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Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries

ABSTRACT **The United States is in the midst of the most sweeping health insurance expansions and market reforms since the enactment of Medicare and Medicaid in 1965. Our 2013 survey of the general population in eleven countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—found that US adults were significantly more likely than their counterparts in other countries to forgo care because of cost, to have difficulty paying for care even when insured, and to encounter time-consuming insurance complexity. Signaling the lack of timely access to primary care, adults in the United States and Canada reported long waits to be seen in primary care and high use of hospital emergency departments, compared to other countries. Perhaps not surprisingly, US adults were the most likely to endorse major reforms: Three out of four called for fundamental change or rebuilding. As US health insurance expansions unfold, the survey offers benchmarks to assess US progress from an international perspective, plus insights from other countries' coverage-related policies.**

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The Affordable Care Act insurance exchanges, or Marketplaces, which opened for business in October 2013, signaled the start of a complex array of major health insurance reforms that take effect in 2014. Key features of the reforms include new federal subsidies to buy private insurance, the expansion of public coverage for the poor, and insurance market reforms to establish minimum standards for benefits and to prohibit insurers from charging more or denying coverage altogether based on a person's sex or health status.[1]

The nationwide effort is the most significant health insurance change since the enactment of Medicare and Medicaid in 1965. There are an estimated fifty million uninsured people in the United States and millions more who are insured but who pay a high share of their income for medical care (a group known as the underinsured).[2] The reforms thus seek to improve access and affordability for more than one-third of the US population under age sixty-five.

One way to assess the impact of US health reforms is to track how the health care experiences of US citizens compare over time to those of people in industrialized countries that implemented universal or near-universal coverage decades ago. This article reports on a 2013 survey of adults in the United States and ten other developed nations concerning access and affordability of care and insurance complexity. The ten other countries are Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. The countries with universal coverage differ in their approaches to coverage and other policies relevant to access and affordability. The study thus offers a global perspective to augment domestic perspectives in the

United States as reforms are implemented and evolve.

Among the eleven countries, the United States stands out for spending by far the most on health care, either per person or as a share of the national economy. The United States spends almost $3,000 more per person compared to the second-highest spender, Norway. The United States also spends almost 6 percent more as a share of the economy than the Netherlands, the country that devotes the next-largest share of its economy to health care (for details on country spending and some aspects of insurance design, see online Appendix 1).[3]

In addition, the United States is unique in its complexity of health insurance designs, mix of public and private insurance, and relatively limited insurance market regulations. The Netherlands, Switzerland, and Germany each rely on competing insurers (private insurers in Switzerland and the Netherlands, and social insurance "sickness funds" in Germany). However, insurers in these three countries cover the full population, irrespective of beneficiaries' age or income; are required to accept any applicant; and are barred from charging higher prices for premiums to people with poorer health status. To limit adverse selection and incentives to cherry-pick healthier applicants, the countries have mechanisms for risk adjustment among competing insurers.[4]

Canada, France, and Australia all have core public insurance systems, with varying roles for private supplemental coverage. New Zealand, Norway, Sweden, and the United Kingdom operate public health care systems, with a more limited role for private insurance.[5]

As described in an earlier article that focused on insurance design, the scope of coverage for medical care and the inclusion of cost sharing for patients in the form of deductibles or copayments for services also varies across the countries.[6] Among the eleven countries, only the Netherlands, Switzerland, and the United States employ deductibles as part of the core design. The Dutch and Swiss limit the level of deductibles; the United States does not.

Unlike other countries with relatively high cost sharing, the United States also lacks standards limiting out-of-pocket spending for covered benefits (Appendix 1).[3] As of 2012, 31 percent of the privately insured US population under age sixty-five had a deductible of $1,200 or more, nearly double the prevalence in 2007 (17.5 percent).[7]

The US market reforms scheduled to be implemented in 2014 will for the first time set standards on private insurance that limit out-of-pocket exposure. The reforms will also provide income-related public subsidies for premiums and reduce cost sharing for people whose incomes fall below certain thresholds. These efforts will be similar in concept to provisions in Switzerland, the Netherlands, and France that seek to limit financial exposure for people who are in poor health or have low incomes.

