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In New Survey Of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care

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ABSTRACT Surveys of patients' experiences with health care services can reveal how well a country's health system is meeting the needs of its population. Using data from a 2016 survey conducted in eleven countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—we found that US adults reported poor health and well-being and were the most likely to experience material hardship. The United States trailed other countries in making health care affordable and ranked poorly on providing timely access to medical care (except specialist care). In all countries, shortfalls in patient engagement and chronic care management were reported, and at least one in five adults experienced a care coordination problem. Problems were often particularly acute for low-income adults. Overall, the Netherlands performed at the top of the eleven-country range on most measures of access, engagement, and coordination.

Surveys of patients' experiences with health care services can provide a valuable window into how well a nation's health system is meeting the needs of its population. In this article we report findings from a 2016 survey of adults in eleven countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. This is the latest in a unique series of international surveys conducted by the Commonwealth Fund since 1998 that explores the experiences of doctors and patients, to highlight opportunities for cross-national learning and health system improvement.¹

The focus of the 2016 survey was on the health and health care experiences of the general adult population. Past articles on the general population in these countries have focused primarily on specific factors such as health care costs, access to care, and insurance complexity.² This article takes a broader perspective and compares the

public's assessments of access, coordination, patient-centeredness, and chronic care management. Recent or ongoing reforms in many of the countries have been designed to improve health system performance in these high-priority areas.

In addition, this article shows, for the first time, cross-national results on measures of self-reported health and well-being and the prevalence of material hardship for the adult population, which can lead to poor physical and mental health.³ We also present data on key performance measures for adults with low incomes, whose greater health needs and more complex social challenges make their care a telling indicator of both a health system's capabilities for all adults and its commitment to achieving equitable health outcomes.

Study Data And Methods

Data came from telephone surveys conducted in the period March–June 2016 in each country

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among nationally representative samples of non-institutionalized adults ages eighteen and older. Samples were generated using probability-based overlapping landline and mobile phone sampling designs in most countries;⁴ both mobile and landline telephone numbers were included to improve representativeness. Standard within-household selection procedures were used to increase the likelihood of reaching an eligible respondent for landline samples.⁵

In collaboration with researchers in each of the eleven countries, a common questionnaire was developed, translated, adapted, and pretested.⁶ Interviewers were trained to conduct interviews using a standardized protocol. Computer-assisted telephone interviews lasted from an average of seventeen minutes (in the United Kingdom) to an average of twenty-five minutes (in France) (details are in online Appendix 1).⁷ The period when data were collected in a given country ranged from seven to thirteen weeks. The overall response rates varied from 11 percent (Norway) to 47 percent (Switzerland).⁸

International partners joined with the Commonwealth Fund to sponsor country surveys, and some countries supported the use of expanded samples to enable within-country analyses.⁹ Final country population samples ranged from 1,000 to 7,124. Data were weighted to ensure that the final outcome was representative of the adult population in each country. Weighting procedures took into account the sample design, probability of selection, and systematic nonresponse across known population parameters including region, sex, age, education, and other demographic characteristics (Appendix 1).⁷

STATISTICAL ANALYSIS All analyses took into account the sample design and included final sample weights (Appendix 1).⁷ Bivariate analyses are shown below, and Appendices 3–7⁷ indicate where between-country differences were significant based on logit regressions.

LIMITATIONS Our study had several limitations. First, populations that were hard to reach—undocumented immigrants and adults with relatively low incomes, people who lack proficiency in the relevant language, those who are transient, and those who do not have mobile or landline telephones—have increased likelihood of being missed in a survey of the general population. Therefore, our study may have underestimated their concerns. Second, the survey had reasonable but still low response rates, which might introduce bias in an unknown direction.

However, survey design strategies such as using representative dual-frame mobile and landline sampling frames or federal registries of phone numbers, making up to nine calls to active

numbers, careful training of interviewers to reduce item nonresponse, and the use of weighting procedures helped ensure that outcomes were representative of the adult population in each country.

