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International Survey Of Older Adults Finds Shortcomings In Access, Coordination, And Patient-Centered Care

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ABSTRACT Industrialized nations face the common challenge of caring for aging populations, with rising rates of chronic disease and disability. Our 2014 computer-assisted telephone survey of the health and care experiences among 15,617 adults age sixty-five or older in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States has found that US older adults were sicker than their counterparts abroad. Out-of-pocket expenses posed greater problems in the United States than elsewhere. Accessing primary care and avoiding the emergency department tended to be more difficult in the United States, Canada, and Sweden than in other surveyed countries. One-fifth or more of older adults reported receiving uncoordinated care in all countries except France. US respondents were among the most likely to have discussed health-promoting behaviors with a clinician, to have a chronic care plan tailored to their daily life, and to have engaged in end-of-life care planning. Finally, in half of the countries, one-fifth or more of chronically ill adults were caregivers themselves.

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Across the industrialized world, countries are experiencing unprecedented demographic change as life expectancy increases and the baby-boom generation ages. For all the rewards of a longer life, these extra years often mean living with chronic conditions; diminished capacity to manage activities of daily living; and, for many, the added burden of being a caregiver for another sick or frail family member or friend.[1,2]

As a result, countries face the challenge of trying to retrofit current health care delivery systems—originally designed to treat acute illness—to meet the needs of older patients who often present with chronic and degenerative conditions. In the United States, 85 percent of all health care services are currently used by people with at least one chronic disease,[1] and nearly half of spending in the US Medicare program—$140 billion out of a total of approximately $300 billion in 2010—is for patients with six or more chronic conditions (14 percent of Medicare beneficiaries).[3]

With older patients often receiving care from multiple providers, taking multiple prescription drugs, and managing complicated care regimens, these people are vulnerable to health system failures that can result in fragmented and poorly coordinated care, as well as costly and injurious medical errors.

To meet the demands of an aging population, all eleven countries that participated in the survey that is the subject of this article are considering how to redesign health care systems to better coordinate care and support frail elderly people in community settings. Many are retooling their workforces to better manage patients needing ongoing care and coaching in self-management. Others are restructuring payment

systems to incentivize health promotion or integrate care across the continuum of health care services.[4]

Patient surveys offer timely feedback on how well the current systems perform for older adults, identify failures amenable to policy action, and help assess where reforms are making a difference. This article reports results from a 2014 survey of 15,617 adults age sixty-five or older in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. It is the seventeenth in a series of international survey analyses. The survey focused on access to care, chronic conditions and care coordination, patient engagement, social care needs, and end-of-life care planning.

The eleven countries studied have diverse public and private health care delivery systems. They differ in how primary care is organized; the use of multidisciplinary teams; the role of formal and informal caregivers; and the ways in which primary care providers, specialists, and hospitals are paid and incentivized. How these different features work in practice affects the overall experience of the older adults surveyed and can determine whether care is accessible, patient-centered, and coordinated, particularly for those patients with complex needs. (For an overview of primary care organization and payment mechanisms across countries, see online Appendix A1.)[5]

The surveyed countries present a kaleidoscope of funding models, from tax-funded national health systems to national insurance systems with competing regulated private health insurance plans, some operating through so-called health insurance Marketplaces or their equivalent. The extent to which the nations studied meet the needs of their most vulnerable populations varies with benefit design, cost-sharing thresholds and exemptions, and subsidies. (For an overview of health care system financing and benefit design across countries, see Appendix A2.)[5]

In previous surveys of general populations (adults age eighteen or older) in this series, the United States has been the outlier among the surveyed countries for its high numbers of uninsured people and the absence of national standards for essential benefits or financial protection.[6] That distinction no longer holds, since the 2014 survey focused on older adults and our analysis focused on those age sixty-five or older, who, in the United States, have the benefit of near-universal coverage under Medicare and the broad access to care that it affords. This enabled us to compare more directly the performance of the US health care delivery system with the delivery systems of other industrialized nations in their care of older residents. Our study reveals variation in health status and access to and receipt of services, and opportunities for improvement and innovation across all eleven health systems.

Study Data And Methods

SURVEY The 2014 Commonwealth Fund International Health Policy Survey of Older Adults consisted of computer-assisted telephone interviews of nationally representative random samples of adults age fifty-five or older in eleven countries, using a common questionnaire that was translated and adjusted for country-specific wording as needed. This analysis focuses on respondents age sixty-five or older.

