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Older Americans Were Sicker And Faced More Financial Barriers To Health Care Than Counterparts In Other Countries

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ABSTRACT **High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The 2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services—a gap that can undermine health. New to the survey is a focus on the "high-need" elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.**

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Health care systems across high-income countries share the challenge of an aging population with unprecedented levels of chronic illness.[1] Often these older adults are living with frailty, advanced illness, or diminished ability to manage the basic activities of daily living, such as preparing meals, bathing, or managing one's medications. Across countries, health care spending is concentrated among these older patients, whose complex needs are often at odds with health care systems designed to treat patients needing acute episodic care.

This article uses data from the 2017 Commonwealth Fund International Health Policy Survey of Older Adults, the twentieth study in this international series, to report on the challenges that elderly adults (those ages sixty-five and older) face across eleven countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. For the first time we show cross-national data on the prevalence of social isolation and material hardship among the elderly, recognizing the impact that social determinants may have on health, health care use, and outcomes.

The 2017 survey also introduces key performance measures for a subpopulation of high-need elderly people, defined as those who have three or more chronic conditions or need help with activities of daily living because of a health problem. Focusing on the experiences of high-need patients has become increasingly important for policy makers and health care delivery systems because the members of this population are frequent users of health and social care systems and account for a disproportionate share of total health care spending.[2]

This analysis compares how well US seniors fare under Medicare relative to the elderly in ten

other high-income countries that provide universal health insurance coverage for this population, but differ from the United States in how health care is financed and organized, and in the social services support provided to the most economically vulnerable. The analysis also raises the issue of how the proportion of spending allocated to health versus social services differs across countries.[3]

Despite these differences, all eleven countries in the survey are engaged in ongoing health care reforms and efforts to transform delivery systems to better support patients with complex illnesses and elderly people in the community.[4] The 2017 survey findings offer a unique opportunity for cross-national learning.

Study Data And Methods

DATA In collaboration with country contractors, SSRS, a survey research firm, surveyed nationally representative samples of adults ages sixty-five and older in eleven countries. Interviews were conducted in the period March–June 2017 by telephone (mobile and landline) and also online in Switzerland to improve representativeness.[5] Field times in each country ranged from seven to fourteen weeks.

With the help of researchers in the eleven countries, a common questionnaire was developed based on previously published surveys.[6–8] The survey was translated, adapted, pretested, and adjusted for country-specific terminology. Interviewers across countries were trained using a standardized protocol. Overall response rates ranged from 15 percent (in Norway) to 52 percent (in the Netherlands).[9]

International partners joined with the Commonwealth Fund to sponsor country surveys.[10] Final country population samples ranged from 500 to 7,000. Data were weighted to ensure that estimates were representative of the adult population ages sixty-five and older in each country, regardless of final sample sizes.[11]

ANALYSIS The analysis is based on all adult respondents ages sixty-five and older. We also examine the experiences of a subpopulation of elderly respondents who had more complex care needs—they reported having three or more chronic conditions or needing help with basic activities of daily living—and thus are considered high-need (see online Appendix A2).[12] Our definition of *high-need* is derived from previous work and also takes into account sample size limitations.[2,13–15] This is broader than other definitions, but it still represents a segment of the elderly with more complex care needs and higher utilization—as shown by their significantly higher rates of prescription drug use and emergency department (ED) and doctor visits—than the elderly who were not high-need (see Appendix A7).[12]

All exhibits show key outcomes by country, and Appendices A2–7 indicate where between-country differences are significant ($p < 0.05$ or lower), based on logit regressions.[12]

LIMITATIONS Our study had several limitations. First, older adults living in nursing homes and other facilities were not sampled. Countries in which institutionalization is more common may seem to be healthier than countries with lower rates of institutionalization.[16]

Second, the survey findings are based on patient-reported experiences. Thus, our results might differ from those of a study based on clinical or administrative data.

Finally, the survey had response rates in line with industry standards for short field periods, but lower response rates in some countries could introduce bias in an unknown direction. Survey design strategies such as using representative sampling frames or federal registries, including mobile and landline telephones, conducting up to nine call-backs on active numbers, and careful training of interviewers to reduce item nonresponse helped ensure that outcomes were representative of the elderly population in each country.

