bank Open Data, Population, total – United States, distributed by World Bank Group, accessed December 5, 2025.

General and family medicine accounts for nearly one in four primary care office visits, the largest proportion of any specialty.[57] Rural areas are more reliant on generalists, while urban centers are dominated by specialists. Out-of-hours care is commonly provided through group or extended-hours arrangements, whereby PCPs — often from within the same network — share responsibility for care that falls outside regular hours.[58] However, out-of-hours care is not always mandated, meaning not all patients can access it.

Significant challenges remain in the primary care infrastructure. Many regions, particularly rural and economically disadvantaged areas, are *primary care deserts* — regions with limited or no access to PCPs — due to a dwindling supply of primary care clinicians and uneven workforce distribution.[59] The U.S. primary care physician workforce is shrinking as fewer medical graduates choose primary care specialties, a trend compounded by inadequate funding and incentives and by the growing problem of burnout among existing physicians.[60] These workforce shortages threaten access to timely, high-quality primary care and exacerbate geographic disparities in health outcomes.[61]

Outpatient/Specialist Care

Specialist (secondary) care includes outpatient services in fields such as cardiology, oncology, and orthopedics. Patients don't always need a referral to see a specialist, but some plans require one.[62]

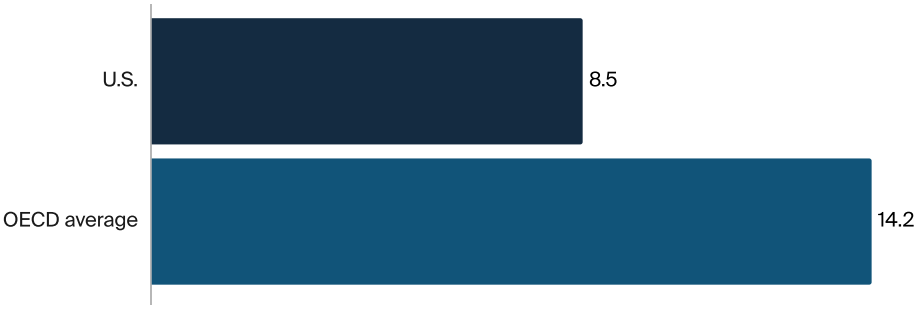
As of 2023, there were 196 specialist medical practitioners for every 100,000 people. Specialists constitute about two-thirds of the physician workforce.[63]

However, access to specialist care is uneven, hindered by geographic, financial, and workforce-related barriers.[64] There are notable workforce shortages in some specialties, exacerbated by physician retirements, burnout, and uneven distribution between urban and rural areas. The Association of American Medical Colleges projects continued physician shortages through 2037, with significant gaps expected in high-demand specialties such as cardiology and oncology.[65]

Physician Education and the Workforce

The U.S. has 162 accredited medical schools and trains one of the world's largest physician workforces.[66] In 2023, the health sector employed more than 17 million people, making it the country's largest employment sector.[67]

Number of Medical Graduates per 100,000 People, 2021



Source: Health at a Glance 2023 (Organisation for Economic Co-operation and Development, November 7, 2023), 191.

Despite being the largest employment sector, there are persistent access gaps. As of mid-2024, nearly one in four Americans lived in areas with an insufficient number of PCPs.[68] Shortfalls are especially acute in rural regions, which struggle to attract and retain clinicians (*see Primary Care*). Meanwhile, the prospect of lower pay, together with high education costs, is deterring many graduates from pursuing generalist roles.[69]