Although the comparison countries insure all or nearly all of their populations, those countries face the challenge of how to ensure timely, affordable access in the years ahead if health care costs rise faster than economic growth. The 2013 Commonwealth Fund survey examined comparative experiences at a time of economic constraints. It also provides baseline data and benchmarks for the United States as it begins implementing health insurance reforms.

Study Data And Methods

THE SURVEY The 2013 survey of the general population consisted of computer-assisted telephone interviews of random samples of adults ages eighteen and older in eleven countries, using a common questionnaire that was translated and adjusted for country-specific wording as needed. Social Science Research Solutions and country contractors conducted the interviews during February–June 2013. For the first time in the survey series, mobile phone numbers were included in all countries.[8] Field times in each country ranged from four to ten weeks; most field times were eight weeks.

International partners joined with the Commonwealth Fund to sponsor country surveys or expand samples beyond the minimum (1,000 respondents) for further country analyses.[9] Final country samples, shown in Exhibit 1, ranged from 1,000 to more than 5,000. The analysis weighted final samples to reflect the distribution of the adult population in each country.[10]

The margin of sample error for country averages was approximately plus or minus 2 percent for Canada; plus or minus 3 percent for Australia, France, Germany, the Netherlands, Sweden, Switzerland, and the United States; and plus or minus 4 percent for Norway, New Zealand, and the United Kingdom (all at the 95 percent confidence level).[11] We included some data from the 2012 international survey of primary care physicians[12,13] to compare with the patients' reports in the 2013 survey. Appendix tables show statistical tests that compare each country to each of the other ten.[3]

LIMITATIONS This was a rapid-response survey with field times of four to ten weeks, as noted above. Although interviewers called at least eight times if they did not receive a response, response

EXHIBIT 1

Adults' Cost-Related Access To Health Care And Affordability Problems In Eleven Countries, 2013

		Percent of adults who:						
		In the past year:						
Country	Sample size	Did not see doctor when sick or did not get recommended care because of cost	Did not fill Rx or skipped doses because of cost	Had either cost-related access problem	Had serious problem paying or was unable to pay medical bills	Had $1,000 or more out-of-pocket medical spending	Skipped dental care or checkups because of cost	In the past 2 years had not visited dentist
AUSTRALIA								
All adults	2,200	14	8	16	8	25	29	28
Has chronic condition[a]	538	24**	14**	27**	13**	36**	37**	28
CANADA								
All adults	5,412	8	8	13	7	14	21	23
Has chronic condition[a]	1,702	11**	13**	18**	11**	18**	22	29**
FRANCE								
All adults	1,406	14	8	18	13	7	20	27
Has chronic condition[a]	381	15	6	18	15	7	23	27
GERMANY								
All adults	1,125	10	9	15	7	11	8	10
Has chronic condition[a]	338	14	11	18	9	14	8	14**
NETHERLANDS								
All adults	1,000	20	8	22	9	7	19	19
Has chronic condition[a]	275	24	11**	26	12**	8	24**	20
NEW ZEALAND								
All adults	1,000	20	6	21	10	9	32	41
Has chronic condition[a]	304	25	6	25	11	5**	34	48**
NORWAY								
All adults	1,000	8	5	10	6	17	25	11
Has chronic condition[a]	350	7	9**	11	4	18	23	13
SWEDEN								
All adults	2,400	4	4	6	4	2	12	10
Has chronic condition[a]	814	6**	7**	10**	8**	4	15**	10
SWITZERLAND								
All adults	1,500	10	6	13	10	24	11	22
Has chronic condition[a]	278	15**	9	18**	16**	39**	12	25
UNITED KINGDOM								
All adults	1,000	4	2	4	1	3	6	26
Has chronic condition[a]	225	4	1**	5	4**	4	9	23
UNITED STATES								
All adults	2,002	32	21	37	23	41	33	27
Has chronic condition[a]	786	38**	29**	43**	26**	44	37**	33**
Insured all year	1,639	21	15	27	15	42	24	22
Uninsured	361	58**	36**	63**	42**	39	54**	40**

SOURCE 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries. **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 5 (see Note 3 in text). For all countries, significance indicators indicate significant within-country difference with respondents without a chronic condition. For the United States, significance indicators indicate significant difference with US respondents who were insured all year. [a]Respondents reported having been diagnosed with at least one of the following four chronic conditions: asthma or chronic lung problems, cancer, diabetes, and heart disease. **$p < 0.05$

rates were relatively low. The rates were as follows: Australia, 30 percent; Canada, 24 percent; France, 32 percent; Germany, 11 percent; the Netherlands, 23 percent; New Zealand, 30 percent; Norway, 11 percent; Sweden, 29 percent; Switzerland, 33 percent; the United Kingdom, 20 percent; and the United States, 22 percent. Particularly in Germany and Norway, the response rates introduce potential bias, although the direction of that bias is unknown. To the extent that the survey missed adults with more complex conditions, low incomes, or lack of proficiency in the survey languages, the results may underestimate concerns.

