SURVEY BRIEF
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What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?

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Women in the United States have long lagged behind their counterparts in other high-income countries in terms of access to health care and health status. This brief compares U.S. women's health status, affordability of health plans, and ability to access and utilize care with women in 10 other high-income countries by using international data.

HIGHLIGHTS

- U.S. women report the least positive experiences among the 11 countries studied. They have the greatest burden of chronic illness, highest rates of skipping needed health care because of cost, difficulty affording their health care, and are least satisfied with their care.
- Women in the U.S. have the highest rate of maternal mortality because of complications from pregnancy or childbirth, as well as among the highest rates of caesarean sections. Women in Sweden and Norway have among the lowest rates of both.
- Women in Sweden and the U.S. report the highest rates of breast cancer screening among countries surveyed; women in Norway, Sweden, Australia, and the U.S. have the lowest rates of breast cancer–related deaths.
- More than one-quarter of women in the U.S. and Switzerland report spending $2,000 or more out of pocket on medical costs for themselves or their family in the past year compared to 5 percent or fewer in most of the other study countries.
- More than one-third of women in the U.S. report skipping needed medical care because of costs, a far higher rate than the other countries included in the study.
- U.S. women are less likely to rate their quality of care as excellent or very good compared to women in all other countries studied.

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BACKGROUND

Compared to women in other high-income countries — like, for instance, Germany or Australia — American women have long struggled to access the health care they need. The United States spends more on health care than other countries do, but Americans report high rates of not seeking care because of costs, as well as high instances of chronic disease. Prior research has found that poor access to primary care in the United States had led to inadequate management and prevention of diagnoses and diseases.

With the Affordable Care Act (ACA) now in place, most women in the U.S. have guaranteed access to health coverage (Appendix 2); more than 7 million working-age women have gained insurance since the implementation of the law. Millions of others who had been insured now receive additional benefits and cost protections through the law's reforms. But recent changes by the Trump administration and Congress may jeopardize this progress. These changes include repeal of the law's individual mandate penalty; expansion of plans that do not have to comply with the law's consumer protections and benefit requirements, including the requirement to provide maternity care; threats to remove guaranteed coverage of preexisting conditions; and proposed changes to Title X funding. In the future, these changes may raise costs and limit access to health insurance and services for people who do not qualify for subsidized care, especially those with health problems. They could reduce the recent gains U.S. women have made and widen differences between women in the U.S. and those in other countries.

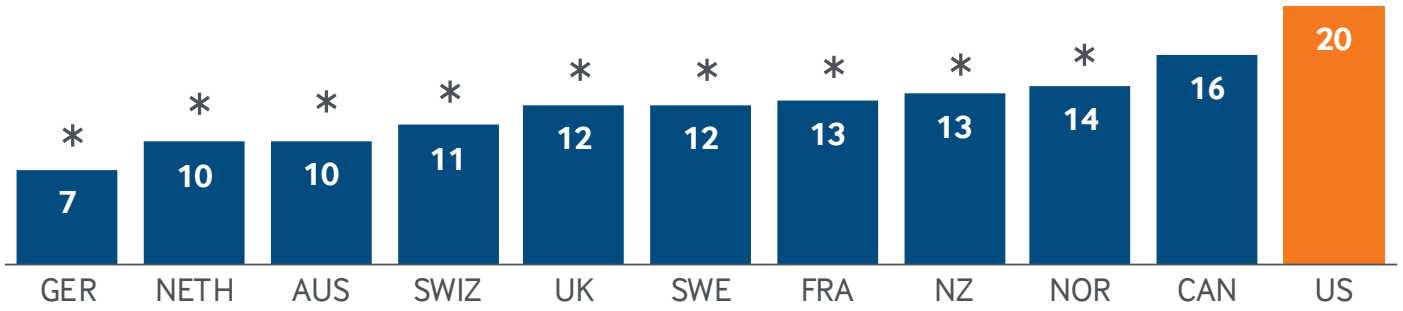
Using data from the Commonwealth Fund International Health Policy Survey (2016) and measures from the Organisation for Economic Co-operation and Development (OECD) and the United Nations Children's Fund (UNICEF), this brief compares U.S. women's health status, affordability of health plans, and ability to access and utilize care with women in 10 other industrialized countries.

For an overview of each country's health care system, see Appendix 1, and for further detailed information on each country's health system, see the Commonwealth Fund International Health Care System Profiles here.

WOMEN'S HEALTH

High Chronic Disease Burden Among U.S. Women

*Percent of women ages 18–64 who had two or more chronic conditions^*



Notes: ^ Having a chronic disease defined as ever being told by a doctor as having two or more of the following: joint pain or arthritis; asthma or chronic lung disease; diabetes; heart disease, including heart attack; or high blood pressure. * Statistically significant difference compared to the United States ($p<.05$).

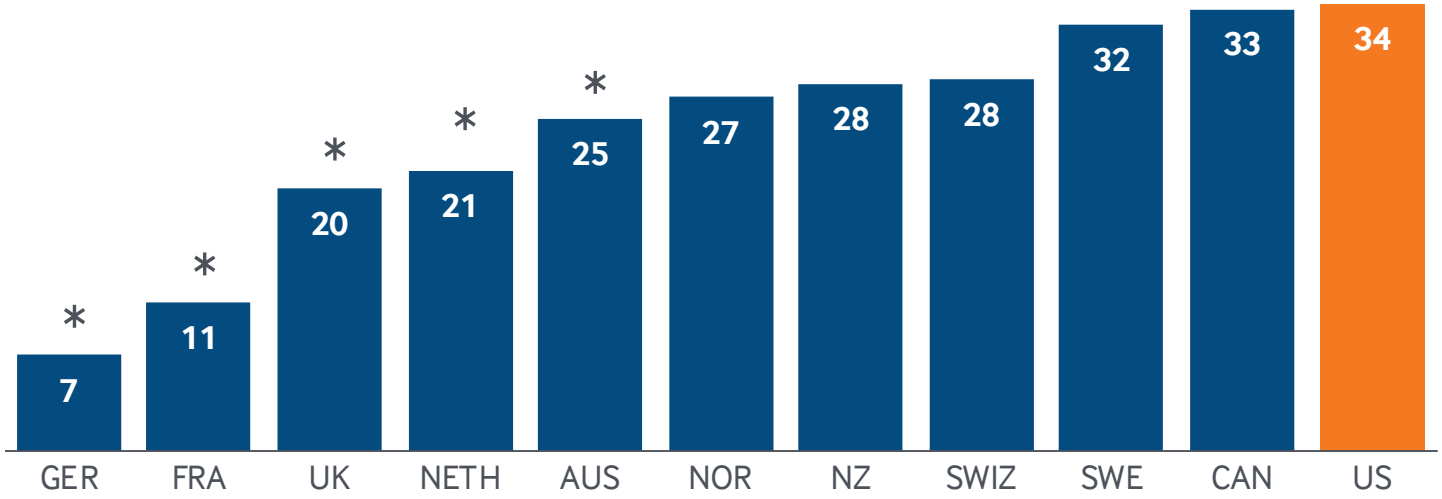
Data: The Commonwealth Fund International Health Policy Survey, 2016.