Study Results

HEALTH, WELL-BEING, AND MATERIAL DEPRIVATION On average, US adults reported poorer health than their counterparts in other countries. Twenty-eight percent of US adults reported that they had at least two chronic conditions (Exhibit 1). Similarly, 26 percent of US adults said that they had experienced emotional distress in the past year that was difficult to cope with alone. Canadian adults also reported higher rates of chronic conditions and emotional distress relative to their peers in the other countries. While rates of chronic conditions and emotional distress were lower in other countries, at least 14 percent of adults elsewhere reported these concerns, with the exception of low rates of emotional distress in France and Germany (12 percent and 7 percent, respectively).

We also asked respondents whether their health prevented them from working full time or limited their ability to perform daily activities. Australians were the least likely (12 percent) to say that this was the case, and the French were the most likely (24 percent), with Canada and the United States again near the upper end of the distribution.

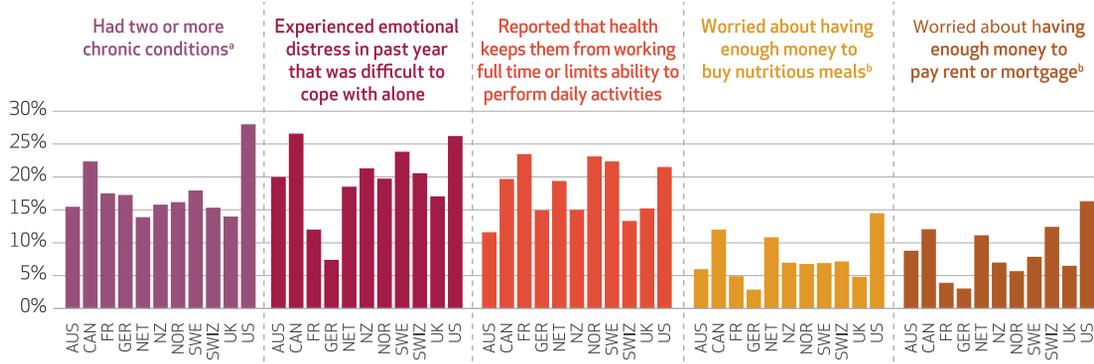
On two measures of material hardships that can affect health and indicate broader social challenges, the United States also stood out: US adults were more likely than adults in all other countries to report that they were “always” or “usually” worrying about having enough money to buy nutritious meals and to pay their rent or mortgage. Relative to other countries, reports of material hardships were also higher in Canada and the Netherlands (and Switzerland, in the case of paying rent or mortgage); they were lowest in Germany.

FINANCIAL BARRIERS AND ACCESS TO HEALTH CARE Across countries, access to care varied widely, perhaps reflecting differences in both health insurance design and primary care organization and capacity. Countries may do well in terms of insurance design and poorly in terms of primary care organization and capacity, but unless they perform highly in both areas, significant numbers of adults will report not being able to get health care when and where they need it.

US adults were the most likely to report financial barriers to health care, with 33 percent reporting that they had had a cost-related access problem in the past year—a statistically signifi-

EXHIBIT 1

Percentages of adults in eleven countries who reported problems with health status and material hardship, 2016



SOURCE 2016 Commonwealth Fund International Health Policy Survey. **NOTES** The numbers of respondents were as follows: Australia, 5,248; Canada, 4,547; France, 1,103; Germany, 1,000; the Netherlands, 1,227; New Zealand, 1,000; Norway, 1,093; Sweden, 7,124; Switzerland, 1,520; the United Kingdom, 1,000; and the United States, 2,001. ^aJoint pain or arthritis; asthma or chronic lung disease; diabetes; heart disease, including heart attack; and hypertension or high blood pressure. ^bIn the past year, were “always” or “usually” stressed or worried about having enough money for this purpose. Possible responses were “always,” “usually,” “sometimes,” “rarely,” and “never.”

cant decline from 37 percent in the 2013 survey in this series² (Exhibit 2). Swiss adults were the second most likely to report such barriers. In contrast, only 7–8 percent of adults in Germany, the Netherlands, Sweden, and the United Kingdom did not get needed medical care because of costs.

reported financial barriers to dental care than those who reported barriers to medical care. Rates of financial barriers to dental care were lowest in the Netherlands and the United Kingdom (11 percent for both countries) and Germany (14 percent) and highest in the United States (32 percent).