Study Results

COST-RELATED ACCESS AND AFFORDABILITY CONCERNS Adults responding to the survey were asked several questions regarding the affordability of health care and whether cost posed a barrier to access. As in previous international surveys, US respondents were the most likely to report high out-of-pocket costs for medical care (having spent $1,000 or more in the past year), problems paying medical bills, and forgoing care because of costs (Exhibit 1).

Not surprisingly, access and affordability problems in the United States were far higher among the uninsured: Nearly two-thirds of these respondents reported that costs had led them to skip care (Exhibit 1). However, even among respondents who were insured all year, US adults were significantly more likely than adults in the other countries to go without care because of costs, face high out-of-pocket spending, or (except for adults in France) be financially burdened by medical bills. This likely reflects both the comparatively high deductibles and cost sharing in many US insurance plans and the high underlying cost of US health care. Notably, roughly 40 percent of both insured and uninsured US respondents had spent $1,000 or more during the past year on medical care, not counting premiums. Those percentages point to often high patient cost sharing or frequent benefit gaps.

In contrast to experiences in the United States, fewer than 10 percent of adults reported high out-of-pocket costs in Sweden, the United Kingdom, France, the Netherlands, and New Zealand. A larger proportion of adults reported high spending in Australia and Switzerland. However, few respondents in either country said that these costs had led to access or affordability concerns, possibly reflecting spending caps and other protections in these countries' insurance systems.[5] In contrast, 25 percent of US adults had spent $2,000 or more and 9 percent had spent $5,000 or more in the past year—rates that were more than double those in any other country, except Australia (where 14 percent had spent $2,000 or more and 5 percent had spent $5,000 or more) (data not shown).

US respondents were the most likely to report high out-of-pocket costs, problems paying medical bills, and forgoing care because of costs.

Of potential concern for access in the Netherlands, the percentage of Dutch respondents who reported forgoing care because of cost increased substantially from the 2010 international survey, from 6 percent to 22 percent (Appendix 2).[3] In response to austerity pressures, recent changes in the Dutch health insurance system have allowed cost sharing to increase. Although the new levels are still low by US standards, they may be discouraging care seeking where they have been introduced.

Many adults are healthy and may not need many health services in a given year. Therefore, we examined the financial protectiveness of different systems for the subset of adults with one or more of the following four chronic conditions that typically entail more frequent need of medical care: diabetes, heart disease, cancer, and asthma or chronic lung problems.

We found that chronically ill patients in France, Germany, the Netherlands, Norway, and the United Kingdom were not significantly more likely than those without these conditions to forgo care or report high out-of-pocket costs (Exhibit 1). Rates of cost exposure were also low in Sweden for such vulnerable patients.

In Australia, Canada, Switzerland, and the United States, costs play a greater role in deterring care and causing financial stress for the chronically ill than for those without such conditions. Here, too, US responses stand out, with 43 percent of the chronically ill going without care because of costs and one in four having problems paying medical bills. These country

41%

Spent $1,000

Roughly 4 in 10 US respondents, both with and without insurance, spent $1,000 or more out of pocket on medical care during the past year.

variations likely reflect the combined impact of insurance benefits, levels of cost sharing, and income- or disease-specific protections, such as French provisions protecting those with chronic conditions in care plans.[6]

The survey also asked respondents about their access to and use of dental care—a benefit covered for adults in only some of the countries (Appendix 1).[3] A high share of US and New Zealand adults (33 percent and 32 percent, respectively) had gone without dental care because of costs in the past year (Exhibit 1). Germany and the United Kingdom appear to be the most protective in terms of dental cost barriers.

In the United States, rates of forgoing dental care were particularly high for uninsured adults, where one in two had not seen a dentist because of costs. However, dental access concerns appear in other countries as well. More than one-fourth of adults in Australia, France, New Zealand, and the United Kingdom had not visited a dentist or received preventive dental care in the past two years.