Women in the U.S. reported a higher rate of having multiple chronic diseases compared to women in the 10 other countries, with German women reporting the lowest rates. One of five U.S. women reported having two or more chronic conditions, compared to one of 10 or less in Germany, the Netherlands, and Australia. Chronic diseases include a diagnosis of joint pain or arthritis, asthma or chronic lung disease, diabetes, heart disease, or high blood pressure.

WOMEN'S HEALTH

U.S. Women Have the Highest Rate of Emotional Distress

*Percent of women ages 18–64 who experienced emotional distress^*



Notes: ^ Question: "In the past two years, have you experienced emotional distress such as anxiety or great sadness which you found difficult to cope with by yourself?" * Statistically significant difference compared to the United States (p<.05).

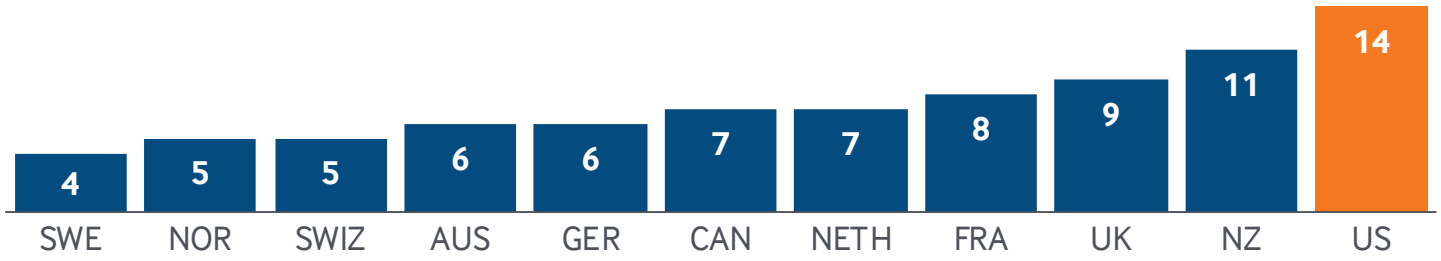
Data: The Commonwealth Fund International Health Policy Survey, 2016.

The relationship between emotional distress and health is complex, but some research shows emotional distress can exacerbate physical illness as well as lead to difficulties managing other aspects of life, such as the ability to work. One-quarter or more of women in Australia, Norway, New Zealand, Switzerland, Sweden, Canada, and the U.S. reported having experienced emotional distress — that is, anxiety or sadness that was difficult to cope with alone in the past two years. Only 7 percent of women in Germany reported having emotional distress and only 11 percent of women in France.

WOMEN'S HEALTH

Maternal Mortality Rate Is Highest in the U.S.

Maternal mortality ratio (maternal deaths/100,000 live births) among women ages 15–49



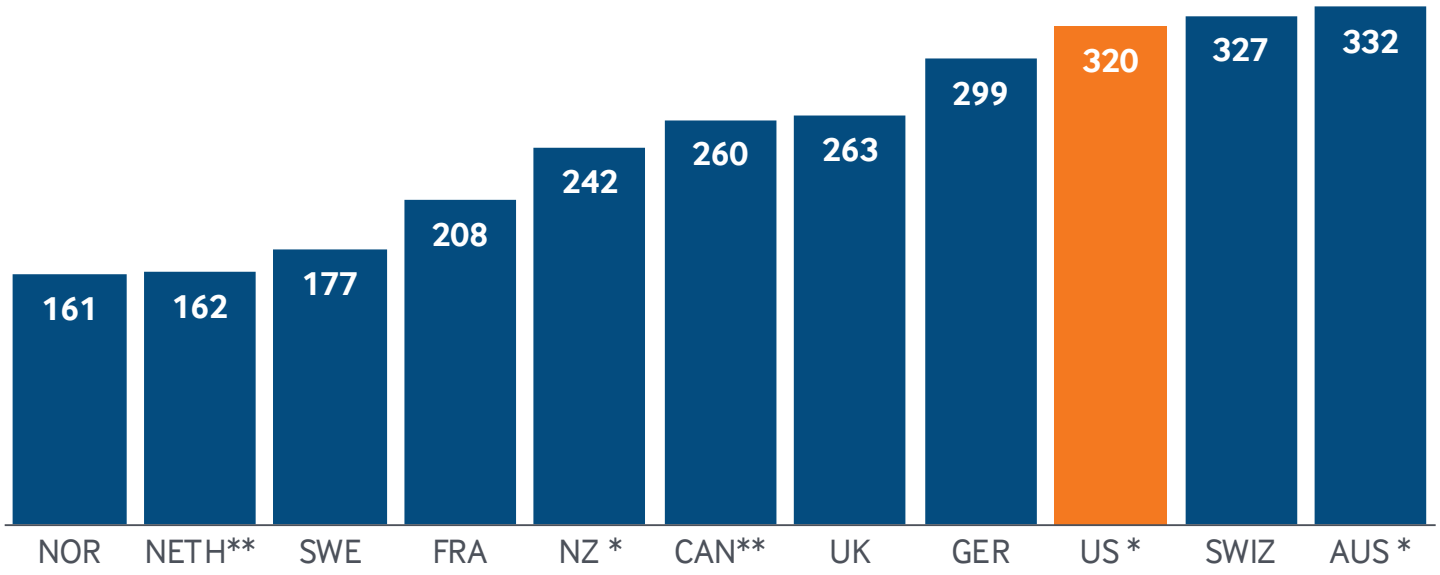
Data: The data reflect UNICEF estimates because of missing internationally comparable data for the U.S. National statistics are available for most countries from the OECD.

Women in the U.S. had the highest rate of maternal mortality because of complications from pregnancy or childbirth; women in Sweden and Norway had among the lowest rates. High rates of caesarean sections, lack of prenatal care, and increased rates of obesity, diabetes, and heart disease may be contributing factors to the high rate in the U.S.

WOMEN'S HEALTH

Rates of Caesarean Sections Highest in Australia, Switzerland, and the U.S.

Caesarean sections — inpatient procedures per 1,000 live births



Notes: * 2015 data; ** 2014 data.