In most countries, a greater share of adults

In all eleven countries, some adults reported

EXHIBIT 2

Percentages of adults in eleven countries who reported having access problems and using the emergency department (ED), 2016

Country	Percent of adults who:						
	Had any cost-related access problem to medical care in past year ^a	Skipped dental care or checkup because of cost in past year	Did not see a doctor or nurse on same or next day, last time they needed care ^b	Did not “always” or “often” hear from regular doctor on same day, when contacted doctor with a medical concern ^c	Said it was “somewhat” or “very” difficult to obtain after-hours care ^d	Used ED in past two years	Waited two months or longer for specialist appointment ^e
AUS	14	21	31	14	44	22	13
CAN	16	28	53	32	63	41	30
FR	17	23	44	14	64	33	4
GER	7	14	47	13	64	11	3
NET	8	11	19	13	25	20	7
NZ	18	22	22	17	44	23	20
NOR	10	22	50	22	40	26	28
SWE	8	19	41	24	64	37	19
SWIZ	22	21	43	12	58	30	9
UK	7	11	41	21	49	24	19
US	33	32	42	27	51	35	6

SOURCE 2016 Commonwealth Fund International Health Policy Survey. **NOTE** For numbers of respondents, see the Notes to Exhibit 1. ^aOne or more of the following problems: did not see a doctor when sick, skipped a medical test or treatment recommended by a doctor, and did not fill a prescription or skipped doses because of the cost in past year. ^bExcluding adults who did not need to make an appointment to see a doctor or nurse. ^cExcluding adults who did not report having a regular doctor or place of care. Possible responses were “always,” “often,” “sometimes,” and “rarely or never.” ^dExcluding adults who did not need after-hours care. Possible responses were “very difficult,” “somewhat difficult,” “somewhat easy,” and “very easy.” ^eExcluding adults who did not see or need to see a specialist in the past two years.

not seeing a doctor or nurse on the same or next day the last time they needed care. Roughly half of Canadian, German, and Norwegian adults (47–53 percent) were not able to get an appointment the same or next day (Exhibit 2), and at least one in five (20–29 percent) in Canada, Germany, Norway, Sweden, and the United States waited six days or more (data not shown). In contrast, only one in five adults in the Netherlands (19 percent) and New Zealand (22 percent) were not able to see a health care provider the same or next day (Exhibit 2).

Same- or next-day appointments may be less critical if patients have good access to their doctor by telephone. Respondents in Australia, France, Germany, the Netherlands, New Zealand, and Switzerland were the most likely to hear back from their doctor on the same day when they contacted the doctor's office with a medical concern.

In all countries except the Netherlands, at least 40 percent of adults reported that it was somewhat or very difficult to get health care in the evenings, on weekends, or on holidays without going to the emergency department (ED). In the Netherlands, by contrast, only 25 percent of adults said that getting after-hours care was somewhat or very difficult.

The ED often serves as the default health care provider. One-third or more of adults in Canada, France, Sweden, and the United States reported going to the ED for care in the past two years. Rates of ED use were strikingly lower in Germany—only 11 percent.

Adults in Canada, a country that stood out for the most serious access problems to primary care, also were the most likely to report having to wait two months or longer to see a specialist (30 percent), along with adults in Norway (28 percent). In contrast, fewer than 10 percent of adults reported waiting that long in France, Germany, the Netherlands, Switzerland, and the United States.

PRIMARY CARE EXPERIENCES AND CHRONIC DISEASE MANAGEMENT In all countries, the vast majority of adults reported having a regular doctor or place of care (Appendix 5).⁷ However, many respondents with a regular doctor reported that he or she did not “always” or “often” know their medical history, including approximately 24 percent of the respondents in both France and Sweden (Exhibit 3). Furthermore, roughly one-third of adults in those two countries with a regular doctor reported that he or she did not “always” or “often” spend enough time with them and explain things understandably. In contrast, fewer than one in ten adults in the Netherlands reported either problem.