ACCESS AND WAITING TIMES A strong primary care infrastructure is recognized as the cornerstone of a high-performing health care system, offering a critical entry point and a hub for organizing care that is patient centered, coordinated, and comprehensive. Enhanced, accessible primary care that employs teams—including nurses—supported by information systems to help provide, manage, and coordinate care has the potential to improve health outcomes, reduce hospital use, improve equity, and slow the rate of cost growth.[14,15]

Although the vast majority of adults in all countries reported having a regular doctor or place of care (data not shown), access experiences varied widely (Exhibit 2). Roughly 70 percent of the respondents in Germany and New Zealand reported having been able to get a same- or next-day appointment the last time they were sick. In contrast, fewer than half of adults in Canada and the United States reported such speedy access. And at least one in four adults in Canada, Norway, and the United States waited six days or more to see a doctor or nurse when sick.

Asked how often they heard back the same day when they called their regular practice with a medical question, German adults were the most likely (90 percent) to say always or often (Exhibit 2). At the low end of the spectrum, 25 percent or more of UK and US adults and 30 percent or more of Canadian and French adults said that this happened only sometimes, rarely, or never.

Access to specialists also varied notably. In Norway and Canada more than one in four of adults needing to see a specialist waited two months or longer (Exhibit 2). In contrast, most

EXHIBIT 2

Adults' Access To Health Care And Wait Times In Eleven Countries, 2013

	Percent of adults who:					
	Saw a doctor or nurse last time they needed care		Heard from the doctor's office the same day after calling with a question during practice hours[a]		Waited to see a specialist[b]	
Country	Same or next day	Waited 6 days or more	Always/ often	Sometimes/ rarely or never	Less than 4 weeks	2 months or more
AUS	58	14	79	21	51	18
CAN	41	33	67	33	39	29
FRA	57	16	63	37	51	18
GER	76	15	90	10	72	10
NETH	63	14	84	16	75	3
NZ	72	5	80	20	59	19
NOR	52	28	78	22	46	26
SWE	58	22	84	16	54	17
SWI	—[c]	—[c]	82	18	80	3
UK	52	16	75	25	80	7
US (all)	48	26	73	27	76	6
Insured all year	53	21	75	25	77	5
Uninsured	36**	40**	65**	35**	70**	10

SOURCE 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries. **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 6 (see Note 3 in text). Significance indicators indicate significant difference with US respondents who were insured all year. [a]Of those who called. [b]Of those who needed to see a specialist in the past two years. [c]Question asked differently in Switzerland. **$p < 0.05$

(72–80 percent) Swiss, UK, US, Dutch, and German adults said that they were seen within four weeks.

In the United States, lack of insurance undermined access to both primary and specialized care. Compared to those with insurance, uninsured adults were significantly less likely to be seen quickly when they needed care, to be called back by the practice the same day, and to be seen by a specialist within four weeks (Exhibit 2). Same- or next-day access to a provider for insured US adults was also relatively low (53 percent) compared to rates reported in Germany, New Zealand, and the Netherlands—which suggests that there is room to improve primary care access for both the insured and the uninsured in the United States.

AFTER-HOURS AND E-MAIL ACCESS AND EMERGENCY DEPARTMENT USE For primary care to be accessible, it must be available after hours—during the evening and on weekends and holidays—as well as during the workday. Yet fewer than 40 percent of US, Canadian, French, and Swedish adults reported that it was very or somewhat easy to be seen for care after hours without going to the emergency department (ED) (Exhibit 3). In contrast, more than half of the adults in five countries—the United Kingdom had the highest rate, 69 percent—said that getting after-hours care was easy.

In most of the countries where adults reported easy access—the United Kingdom, New Zealand, the Netherlands, and Germany—primary care practices have a statutory responsibility to make arrangements to provide after-hours care. In our 2012 international survey of physicians, 90 percent or more of primary care doctors in these countries confirmed that they had set up arrangements to allow patients to see a doctor or nurse after hours (Exhibit 3).

