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# New 2011 Survey Of Patients With Complex Care Needs In Eleven Countries Finds That Care Is Often Poorly Coordinated

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**ABSTRACT** Around the world, adults with serious illnesses or chronic conditions account for a disproportionate share of national health care spending. We surveyed patients with complex care needs in eleven countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States) and found that in all of them, care is often poorly coordinated. However, adults seen at primary practices with attributes of a patient-centered medical home—where clinicians are accessible, know patients' medical history, and help coordinate care—gave higher ratings to the care they received and were less likely to experience coordination gaps or report medical errors. Throughout the survey, patients in Switzerland and the United Kingdom reported significantly more positive experiences than did patients in the other countries surveyed. Reported improvements in the United Kingdom tracked with recent reforms there in health care delivery. Patients in the United States reported difficulty paying medical bills and forgoing care because of costs. Our study indicates a need for improvement in all countries through redesigning primary care, developing care teams accountable across sites of care, and managing transitions and medications well. The United States in particular has opportunities to learn from diverse payment innovations and care redesign efforts under way in the other study countries.

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**I**n all high-income countries, patients with serious illnesses or complex chronic conditions account for a disproportionate share of national health spending. In the United States, for example, 89 percent of total national health spending is concentrated on the sickest 30 percent of the population.<sup>1</sup> Because these patients typically see multiple clinicians at different locations, care coordination is imperative. Without effective communication among providers, these patients are at risk for experiencing delays, errors, and ineffective care.

In addition, the growth of ever-more-specialized care has tended to fragment delivery sys-

tems, and community-based practices, hospitals, and long-term care often are not well coordinated. To improve care, initiatives under way internationally are focused on developing integrated care and team approaches that organize care around patients and their families. In the United States, such initiatives include redesigning primary care into patient-centered medical homes that provide enhanced access and comprehensive, coordinated care, including teams to manage care for those with chronic conditions.<sup>2</sup>

Patient surveys offer valuable perspectives on care gaps and targets for improvement to inform these redesign efforts. Building on past international surveys, in this article we report results

from a 2011 survey of patients with serious illnesses, serious injuries, or chronic diseases in eleven countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The survey focused on access, care coordination and management, patient engagement, safety, and the extent to which having a primary care practice with attributes of a patient-centered medical home influenced the patient's care experience.

The surveyed countries represent a diverse mix of care systems and provider payment systems, and they differ in the way they pay primary care practices and specialists, use incentives to improve or support care teams, and encourage the use of electronic health records (Appendix Exhibit 1).<sup>3-6</sup>

The countries also differ in insurance designs.<sup>7</sup> Some countries, such as the United Kingdom, Sweden, Norway, and New Zealand, feature national health systems where primary care practices are community based and where hospitals typically operate within set budgets and with salaried specialists. In the Netherlands, the United Kingdom, and New Zealand, patients register with general (primary care) practices, which serve as gateways for referrals to more-specialized care.

Universal insurance systems are present in Australia, Canada, France, Germany, the Netherlands, and Switzerland. In these systems, national (France), provincial (Australia, Canada), or competing health insurers (Germany, the Netherlands, Switzerland) finance care for the population, supported by varying mixes of premiums and taxes. Hospitals in these countries are a mix of public and private institutions. France, Germany, Norway, and Canada use financial incentives to encourage patients to use primary care for referrals but do not require it.

The United States has a mix of publicly and privately financed insurance ~~coverage~~, supported by varying mixes of premiums and taxes. Most hospitals are private, but many are public. The United States is unique in its high percentage of uninsured people and the absence of national standards for essential benefits or financial protection. However, with full implementation of the Affordable Care Act in 2014, the number of uninsured people will fall dramatically, and there will be new insurance standards.

Amid these distinct systems, the countries share the challenge of how to meet the needs of patients with complex conditions in often fragmented systems. Our study points to areas of shared concern and opportunities to improve primary care, care coordination, and communi-

cation.

## Study Data And Methods

The survey screened random samples of adults age eighteen or older to identify people with complex health care needs who met at least one of four criteria: They rated their health as fair or poor; reported having received medical care for a serious chronic illness, serious injury, or disability in the past year; reported having had surgery in the past two years; or reported having been hospitalized in the past two years.