SSRS, a market and survey research firm, and country contractors conducted the interviews from March through May 2014. Field times in each country ranged from six to eleven weeks. Most field times were ten weeks. Respondents were called an average of nine times if they did not respond. Mobile and landline phone numbers were included in all countries except Canada, where only landline phone numbers were used.

International partners joined with the Commonwealth Fund to sponsor country surveys or expand samples for further country analyses.[7] Final country samples for those age sixty-five or older, shown in Exhibit 1, ranged from 379 to 5,000.[8] The analysis weighted final samples to reflect the demographic characteristics of the older adult population in each country.[9,10]

LIMITATIONS Our study has several limitations. This was a rapid-response survey with field times of six to eleven weeks, as noted above. Response rates ranged from 16 percent in Norway to 31 percent in Australia where random-digit dialing was used, and 60 percent in Switzerland, which used a nationwide population registry.[11] Low response rates in some countries may introduce bias, although the direction of that potential bias is unknown. Older adults living in nursing homes and other facilities were not sampled. Countries where institutionalization is more common may present as healthier than countries with lower rates of institutionalization.[12]

Study Results

HEALTH AND HEALTH CARE USE The majority of surveyed adults age sixty-five or older had at least one chronic condition (Exhibit 1). However, the United States stood out for having the highest rates of chronic conditions: 87 percent of US older adults reported at least one of

EXHIBIT 1

Health And Health Care Use Among Adults Age Sixty-Five Or Older In Eleven Countries, 2014

	Percent of respondents who:				
	Had chronic conditions[a]		Were hospitalized overnight in past 2 years	Saw 4 or more doctors in past year	Took 4 or more Rx
Country (sample size)	Any	Two or more			
Australia (1,670)	82%	54%	30%	18%	39%
Canada (3,147)	83	56	23	13	42
France (860)	81	43	17	6	29
Germany (547)	81	49	36	39	39
Netherlands (582)	78	46	27	17	44
New Zealand (379)	63	37	26	14	43
Norway (651)	74	43	35	11	41
Sweden (5,000)	75	42	29	18	40
Switzerland (1,084)	78	44	32	8	29
United Kingdom (581)	68	33	18	15	41
United States (1,116)	87	68	29	25	53

SOURCE 2014 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** Excludes respondents who declined to answer or who answered "don't know" or "not applicable." Between-country significance tests are available in online Appendix A5 (see Note 5 in text). [a]Includes hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis.

seven conditions, and 68 percent reported two or more conditions. In contrast, only one-third of older adults in the United Kingdom reported having multiple chronic conditions.

Given the prevalence of chronic conditions among the respondents, it is not surprising that they also reported frequent contact with the health care system. French respondents were among the least likely to have seen four or more doctors in the past year and to have been hospitalized in the past two years, while German respondents were among the most likely to report these experiences. The complexity of managing the care of these older patients was also evident in the large proportion of respondents taking multiple medications. More than half of US older adults (53 percent) and about 40 percent of older patients in eight other countries reported taking four or more medications. French and Swiss older adults were the least likely to report this rate of medication use.

HEALTH CARE COSTS AND ACCESS Despite near-universal insurance coverage through Medicare, US respondents were the most likely to report that cost posed a barrier to their care (Exhibit 2). One-fifth (19 percent) said that in the past year, if they had a medical problem, they did not visit a doctor, skipped a medical test or treatment that a doctor recommended, or did not fill a prescription or skipped doses because of cost (see online Appendix A3).[5] In addition, 21 percent of US respondents spent $2,000 or more out of pocket for care, and 11 percent reported having problems paying or being unable to pay medical bills in the past year (Exhibit 2).

In most other countries surveyed, fewer than 10 percent of older adults spent $2,000 or more out of pocket or experienced access barriers because of medical costs. French respondents were among the least likely to report cost-related problems. Among Swiss respondents, 22 percent spent $2,000 or more out of pocket in the past year, but few reported that these costs posed a barrier to care (6 percent) or that paying medical bills had been a problem (2 percent).