In all countries except the United States, large

Despite gains, the United States remains an outlier among high-income countries in ensuring access to health care.

majorities of adults (59–83 percent) with a regular doctor reported that neither the doctor nor other clinical staff had discussed healthy diet and exercise with them in the past two years. Although the United States performed better on this measure, 41 percent of Americans with a regular doctor reported not having had such discussions.

Diagnosing and helping patients manage depression and other mental health problems is a key responsibility of primary care. Yet in Germany over half of the adults with a regular doctor and a previous diagnosis of depression, anxiety, or another mental health problem reported that in the past two years they had not discussed with a clinician at their regular practice things in their life that worried or caused them stress. In Canada, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom, and the United States, 33–39 percent of comparable adults also reported that they had not discussed these topics.

Self-management is key to caring for growing populations of chronically ill patients. Yet close to half of chronically ill adults in Norway and Sweden had not discussed with a health professional their main goals and priorities in caring for their condition (44 percent and 51 percent, respectively) or their treatment options (52 percent and 48 percent, respectively). Even in Australia, the best performer on these measures, one in four chronically ill adults reported not having had such discussions.

Finally, 14 percent of chronically ill US adults did not feel that they had the support they needed from health care providers to manage their health problems, joining Canada, France, Norway, and Sweden on the high end, compared with Australia, Germany, the Netherlands, New Zealand, and Switzerland on the low end.

COORDINATION OF HEALTH CARE Failure to coordinate health care delivered over time and across different providers can put patients at risk

EXHIBIT 3

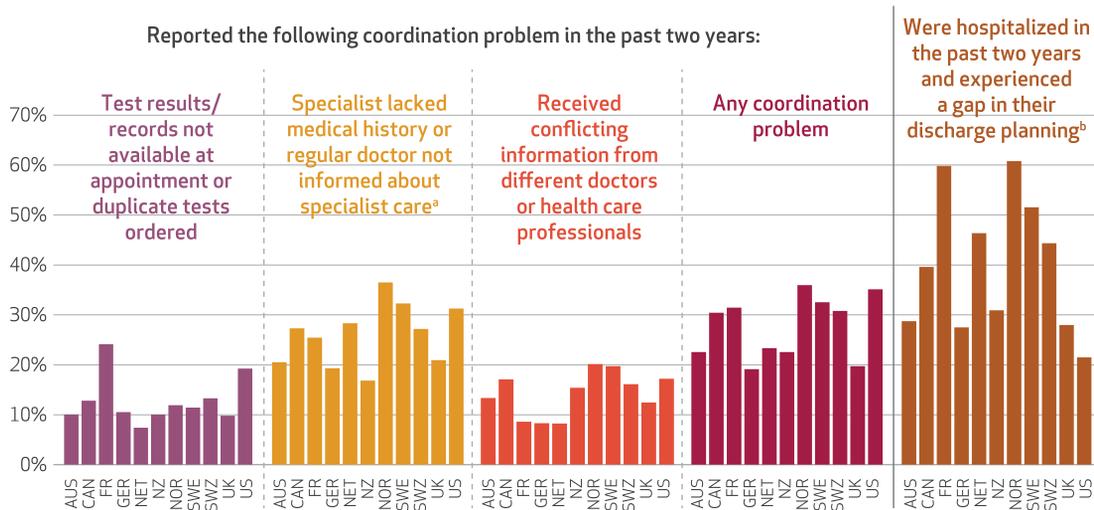
Percentages of adults in eleven countries who reported shortfalls in primary care and chronic care management, 2016

Country	Percent of adults with a regular doctor or place of care who: ^a				Percent of adults with a chronic condition who: ^b		
	Reported regular doctor did not “always” or “often”: ^c		During past two years, did not talk with doctor or other clinical staff at regular place of care about:		In past year did not discuss with a health professional their main goals and priorities in caring for their condition	In past year did not discuss with a health professional their treatment options, including side effects	Did not feel they had the support they needed from health professionals to manage their health problems ^d
	Know important information about their medical history	Spend enough time with them and explain things in a way they could understand	A healthy diet, exercise, and physical activity	Things in life that cause worry or stress, among those with a history of mental illness ^e			
AUS	13	11	60	25	24	26	6
CAN	14	26	59	36	39	38	14
FR	24	36	83	— ^f	31	37	13
GER	10	22	83	54 ^g	31	38	0
NET	4	9	76	37 ^g	37	38	5
NZ	12	17	62	33	36	35	6
NOR	17	29	80	37	44	52	13
SWE	24	34	78	39	51	48	12
SWIZ	15	18	72	27	26	31	7
UK	12	19	67	37	36	42	10
US	16	23	41	34	32	36	14