The survey was administered using computer-assisted telephone interviews and a common questionnaire that was translated and adjusted for country-specific wording. Random samples, designed to ensure geographic representation, drew from national phone directories. Mobile phones were included in France, the Netherlands, and Norway, where there was easy access to mobile phone registries. Harris Interactive and country contractors conducted the interviews from March through June 2011 (field times varied by country). International partners joined with the Commonwealth Fund to sponsor country surveys or expand samples beyond the minimum (750) for within-country analyses.<sup>8</sup>

After screening, the final country samples, shown in Exhibit 1, ranged from 750 to more than 4,800.<sup>9</sup> The analysis weighted final samples to reflect the distribution of the adult population in each country.<sup>10</sup>

The survey questions identified adults who had complex chronic conditions and had recently made extensive use of the health system. Across countries, 60–80 percent of the final samples reported at least one of eight chronic conditions; one-fourth or more had two or more conditions (Appendix Exhibit 2).<sup>3</sup> More than half of the respondents in all countries had received care for a serious illness, injury, or disability in the past year; one-third or more had been hospitalized or had had major surgery in the past two years; and the vast majority had seen multiple physicians.

We refer to the final samples as “sicker adults” throughout the analysis, given their health and recent care experiences. Exhibits 1–4 show country averages. These are repeated in Appendix Exhibits 3–6 with statistical tests that compare each country to the other ten ( $p < 0.05$ ).<sup>3</sup>

**PRIMARY CARE MEDICAL HOME** To provide a working definition of the *medical home* concept, we used positive responses to four domains of patient experiences to create a composite indicator. These responses were as follows: The adult reported having a regular doctor or place of care; the practice staff always or often knew important

**EXHIBIT 1**

**Health Care Costs And Access Among Sicker Adults In Eleven Countries, 2011**

Percent of respondents who:

Country (N)	Had out-of-pocket costs in past year:		Had difficulty paying or unable to pay medical bills in past year	Had cost-related access problems in past year <sup>a</sup>	Saw a doctor or nurse the last time they were sick:		Said obtaining after-hours care was somewhat or very difficult <sup>b</sup>	Used ED in past 2 years
	Less than <=\$100	More than >\$1,000			Same or next day	After 6 days or more		
AUS (1,500)	13%	39%	8%	30%	63%	10%	56%	48%
CAN (3,958)	30	24	8	20	51	23	63	58
FRA (1,001)	47	6	5	19	75	8	55	33
GER (1,200)	20	12	6	22	59	23	40	31
NETH (1,000)	30	11	14	15	70	12	34	32
NZ (750)	29	13	11	26	75	5	40	47
NOR (753)	12	16	7	14	59	14	35	40
SWE (4,804)	21	5	4	11	50	22	52	50
SWI (1,500)	14	35	8	18	79	4	26	39
UK (1,001)	58	1	1	11	79	2	21	40
US (1,200)	19	36	27	42	59	16	55	49

**SOURCE** 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults In Eleven Countries. **NOTES** Significance tests are available in online Appendix 3 (Note 3 in text). ED is emergency department. <sup>a</sup>See online Appendix 7 for details (Note 3 in text). <sup>b</sup>Base: needed care.

information about the patient’s medical history; the adult received an appointment the same or next day the last time he or she was sick, or the practice always or often called back the same day to answer questions; and the practice always or often helped coordinate or arrange care from other providers, or, if the adult reported a chronic condition, there was one person responsible for care received for that condition.

The composite medical home variable thus indicates adults who have a primary care source that knows them, is accessible, and helps coordinate care. In contrast, we classified adults with a negative answer to any domain as having no medical home. In the analysis, we compared experiences within each country for adults with or without a medical home.

**LIMITATIONS** This was a rapid-response survey that drew from a combination of land lines and mobile phones in France, the Netherlands, and Norway, and land lines only in the other countries. The relatively low response rates or lack of mobile phones in some countries introduces potential bias, although the direction of that potential bias is unknown. To the extent that the survey missed adults with more-complex conditions or those who are more vulnerable because of low incomes or lack of proficiency in the survey languages, the results may underestimate concerns.

**Study Findings**

**COSTS AND ACCESS** Given their frequent care

needs, sicker adults can be particularly vulnerable to high out-of-pocket spending for services. The survey results showed wide differences among countries regarding exposure to such spending (Exhibit 1). Australian, US, and Swiss patients were significantly more likely to have spent more than US\$1,000 out of pocket in the past year than patients in the other countries.<sup>11</sup> Patients in the United Kingdom were the most protected.

High out-of-pocket expenses, though, did not always translate into greater difficulty paying medical bills. Here US sicker adults stood out: 27 percent encountered serious problems paying or were unable to pay medical bills in the past year, compared with only 8 percent of Australian and Swiss patients who reported problems paying bills (Exhibit 1). In those two countries, a mix of out-of-pocket spending caps and protections for lower-income patients appeared to help shield more-vulnerable households from economic distress because of sickness- and disability-related costs.<sup>7</sup> Patients in the United Kingdom, Sweden, and France were the least likely to report high out-of-pocket expenses or problems paying for care.