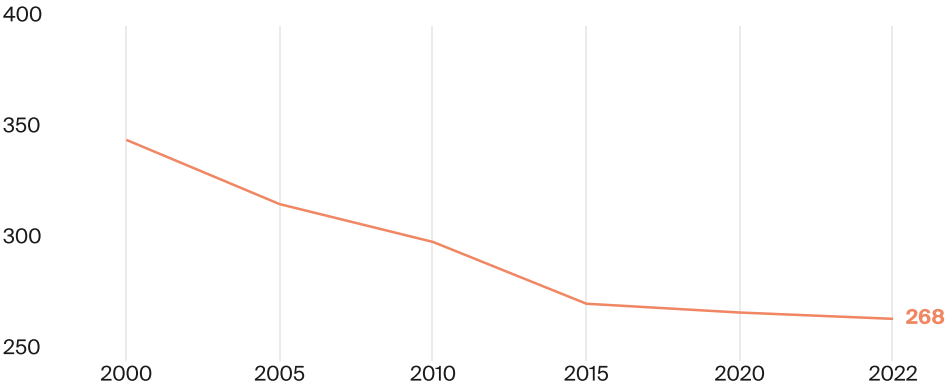
To support workforce growth, the federal government supports a range of initiatives. The Medical Student Education Program, for instance, funds public medical schools in states with projected provider shortages to encourage students to choose primary care residencies and careers.[70] The Uniformed Services University of the Health Sciences, meanwhile, offers tuition-free training to individuals who commit to serving in the military or public health service after graduation.[71] The National Health Service Corps provides scholarships and loan repayment for students who commit to working in underserved areas.[72] The Teaching Health Center Graduate Medical Education offers a federally funded program that trains physicians and dentists in community-based settings, with a focus on rural and underserved communities. The training program, which covers the residents' salary and benefits, has trained 2,721 physicians and dentists since its inception in 2011.[73]

Foreign graduates play a vital role in health care and make up about 25 percent of the total physician workforce.[74]

Hospitals

As of 2025, there were 6,093 hospitals — mostly nonprofit. About 20 percent were owned by private investors.[77] Hospital mergers and acquisitions have increased since 2010, contributing to the rise of large multihospital systems. The proportion of community hospitals that were part of multihospital systems increased from 10 percent in 1970 to 67 percent in 2019, resulting in 3,436 hospitals within 368 systems.[78]

Number of Hospital Beds per 100,000 People, 2000–22



Source: The Global Health Observatory, Beds, hospital beds (per 10,000 population), distributed by World Health Organization, accessed December 15, 2025.

HOSPITALS BY THE NUMBERS

In 2025, there were **266 hospital beds per 100,000 people** (compared with 537 across high-income countries in 2021).[75]

In 2022, there were **1,321 nurses per 100,000 people**.[76]

Mental Health Care

Mental health care spans a wide range of services, from outpatient therapy and medication management to inpatient psychiatric care. Services are delivered in multiple settings, including community mental health centers, private practices, general hospitals, and dedicated psychiatric hospitals.[81] Care is primarily accessed through private insurance, Medicaid, or out-of-pocket payments and increasingly via telehealth platforms.[82]

Demand is high: about 23 percent of adults — more than 59 million people — experienced a mental illness in 2022.[83] However, in 2021, only 47.2 percent of adults with a mental illness received care, with physician shortages most acute in rural and low-income areas.[84] The national 988 Suicide & Crisis Lifeline and youth mental health grants authorized by the Bipartisan Safer Communities Act aim to improve and expand access to crisis response systems.[85]

MENTAL HEALTH CARE BY THE NUMBERS

There were **7 psychiatrists per 100,000 people** in 2023, the same as for high-income countries in 2024.[79]

In 2023, there were **28 psychiatric hospital beds per 100,000 people** (compared with 23 for high-income countries in 2024).[80]

Long-Term Care and Social Support

Long-term care includes a mix of home-based, community, and institutional services for individuals who have functional limitations. Delivery is fragmented, with services varying by care provider and state.

Long-term care is primarily publicly funded. In 2023, 69.4 percent of spending was covered by public sources, with 45.6 percent coming from Medicaid and 18 percent from Medicare.[86]

Access can be a challenge. Costs are high, and the system can be difficult to navigate. Medicare does not cover extended custodial care, and Medicaid eligibility is means-tested and varies by state.[87] Workforce shortages — particularly among home health aides and nursing assistants — undermine the capacity and continuity of care.[88] In response, in 2024, the federal government announced funding of over USD 200 million to support geriatric care training and expand the workforce.[89]