TIMELINESS OF CARE Canadian, Swedish, and US respondents were among the least likely to be able to get a same- or next-day appointment when sick and to report that after-hours care was somewhat or very easy to obtain without going to the emergency department (ED). They were also among the most likely to report having used the ED in the past two years, including for conditions that in the respondent's opinion could have been treated by his or her regular doctor had he or she been available. In contrast, four out of five respondents in Germany (81 percent), France (83 percent), and New Zealand (83 percent) reported same- or next-day access. French respondents were the least likely to have used the ED (15 percent).

Regarding access to specialists, US (86 percent) and Swiss (82 percent) respondents were the most likely to report getting an appointment within four weeks. Canadians (46 percent), Norwegians (46 percent), and Swedes (50 percent) were the least likely to report this.

CARE COORDINATION AND SAFETY Failure to coordinate care can compromise patients' safety and lead to unnecessary and costly treatment,

EXHIBIT 2

Health Care Costs And Access Among Adults Age Sixty-Five Or Older In Eleven Countries, 2014

	Percent of respondents who:							
Country	Had any cost-related access problem in past year[a]	Had out-of-pocket medical expenses of $2,000 or more in past year	Had problems paying or were unable to pay medical bills in past year	Could get same- or next-day appointment to see someone when sick	Said it was somewhat or very easy to get after-hours care[b]	Used ED in past 2 years	Had avoidable ED visit[c]	Waited less than four weeks for specialist appointment[d]
Australia	8%	13%	7%	71%	54%	30%	7%	64%
Canada	9	9	4	45	41	39	15	46
France	3	0	2	83	69	15	4	60
Germany	7	7	3	81	62	21	3	61
Netherlands	6	4	4	76	77	29	6	71
New Zealand	10	4	4	83	69	33	10	62
Norway	4	6	1	54	66	27	5	46
Sweden	4	6	1	53	37	35	10	50
Switzerland	6	22	2	69	66	27	8	82
UK	5	2	5	65	71	19	4	60
US	19	21	11	57	55	39	13	86

SOURCE 2014 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** Excludes respondents who declined to answer or who answered "don't know" or "not applicable." Between-country significance tests are available in online Appendix A6 (see Note 5 in text). For sample sizes, see Exhibit 1. [a]Includes the following: had a medical problem but did not visit doctor, skipped medical test or treatment recommended by doctor, or did not fill prescription or skipped doses because of the cost. [b]Base: needed after-hours care. [c]Went to the emergency department (ED) for a condition that could have been treated by a regular doctor or place of care if available. Base: had a regular doctor or place of care. [d]Base: saw or needed to see a specialist in the past two years.

especially for patients with multiple chronic conditions.[13] Our findings suggest that all countries face coordination and safety problems for this population.

American older adults were the most likely to report that their medical records or test results were not available at a scheduled appointment or that tests were duplicated (23 percent), while 17 percent or fewer of respondents in other countries reported this issue (Exhibit 3). Regarding communication problems between specialists and doctors, rates ranged from 6 percent in France to 43 percent in Norway. French respondents were also the least likely to report receiving conflicting information from different doctors (2 percent), while other country rates ranged from 7 percent (the Netherlands) to 16 percent (US). Overall, in every country but France, one-fifth or more of older adults reported experiencing at least one of these coordination problems (Exhibit 3).

Older patients taking multiple medications are at risk for both harmful interactions and nonadherence to their treatment regimens.[14] However, between 14 percent (US) and 48 percent (Sweden) of respondents who regularly take four or more prescriptions reported that their medications were not reviewed by a health care professional in the past year (Exhibit 3).

Gaps in hospital discharge planning—defined as not receiving a written discharge plan, not having a follow-up appointment arranged, not being given instructions on the purpose of taking each medication, or not knowing whom to contact with questions—ranged widely, from 70 percent in Norway to 28 percent in the United States (Exhibit 3 and online Appendix A4).[5] Additionally, 4–15 percent of respondents in all countries but Sweden (31 percent) said that their regular doctor seemed uninformed about their hospital care after discharge.

DOCTOR-PATIENT RELATIONSHIP In all countries surveyed, most respondents—ranging from 79 percent (Sweden) to 94 percent (France and the Netherlands)—reported that their doctor spent a sufficient amount of time with them (Exhibit 4). With the exception of respondents in Norway and Sweden, a majority of adults reported that their primary health provider encourages them to ask questions about their health and care (Exhibit 4).