In addition to financial burdens, US sicker adults were the most likely to forgo needed care because of cost in the past year: 42 percent reported not visiting a doctor, not filling a prescription, skipping doses of medication, or not getting recommended care. In the United States, rates of forgone care because of cost were at least

double the rates in every other country but Australia, New Zealand, and Germany.

The survey found wide variations in access to care across countries. When asked how quickly they saw a doctor or nurse when last sick, more than seven in ten patients reported same- or next-day appointments in the United Kingdom, Switzerland, France, New Zealand, and the Netherlands (Exhibit 1). In contrast, only half of Swedish and Canadian patients reported such rapid access, and more than one in five waited six days or more. Compared with the leading countries, German, Norwegian, and US patients were also less likely to have timely access.

Asked about gaining access to care during evenings and weekends without going to the emergency department, more than half of the sicker adults in Canada, Australia, the United States, France, and Sweden reported difficulty obtaining such care. Swiss and UK patients were the least likely to report difficulty gaining access after hours, followed by their Dutch and Norwegian peers.

Hospital emergency departments play a central role in providing care for sicker adults. In all eleven countries one-third or more of the sicker adults had visited the emergency department in the past two years. Emergency department use rates in Canada, Sweden, the United States, Australia, and New Zealand were significantly higher than use rates in the other countries. About half or more of patients in these five countries reported such use, often multiple times. Canadian patients reported the highest use rates, which probably reflects the lack of after-hours alternatives.

Across countries, the United Kingdom stands out for low cost burdens and, with Switzerland, for rapid access to primary care and easy access to after-hours care.

**CARE COORDINATION AND SAFETY** Well-coordinated care is critical for sicker patients, many of whom have multiple conditions. Without communication and accountability when receiving care in different settings, such patients are at risk for complications, medical errors, and undergoing duplicate tests. Patient reports indicate that coordination gaps exist in all countries to varying degrees (Exhibit 2). One-fifth to more than half of the sicker adults identified in the survey reported coordination gaps related to medical records or tests, or communication failures between providers. Among the eleven countries, patients in the United Kingdom and Switzerland reported the lowest rates of coordination gaps.

With respect to medical records or tests, one-fourth of US and Canadian patients and 22 percent of Norwegian patients reported that their

medical records or test results were not available during a scheduled visit or that tests were duplicated—nearly double the rates reported in the United Kingdom and Switzerland (Exhibit 2). Regarding communication between clinicians, French and German patients were the most likely to report that specialists and primary care physicians failed to share information with one another, and Germans were the most likely to say that providers failed to share important information.

Comparatively high proportions of Norwegian and Swedish patients also reported communication gaps. Combining the two categories—patients reporting that medical records were not available during a scheduled visit or that their doctors did not share information with each other—40 percent of Canadian, Norwegian, Swedish, and US sicker adults and more than half of French and German sicker adults reported that they had experienced these failures to coordinate care.

When respondents were asked about experiences after surgery or after being discharged from the hospital, a significant percentage in all countries reported gaps in discharge planning. These included not receiving instructions about when to seek follow-up care, not knowing whom to contact with questions, not having a written discharge plan or follow-up appointment, or not being given clear instructions about what medications to continue taking. Discharge planning gaps ranged from 26 percent and 29 percent of UK and US patients, respectively, to half or more patients in the other countries. The most common discharge gaps were not planning for follow-up care and not providing written instructions. (For details, see Appendix Exhibit 8.)<sup>3</sup>

Further indicating lack of follow-up after discharge, one-third of Swedish patients and one-fifth of patients in Australia, Canada, New Zealand, and Norway said that their regular doctor was not informed about the care received while they were hospitalized (Exhibit 2). In contrast, only 10 percent or fewer Dutch, US, or UK patients reported this concern.