SOURCE 2016 Commonwealth Fund International Health Policy Survey. **NOTE** For numbers of respondents, see the Notes to Exhibit 1. ^aExcluding adults who did not report having a regular doctor or place of care. ^bHad ever been diagnosed with joint pain or arthritis; asthma or chronic lung disease; diabetes; heart disease, including heart attack; and hypertension or high blood pressure. ^cPossible responses were “always,” “often,” “sometimes,” and “rarely or never.” ^dExcluding adults who did not report ever being diagnosed with depression, anxiety, or other mental health problem. ^ePossible responses were “yes, definitely,” “yes, to some extent,” and “no.” ^fSample size was less than sixty. ^gSample size was less than 100.

EXHIBIT 4

Percentages of adults in eleven countries who reported having care coordination problems, 2016



SOURCE Authors’ analysis of data from the 2016 Commonwealth Fund International Health Policy Survey. **NOTES** For the numbers of respondents, see the Notes to Exhibit 1. Duplicate tests refers to such tests that respondents believed to be unnecessary. ^aExcluding adults who did not see or need to see a specialist in the past two years and who did not report having a regular doctor or place of care. ^bExcluding adults who were not hospitalized in the past two years. Gaps in discharge planning include failure to discuss the purpose of taking a medication, make arrangements for follow-up care with a doctor or other health professional, and provide written information for the patient about what to do after returning home and what symptoms to watch for.

and lead to inefficiency and waste.

Adults in France (24 percent) and the United States (19 percent) were the most likely to say that their records or test results had not been available at an appointment in the past two years, or that duplicate tests had been ordered (Exhibit 4). These problems were less common in the other countries. In addition, across the eleven countries, 17–36 percent of adults with a regular place of care who had seen a specialist reported that information had not flowed between the two sites of care.

One concern is that, possibly as a result of poor coordination and communication between providers, patients receive conflicting information from their clinicians. Twenty percent of adults in Norway and Sweden reported that this had occurred, compared to fewer than 10 percent in France, Germany, and the Netherlands.

Approximately one-third of adults reported experiencing at least one of these care coordination problems in Canada, France, Norway, Sweden, Switzerland, and the United States in the past two years. And even in the countries that performed better on this measure, about one in five adults still reported at least one of these problems. In addition, among adults with recent hospitalizations, gaps in hospital discharge planning were reported in all countries, though

rates were comparably low in the United States (22 percent compared to 28–61 percent elsewhere).

HEALTH CARE EXPERIENCES FOR ADULTS WITH LOW INCOMES Finally, we looked at how countries performed with low-income adults—those in households that earned less than half of the country’s median income—on several of the key measures shown in Exhibits 2–4 (Exhibit 5). In all countries, low-income adults were far more likely than other adults to report experiencing the health problems and material hardship described in Exhibit 1 (data not shown). As a result, their health care experiences shine a light on how well their country’s health system responds to the needs of some of its most complex and socially vulnerable patients.

Forty-three percent of low-income adults in the United States reported cost barriers to health care—the highest rate in any country (Exhibit 5). Rates in other countries were only 8–31 percent (in the United Kingdom and Switzerland, respectively). The United Kingdom was the only country where low-income adults were not significantly more likely than the rest of the population to report cost-related problems (Appendix 7).⁷ In Canada, France, Germany, Sweden, the United Kingdom, and the United States, low-income adults reported longer waits for

EXHIBIT 5

Percentages of low-income adults in eleven countries who reported problems in several key health system areas, 2016