HEALTH PROMOTION American respondents were particularly likely to report that their doctors had discussed with them how to live a healthy life. The United States was at or near the top in the reported frequency with which doctors discussed diet or exercise (76 percent) and stress (29 percent) with their patients (Exhibit 4).

END-OF-LIFE PLANNING The survey also asked whether the respondents had discussed their care wishes with their doctor, friends, or family or had a written plan in place if they found themselves too ill to make decisions for themselves.

EXHIBIT 3

Care Coordination And Safety Among Adults Age Sixty-Five Or Older In Eleven Countries, 2014

	Percent of respondents who:						
	Experienced coordination problems in the past two years						
Country	Test results/ records not available at appointment, or duplicate tests ordered	Received conflicting information from different doctors	Specialist lacked medical history, or regular doctor not informed about specialist care[a]	Had any coordination problem	Reported health care professional did not review Rx in past year[b]	Experienced gaps in hospital discharge planning in past 2 years[c]	Reported regular doctor seemed uninformed about hospital care after discharge in past 2 years[d]
Australia	13%	10%	15%	21%	16%	41%	10%
Canada	15	12	29	32	16	44	14
France	4	2	6	7	47	54	15
Germany	15	14	31	41	19	56	9
Netherlands	9	7	18	21	37	59	4
New Zealand	9	9	14	20	23	—[e]	—[e]
Norway	9	11	43	37	36	70	8
Sweden	10	12	23	24	48	67	31
Switzerland	17	9	19	29	27	56	10
UK	12	10	20	24	21	38	—[e]
US	23	16	19	35	14	28	11

SOURCE 2014 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** Excludes respondents who declined to answer or who answered "don't know" or "not applicable." Between-country significance tests are available in online Appendix A7 (see Note 5 in text). For sample sizes, see Exhibit 1. [a]Base: had a regular doctor or place of care and saw or needed to see a specialist in the past two years; Australia ($n = 1,060$), Canada ($n = 1,763$), France ($n = 524$), Germany ($n = 453$), the Netherlands ($n = 385$), New Zealand ($n = 190$), Norway ($n = 392$), Sweden ($n = 2,439$), Switzerland ($n = 698$), United Kingdom ($n = 252$), United States ($n = 753$). [b]Base: taking four or more prescription drugs regularly. [c]The question read as follows: When discharged from the hospital, you did not receive written information about what to do when you returned home and symptoms to watch for; hospital did not make sure you had arrangements for follow-up care; someone did not discuss with you the purpose of taking each medication; or you did not know who to contact if you had a question about your condition or treatment. Base: hospitalized overnight in the past two years. [d]Base: hospitalized overnight in the past two years and had a regular doctor or place of care. [e]Omitted because of small *N* (fewer than 100 respondents).

EXHIBIT 4

Doctor-Patient Relationship, Health Promotion, And End-Of-Life Planning Among Adults Age Sixty-Five Or Older In Eleven Countries, 2014

	Percent of respondents who:						
	Reported regular doctor always or often:		Had health care professional talk to them in the past 2 years about:		Had a discussion with someone[a] about health care treatment they want if they become very ill and cannot make decisions for themselves	Had a written plan:	
Country	Spends enough time with them	Encourages them to ask questions	Healthy diet or exercise	Things that can cause stress		Describing treatment they want at end of life	Naming someone to make treatment decisions for them if they cannot do so
Australia	91%	80%	64%	31%	59%	31%	53%
Canada	84	72	63	21	66	46	62
France	94	88	61	18	12	5	16
Germany	92	82	70	31	72	58	58
Netherlands	94	55	41	12	43	16	16
New Zealand	93	80	57	22	44	23	38
Norway	81	40	50	13	20	4	6
Sweden	79	43	45	9	30	5	8
Switzerland	93	70	52	15	55	25	28
UK	85	79	62	25	39	20	47
US	86	81	76	29	78	55	67

SOURCE 2014 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** Excludes respondents who declined to answer or who answered "don't know" or "not applicable." Between-country significance tests are available in online Appendix A8 (see Note 5 in text). For sample sizes, see Exhibit 1. [a]Including with family, a close friend, or a health care professional.