A significantly lower percentage of UK and Swiss patients reported experiencing medical, medication, or laboratory test errors (Exhibit 2) than did patients in the other countries (8 percent and 9 percent, respectively, compared with 25 percent of Norwegian patients and 22 percent of US and New Zealand patients). In seven countries, including the United States, one-fifth to one-fourth of patients reported experiencing at least one type of error in the past two years. In all countries, the likelihood of an error increased with the number of doctors seen (data

**EXHIBIT 2**

**Coordination Of Care, Medical Errors, And Safety Among Sicker Adults In Eleven Countries, 2011**

Percent of respondents who:

**Experienced coordination gaps in past 2 years**

Country	Test results/ records not available at appointment or duplicate tests ordered	Key information not shared among providers	Specialist lacked medical history or regular doctor not informed about specialist care	Any gap	Experienced gaps in hospital/ surgery discharge planning <sup>a</sup>	Reported regular doctor seemed uninformed about hospital/ surgery care <sup>b</sup>	Experienced medical, medication, or lab error <sup>c</sup>	Reported pharmacist or doctor did not review prescriptions in past year <sup>d</sup>
AUS	19%	12%	19%	36%	55%	18%	19%	34%
CAN	25	14	18	40	50	19	21	28
FRA	20	13	37	53	73	15	13	58
GER	16	23	35	56	61	17	16	29
NETH	18	15	17	37	66	9	20	41
NZ	15	12	12	30	51	19	22	31
NOR	22	19	25	43	71	18	25	62
SWE	16	18	20	39	67	35	20	55
SWI	11	10	9	23	48	15	9	25
UK	13	7	6	20	26	11	8	16
US	27	17	18	42	29	12	22	28

**SOURCE** 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults In Eleven Countries. **NOTE** Significance tests are available in online Appendix 4 (Note 3 in text). <sup>a</sup>Base: hospitalized/had surgery in past two years. See online Appendix 8 for details (Note 3 in text). <sup>b</sup>Base: has regular doctor or place of care and hospitalized/had surgery in past two years. <sup>c</sup>In past two years, medical mistake, given wrong medication or dose, lab test error, and/or delay receiving abnormal test results. <sup>d</sup>Base: taking two or more drugs.

not shown).

Failure to review medications regularly can also put patients at risk. Yet with the exception of patients in the United Kingdom, between one-quarter to more than half of the patients taking more than one medication said that their medications had not been reviewed in the past year (Exhibit 2).

**ENGAGING PATIENTS AND CARE MANAGEMENT**

Communicating well with patients who have serious illnesses or chronic conditions and helping patients manage their care at home can be instrumental in avoiding complications and improving outcomes. Such patients often follow complex regimens of medication, diet, exercise, and self-monitoring. Adherence depends on clear instructions, supportive teams, and shared decision making about care. The survey indicates opportunities to improve communication and patient engagement in all countries (Exhibit 3).

Asked about interactions with their regular doctors or care team, one-fourth to more than half of sicker adults in all eleven countries said that their doctor did not spend enough time with them, encourage them to ask questions, or explain things in a way that is easy to understand.

Patients in Norway and Sweden were the least likely to report positive interactions; rates there were particularly low on encouraging questions and providing explanations. Swiss, UK, Australian, New Zealand, and US patients were the most positive, with strong majorities (65–73 percent) saying that their clinicians always or often spent enough time with them, encouraged questions, and provided clear explanations (Exhibit 3).

The patients surveyed gave a wide range of responses when asked whether specialists engaged them in shared decision making over treatment options. Just half or fewer of German, French, Norwegian, and Swedish patients said that specialists often or always provide opportunities to ask questions, tell them about choices, or involve them in decisions about care. In contrast, eight in ten Swiss and UK patients reported shared decision making with specialists.

Among patients reporting chronic disease, the survey found sizable gaps in guidance and support in managing their condition. Thirty percent to more than half of chronically ill patients said their care team did not discuss main goals, help make a plan, or give clear instructions in the past year (answered “no” on at least one question).

## EXHIBIT 3

## Patient-Centeredness, Engagement, And Chronic Care Management Among Sicker Adults In Eleven Countries, 2011

Country	Percent of respondents who:					Percent with chronic condition who said, between visits, have health professional who:		
	Report that doctor/staff at regular place always or often: <sup>a</sup>					You can easily call to ask a question or get advice		
	Spends enough time with them	Encourages questions, explains things clearly	Always/often to both	Report shared decision making with specialists <sup>b</sup>	Report patient engagement in care management for chronic condition <sup>c</sup>	Contacts you to see how things are going	Percent reporting that blood pressure was controlled last time checked <sup>d</sup>	
AUS	85%	69%	66%	64%	48%	59%	16%	79%
CAN	77	59	54	61	49	62	16	85
FRA	82	53	50	37	30	54	9	83
GER	86	64	61	50	41	55	14	78
NETH	87	54	52	67	42	70	22	74
NZ	87	67	65	72	45	71	22	84
NOR	71	31	27	40	23	63	12	85
SWE	70	41	37	48	22	73	22	84
SWI	88	77	73	80	67	68	24	69
UK	87	77	72	79	69	81	29	69
US	81	71	65	67	58	77	31	85

**SOURCE** 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults In Eleven Countries. **NOTE** Significance tests are available in online Appendix 5 (Note 3 in text). <sup>a</sup>Base: has regular doctor or place of care. <sup>b</sup>Base: seen specialist in past two years. See online Appendix 9 for details (Note 3 in text). <sup>c</sup>Base: has chronic condition. See online Appendix 10 for details (Note 3 in text). <sup>d</sup>Base: has diabetes, heart disease, and/or hypertension, and had blood pressure checked in past year.