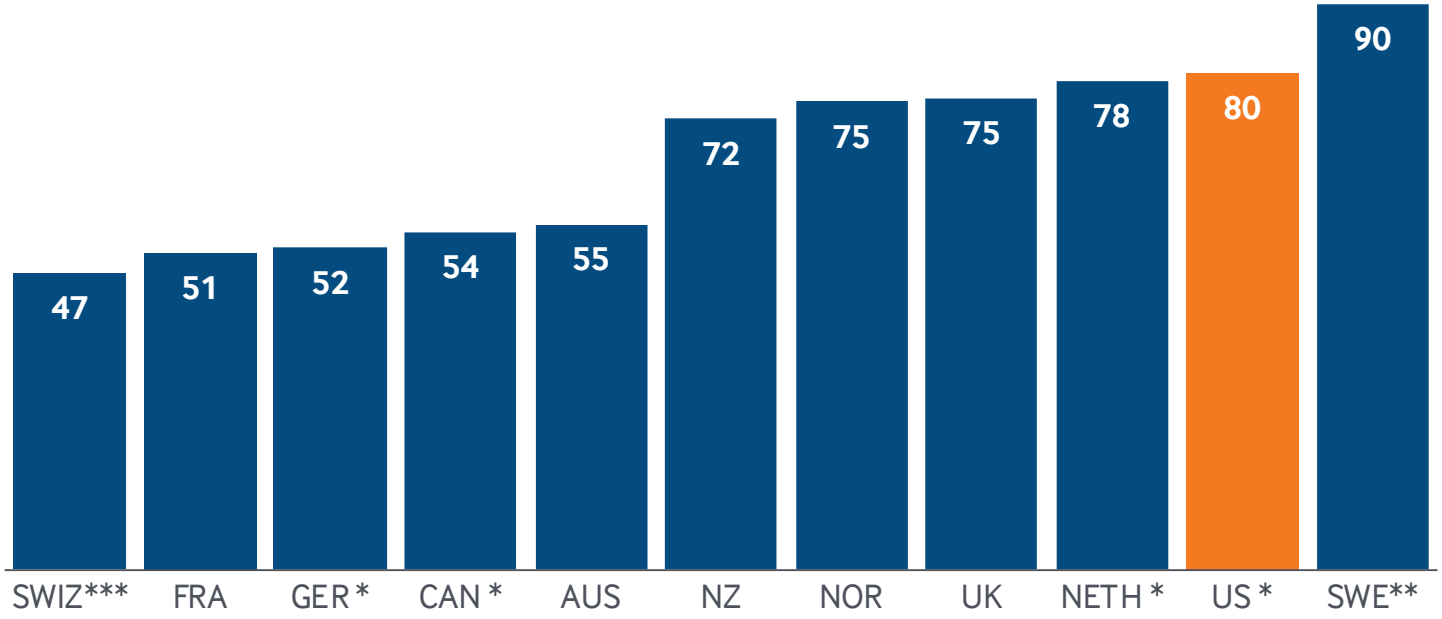
Data: Organisation for Economic Co-operation and Development, *Health Statistics* (OECD, 2018).

Caesarean sections are generally not recommended for younger mothers with uncomplicated births and are often more costly than vaginal births because of the costs of the operating room and medical personnel, longer recovery, and hospital stays. Australia, Switzerland, and the U.S. have the highest rates, while women in Norway and the Netherlands have the lowest rates — approximately half the rate of the highest-ranking countries. The reasons behind the wide variation observed in caesarean section rates across developed countries warrants further investigation; however, some researchers suggest it is a combination of a country's specific health system, physician and patient preferences, cultural factors, population characteristics, and payment incentives.

WOMEN'S HEALTH

Breast Cancer Screening Rates Highest in Sweden and the U.S.

Breast cancer screening rates, percent of women ages 50–69 screened



Notes: Number of women ages 50–69 who have received a bilateral mammography within the past two years (or according to the specific screening frequency recommended in each country) divided by the number of women ages 50–69 answering survey questions on mammography (for survey-based data) or eligible for an organized screening program (for program-based data). Eight countries based on programmatic data, three countries based on survey data. * 2015 survey data; ** 2014 survey data; *** 2012 survey data.

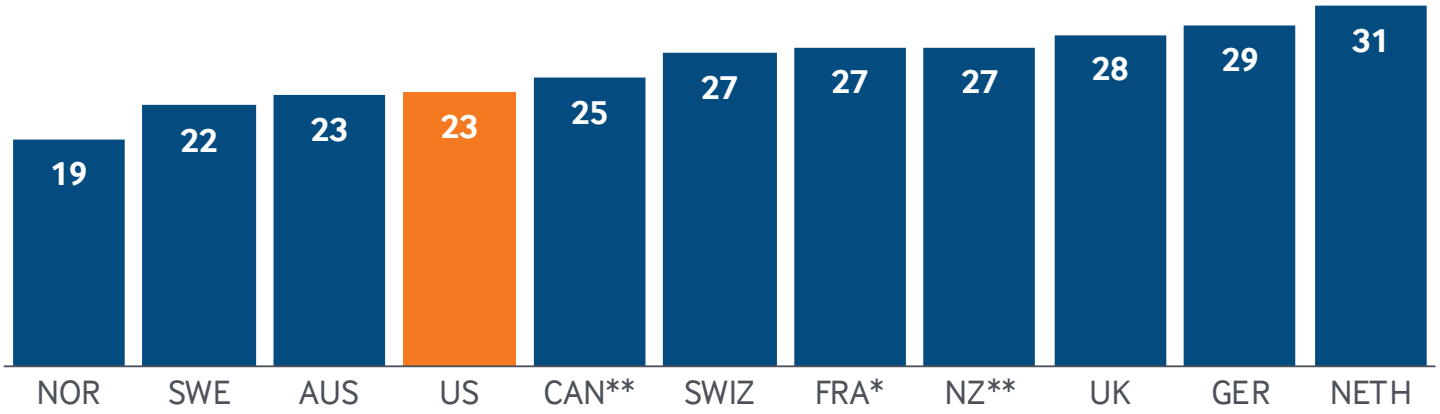
Data: Organisation for Economic Co-operation and Development, *Health Statistics* (OECD, 2018).

It is recommended that women have screenings for breast and cervical cancers. The U.S. fares well compared to other countries on these indicators. Older women in the U.S. and Sweden are screened for breast cancer more often than women in the other countries analyzed; women in Switzerland are screened at the lowest rate.

WOMEN'S HEALTH

Lowest Rates of Breast Cancer–Related Deaths in Women Are in Norway, Sweden, Australia, and the U.S.

Malignant neoplasms of female breast, deaths per 100,000 females (age-standardized)



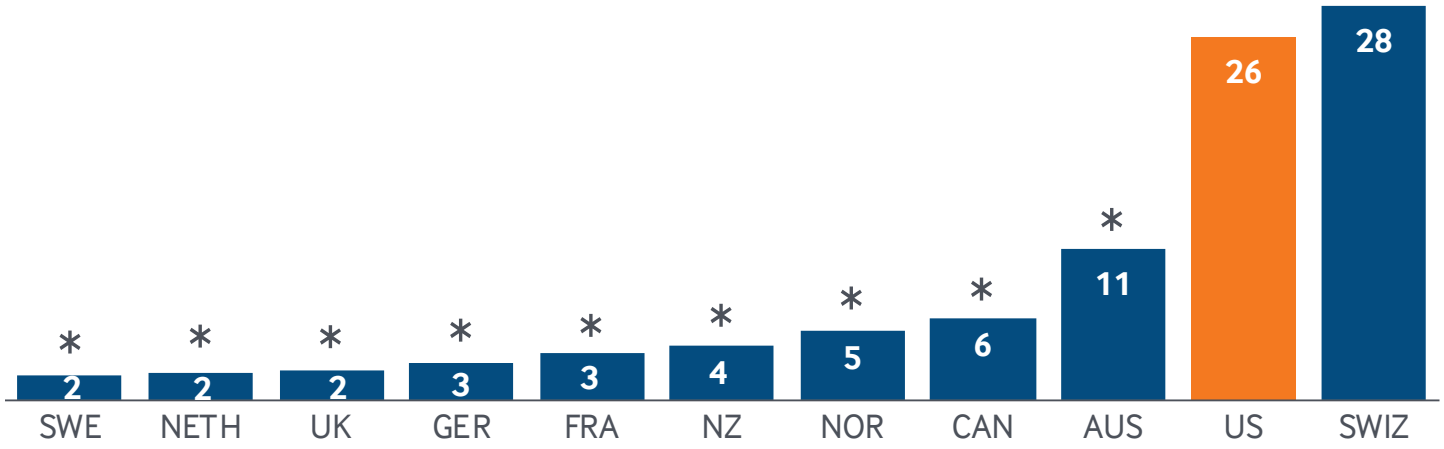
Women in the U.S. had among the lowest rates of breast cancer–related deaths, after Norway, Sweden, and Australia. Women in the Netherlands and Germany had the highest rates.