Relatively frequent use of the ED generally tracked reports of limited access to after-hours care or lack of timely access when sick. One-third or more of adults in the United States, Canada, France, and Sweden reported having used the ED in the past two years. Patients in these countries were also among the most likely to experience long waits in the ED, with more than one in four US adults; roughly one-third of French, Norwegian, and Swedish adults; and nearly half of Canadian adults saying they had waited two hours or more to be treated (Exhibit 3).

Primary care practices have the potential to expand patients' access beyond visits and phone

EXHIBIT 3

Reports Of Adults And Primary Care Physicians On After-Hours Care, Emergency Department (ED) Use, And E-Mail Access In Eleven Countries, 2012 And 2013

	Percent of adults (2013) or primary care physicians (2012)						
	After-hours care		ED use		E-mail access to doctor		
Country	Adults report it is somewhat or very easy to obtain[a]	Physicians report they have arrangement[b]	Adults report using ED in the past 2 years	With wait of 2 hours or more before being treated[c]	Physicians report patients can e-mail practice with questions or concerns	Adults report they can e-mail their regular practice with a medical concern[d]	Adults report e-mailing their regular practice with a medical question in past 2 years[d,e]
AUS	46	81	22	25	21	24	9
CAN	38	46	41	48	11	10	2
FRA	36	76	31	36	39	9	2
GER	56	90	22	23	45	19	3
NETH	56	95	24	17	47	32	20
NZ	54	90	28	14	39	16	5
NOR	58	80[f]	28	34	27	22	6
SWE	35	68	32	32	44	20	9
SWI	49	78	28	18	68	29	15
UK	69	95	27	16	35	25	13
US (all)	39	35	39	28	35	28	6
Insured all year	43	—[g]	36	24	—[g]	31	7
Uninsured	30**	—[g]	48**	36**	—[g]	19**	4

SOURCES Commonwealth Fund, 2012 Commonwealth Fund International Survey of Primary Care Physicians (see Note 12 in text); 2013 Commonwealth Fund International Health Policy Surveys. **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 7 (see Note 3 in text). Significance indicators indicate significant difference with US respondents who were insured all year. [a]Of those who needed after-hours care. [b]Practice has arrangement for patients to see a doctor or nurse after hours without going to the ED. [c]Of those who used the ED in past two years. [d]Of those with a regular doctor or place of care. [e]Respondents reporting that they did not have a computer or e-mail were coded as "no": Australia, 4%; Canada, 3%; France, 5%; Germany, 4%; the Netherlands, 2%; New Zealand, 5%; Norway, 2%; Sweden, 4%; Switzerland, 4%; United Kingdom, 5%; United States, 3%. [f]In Norway, respondents were asked whether their practice had arrangements or there were regional arrangements. [g]Not applicable. $^{**}p < 0.05$

calls through e-mail and other electronic exchanges. Comparisons of patients' 2013 survey responses with the 2012 responses of primary care physicians indicate that use of such electronic access is spreading slowly, and that patients may not be informed of or encouraged to use such tools (Exhibit 3). Thirty-two percent of adults in the Netherlands said that they could e-mail their regular practice with a medical concern; the percentages in the other countries were lower. Only 2 percent of patients in Canada and France said they had e-mailed their regular practice with a question; the highest rate of use was in the Netherlands, with 20 percent.

In all of the countries except Australia and Canada, the share of primary care physicians who said that their patients had e-mail access to their practice tended to be far higher than the percentage of patients who were aware of that capacity (Exhibit 3). The gap between patient and physician reports was widest in Switzerland—almost forty percentage points.

US patients' reports of having e-mail access to their regular practice rivaled responses from the leading countries, especially among the insured (Exhibit 3). For all patients, the United States ranked third among the eleven countries, at 28 percent. However, rates of e-mail use still remain low.

Reflecting their more limited access to primary care, uninsured US adults were more likely than those with insurance to face difficulties getting after-hours care, to seek care in the ED, and to endure long waits when in the ED (Exhibit 3). The uninsured were also less likely than the insured to report having e-mail access to their regular practice (19 percent versus 31 percent).

ADMINISTRATIVE COSTS AND COMPLEXITY

Administrative complexity can generate hidden health care costs, requiring time and resources from patients, physicians, and payers. Complying with coverage restrictions, billing documentation, and other regulations can elevate the price and erode the quality of interactions with the health system.