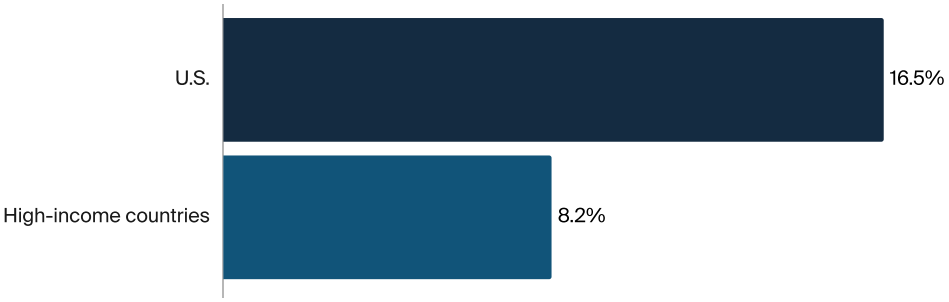
Medicaid waiver programs and the Program of All-Inclusive Care for the Elderly aim to help eligible individuals remain in their homes or communities by providing person-centered care services at home or in their communities. This, in turn, reduces dependence on institutional care.[90]

Cost and Affordability

Health Care Spending Overview

In 2023, the U.S. spent 18 percent of gross domestic product (GDP) on health.[91] At about USD 14,570 for every person, this is the highest in the world, and more than 2.5 times the high-income average of about USD 5,930 for every person.[92]

Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory, Current health expenditure (CHE) as percentage of gross domestic product (GDP)(%), distributed by World Health Organization, accessed December 5, 2025.

Health spending is financed through a mix of public and private sources. In 2023, the government's spending accounted for USD 2.7 trillion (55.5%), voluntary health spending for USD 3.6 trillion (11.5%), and out-of-pocket payments for USD 506 billion (7.2%).[93]

Pharmaceutical Spending

Pharmaceutical spending is a major part of U.S. health care costs. In 2022, per capita spending on outpatient prescription and over-the-counter medication was USD 1,227 for every person, the highest among the Organisation for Economic Co-operation and Development (OECD) nations.[94] Retail prescription drugs accounted for 9 percent of total health expenditures in 2023.[95]

The U.S. system is notable for relatively limited government regulation of drug prices compared with other high-income countries. Unlike many of its OECD peers, the U.S. does not have direct governmental price controls on most prescription drugs. Instead, pricing is influenced by negotiations between manufacturers, pharmacy benefit managers, insurers, and pharmacies.[96] There are moves to change this: the 2022 Inflation Reduction Act has enabled Medicare to negotiate prices for 10 of the most expensive drugs covered by the program. The negotiated prices will take effect in 2026 and are expected to save the program an estimated USD 6 billion every year, while reducing enrollees' annual out-of-pocket costs by USD 1.5 billion.[97]

Public programs have caps on pharmaceutical spending; Medicaid programs often use formularies and preferred drug lists to manage costs, leveraging rebates from manufacturers to reduce net prices. Some states impose limits on drug spending growth or require prior authorization for high-cost drugs, but there is no uniform national spending cap.

The overall absence of direct price regulation, combined with complex rebate systems, contributes to high U.S. pharmaceutical spending relative to other countries.[98]

Cost Sharing and Out-of-Pocket Spending

Out-of-pocket spending accounted for 11.1 percent of total health expenditure in 2022, below the average of 12.9 percent in high-income countries.[99] However, because overall spending is far higher, people in the U.S. pay more in absolute terms — about USD 1,400 for every person in 2022, compared with about USD 780 on average for high-income countries.[100]

Patients commonly pay out of pocket for outpatient visits, dental and vision care, prescription drugs (especially branded drugs), and out-of-network services.[101] Medicaid limits or prohibits cost sharing for certain groups, including children, terminally ill patients, and people living at or below the FPL.[102] Medicare enrollees have an annual deductible (USD 257 in 2025) and typically pay 20 percent coinsurance for outpatient services. Deductibles and copayments for Medicare Advantage enrollees vary by plan.[103] Private insurance plans vary but often include high deductibles; in 2023, these averaged USD 1,735 for single coverage in employer plans. There are also copayments for primary and specialty care visits.[104]

How Are Costs Contained?