Data: Organisation for Economic Co-operation and Development, *Health Statistics* (OECD, 2018). * 2014 data; ** 2013 data.

AFFORDABILITY

Women in Switzerland and the U.S. Report Very High Out-of-Pocket Costs

*Percent of women ages 18–64 with out-of-pocket costs of $2,000 or more^*



High health care costs create significant financial burdens on U.S. household budgets, even among insured families. Over one-quarter of women in Switzerland and the U.S. reported spending $2,000 or more in out-of-pocket medical costs for themselves or their family in the past year. In comparison, no more than one of 20 women reported such high costs in most other countries included in the study.

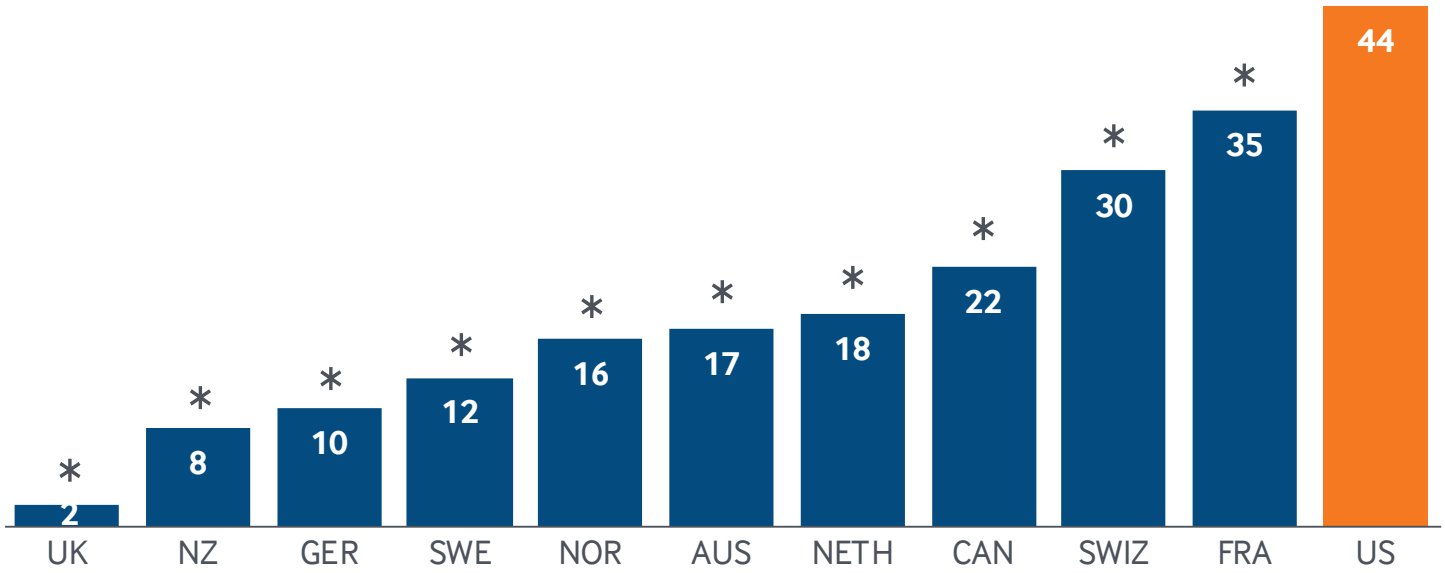
Notes: ^ Percent of respondents who reported that their annual (past year) family out-of-pocket spending for medical treatments or services, that were not covered by public or private insurance, was $2,000 or more. Does not include adults who reported "don't know"/refused to respond. * Statistically significant difference compared to the United States (p<.05).

Data: The Commonwealth Fund International Health Policy Survey, 2016.

AFFORDABILITY

Nearly Half of U.S. Women Report Medical Bill Problems

*Percent of women ages 18–64 with at least one medical bill problem^*



U.S. women most often reported problems paying or disputing medical bills or spending time on related paperwork. Nearly half (44%) of women in the U.S. faced such problems compared with only 2 percent in the U.K. U.S. women had the highest rates of having payment denied by their insurers or receiving a smaller insurance payment than they expected, compared to women in other countries (Appendix 4).

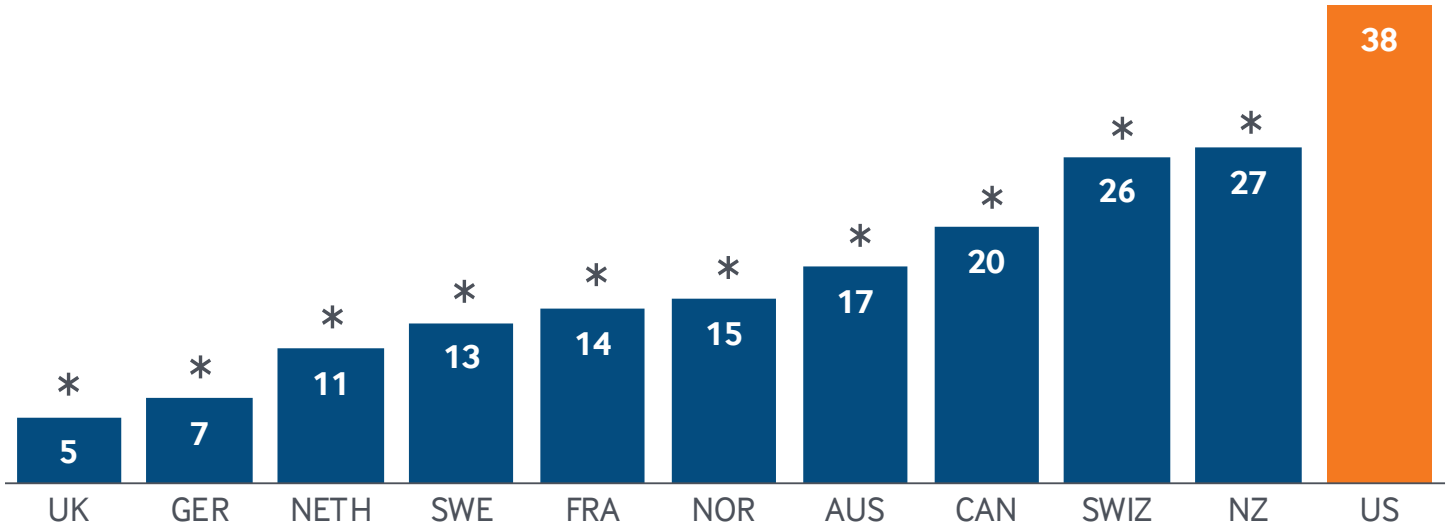
Notes: ^ Medical bill problems include any of the following in the past year: 1) serious problems paying or were unable to pay medical bills; 2) spent a lot of time on paperwork or disputes related to medical bills; 3) insurance denied payment or paid less than expected. * Statistically significant difference compared to the United States (p<.05).