Swiss and UK patients were the most likely (69 percent and 67 percent, respectively) and Swedish and Norwegian patients the least likely (22 percent and 23 percent, respectively) to respond positively to all three questions, repeating the pattern observed with regular doctor communication. However, in all countries except Switzerland, the United Kingdom, and the United States, one-third or more patients answered “no” to each question concerning their engagement in managing care.

Deficits also emerged in access to advice and follow-up between visits for chronically ill patients. Across countries, 20 percent to more than 40 percent of patients answered “no” when asked if they could easily call their caregiver to ask a question or get advice, with French and German patients the least likely to report easy access to advice by phone (Exhibit 3). In all countries, only a minority said that someone called them between visits to follow up on their care.

To explore how patients fared on clinical outcomes, we asked patients with hypertension, heart disease, or diabetes about their blood pressure control. We found that the responses did not always track patterns on care management interactions in their countries. Norway and Sweden joined the leaders (Canada, France, New Zealand, and United States) with 83 percent and 85 percent of patients, respectively, report-

ing that their blood pressure was under control the last time it was checked. Swiss and UK patient-reported rates of control were significantly lower than rates reported by the leading countries.

Those variations underscore the importance of assessing chronic care outcomes and not just process outcomes or interpersonal interactions. However, caution is needed in interpreting patient-reported hypertension control without clinical follow-up. To the extent that clinicians in some countries are more focused on telling patients their results or, in the case of the United States, uninsured patients are unaware of their conditions, patient-reported outcomes might not track clinical exam outcomes.

**PATIENT-CENTERED MEDICAL HOMES** A strategy gaining international momentum to improve access, coordination, and outcomes for patients with complex care needs is to invest in enhanced primary care.<sup>4,12</sup> Known primarily in the United States as patient-centered medical homes, such practices not only provide primary and preventive care, but they also ensure timely access, know their patients’ medical histories, and help coordinate or arrange for care.

In the survey, 91–100 percent of patients in all countries said that they had a regular doctor or place they relied on for care (Exhibit 4). However, when respondents were probed about

access and whether their practice team knows them well and helps coordinate care, the percentage of sicker adults seen at practices with attributes of a medical home dropped sharply, ranging from a high of 74 percent in the United Kingdom to about half or fewer sicker adults in several other countries.

As detailed in Exhibit 4, patients in the various countries differed in terms of reporting whether the physician practices they used exhibited relatively stronger or weaker medical home attributes. Patients in Switzerland and the United Kingdom reported that the practices they used performed well on such medical home attributes as access, knowing patients, and coordination. In contrast, patients in Sweden reported that the practices they used exhibited poor performance in the last two areas.

Patients in other countries also pointed to deficits of various different medical home attributes. Those in the United States, Norway, Canada, and Australia reported that access was lacking, while those in France and Germany reported relatively low rates of coordination among their providers.

**MEDICAL HOMES AND CARE EXPERIENCES**

Adults with a medical home were significantly more positive about their care experiences than were those without a medical home (Exhibit 5). Within countries there was spread of eighteen to thirty-nine percentage points between those with and without a medical home over such ques-

tions as whether their doctor spends enough time with them, encourages them to ask questions, and explains things clearly. The same pattern was true for questions pertaining to engaging patients in managing their chronic conditions.

Confirming medical home patients' general perceptions that these practices help coordinate care, in all countries except Germany, where the difference was not statistically significant, having a relationship with a medical home was associated with reduced coordination gaps (Exhibit 5). Hallmarks of superior performance included better information flow between specialists and primary care practices, availability of records and tests, and the absence of duplicate tests.

Practices with medical home attributes also appear to help mitigate the risk of error. Patients who reported having a medical home were also less likely to report medical errors, although in two countries, Germany and the Netherlands, the results were not statistically significant (Exhibit 5).