Evidence shows that such advance care planning can lead to higher patient satisfaction with care at the end of life and can reduce anxiety and depression for both patients and surviving relatives.[15] There was wide variation in reports across countries of the occurrence of various advance care planning practices. The United States stood out for the frequency with which respondents reported having had a conversation (78 percent) about advance care planning and having a written plan naming a health care proxy (67 percent), and US respondents were among the most likely to report having a written plan regarding the end-of-life treatment they wanted (55 percent) (Exhibit 4).

Germany and Canada also had large proportions of respondents reporting end-of-life discussions and plans. In contrast, France, Norway, and Sweden ranked much lower in reported advance care planning. In France, doctors have traditionally made many end-of-life decisions on behalf of patients, even against the wishes of patients and family members, although that practice is currently under challenge.[16]

MANAGEMENT OF CHRONIC CONDITIONS AND CAREGIVING For patients living with chronic conditions, being engaged in their own care and having a supportive care team that helps manage and monitor their conditions can improve health outcomes.[17,18] The survey found substantial variation in the degree of patient engagement and support received from providers by older patients with chronic conditions. The United States and the United Kingdom ranked among the top performers on these measures, with 58 percent of US and 59 percent of UK chronically ill respondents reporting that they discussed the main goals in caring for their condition with their doctors and were given clear instructions about when to seek further care (Exhibit 5). Fewer than half of patients in the nine other countries received this type of guidance. When asked whether they had a treatment plan for their conditions that they could carry out in their daily life, at least three-fourths of chronically ill respondents in Australia, Canada, the United Kingdom, and the United States replied affirmatively, with Germans (30 percent) the least likely to have a plan.

Chronically ill respondents in the United Kingdom stood out with 47 percent reporting that their providers proactively contact them to check in between visits, compared to 30 percent or fewer elsewhere. In all countries except Germany, France, Norway, and Switzerland, at least two-thirds or more of older patients said that they can easily contact a health professional to ask a question or get advice.

In addition to managing their own health care needs, many chronically ill older adults helped care for someone living with an age-related condition or disability, perhaps signaling an unmet need for more home health care support. In Norway, Germany, Australia, Sweden, and the United States, one-fifth or more chronically ill

EXHIBIT 5

Management Of Chronic Conditions And Caregiving Among Adults Age Sixty-Five Or Older In Eleven Countries, 2014

	Percent of respondents who had chronic condition and:					
			Had a health care professional who between doctor visits:			
Country	Health care professional discussed their main goals and gave instructions on symptoms to watch for	Had a treatment plan for their condition they could carry out in their daily life	Contacted them to check in	They could easily contact to ask questions or get advice	Provided care at least once a week to someone with an age-related problem, chronic condition, or disability	Provided care for 20 or more hours per week[a]
Australia	48%	80%	24%	65%	24%	54%
Canada	46	76	16	67	16	35
France	43	62	23	53	3	—[b]
Germany	48	30	14	43	25	—[b]
Netherlands	35	41	24	83	19	—[b]
New Zealand	39	64	28	75	16	—[b]
Norway	27	53	15	55	27	21
Sweden	23	41	17	75	21	20
Switzerland	33	47	9	58	13	10
UK	59	73	47	71	14	—[b]
US	58	83	30	84	20	34

SOURCE 2014 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** Excludes respondents who declined to answer or who answered "don't know" or "not applicable." Between-country significance tests are available in online Appendix A9 (see Note 5 in text). For sample sizes, see Exhibit 1. [a]Base: provides care to someone with an age-related problem, chronic health condition, or disability at least once a week. [b]Omitted because of small *N* (fewer than 100 respondents).

older adults cared for someone else (usually a family member) at least once a week (Exhibit 5). This burden disproportionately falls on women (data not shown). A third to more than half of these respondents in Australia, Canada, and the United States said that they provide care to someone for twenty or more hours per week.

Discussion

Across countries, the survey findings highlight both strengths and potential deficits in care for elderly people. Overall, the findings show that the elderly experienced few financial barriers to care (with the possible exception of the United States), but substantial numbers reported difficulty with prompt access to primary or specialty care. Despite high ratings for the doctor-patient relationship, the survey revealed frequent failure by providers to coordinate care, share information, and talk with patients about how they can promote good health or about their end-of-life care preferences. Health professionals also often missed the opportunity to engage chronically ill patients as partners in their care and help them manage their conditions at home.