Data: The Commonwealth Fund International Health Policy Survey, 2016.

AFFORDABILITY

More Than One-Third of Women in U.S. Skip Care Because of Cost vs. 5 Percent in U.K.

*Percent of women ages 18–64 with at least one cost-related access problem^*



Notes: ^ Cost-related access problems include any of the following in the past year: 1) having a medical problem but did not visit a doctor; 2) skipped a medical test, treatment, or follow-up recommended by a doctor; or 3) did not fill or collect a prescription for medicine, or skipped doses of medicine, because of the cost in the past 12 months. * Statistically significant difference compared to the United States (p<.05).

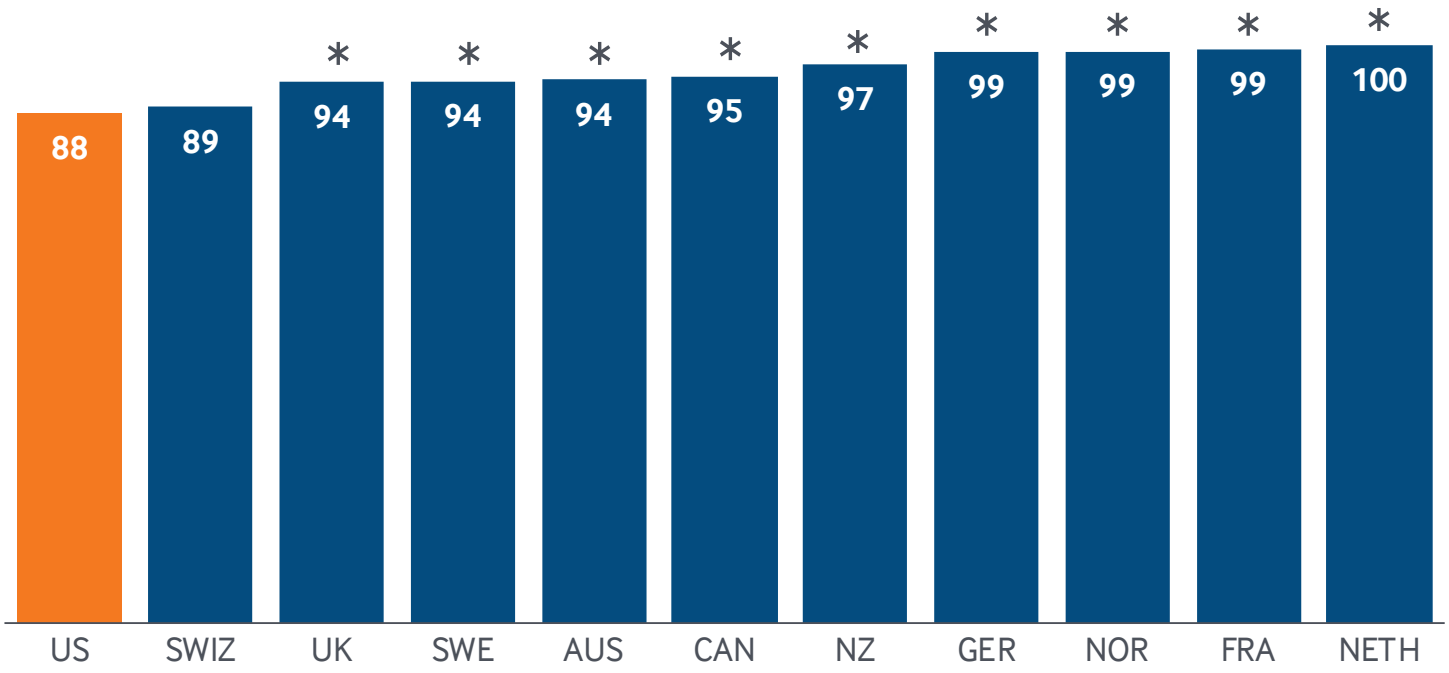
Data: The Commonwealth Fund International Health Policy Survey, 2016.

Many women in the U.S. skip needed medical care because of costs, likely because of high out-of-pocket costs and the fact that 11 million women still have no insurance coverage. Thirty-eight percent of women in the U.S. reported they went without recommended care, did not see a doctor when sick, or failed to fill prescriptions because of costs in the past year. This is the highest rate among the 11 countries in our analysis (Appendix 5). Before the implementation of the ACA in the U.S., the rate was even higher, 43 percent. In the U.K. and Germany, only 5 percent and 7 percent of women, respectively, reported forgoing care because of cost.

QUALITY, UTILIZATION, AND ACCESS TO CARE

Women in the U.S. and Switzerland Report the Lowest Rates of Having a Regular Doctor or Place of Care

Percent of women ages 18–64 who reported having a regular doctor/regular place of care



Notes: * Statistically significant difference compared to the United States (p<.05).

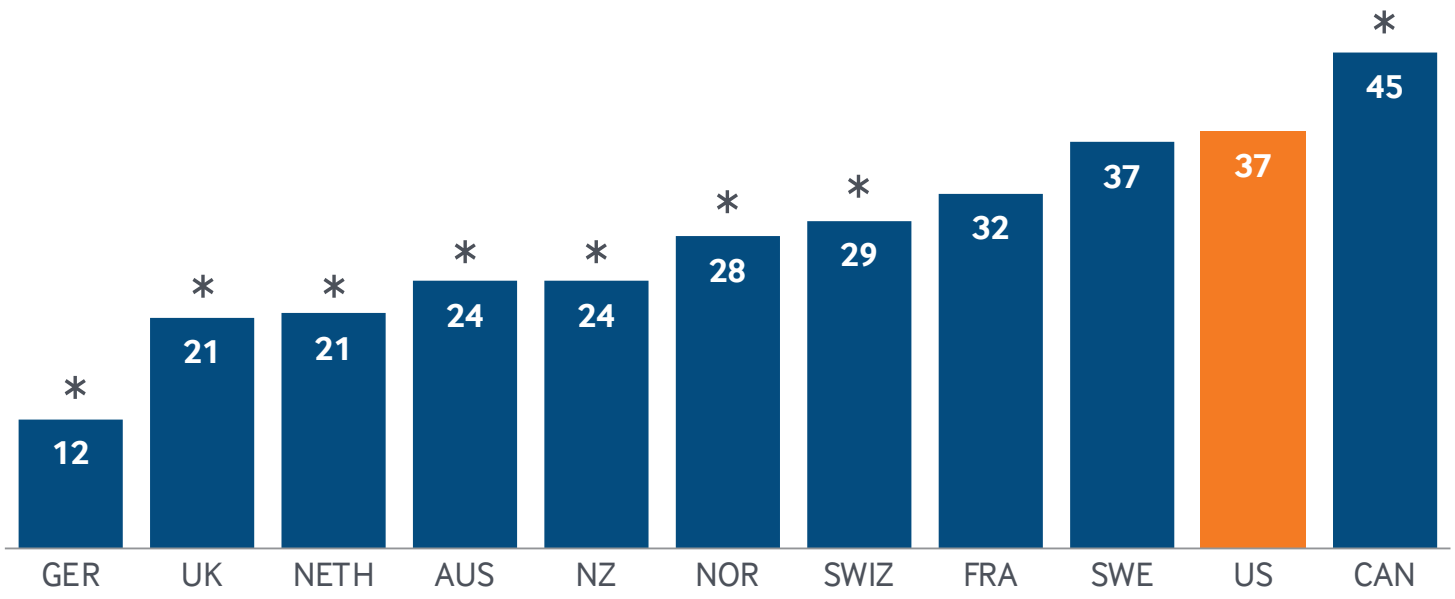
Data: The Commonwealth Fund International Health Policy Survey, 2016.