Country	Percent of adults whose household income was less than half of country median:	Percent of low-income adults who reported the following:				
		Cost-related access problem in past year ^a	Waited six days or more to see a doctor or nurse, last time they needed care ^b	Used ED in past two years	Regular doctor did not “always” or “often” spend enough time and explain things in a way they could understand ^c	Any coordination problem in past two years ^d
AUS	16	24	11	27	13	28
CAN	19	30	37	44	31	33
FR	23	30	27	46	39	48
GER	13	16	38	11	34	24
NET ^e	7	23	5	23	12	25
NZ	15	28	7	31	33	36
NOR	16	20	29	35	29	39
SWE	14	16	32	39	39	36
SWIZ	14	31	14	35	20	25
UK ^e	9	8	27	31	19	37
US	18	43	35	50	28	36

SOURCE 2016 Commonwealth Fund International Health Policy Survey. **NOTES** Numbers of low-income respondents (and the levels of household income for low-income residents) were as follows: Australia, 821 (AUD 35,000); Canada, 769 (CAD 35,000); France, 172 (€21,000); Germany, 147 (€23,000); the Netherlands, 85 (€17,000); New Zealand, 144 (NZD 33,000); Norway, 155 (NOK 340,000); Sweden, 1,070 (SEK 170,000); Switzerland, 202 (CHF 48,000); the United Kingdom, 97 (£14,000); and the United States, 341 (USD 25,000). ED is emergency department. ^aOne or more of the following problems: did not see doctor when sick, skipped medical test or treatment recommended by doctor, and did not fill a prescription or skipped doses because of cost in past year. ^bExcluding adults who did not need to make an appointment to see a doctor or nurse. ^cExcluding adults who did not report having a regular doctor or place of care. Possible responses were “always,” “often,” “sometimes,” and “rarely or never.” ^dTest results or records not available at appointment or duplicate tests ordered, specialist lacked medical history or regular doctor not informed about specialist care, or received conflicting information from different doctors or health care professionals. ^eSample size was less than 100.

health care than the rest of the population. In those countries, one-third or more reported waiting at least six days to see a doctor or nurse (except in France and the United Kingdom, where 27 percent reported such waits) (Exhibit 5). Across all countries, between one-fourth and one-half of low-income adults reporting having used the ED in the past two years (except in Germany, where 11 percent reported doing so). This may reflect the fact that low-income people lacked other forms of timely access to health care.

Deficits also emerged in the degree to which clinicians engaged with low-income adults. In Canada, Germany, New Zealand, and Sweden, these adults were significantly more likely than the rest of the population to report that their doctor did not spend enough time with them or explain things clearly (Appendix 7).⁷

Finally, between one-fourth and one-half of low-income adults reported having a care coordination problem in the past two years (Exhibit 5). Rates among low-income adults in France, New Zealand, and the United Kingdom were nearly twice as high as rates among the rest of the adult population in those countries (Appendix 7).⁷ While perhaps not surprising, given low-income adults' greater health care needs, these gaps underscore the often unsolved challenges of providing seamless care to this population.

Discussion

The variations in health system performance highlighted in this survey of the public in eleven countries may offer useful insights as the United States and the other countries grapple with health reforms. The results suggest that the health care systems of these industrialized countries often fall short of their goals of providing health care that is accessible, affordable, and of high quality. Adults reported not getting needed care, experiencing gaps in care coordination, and missed opportunities for their engagement in preventive care and chronic care self-management. Adults who are most vulnerable because of very low incomes and poor health often have greater difficulty accessing care—and when they do get care, they often have more negative experiences than the rest of the population.

Relative to other countries, the health care system in the United States appears to perform poorly in meeting several population health goals. As we have noted previously, out-of-pocket spending is an important barrier to care in the United States, reducing access to services.² The availability of after-hours care, coordination of care, and management of chronic illness are especially problematic, as seen in this survey and

our previous survey of older adults.¹⁰ Compared to other surveyed countries, the United States is notable for having a larger share of the population that reports multiple chronic conditions and material hardship.