Highlighted problems could increase as populations age and chronic conditions and disabilities become more prevalent. Even where performance is strong, nations may have difficulty maintaining this level of care in the face of demographic trends. Meeting these challenges will require innovative approaches to redesign health care delivery systems and social services. Given the wide variation in performance across the surveyed countries, it seems likely that they have much to learn from one another as they each grapple with the common problems posed by aging populations.

SYSTEM EFFECTS ON PERFORMANCE Variation in reported performance may be explained in some instances by specific policies or approaches that could be transferred from high-performing to lower-performing countries. While inferences about the effects of particular programs or policies must be drawn with care, there are intriguing correlations.

On access to care, policies in some countries appear to be effective in protecting the elderly and minimizing financial barriers to care. How the surveyed countries achieve good access varies—from the United Kingdom, where care is free at the point of service; to France, which has eliminated all copays for patients with any one of thirty-two chronic conditions; to Switzerland, where low-income adults receive subsidies to help them afford plans on competitive insurance markets.[4]

The survey results highlight that getting in quickly to see the doctor when sick can be a problem for elderly people. Even in the top-performing countries, one in four have difficulty getting after-hours care. Many countries that reported easier after-hours access, such as the Netherlands, the United Kingdom, New Zealand, and Germany, have statutory or contractual requirements that primary care practices provide arrangements for after-hours care, preempting the use of the ED as the default.[4]

Poor information flow and handoffs between providers that are common to fragmented health care systems can put older patients coping with multiple chronic conditions at particular risk. France stood out for good care coordination, perhaps in part reflecting its "Médecin Traitant" program, implemented in 2004, which encourages patients to register with a primary care physician and incentivizes primary care physicians and specialists to develop shared care plans.[4] Comparatively strong performance in New Zealand, the Netherlands, and Australia may be facilitated by the financial incentives that practices receive to manage patients with complex chronic conditions, including support for nurses to coordinate care (see Appendix A1).[4,5]

Among the countries that did relatively well on medication management, the United States, Australia, and the United Kingdom have expanded the role of community pharmacists and provide financial incentives for doing medication reviews to improve coordination and patient safety.[19] Nonetheless, the survey draws attention to how often, in all countries, information does not follow the patient, which underscores the need for progress on electronic health records with greater interoperability.

As patients cope with complicated care plans that may be difficult to follow, the failure to support and make them partners in their care may result in poorer adherence, outcomes, and satisfaction.[20] In the United Kingdom, which was among the top performers for supporting patients with ongoing self-management, more than three-fourths of primary care practices use nurse case managers or navigators for patients with serious chronic conditions (see Appendix A1).[5] The United States was also one of the top performers for engaging patients in managing their chronic conditions. This finding may reflect the influence of ongoing activities, such as multipayer initiatives, which have been transforming primary care practices across the country into patient-centered medical homes that follow national guidelines for supporting patient self-management, and the influence of payer-initiated patient survey activities, such as the Consumer Assessment of Healthcare Providers and Systems, which value patient engagement.

While most of the adults surveyed were burdened with some chronic condition, as many as one in four chronically ill respondents were themselves caregivers—a reminder of how interwoven health and social care needs can be in this population. It is instructive to note that many countries are addressing this concern with innovative policies. Integrated Care Pilots in England and much of the focus on "dual eligibles" (those eligible for both Medicare and Medicaid) in the United States reflect efforts to bridge the divide between health and social care and to coordinate funding and service delivery.[21,22] Programs to give patients personal health budgets, widely in place in Germany, France, the Netherlands, and England, further aim to help the elderly engage formal and informal caregivers to meet their needs.[23]

COMPARATIVE US PERFORMANCE AND CHALLENGES GOING FORWARD Despite having Medicare coverage, older US adults remained much more likely to face financial barriers to care than their counterparts in other developed countries. This may be surprising, as other studies have found that Medicare offers more stable and protective insurance than other forms of coverage in the United States, including employer-sponsored private coverage.[24] However, it is still clearly less protective than the universal coverage offered in the health systems of other countries surveyed. This finding likely reflects limitations in Medicare coverage, including substantial deductibles and copayments, especially for pharmaceuticals, which are often more expensive in the United States than elsewhere.[25] The absence of limitations on catastrophic expenses and long-term care coverage likely play a role as well. The Affordable Care Act addresses some of Medicare's coverage gaps—including reducing the size of the Medicare prescription drug "doughnut hole" with incremental reductions in beneficiaries' out-of-pocket obligations until 2020.