Having a regular doctor or place of care, such as a primary care physician, is important for preventing disease, managing chronic conditions, and coordinating specialist visits. Majorities of women in all 11 countries reported having a regular doctor or place of care. But somewhat fewer women in the U.S. and Switzerland reported having a regular doctor, compared to those in the other nine countries. In contrast, all women in the Netherlands reported having a regular doctor or place of care.

QUALITY, UTILIZATION, AND ACCESS TO CARE

In Canada, the U.S., and Sweden, More Than One of Three Women Report Emergency Department Visits in the Past Two Years

Percent of women ages 18–64 who reported going to the emergency department in the past two years



More than one of three women in Canada, the U.S., and Sweden reported emergency department (ED) visits in the past two years; rates were lower in other countries. Women in Germany had the lowest rate of ED visits.

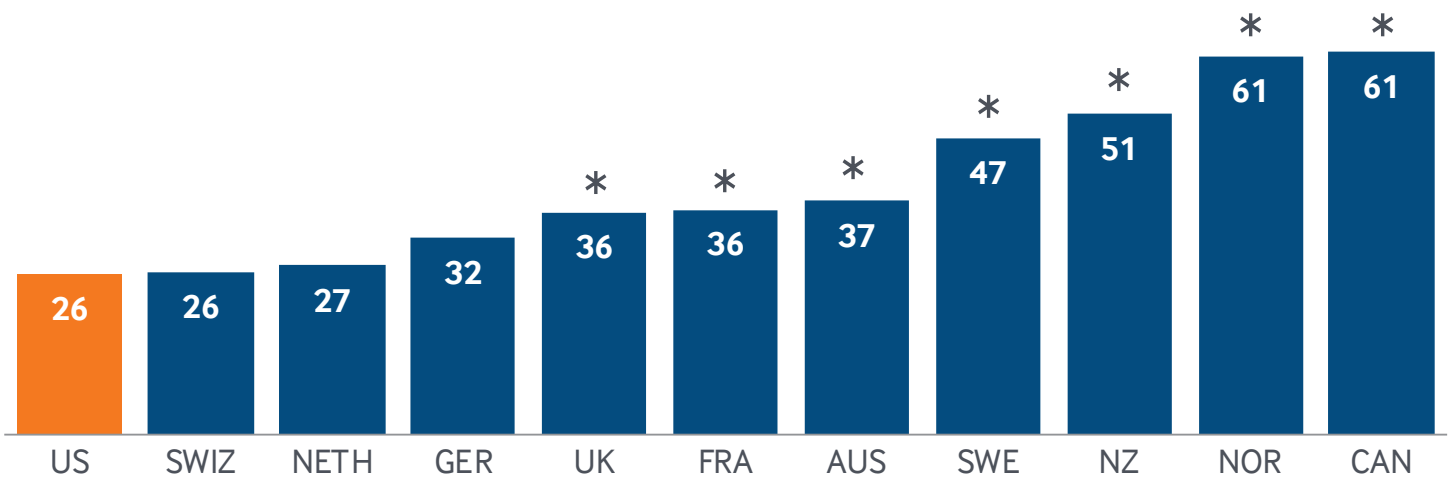
Notes: * Statistically significant difference compared to the United States (p<.05).

Data: The Commonwealth Fund International Health Policy Survey, 2016.

QUALITY, UTILIZATION, AND ACCESS TO CARE

Fewer Women in the U.S. Wait to See Specialists

*Percent of women ages 18–64 who reported having to wait more than four weeks to see a specialist^*



Notes: ^ Excludes women who did not need to see a specialist in the past two years. * Statistically significant difference compared to the United States (p<.05).

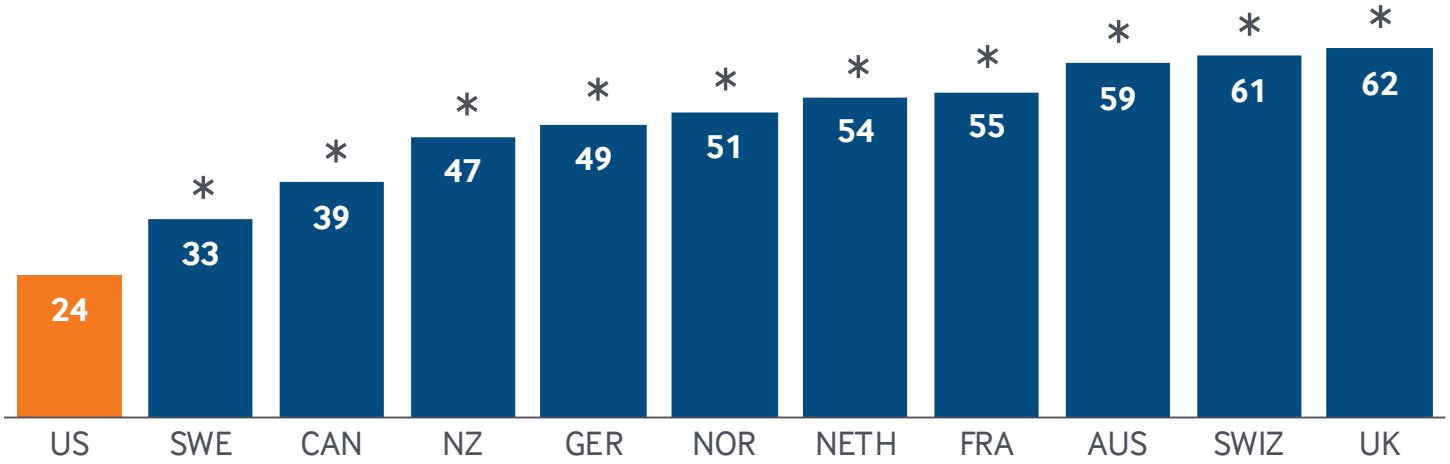
Data: The Commonwealth Fund International Health Policy Survey, 2016.

Women in the U.S., Switzerland, and the Netherlands had quicker access to specialist care. Among women who needed to see a specialist in the past two years, only a quarter of women in these countries had to wait more than four weeks for an appointment, compared to the majority of women in Canada and Norway.

QUALITY, UTILIZATION, AND ACCESS TO CARE

One-Quarter of Women in the U.S. Rate Their Quality of Care as Excellent or Very Good

*Percent of women ages 18–64 who rated their quality of medical care as excellent or very good^*



Notes: ^ Other answer categories were 'good', 'fair' and 'poor'. Excludes women who did not receive care in the past year, and women who did not have a regular doctor or place of care. * Statistically significant difference compared to the United States (p<.05).

Data: The Commonwealth Fund International Health Policy Survey, 2016.