Practices with medical home characteristics may be more connected with other providers. Patients with medical homes who were hospitalized or had surgery were more likely to report having arrangements for follow-up care or knowing whom to contact—which contributed to lower discharge gaps. Patients with medical homes were also more likely to say that their

**EXHIBIT 4**

**Medical Homes Among Sicker Adults In Eleven Countries, 2011**

Country	Percent with a regular doctor or place of care	Percent reporting that regular doctor or place of care:			Percent with a medical home
		Is accessible <sup>a</sup>	Knows them <sup>b</sup>	Helps coordinate care <sup>c</sup>	
AUS	97%	79%	84%	66%	51%
CAN	96	70	80	71	49
FRA	99	91	88	60	52
GER	97	85	91	56	48
NETH	100	89	79	59	48
NZ	99	91	89	72	65
NOR	99	80	76	67	53
SWE	95	83	66	42	33
SWI	99	89	96	80	70
UK	99	90	94	83	74
US	91	80	84	71	56

**SOURCE** 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults In Eleven Countries. **NOTE** Significance tests are available in online Appendix 6 (Note 3 in text). <sup>a</sup>Able to get same-/next-day appointment or always/often receives same-day callback from regular practice in response to questions. <sup>b</sup>Regular practice always/often knows important information about medical history. <sup>c</sup>Regular practice always/often helps coordinate care, or one person is responsible for all care received for chronic condition.

## EXHIBIT 5

## Care Experiences Among Sicker Adults With And Without Medical Homes In Eleven Countries, 2011

	Patient- doctor relationship (always/ often to all)	Patient engagement for chronic condition (yes to all)	Controlled blood pressure	Coordination gap in past 2 years (any gap)	Medical errors in past 2 years (any error)	Gap in hospital/ surgery discharge planning (any gap)	Regular doctor not informed about hospital/ surgery care	Care quality in past year was excel- lent/ very good
<b>AUSTRALIA</b>								
Medical home	79% <sup>a</sup>	56% <sup>a</sup>	85% <sup>a</sup>	31% <sup>a</sup>	15% <sup>a</sup>	49% <sup>a</sup>	13% <sup>a</sup>	79% <sup>a</sup>
No medical home	52	38	71	41	23	63	23	56
<b>CANADA</b>								
Medical home	70 <sup>a</sup>	59 <sup>a</sup>	88 <sup>a</sup>	30 <sup>a</sup>	15 <sup>a</sup>	43 <sup>a</sup>	11 <sup>a</sup>	72 <sup>a</sup>
No medical home	38	38	82	49	27	57	28	46
<b>FRANCE</b>								
Medical home	59 <sup>a</sup>	34 <sup>a</sup>	84	49 <sup>a</sup>	10 <sup>a</sup>	66 <sup>a</sup>	12 <sup>a</sup>	49 <sup>a</sup>
No medical home	40	24	82	57	15	82	19	38
<b>GERMANY</b>								
Medical home	72 <sup>a</sup>	47 <sup>a</sup>	79	53	15	60	10 <sup>a</sup>	35 <sup>a</sup>
No medical home	50	33	75	59	18	63	25	27
<b>NETHERLANDS</b>								
Medical home	65 <sup>a</sup>	54 <sup>a</sup>	78	32 <sup>a</sup>	16	59 <sup>a</sup>	3 <sup>a</sup>	44 <sup>a</sup>
No medical home	40	29	70	42	23	74	15	26
<b>NEW ZEALAND</b>								
Medical home	76 <sup>a</sup>	51 <sup>a</sup>	84	25 <sup>a</sup>	19 <sup>a</sup>	42 <sup>a</sup>	13 <sup>a</sup>	83 <sup>a</sup>
No medical home	45	27	83	41	29	68	31	59
<b>NORWAY</b>								
Medical home	36 <sup>a</sup>	29 <sup>a</sup>	88 <sup>a</sup>	36 <sup>a</sup>	22 <sup>a</sup>	64 <sup>a</sup>	10 <sup>a</sup>	65 <sup>a</sup>
No medical home	18	16	80	51	29	78	28	34 <sup>a</sup>
<b>SWEDEN</b>								
Medical home	55 <sup>a</sup>	32 <sup>a</sup>	86	32 <sup>a</sup>	16 <sup>a</sup>	59 <sup>a</sup>	25 <sup>a</sup>	62 <sup>a</sup>
No medical home	28	15	82	42	22	70	40	44
<b>SWITZERLAND</b>								
Medical home	82 <sup>a</sup>	73 <sup>a</sup>	73 <sup>a</sup>	20 <sup>a</sup>	6 <sup>a</sup>	41 <sup>a</sup>	12 <sup>a</sup>	72 <sup>a</sup>
No medical home	51	51	58	30	15	67	23	57
<b>UNITED KINGDOM</b>								
Medical home	79 <sup>a</sup>	76 <sup>a</sup>	70	15 <sup>a</sup>	6 <sup>a</sup>	17 <sup>a</sup>	9 <sup>a</sup>	88 <sup>a</sup>
No medical home	54	46	65	33	14	53	17	60
<b>UNITED STATES</b>								
Medical home	80 <sup>a</sup>	67 <sup>a</sup>	90 <sup>a</sup>	33 <sup>a</sup>	17 <sup>a</sup>	19 <sup>a</sup>	9 <sup>a</sup>	77 <sup>a</sup>
No medical home	41	45	76	54	29	46	15	43