Financial barriers aside, elderly Americans also face comparatively poor access to primary care and after-hours care, relatively high dependence on the ED, and large gaps in care coordination. Yet the survey also captures areas where the experience of US older adults is favorable. Both comparatively and objectively, Americans reported good access to specialists. The US health care system also performed relatively well when it came to hospital discharge planning and on the more patient-centered measures of health promotion, self-management support for chronically ill patients, and support for end-of-life planning. These strengths and weaknesses in US performance have also been observed in earlier international surveys of the general population (except end-of-life planning, which was not previously studied).[26] This suggests that these positive and negative findings reflect features of the US delivery system as a whole, instead of being specifically related to the elderly population or Medicare coverage.

Finally, the US elderly population is sicker than the comparable population in other surveyed nations, reporting a much higher incidence of chronic disease. This higher disease burden will pose critical challenges for US policy makers in years to come. The United States already significantly outspends all of the other countries in the survey—often by a two-to-one margin—despite having the youngest population.[27] Although the growth in health care costs has slowed in recent years in all of these countries,[28] these considerations suggest that the United States will face growing cost pressures. It will be hard to maintain the current low-growth trajectory unless the United States successfully implements delivery and payment system reforms that reduce the cost of care and finds a way to narrow the health gap between itself and other countries. Similarly, it will be critical for US policy makers to make progress in identifying a more stable and more affordable, long-term care system.

Conclusion

While each of the health care systems in the surveyed countries has its strengths, all countries surveyed have room for improvement—no health system consistently offers older adults accessible, coordinated, and patient-centered care. As industrialized countries recognize the increased demands that will be placed on their already stressed health care system by an aging population, they are all experimenting with policy reforms and delivery system innovations to improve care and quality of life.

Building on approaches such as the Chronic Care Model, which has been widely adopted around the world,[29] countries are testing new ways to deliver care, moving services from institutions into the community and home, and empowering patients to manage their conditions with technology. Similarly, countries are using new payment systems, including risk sharing, shared savings models, and bundled payment, to foster better communication among providers, care coordination, and accountability.

While there is some similarity in the strategies these countries are using, they each start from a different place, and each approach is tailored to fit a unique country context. Monitoring their impacts will allow us to learn more about what works and what does not. ■

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NOTES

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7 The Commonwealth Fund provided core support, with cofunding from the German Federal Ministry of Health and the German National Institute for Quality Measurement in Health Care; Haute Autorité de Santé and Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (France); Dutch Ministry of Health, Welfare, and Sport and the Scientific Institute for Quality of Healthcare at Radboud University Nijmegen Medical Centre (the Netherlands); Norwegian Knowledge Centre for the Health Services; Swedish Ministry of Health and Social Affairs; and Swiss Federal Office of Public Health. Support to expand samples was provided by the New South Wales Bureau of Health Information (Australia) and the Canadian Institute for Health Information, Canadian Institutes of Health Research, Health Quality Ontario, Commissaire à la Santé et au Bien-être du Québec, and Health Quality Council of Alberta.
8 Full country samples (adults age fifty-five or older) ranged from 750 to 7,206.
9 Weights included age, sex, region, education, and additional variables consistent with standards for each country. In the United States, weights also included race and ethnicity.
10 Comparisons between this and previous international surveys in this series cannot reliably be drawn because of age differences in the population sampled and in some countries, such as France and Switzerland, in the sampling strategy used (overlapping, dual-frame random-digit dialing sampling was used for the first time in France; a population registry was used in Switzerland).
11 Response rates: 31 percent Australia; 28 percent Canada; 29 percent France; 26 percent Germany; 25 percent Netherlands; 27 percent New Zealand; 16 percent Norway; 23 percent Sweden; 60 percent Switzerland; 23 percent UK; and 24 percent US.
12 Cross-national comparisons of institutionalization rates must be drawn cautiously because of differences in definitions and types of long-term care services and institutions, as well as in available data. However, Organization for Economic Cooperation and Development health data from the period 2010–12 show that institutionalization rates among adults age sixty-five or older in the countries sampled range from 3.3 percent (United States) to 6.7 percent (Australia). Organization for Economic Cooperation and Development. OECD health data 2014: statistics and indicators. Paris: OECD; 2014.
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