U.S. women were the least likely to rate their quality of care as excellent or very good compared to women in all other countries studied. More than 60 percent of women in the U.K. and Switzerland rated the quality of their health care as high, compared with one-quarter in the U.S. Further analyses showed that women with multiple chronic conditions or emotional distress, and those who faced high out-of-pocket costs, medical bill or cost-related access problems, long specialty wait times, or had emergency department visits were significantly less likely to rate their quality of care as good (data not shown).

CONCLUSIONS AND POLICY IMPLICATIONS

Women in the United States continue to be disadvantaged by their relatively poorer health status and higher costs of care, while benefiting from higher rates of preventive screenings and quicker access to specialty care. While this study did not investigate the reasons behind these findings, they might be viewed in the context of lower rates of health insurance coverage in the U.S., as well as differences in health care delivery systems and the level of social protection across countries.

Consistent with other research, we find that U.S. women have the highest rate of maternal mortality among high-income countries. What's more, this rate has been steadily rising in the past decades. Considerable racial, rural-urban, and other socioeconomic disparities also persist. U.S. maternal mortality is three times higher among African American mothers — with rates similar to those found in developing countries — compared to white mothers.

It is notable that U.S. women face fewer barriers to accessing specialist care relative to women in most of the 10 other countries analyzed. The U.S. also outperforms most countries in terms of breast cancer screenings. This, coupled with relatively low rate of breast cancer deaths, may be associated with the high quality of cancer care delivered in the U.S., including extensive screenings, treatments, and technology.

Despite the significant gains the United States has made in health insurance coverage since the implementation of the ACA, the U.S. remains the only country in this study without universal coverage. Uninsured adults most often cite concerns about affordability as the reason they do not shop for coverage. Coverage is out of reach for people with low incomes who live in states that have not expanded Medicaid and those who are undocumented and therefore ineligible for coverage. In addition, many people in the U.S. have insurance plans with high levels of cost-sharing. More than one-third of women in the U.S. continue to skip needed care because of costs. While the rates of going without needed care because of costs and problems paying medical bills have decreased since 2010, they are still the highest among all 11 countries included in the 2016 Commonwealth Fund International Health Policy Survey.

The continued efforts by Congress and the Trump administration to weaken the ACA, rather than improve the quality and affordability of health insurance, may increase the cost of insurance and make it more difficult for some women to afford comprehensive health coverage. These actions include the administration's support for ending the ACA's guaranteed issue and preexisting conditions protections, which ensure every individual has access to insurance regardless of their health status, and expanding the availability of plans which are not required to comply with the law's consumer protections. A recent analysis of 24 short-term insurance policies found that none provided coverage for maternity care.

The administration's recently proposed changes to the Title X program — including cuts to funding for family planning services, counseling, and routine exams and cancer screenings — will reduce access to health services among low-income women and minorities. The proposed regulations would block federal funding to family planning providers that provide abortion services. Nearly 4,000 health centers across the country receive such Title X funding, and over 4 million women, the vast majority of whom have incomes below 150 percent of the federal poverty level, annually receive services from these centers. Many women also receive routine primary care and behavioral health services at women's health centers. But states can take steps toward prioritizing women's health. For example, California successfully reduced the rate of maternal mortality by 55 percent in less than a decade, through the statewide Pregnancy-Associated Mortality Review (CA-PAMR) program that introduced surveillance, public health, and quality improvement initiatives for maternal care.

Given the substantial maternal mortality gap between U.S. women and their counterparts in other countries, policymakers might also look at the organization of health systems of these countries. For example, in many other countries compared in this brief, maternal care is free at the point of delivery, including postpartum care (Appendix 1). Furthermore, most countries deliver maternal care in primary care or community-based settings by nurses or midwives, rather than in specialty or inpatient settings using obstetricians, as is often the case in the U.S. This not only makes care more expensive, but also limits women's choices around childbirth. Midwives attend only 12 percent of U.S. vaginal births. Other countries also provide greater social protection for women of reproductive age. The U.S. remains the only country in the developed world that does not guarantee paid maternity leave, despite International Labor Organization standards recommending that new mothers should be provided at least two-thirds of previous earnings for a minimum of 14 weeks.

Finally, since research suggests that the differences in health spending between the U.S. and the rest of the world stem largely from higher prices, payment and delivery system reform must be at the top of the nation's policy agenda. For example, international data show that the average costs of a normal delivery or a caesarian section are about twice as high in the U.S. as in Australia and about 40 percent to 60 percent higher than in Switzerland. Bringing health costs under control will help improve access to health insurance and health care.

HOW WE CONDUCTED THIS STUDY

This brief includes data from the 2016 Commonwealth Fund International Health Policy Survey of Adults in 11 Countries, conducted by SSRS and country contractors in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. between March and June 2016. The survey was administered by telephone (mobile and landline) using a common questionnaire that was translated and adjusted for country-specific wording. Response rates ranged from 11 percent in Norway to 47 percent in Switzerland. The analysis weighted final samples to reflect the distribution of the adult population in the country, adjusting for age, sex, region, education, and additional variables consistent with country standards. This brief restricts the analysis to 9,254 women ages 18 to 64. Sample sizes for each country are included in Appendix 3. The U.S. sample includes women who reported being uninsured for some of part of the previous calendar year (12 months; 8.3%).

The Organisation for Economic Co-operation and Development (OECD) is an international organization representing 36 industrialized countries that share a commitment to democracy and a market economy. The OECD produces reports and data on a wide range of economic and social issues, including the OECD Health Data series, an annual release of data on various aspects of health and health care in the member countries. Working with statistical offices in each member country, the OECD produces the most accurate and comprehensive international health care data available on its member nations. Each year, the OECD releases health data on a range of topics, including spending, hospitals, physicians, pharmaceuticals, prevention, mortality, quality, and safety.

Commonwealth Fund staff analyzed data from the Commonwealth Fund International Health Policy Survey of Adults in 11 Countries as well as data extracted from the OECD on August 6, 2018, and the UNICEF database (maternal mortality only) on June 6, 2018, for the 11 countries. As of December 5, 2018, the UNICEF and OECD data were unchanged.

ABOUT THE AUTHORS

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About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Appendix 1. Coverage and Cost-Sharing Protections for Women in 11 Countries