HEALTH CARE COVERAGE AND DESIGN MATTER

Although the United States has made significant progress in expanding coverage under the Affordable Care Act (ACA), it remains an outlier among high-income countries in ensuring access to health care.¹¹ The major coverage expansions of the law were launched only in 2014 and are thus still in a ramping-up period. In addition, there are ongoing barriers to coverage, including the fact that—as of November 2016—nineteen states have not chosen to expand eligibility for their Medicaid programs, the exclusion of undocumented immigrants from both Marketplace and Medicaid coverage, low awareness of coverage options, and concerns about affordability among those who remain uninsured.¹² An estimated twenty-three million adults in the United States lack health insurance, while the other countries in our survey have universal coverage.¹³

The US expansions of health care coverage have made private insurance that consumers buy on their own through the Marketplaces or directly from insurance companies substantially more affordable than was the case before passage of the ACA—through consumer protections, targeted subsidies, caps on out-of-pocket spending, and cost-sharing subsidies for vulnerable populations. However, other countries generally provide better cost protection. For example, the health care systems in Canada, the Netherlands, and the United Kingdom have no deductibles or cost sharing for primary care; the French system exempts low-income adults and those with chronic illnesses from cost sharing; and out-of-pocket spending is capped at 1 percent of income for the chronically ill in Germany and at US \$123 annually in Sweden.¹⁴

Beyond universal coverage, the scope and design of health coverage matters. For example, adults in Canada (which does not universally cover prescription drugs) and Switzerland (which often has high copayments) have rates of financial barriers to care that are twice as high as those of their counterparts in Germany, the Netherlands, Sweden, and the United Kingdom.¹⁴ The United Kingdom stands out for providing the most financial protection, including for its poorest population.

PRIMARY CARE THAT WORKS Countries differ in how they finance and organize primary care, with varying results. A 2015 survey of primary care providers in ten countries found that levels of self-perceived “preparedness” to manage

chronic and complex conditions varied significantly.¹⁵ After-hours care, communication and coordination with outside health and social service providers, team work, and the use of health information technology were some of the important capabilities related to “preparedness” that varied across countries.

The Dutch system—which includes the best access to same- or next-day appointments and after-hours health care, low use of the ED, relatively few problems with coordination of care, and the lowest rate of reported gaps in the doctor-patient relationship—provides an example of what works. One of the system’s features that underpin its performance is that almost all Dutch citizens are registered with a general practitioner of their choice, so that doctors know their patients’ medical history.¹⁴ Dutch general practitioners also have a statutory responsibility to provide after-hours care, which is usually met through cooperatives that provide walk-in care and also have electronic access to the patient’s primary care record—thus ensuring an alternative to the ED and reducing fragmentation of care.¹⁶ In addition, 88 percent of Dutch general practitioners make home visits.¹⁵ Dutch primary care doctors were early adopters of electronic medical records and report one of the highest rates (70 percent) of being able to exchange information electronically of doctors in the eleven countries, facilitating care coordination between providers. Multidisciplinary teams are the norm in Dutch primary care, with over 90 percent of health care practices employing nurses or case managers to help manage care for patients with chronic conditions, and an increasing number of practices are participating in care groups that receive payments to assume overall clinical responsibility for managing and coordinating care for such patients.¹⁷ All of these system features help make Dutch primary care particularly effective.

In addition to building on many of the features that are part of the Dutch health system, innovative and potentially transformative health reforms are under way in many of the other countries we studied, with the goal of creating more integrated care systems. In England, an investment has been made to shift resources from acute care to primary and community care through what are known as clinical commissioning groups (led by general practitioners) and to test a plethora of new care models that support multispecialty provider groups and the integration of acute, primary, mental health, and social care.^{18,19} There are also experiments under way with personal health budgets to enable people to coordinate their own health and social care.²⁰

Australia has recently established Primary

Improving the performance of the US health care system will require a sustained commitment over the next decades.

Health Networks nationwide to identify population health needs and support integration and coordination of care across providers.²¹ France has introduced multidisciplinary health homes with targeted payments to improve care coordination, pilot programs for care of the frail elderly that integrate health and social services, and regional provider networks to support primary care practices in managing patients with complex needs.^{22,23} And in New Zealand, new integrated family health centers have been introduced, as well as a requirement that primary health organizations and public hospitals establish formal alliances with community organizations to encourage a whole-system approach.¹⁴ All of these reforms are works in progress that promise to offer insights and lessons.