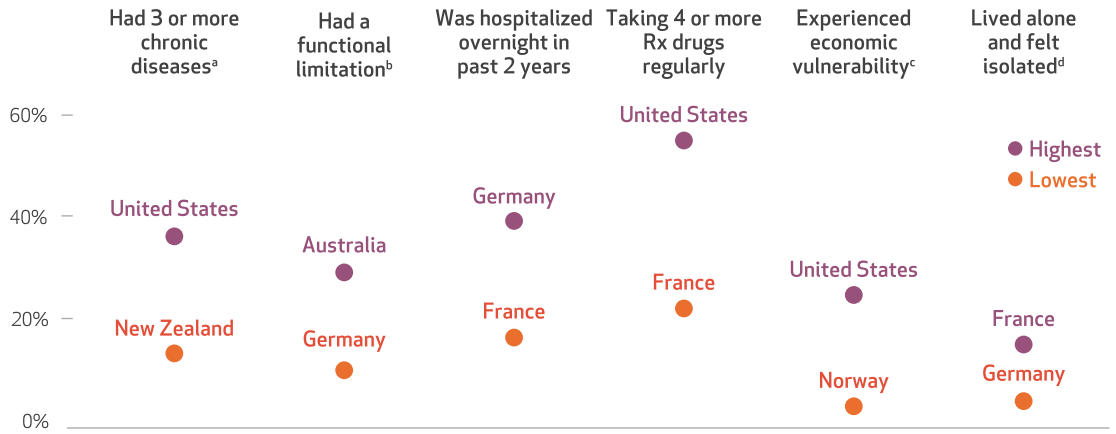
Study Results

HEALTH STATUS, UTILIZATION, AND ECONOMIC AND SOCIAL VULNERABILITY Older adults across eleven nations face a range of health and social challenges that should inform the planning of services that are necessary to preserve their health and well-being. At least one in eight older adults in our survey reported having three or more chronic conditions, with rates ranging from a high of 36 percent in the United States to a low of 13 percent in New Zealand (Exhibit 1). The rates were 17 percent in Australia, the Netherlands, Norway, and Switzerland (Appendix A3).[12] At least 10 percent of older adults also reported having a functional limitation, with the elderly in Germany least likely and those in Australia most likely to report needing help with shopping, managing prescription drugs, or other daily activities (Exhibit 1). Rates of functional limitation were below 15 percent in Canada, Norway, Sweden, and Switzerland as well as in Germany (Appendix A3).[12]

Health care use among older adults, such as hospitalizations and prescription medications, varied widely. The French elderly reported the lowest (16 percent) rates of hospitalizations in the past two years (Exhibit 1), while Germans and Norwegians reported the highest (39 percent

EXHIBIT 1

Percentages of adults ages 65 and older in eleven countries who had selected health and socioeconomic characteristics, 2017



SOURCE 2017 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTE** The findings for additional characteristics, along with significance indicators, are in Appendix A3 (see Note 12 in text). [a]Includes joint pain or arthritis; asthma or chronic lung disease; cancer; diabetes; heart disease, including heart attack; hypertension; and stroke. [b]Because of health, needs someone to help with housework, meals, daily medications, or shopping. [c]Having had problems paying or having been unable to pay any medical bills in the past year; being "always" or "usually" stressed or worried about having enough money to do at least one of the following in the past year: buy nutritious meals, pay rent or mortgage, pay other monthly bills (such as electricity, heat, and telephone); or both. [d]Lived alone and responded "often" or "some of the time" (instead of "hardly ever or never") to the question: "How often do you feel isolated from others?"

and 33 percent, respectively) (Appendix A3).[12] In most countries at least 30 percent of older adults reported taking four or more prescription medications regularly, with the highest rate in the United States (55 percent) and the lowest in France (22 percent).