**SOURCE** 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults In Eleven Countries. <sup>a</sup>Indicates significant within-country differences ( $p < 0.05$  or better).



doctors were up-to-date on the care they had received while hospitalized.

Perhaps not surprisingly, patients with medical homes also were more likely to rate the quality of their care positively (Exhibit 5). The bivariate findings of the significant positive association of having a medical home with care experiences generally held in multivariate analyses that controlled for age, health, income, and, in the United States, insurance status.<sup>13</sup>

**UNITED STATES: MEDICARE MAKES A DIFFERENCE** Within the United States, gaps in coverage, frequent changes of plans, and high rates of uninsurance among the population under age sixty-five put their access, continuity, and care coordination at risk. For patients age sixty-five and older, Medicare offers a more secure, stable source of insurance and care and, with supplements, financial protection.

In the survey, US adults age sixty-five and older reported significantly more positive access- and cost-related experiences than did younger US adults, including those insured all year. The older patients were far less likely to have gone without care because of cost (19 percent, compared with 51 percent under age sixty-five) or to have had problems paying bills (6 percent, compared with 35 percent under age sixty-five). Although uninsured adults were most at risk, adults younger than sixty-five who were insured all year reported rates of access and cost concerns that were double the levels reported by people age sixty-five or older (Appendix Exhibit 11).<sup>3</sup>

## Discussion And Implications

Overall, patients' experiences in these eleven diverse countries point to the shared challenges of ensuring access to well-coordinated care for adults with complex care needs. To varying degrees, coordination gaps emerged in all countries, as did missed opportunities to engage patients in managing their care. Information often failed to flow across sites, such as during transitions from hospitals to community settings and between primary and specialist clinicians. Ensuring regular medication review and timely receipt of test results also emerged as issues common among countries.

Patients' reports also reveal areas in which countries differ. The variations offer insight and targets as health systems within the countries seek to improve.

**CROSS-NATIONAL PATTERNS** In all countries, patients receiving care from practices with patient-reported attributes of medical homes were less likely than others to report coordination gaps and more likely to report positive commu-

nication and care management interactions. Interestingly, the two countries with the highest share of patients with medical homes, Switzerland and the United Kingdom, have quite different delivery and insurance systems. This suggests that coordination is possible in quite different contexts. Patient responses in the United Kingdom and Switzerland were often among the most positive about access, coordination, safety, and engaging patients, and rarely at the bottom of the country range.

Compared with UK patients' responses to earlier surveys, those who responded to this year's survey reported marked improvements in care access, management, and communication. This suggests that policies can have an impact.<sup>14</sup> In the past decade the United Kingdom implemented patient surveys to provide feedback to clinicians. The United Kingdom also uses performance-based payment incentives and quality frameworks that emphasize care plans and teams, while reducing waiting times.<sup>4</sup> However, the comparatively low rates of patient-reported disease control for blood pressure may indicate a need for increased emphasis on outcomes in addition to process metrics.

Among the eleven countries, the United States stands out for cost burdens and cost-related access concerns, as it has in past surveys.<sup>14</sup> These concerns were concentrated in the under-sixty-five population and reflect high rates of uninsured and underinsured patients.<sup>15</sup> Although per capita US spending on health care far exceeds that in any of the other countries, US patients also reported among the highest rates of patient-reported errors and coordination gaps.

At the same time, US patients were more positive than patients in other countries regarding clinicians' efforts to engage them and help them manage their care. Those positive responses may reflect widespread endorsement and spreading use of the chronic care model, which originated in the United States.<sup>16</sup> Such efforts are likely to intensify in the future as reforms embedded in the Affordable Care Act take hold, with payment and information systems to support a more team-based, patient-centered care approach.

In contrast, sicker adults in Norway, Sweden, and, to a lesser extent, Germany and France reported significantly less positive communication and care management experiences than did sicker adults in the United States, although Norway and Sweden were among the leaders in high rates of patient-reported blood pressure control. Both countries are known for population health approaches, including nurse-led clinics in Sweden.