The Inflation Reduction Act of 2022 gave Medicare authority to negotiate prices for some high-cost drugs and introduced a USD 2,000 annual cap on out-of-pocket drug spending for Medicare Part D enrollees, starting in 2025.[105] While this change has limited out-of-pocket costs, studies show that insurers have responded by increasing deductibles and cost sharing, which is predicted to increase total costs for patients who do not meet the cap.[106]

Federal transparency rules introduced in 2021 mandate that hospitals and insurers disclose negotiated rates for common services, although compliance is varied.[107] Telehealth, meanwhile, has reduced administrative costs since these services were expanded during the COVID-19 pandemic.[108] At the state level, cost-control measures include prescription drug affordability boards, cost growth benchmarks, hospital price caps, and state-run public options.[109] Value-based payment models, including Accountable Care Organizations and bundled payments, tie reimbursement to quality and efficiency.[110]

However, there are persistent cost-related barriers to access. In 2022, four in 10 U.S. adults reported some form of health care debt; of these, more than 40 percent said that either they or a household member had used up all or most of their savings as a result.[111] Value-based care models have led to increased reliance on private capital and provider consolidation, which can increase prices and reduce patient choice.[112]

Quality and Outcomes

Health Outcomes

The U.S. continues to lag its high-income peers in overall health outcomes. Life expectancy, at 78.5 years in 2023, is nearly three years lower than the average for high-income countries (81.1 years), a gap reflecting persistent and preventable causes of early death. Women live about five years longer than men, with a life expectancy of 81.1 years vs. 75.9 years for men.[122]

The leading causes of death are ischemic heart disease, cancer, and accidents, followed by stroke.[123] Chronic illnesses, such as diabetes, hypertension, obesity, and coronary artery disease, are highly prevalent.[124] In 2021, 12 percent of U.S. adults had been diagnosed with diabetes.[125] In 2022, the adult obesity rate was 42 percent, far higher than the 26 percent average across high-income countries.[126]

The nation faces overlapping public health crises:

- The opioid epidemic continues to drive record overdose deaths.[127]
- Mental health illnesses affect nearly one in five adults, and suicide rates are well above those of most high-income countries.[128]
- Substance use disorders, including both drug and alcohol addictions, exacerbate the burden of disease and mortality.[129]

HEALTH OUTCOMES **BY THE NUMBERS**

In 2023, average life expectancy was **78.5 years** (compared with 78.8 years in high-income North America).[113]

The avoidable mortality rate was **312 deaths per 100,000** in 2022.[114]

The top three causes of death in 2024 were:

- Ischemic heart disease: **204 deaths per 100,000 people**
- Cancer: **185 deaths per 100,000 people**
- Accidents (unintentional injuries): **59 deaths per 100,000 people**.[115]

The maternal mortality rate was **19 deaths per 100,000 live births** in 2023.[116]

The infant mortality rate was **six deaths per 1,000 live births** in 2023 (compared with an average of four in high-income countries).[117]

In 2021, the share of the population with mental health disorders was **19 percent** (compared with an average of 16% in high-income countries).[118]

The suicide rate was **15.3 deaths per 100,000 people** in 2023, higher than the average of 12 across high-income countries.[119]

Guns were responsible for **14 deaths per 100,000 people** in 2023 (compared with an average of five across high-income countries).[120]

42 percent of adults were affected by obesity in 2022.[121]

On maternal and child health, the U.S. performs worse than most high-income countries: infant mortality remains elevated, and disparities are starkest for Black and Indigenous women and infants.[130]

"Extensive research has shown that prices for health care services in the U.S. are substantially higher than in any other high-income country," explains Singh. "What's striking is that these higher prices often do not translate into higher quality, but are instead driven by market power, administrative complexity, and weaker price regulation."