In terms of just the costs to insurers of health insurance administration—that is, without including administrative costs for physicians or hospitals—the United States is an outlier. According to data from the Organization for Economic Cooperation and Development (OECD),[16] in 2011, US health insurers[17] spent $606 per person on administrative costs—more than two times the amount in the next-highest country participating in the survey (Exhibit 4). Even the multipayer Swiss and Dutch private insurance systems operate with less than half of the US per person administrative overhead.[18]

Insurance-related complexity costs patients time. When asked about administrative hassles in the 2013 survey, US and Swiss adults were the most likely to report that they had spent "a lot of time on paperwork or disputes" concerning medical bills or insurance in the past year (Exhibit 4). And adults in the United States were more likely than those in any other country to say

EXHIBIT 4

Administrative Costs And Complexity Of Health Insurance In Eleven Countries, 2012 And 2013

		Percent of adults reporting, in the past year:			
Country	Per capita spending on health insurance administration, 2011[a]	"Spent a lot of time on paperwork or disputes" for medical bills or insurance, 2013[b]	"Insurance denied payment" or "did not pay as much as expected," 2013[b]	Had either difficulty, 2013[b]	Percent of primary care physicians reporting the time they or their staff spend getting patients needed care because of coverage restrictions is a major problem, 2012[c]
AUS	$70	6	15	16	11
CAN	148	5	14	15	23
FRA	277	10	17	23	20
GER	237	8	14	17	41
NETH	199	9	13	19	28
NZ	128	4	6	7	18
NOR	35	7	3	8	12
SWE	55	2	3	4	12
SWI	266	16	16	25	24
UK	—[d]	2	3	4	10
US	606	18	28	32	54

SOURCES See below. **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 8 (see Note 3 in text). [a]Organization for Economic Cooperation and Development, OECD health data 2013 (see Note 16 in text). Australian data from 2010. All data adjusted for differences in cost of living. [b]2013 Commonwealth Fund International Health Policy Survey in Eleven Countries. [c]2012 Commonwealth Fund International Survey of Primary Care Physicians (see Note 12 in text). [d]Not available.

that their insurance had denied them payment or had not paid them as much as they had expected. About one in three US adults reported having either concern, attesting to the lack of transparency and standardization of benefits coverage, the amount of paperwork required, and the complexity of the US health insurance system.[19]

Notably, US adults younger than age sixty-five were more likely to cite administrative concerns than were adults who were older and thus eligible for Medicare (Appendix 3).[3] This difference may reflect the more stable and more protective coverage available to older adults. US adults ages sixty-five and older were also far less likely than younger adults to go without care because of costs or to have serious problems paying medical bills.

The United States also stood out in the 2012 survey of physicians in eleven countries for time-consuming insurance-related complexity. Fifty-four percent of US primary care physicians said that the amount of time that they and their staff spent dealing with coverage restrictions was a "major problem," a significantly higher percentage than that in any other country (Exhibit 4). In only two other countries, Germany and the Netherlands, did more than a quarter of the physicians report time-consuming insurance problems.

Countries whose health systems operate on a "National Health Service" model—New Zealand, Norway, Sweden, and the United Kingdom—had lower administrative costs than the other study countries, based on OECD data. They also tended to have relatively fewer patients or physicians who complained about spending time on insurance-related paperwork, constraints, or disputes.