### SHARED CHALLENGES

►► **PRESCRIPTION DRUGS:** Managing often

complex medication regimens with accountability for care received across settings presents challenges in all countries. Studies within the United States and other countries repeatedly find that failure to reconcile and revise medications for patients with complex conditions, including after hospitalization, puts patients at risk.<sup>17</sup> A high percentage of sicker adults taking multiple medications reported that their medications were not reviewed, which suggests a common need across the eleven countries to improve medication management.

►►**TRANSITIONS:** Gaps also emerged in all countries at the point of hospital discharge, with at least one in four patients indicating lack of follow-up instructions or arrangements or clear medication directions. US patients reported among the lowest rates of gaps in coordination of hospital discharge, perhaps reflecting intensified payer and policy focus on discharge planning to lower readmission rates. With shorter hospital stays,<sup>18</sup> US patients may also be sicker when they leave the hospital, and more in need of coordination to ensure appropriate transitional care.

**LEARNING FROM LABORATORIES OF SYSTEM CHANGE** As the United States moves to implement a complex set of payment, information, care system, and insurance reforms incorporated in the Affordable Care Act of 2010, the study countries are implementing similar concepts yet adapting their approaches to their unique histories and starting points.

Germany, the Netherlands, and Switzerland, for example, start with hospital payments that include specialists and are considering expansion to payment “bundles” that would cover both hospital and follow-up care.<sup>19</sup> France and Germany reduce cost sharing for chronically ill patients to encourage care and support practices with guidelines to improve chronic disease outcomes.<sup>4</sup>

Canada, New Zealand, and Australia are enacting payment reforms, providing more practice support, and investing in shared community-based teams to enhance primary care and population health management.<sup>12</sup> Sweden and France are developing centers of excellence and referral hubs for complex care for cancer (both nations) and heart attacks (France). Reforms in the United Kingdom continue to em-

phasize reducing disparities and to build on the decline in death rates from conditions amenable to health care that the United Kingdom has achieved over the past decade.<sup>20</sup>

The United Kingdom’s success has come in part by focusing on areas with comparatively poor performance, informed by public reporting. Australia and Germany are similarly investing in generating comparative data to improve. Multiple countries use registries to focus on population health. Efforts within the United States and internationally to add patient-reported outcomes to registries and electronic health records will bring patients’ experiences directly into clinical data systems.

Recent US policy debates have focused on reducing health care spending, including proposals to scale back benefits in public programs. Yet all of the other study countries already spend far less than the United States and provide more comprehensive, protective benefits. Comparative research finds that the higher costs in the United States compared with other countries are largely due to paying higher prices and not related to the generosity of insurance.<sup>18,21</sup> As noted above, reforms resulting from the Affordable Care Act are expected to improve coverage, lowering cost burdens and barriers to care. In addressing future cost trends, US policies will need to maintain this commitment to access and avoid shifting costs to patients with complex health care needs.

Our study indicates a need—in all countries—for improvement in coordinating care for patients with complex conditions. Necessary measures include redesigning primary care, developing care teams accountable across sites of care, and managing transitions and medications well. Given the wide differences revealed by the survey, all countries have opportunities to learn from each other. While implementing health care reforms and experimenting with new initiatives, the United States in particular has opportunities to learn from abroad—including the use of purchasing power to lower prices, payment innovations, and the use of information systems and care system redesign efforts that are under way in several countries included in the study. Given the wide differences observed in the surveys, all countries have opportunities to learn from each other. ■

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## NOTES

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- 9 This was a rapid-response survey. Field times ranged from one to three months; most were two months. Interviewers called up to eight times to make contact. Response rates were: Australia, 24 percent; Canada, 42 percent; France, 28 percent; Germany, 29 percent; the Netherlands, 21 percent; New Zealand, 22 percent; Norway, 16 percent; Sweden, 21 percent; Switzerland, 30 percent; United Kingdom, 28 percent; and United States, 26 percent.
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In this month's *Health Affairs*, Cathy Schoen and coauthors present the results of the Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults in Eleven Countries, including the United States. Although care is often poorly coordinated in all of the countries, the authors found that adults seen at primary care practices with attributes of a patient-centered medical home—where clinicians are accessible, know patients' medical history, and help coordinate care—gave higher ratings to the care they received. They also were less likely to experience coordination gaps or report medical errors, compared to those seeking care at practices without those attributes.

"Although the health care systems in these eleven countries are quite different, the countries are beginning to resemble one another in negative ways, with communication and coordination shortfalls posing serious challenges to sicker adults' receiving quality care," Schoen says. "For this reason, we were heartened to see that the medical home model makes a significant positive impact on patients' satisfaction with the care they receive."

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