HEALTH PROMOTION DEMANDS MORE ATTENTION Among the most striking findings of the survey whose results are reported here are the missed opportunities across countries for health promotion. The vast majority of adults in all countries, except the United States, are not being engaged in conversations about how to lead a healthy lifestyle through good nutrition and exercise. The observation that the United States performs best among the eleven countries on this measure—although it still has room for improvement—may be because it has a higher prevalence of obesity and sedentary lifestyles than the other countries do.^{24,25} In this context, preventive counseling on diet and exercise may be indicated more frequently. For at least twenty years, US health plans have also encouraged preventive care through payer-initiated patient surveys and physician performance measurement, which are now used by more than 90 percent of managed care plans.²⁶

Along with the United States, many of the other eleven countries have used performance targets and feedback, payment incentives, electronic clinical decision support, and clinical guidelines to encourage health promotion, but

with varying success.^{27,28} Acquiring better evidence about how to support and engage primary care practices in effective health promotion activities is important for all countries.

SOCIAL SAFETY NET Patients with multiple chronic conditions and complex needs—particularly those who also experience poverty and material hardship—add stress to health care systems, are challenging to manage well, and are costly. Americans may be particularly at risk, as they have a less extensive safety net to buffer the negative health effects of economic disadvantage, compared to their peers in many other industrialized countries.²⁴

Overall, the survey findings point to the need to take a population health orientation that identifies all of the contributors to poor health, including socioeconomic disadvantages that could affect health and well-being. Across countries—and across states in the United States—the evidence suggests that higher ratios of social to health spending are associated with better health outcomes. An emerging literature shows the positive impact of investments in social services or integrated models of health care and social services (including housing, nutrition, income support, and case management interventions) on both health outcomes and spending.²⁹

As countries grapple with health disparities,

rising health care costs, and additional stresses to their health systems, reallocating funds between health and social services may be a useful strategy.

IMPLICATIONS FOR THE UNITED STATES In comparison to adults in the other ten countries, adults in United States are sicker and more economically disadvantaged. The resulting challenge to the US health system is compounded by higher health care costs, greater income disparities, and relatively low levels of spending on social services, compared to the other countries.

On multiple fronts, the ACA includes provisions that have the potential to improve the health and health care of Americans, including the most disadvantaged citizens.³⁰ As US health reforms gain further traction, they have the chance to close the gaps found in this survey. Improving the performance of the US health care system, however, will require a sustained commitment over the next decades, including the expansion of health coverage to the twenty-three million Americans and undocumented immigrants who still lack insurance,¹³ a willingness to learn from the implementation of the new health care delivery and funding models that are being tested, and having a national conversation on how to get the balance right between health and social care spending. ■

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NOTES

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- 3 Lynch JW, Kaplan GA, Shema SJ. Cumulative impact of sustained economic hardship on physical, cognitive, psychological, and social functioning. *N Engl J Med*. 1997; 337(26):1889–95.
- 4 Random-digit-dialing designs were used for Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. In Norway landline and mobile phone numbers were generated using a listed sample of numbers provided by Bisnode that purportedly covered more than 98 percent of the country's adult population. In Sweden the sample frame was created from the Swedish national registry of landline and mobile phone numbers listed in the database PAR Konsument. The sample in Switzerland was drawn from the Federal Statistical Office Registry of addresses. Each randomly sampled person received an invitation letter to complete the survey online or by telephone.
- 5 In all countries except Switzerland, a modified version of the Rizzo, Brick, and Park within-household sampling methodology was used for landline numbers to increase the likelihood of achieving a representative within-household sample. For mobile phones, the person who answered the phone was interviewed, if he or she was eligible. See Rizzo L, Brick JM, Park I. A minimally intrusive method for sampling persons in random digit dial surveys. *Public Opin Q*. 2004;68(2):267–74.
- 6 Details on the survey development, translation procedures, pretesting, and interviewer training are available from the authors upon request.
- 7 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 8 Across most countries, up to nine calls were made to active numbers if there was no response before that point. Appendix 1 presents response rates across countries (see Note 7).
- 9 The Commonwealth Fund provided core support, with cofunding from the New South Wales Bureau of Health Information and Victoria Department of Health and Human Services (Australia); Health Quality Ontario, the Canadian Institutes of Health Research, Canadian Institute

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