Country	Health care system	Caps on cost-sharing and protections for vulnerable populations
Australia	National health care system (Medicare, regionally administered)	Caps for pharmaceutical out-of-pocket expenditure only, dependent on income and total out-of-pocket expenditure in the same year. Cost-sharing exemptions (free or subsidized care) for pregnant women before, during and after birth, including inpatient and outpatient, scans and home visits.
Canada	National health care model (Medicare), regionally administrated at the provincial/territorial level	No annual caps for cost-sharing, but no cost-sharing for publicly covered services, in addition to protection for low-income people from cost of prescription drugs (varies by region).
France	Statutory health insurance system, with all statutory health insurance insurers incorporated into a single national exchange	No general cap; $60 cap on deductibles for consultations and services. Cost-sharing exemptions for low income, chronically ill and disabled, children and pregnant women (starting in the fifth month of pregnancy). Care for mothers is fully covered up to 12 days postpartum and for newborns up to 30 days postpartum. Maternal and child health centers offer free health care for children up to six years including home visits by midwives.
Germany	Statutory health insurance system (multipayer), with 113 competing sickness funds operating in a national exchange	Cost-sharing capped at 2% of household income/year, and 1% of income for chronically ill. Children and adolescents <18 years of age exempt from cost-sharing. No cost-sharing for pregnant women.
Netherlands	Statutory health insurance system (multipayer), with universally mandated private insurance of 10 competing insurance carriers on a national exchange	No annual cap but annual deductible of $465 covers most cost-sharing. GP care and children exempt from cost-sharing; premium subsidies for low-income. Health insurers legally required to cover maternal care. Maternity care services do not count toward the deductible.
New Zealand	National health care system	No annual caps, but reduced fees after 12 doctor visits per year/patient and no drug copayments after 20 prescriptions per year/family. No primary care consultation charges for children under 13; subsidies for low-income, some chronic condition and high-need groups, and indigenous populations.
Norway	National health care system	Overall cost-sharing ceiling of $223/year. Cost-sharing exemptions for children (<16 years somatic, <18 years psychiatric), pregnant women (prenatal and postnatal follow-up care), for some communicable diseases (including STDs), and those with work-related injuries; low income groups receive free essential drugs and nursing care.
Sweden	National health care system	Annual cap of $123 for health services and $246 for prescription drugs. Some cost-sharing exemptions for children, adolescents, pregnant women (e.g. free checkups at prenatal primary care clinics), and elderly.
Switzerland	Mandatory health insurance (MHI, multipayer), with competing private insurance carriers on regional (cantonal) exchanges	Annual cap of $549 after deductible. Some copayment exemptions and $274 cap for <19 year-olds; income-related premium subsidies. No cost-sharing for maternity care; exempt from deductibles, coinsurance and copayments for most prenatal and maternity care including breastfeeding advice, inpatient, primary and specialty outpatient, and Rx.
United Kingdom	National Health Service	No general cap for medical bills, and most care is provided free of charge at the point of service. Out-of-pocket payments for prescription drugs and medical devices capped at $41/three months or $147/year for those needing a large number of prescription drugs. Drug cost-sharing exemptions for low-income, older people, children, pregnant women, and new mothers. Primary care, which is mostly free of charge, provides family planning and prenatal care.
United States	Multipayer: employer-sponsored insurance, Medicaid/CHIP, Medicare, individual market (private), Veterans Administration, TRICARE, other state-based public programs	Annual out-of-pocket caps in some private plans. Cost-sharing exemptions for low-income adults (Medicaid), older people and some disabled (Medicare); premium subsidies and lower cost-sharing for low- and middle-income families on the exchanges. ACA requires all health plans on exchanges to cover 10 essential health benefits including maternity and newborn care, preventive care (e.g., contraceptives and cancer screenings) and Rx.

Data: 2017 Commonwealth Fund International Profiles of Health Care Systems; 2019 Commonwealth Fund International Profiles of Health Care Systems (forthcoming); and European Observatory on Health Systems and Policies, Health Systems Reviews (HiTs) (2012–2016). Some information also comes directly from government websites (e.g., Australian Medicare).

Appendix 2. How the Affordable Care Act Has Helped Women Gain Access to Health Care

- **Guaranteed issue.** Insurers are no longer allowed to deny coverage to individuals who apply for insurance, including those with preexisting conditions. Female-specific preexisting conditions include having had a caesarian section and being a victim of domestic violence, including rape.
- **Community rate-setting for premiums.** Insurers are no longer allowed to charge women higher health care premiums than males. This was a previously common practice, since women were anticipated to have higher health care costs than men, especially around child-bearing years. Because of the ACA, insurers are only allowed to charge higher premiums based on age.
- **Free preventive services.** The ACA mandates that insurers provide preventive services such as mammograms for breast cancer screening, Pap smears for cervical cancer screening, FDA-approved contraceptives, osteoporosis and chlamydia screening for women in at-risk age groups, without cost-sharing, which includes copays, coinsurance, and deductibles.
- **Essential health benefits.** The ACA mandates that all insurers must cover 10 essential health benefits, including maternity coverage.
- **Support for young mothers.** The ACA mandates that employers with at least 50 employees allow women who are nursing to reasonable breaks from work to express breast milk, and provide them with a private place to do so for the first year after a child's birth.
- **Expanding Medicaid.** Expanded eligibility to individuals with incomes up to 133% of the federal poverty level, left up to the state's discretion. This has led to nearly 3 million* additional women ages 19–64 gaining Medicaid in states that expanded their program before the marketplaces first opened in 2013.
- **Premium subsidies for low-income women.** The ACA provides premiums subsidies for all individuals who earn up to 400% of poverty ($48,240 for an individual and $98,400 for a family of four).
- **Coverage for young women.** The ACA allows young adults to stay on their parents plan until their 26th birthdays. Before the ACA, young women ages 19–25 had among the highest rates of being uninsured.

Notes: * Analysis of the Current Population Survey, 2014 and 2018, CPS Table Creator: https://www.census.gov/cps/data/cpstablecreator.html. Many of these provisions also apply to men.

Appendix 3. Sample Sizes per Country for Survey Data*

Country	Sample size (n)
Australia	2,115
Canada	1,761
France	459
Germany	382
Netherlands	451
Norway	384
New Zealand	428
Sweden	1,608
Switzerland	603
United Kingdom	381
United States	682
Total	**9,254**

Notes: * Applies to Exhibits 1, 2, 7–13 based on data from the 2016 Commonwealth Fund International Health Policy Survey.

Appendix 4. Percentages of Women, Ages 19–64, in 11 Countries Who Reported Medical Bill Problems in the Past 12 Months

	MEDICAL BILL PROBLEMS IN PAST 12 MONTHS			
Country	Had serious problems paying or were unable to pay your medical bills	Spent a lot of time on paperwork or disputes related to medical bills	Insurance denied payment for medical care or did not pay as much as expected	ANY (at least 1)
Australia	7	6	12	**17**
Canada	7	5	16	**22**
France	23	26	23	**35**
Germany	5	6	8	**10**
Netherlands	9	8	9	**18**
Norway	10	6	2	**16**
New Zealand	6	4	2	**8**
Sweden	8	3	2	**12**
Switzerland	13	15	16	**30**
United Kingdom	1	<1	1	**2**
United States	23	19	32	**44**

Data: 2016 Commonwealth Fund International Health Policy Survey.

Appendix 5. Percentages of Women, Ages 19–64, in 11 Countries Who Reported Cost-Related Access Barriers in the Past 12 Months

	COST-RELATED ACCESS PROBLEMS IN PAST 12 MONTHS			
Country	Had a medical problem but did not visit the doctor because of cost in the past year	Skipped a medical test, treatment, or follow-up that was recommended by a doctor because of cost in the past year	Did not fill a prescription or skipped doses because of cost in the past year	ANY (at least 1)
Australia	12	10	8	**17**
Canada	6	7	15	**20**
France	7	9	2	**14**
Germany	2	5	3	**7**
Netherlands	4	4	6	**11**
Norway	8	6	6	**15**
New Zealand	20	16	9	**27**
Sweden	5	5	10	**13**
Switzerland	19	12	10	**26**
United Kingdom	3	1	3	**5**
United States	24	24	22	**38**

Data: 2016 Commonwealth Fund International Health Policy Survey.

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