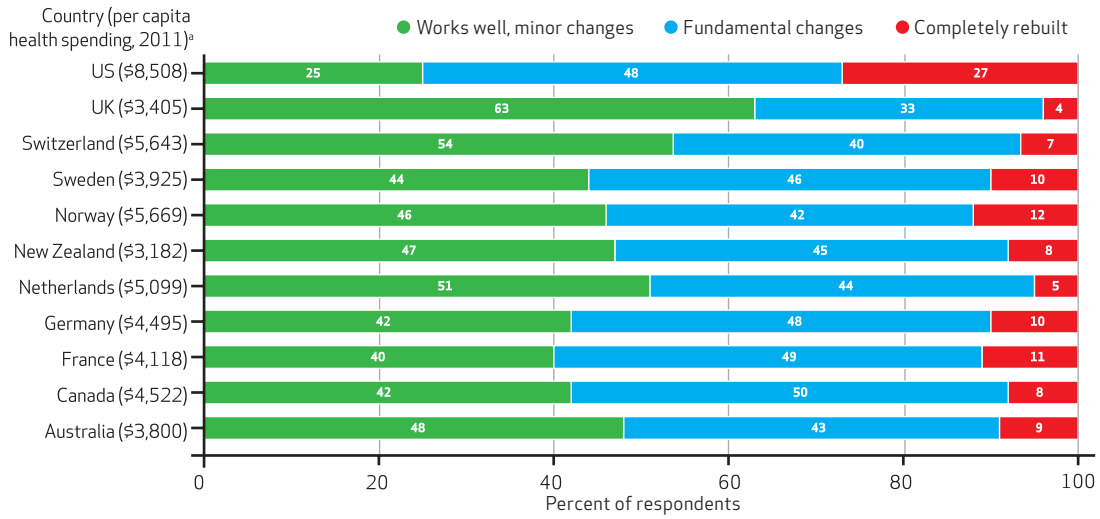
In contrast, countries where private insurers play a larger role, including offering supplemental insurance with varying benefits, and where patients have higher cost sharing tended to have higher administrative costs or more patient or provider concerns. Notably, in Australia, Canada, and New Zealand, patients' concerns about denial of payments were concentrated among people who had private supplemental coverage (data not shown).

SYSTEM VIEWS Repeating a question asked since 1998, the 2013 survey solicited adults' overall views of their country's health system—whether it needed only minor changes, fundamental changes, or to be completely rebuilt. Perhaps reflecting issues related to access, cost, and complexity in the US system, adults in that country were by far the most negative, with three out of four saying that the health system needed to undergo fundamental change or to be rebuilt (Exhibit 5). US calls for change were strongly associated with forgone care because of costs, struggles to pay bills, waits for primary care, lack of after-hours access, and insurance complexity (Appendix 4).[3]

Half or more of the Dutch, Swiss, and UK

EXHIBIT 5

Adults' Views Of The Health System In Eleven Countries, 2013



SOURCES 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries; Organization for Economic Cooperation and Development, OECD health data 2013 (see Note 16 in text). **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 9 (see Note 3 in text). The three response options were that the health system "works well, only minor changes needed"; "needs fundamental changes"; and "needs to be completely rebuilt." [a]Per capita spending adjusted for differences in cost of living. Australian data are from 2010.

By international standards, cost-sharing exposure in the United States will remain high for those with low incomes.

respondents said that their system worked well and needed only minor changes (Exhibit 5). Compared to US adults, adults in the other ten countries were more likely to opt for minor changes and less likely to call for rebuilding the health system. Within the countries, respondents' views were related to their experiences: In countries with long waits for care or high cost burdens, people calling for major change were more likely to have faced such problems (Appendix 4).[3]

Implications

As the United States proceeds to implement insurance expansions and market reforms, this study underscores the vulnerability of the uninsured and the importance of successfully expanding coverage. At the same time, the variable experiences across countries with universal coverage indicate that having insurance is important but not sufficient to ensure timely or affordable access. Study findings across countries suggest the importance of calibrating any cost sharing in insurance policies to people's ability to pay; providing payment as well as regulatory support for increased access to primary care, including after-hours care; and being alert to the time and resources required to deal with insurance complexity. Looking forward, countries can examine their own and others' experiences as they consider reforms that may have an impact on access or affordability.

INSURANCE DESIGN AND AFFORDABILITY In this study, US adults—both the insured and the uninsured—were more likely than adults in other countries to report going without care because of costs, having high out-of-pocket costs, and having difficulty paying medical bills. The experiences in Switzerland and other countries where mandatory insurance includes both deductibles and copayments indicate that it is possible to incentivize patients to be sensitive to price yet protect them against undue financial burdens when they are sick.

Reforms scheduled under the Affordable Care Act provide for subsidies to lower cost sharing for those with incomes below specified thresholds as well as reductions in premiums for people with low or modest incomes. However, by international standards, cost-sharing exposure will remain high for those with low incomes. Also, states will have considerable leeway in insurance design for middle- and high-income families, with annual out-of-pocket maximums and deductibles that will continue to be high compared to those in other countries. For people with chronic, ongoing conditions, the result could be continued high medical cost burdens.