Addressing Health Inequities

Health outcomes vary substantially by race, gender, income, and geography. Black, Hispanic, American Indian and Alaska Native (AIAN), and Native Hawaiian and Pacific Islander populations, for example, experience higher rates of chronic disease and maternal and infant mortality.[131] In 2023, life expectancy was 70.1 years for AIAN people, 74 years for Black people, 78.4 years for white people, and 81.3 years for Hispanic people.[132] Lower-income people and residents of rural communities also face disadvantages, including limited access to care and poorer overall health.[133] Access to care and health outcomes vary widely across different states. A recent study, which assessed each state across a range of health-care-related indicators, found that Massachusetts had the highest overall performance, while Mississippi had the lowest.[134]

Over the past two decades, federal and state governments have implemented targeted efforts to reduce health inequities, most notably through the ACA, to address disparities in coverage and access. However, the 2012 Supreme Court ruling that made Medicaid expansion optional led 10 states to forgo adoption. This decision leaves nearly 1.4 million low-income adults caught in a coverage gap — earning too much to qualify for traditional Medicaid under the old rules but too little to receive subsidies in the insurance marketplaces — and perpetuates disparities in access to care and health outcomes.[135]

Other targeted programs aim to address health workforce shortages and to improve access to maternal and chronic care in underserved communities. For example, the National Health Service Corps provides scholarships and loan repayments for health professionals practicing in shortage areas, while the Rural Maternity and Obstetrics Management Strategies program focuses on improving maternal care in rural regions.[136] The Center for Indigenous Innovation and Health Equity, supported by dedicated funding, works to reduce health disparities among Indigenous populations by advancing culturally relevant research and interventions.[137]

Despite these efforts, disparities in insurance coverage, disease burden, and life expectancy remained as of 2024.[138] Progress is uneven and substantially influenced by political shifts. Medicaid expansion, civil rights protections, and safety-net funding frequently fluctuate with changes in administration, often affecting the scope and sustainability of equity-focused policies across states.

Innovation and Reform

Health Care Innovation

"For patients with rare diseases or complex medical conditions, the U.S. remains one of the best places in the world to receive treatment," says Brown's Yashaswini Singh. "The combination of world-class academic medical centers, subspecialty expertise, and rapid adoption of new technologies allows patients to access cutting-edge therapies that may not be available elsewhere."

The U.S. is heavily invested in medical innovation, from mRNA vaccines to artificial intelligence (AI) in medical diagnostics and care management. In 2024, the U.S. had the largest national pharmaceutical market, comprising about 53 percent of the total pharmaceutical prescription drug market worldwide.[139]

However, advances are unevenly integrated into everyday care owing to geography, insurance coverage, and resource availability, including infrastructure and finance.

National reforms have been introduced to expand telehealth, increase investment in digital infrastructure, and redesign health care payment models. The Medicare Shared Savings Program, for instance, which encourages the formation of Accountable Care Organizations, covered 11 million people and saved Medicare USD 1.8 billion in 2022.[140]

The Centers for Medicare and Medicaid Services has announced plans to create a national Digital Health Ecosystem, which invites organizations from across the health care industry (including health care tech providers) to align around a shared framework for data and access.[141] Meanwhile, the Department of Health and Human Services created an AI Strategic Plan, establishing a strategic framework and operational roadmap for the equitable and safe deployment of emerging technologies in clinical care.[142]

Health Care Technology

Telehealth is used widely in behavioral health and chronic care, particularly in rural and underserved areas.[143] The COVID-19 pandemic accelerated its adoption, and Drug Enforcement Administration rules now allow remote prescribing for some medications.[144]

Adoption of electronic health records is widespread, following the HITECH Act of 2009 and federal incentives.[145] In 2022, 73 percent of patients were offered online access to their health records.[146]

Interoperability is a growing priority. The 21st Century Cures Act of 2016 and the Trusted Exchange Framework and Common Agreement, published in 2022, promote standardized data exchange. Qualified Health Information Networks now link most hospitals. [147]

Use of AI in health care is growing rapidly in the U.S. A 2024 study by McKinsey found that more than 85 percent of health care leaders surveyed (from across the industry) said that their organization had already adopted AI or was exploring use cases.[148]

The rapid growth in wearable health care technology (such as smart watches) is likely to have an impact on health outcomes. Revenues from wearable health care tech are forecast to triple between 2025 and 2032,[149] and studies point to efficacy at identifying issues such as arrhythmias and hypertension.[150] A 2023 survey of U.S. consumers found that 76 percent would like to discuss the data from their wearable devices with a doctor during appointments, while more than half would prefer the data to be automatically uploaded to their electronic medical records.[151]

This profile reflects data as of January 2026. New or updated information may have become available since its release.

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