To avoid such cumulative costs and resulting barriers to effective care, France provides for either low or no cost sharing for treatments that fall within care plans for chronically ill patients. In effect, this approach protects patients' access while ensuring that they receive care according to clinical guidelines. Australia provides additional funds to cap patients' out-of-pocket expenses, and Germany limits out-of-pocket spending relative to income, with lower thresholds for sicker patients. As the US reforms take hold, the purchasers of care—states, private insurers, and employers—could consider how such insurance design provisions could evolve in tandem with efforts to hold care systems accountable for health outcomes, patients' experiences, and costs.

The scope of covered benefits also makes a difference. Across countries, dental care is least often covered for adults (and will not be covered under scheduled US reforms). This study's findings indicate that there is room to improve dental access in multiple countries. This could include incorporating at least preventive dental care into core benefit designs, in recognition of the fact that basic dental care can provide early warnings of potentially serious physical as well as dental risks.

INSURANCE AND PRIMARY CARE Insurance design and payment policies also matter for access and countries' primary care infrastructure. In increasing primary care access, again the United States and other countries can learn from international as well as domestic experiences. The Dutch and UK systems, for example, exempt primary care from deductibles and cost sharing; provide direct support for after-hours care cooperatives and other arrangements; and pay primary care practices in ways that support both ready access to care and the addition of nurses and other staff to primary care teams trained to provide, manage, and coordinate care.[20]

The high rates of ED use associated with long

$606

Per person

In 2011, US health insurers spent $606 per person on administrative costs—more than twice the amount in the next-highest participating country.

waits for primary care in the United States (including among insured patients) and several other countries underscore the importance of 24/7 primary care coverage in terms of overall system cost and resource allocation. Past international surveys of primary care physicians and "sicker" patients—those who have recently been hospitalized, are in poor health, or both—reveal discontinuities and often poor flow of information back to primary care providers for patients who are seen in emergency departments.[12,21] Insurers as payers have access to this information and could do more to facilitate its flow, such as supporting information exchange for practices that are not formally linked to integrated systems.

INSURANCE COMPLEXITY The experiences of patients and physicians in other countries regarding the time-consuming complexity of insurance also provide potential insights for the United States. Although the Dutch, Swiss, and German health care systems all rely on competitive insurance markets, each of these countries has standardized benefits and both more-standardized payment methods across insurers and more-centralized quality and regulatory reporting systems, compared to the United States.

A recent Institute of Medicine study estimated that administrative layers throughout the US health insurance and care system add as much as $360 billion per year to the cost of health care—and much of that sum was deemed to be wasted, with little or no return in value.[22] Evidence from other countries suggests opportunities to reduce such costs. The survey results further indicate the potential to reduce patients' frustration and improve their views of the US health system.

Conversely, the US experience provides a cautionary example for other countries of the potential consequences of insurance complexity. Recent studies[23] suggest that countries seeking to vary their insurance designs to introduce incentives for patients to find and use high-value care may increase administrative costs. By sharing their experiences, all countries will be better able to ensure that resources spent on administrative costs yield net returns.

COST CONTROL A key challenge for the United States is its already high level of health spending, which is 50–167 percent higher per capita than in the other study countries. The higher costs are particularly notable when comparing costs of hip and knee replacements and prescription medicines.[24] These costs undermine the financial protections offered by insurance and drive premiums up. Sustaining access and affordability will likely require systemic reforms to control costs, including payment reforms to make care systems more accountable for health and cost outcomes.

The US experience provides a cautionary example for other countries of the potential consequences of insurance complexity.

Although the level of health care costs in the United States is particularly high, all of the countries face health care spending growth rates that exceed the general growth rate of the economy. Holding the line will require creative responses and vigilance regarding insurance design to achieve the joint goals of safeguarding access, improving health outcomes, and meeting public expectations of high quality.

SUPPORT FOR REFORM Polls in the United States show mixed public support and lack of knowledge about the provisions of the Affordable Care Act.[25] Yet in the survey most US adults called for major change, with a minority preferring the status quo. People who had experienced problems with access to or affordability of care or who had time-consuming insurance problems had more negative views than people who had not had such problems. The areas of access, affordability, and insurance complexity provide key indicators to monitor over time in the United States as well as other countries.

Looking forward, the study indicates likely public support in the United States for reforms if they succeed in improving access and affordability, strengthening primary care, and reducing insurance complexity. ■

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NOTES

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3 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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10 Weights included age, sex, region, education, and additional variables consistent with standards for each country. In the United States the weighted variables also included race and ethnicity.

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