In addition to reporting high rates of multiple chronic conditions, a disproportionate share of US elderly adults face economic challenges, with 25 percent reporting that they were often worried about having enough money to buy nutritious meals and pay for housing, utilities, or medical needs (Exhibit 1).[12] Rates of economic vulnerability were lowest in Norway (3 percent) and Sweden (4 percent) (Appendix A3).[12]

Also of concern to this population is the prevalence of social isolation and loneliness, which has been shown to be associated with increased mortality.[17] More than one out of ten respondents in the United Kingdom (11 percent), Norway (12 percent), Netherlands (13 percent), and France (15 percent) reported living alone and feeling socially isolated "often" or "some of the time," with lower rates in the other countries (Appendix A3).[12]

AFFORDABILITY AND ACCESS BARRIERS Despite near-universal insurance coverage through Medicare, US respondents stand out for reporting financial barriers to care. Twenty-three percent of older adults in the United States said that in the past year they had not visited a doctor when they were sick, had skipped a recommended medical test or treatment, had not filled a prescription, or had skipped doses because of cost (Exhibit 2 and Appendix A4).[12] In contrast, only 5 percent or fewer of older adults in France, Norway, Sweden, and the United Kingdom reported these cost barriers.

The United States and Switzerland were both outliers on out-of-pocket expenses, with nearly one in four US respondents (22 percent) and nearly one in three Swiss respondents (31 percent) reporting that they had spent $2,000 or more out of pocket for medical care in the past year. In all other countries, fewer than 10 percent of older adults reached that threshold. Despite high out-of-pocket expenses, only 11 percent of Swiss respondents reported forgoing needed care (Exhibit 2 and Appendix A4).[12] This may be explained by Switzerland's caps on out-of-pocket spending and its income-based subsidies that cover premiums.[4]

Among the respondents who reported needing help with activities of daily living, 24 percent in the United States, 22 percent in Australia, and 19 percent in Canada did not receive the assistance that they needed because of costs, compared to 2–10 percent of those respondents in the other countries.

In terms of timeliness of care, older adults in Canada, the United Kingdom, and the United States were the most likely to report that they did not always or often hear from their regular doctor on the same day when they contacted the

EXHIBIT 2

Percentages of adults ages 65 and older in eleven countries who reported selected access barriers, 2017

	Cost-related access problems			Timeliness problems			ED use
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	Did not receive help needed because of functional limitations due to cost[b]	Did not always or often hear from regular doctor on same day, when contacted doctor with medical concern[c]	Waited ≥6 days for appointment to see someone when sick[d]	Said it was somewhat or very difficult to get after-hours care[e]	Had avoidable ED visit[f]
AUS	13%	9%	22%	11%	9%	51%	8%
CAN	9	9	19	26	29	58	11
FR	5	1	5	13	22	46	8
GER	10	7	—[g]	9	34	47	7
NETH	7	3	5	10	8	23	5
NZ	11	4	—[g]	11	7	39	7
NOR	4	6	—[g]	20	26	29	6
SWE	3	5	2	21	28	64	8
SWIZ	11	31	10	8	12	54	8
UK	4	3	6	22	24	54	8
US	23	22	24	22	18	41	15

SOURCE 2017 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** The findings for additional access problems, along with significance indicators, are in Appendix A4 (see Note 12 in text). AUS is Australia; CAN is Canada; FR is France; GER is Germany; NETH is the Netherlands; NZ is New Zealand; NOR is Norway; SWE is Sweden; and SWIZ is Switzerland. [a]Reported not doing one or more of the following activities because of cost in the past year: seeing a doctor when sick, having a medical test or treatment recommended by a doctor, filling a prescription, taking all doses of a medication. [b]The sample is adults who reported that because of a health problem, they needed someone to help them with housework, preparing meals, managing daily medications, or shopping. [c]Excludes adults who did not have a regular doctor or place of care and who never tried to contact their doctor. Possible responses were "always," "often," "sometimes," and "rarely or never." [d]Excludes adults who did not need to make an appointment. [e]Excludes adults who did not need after-hours care. [f]Went to the emergency department (ED) for a condition that could have been treated by a regular doctor or place of care if one had been available. Excludes adults without a regular doctor or place of care. [g]Not shown because the sample size was less than 100.

doctor with a medical concern. Long waiting times to see a doctor when sick were most common in Germany, Canada, Sweden, and Norway, where 26–34 percent of older adults said that they had had to wait six or more days for an appointment.

In all countries except the Netherlands and Norway, nearly four in ten 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 ED. In the Netherlands, by contrast, only 23 percent of adults said that getting after-hours care was somewhat or very difficult.

Older adults in the United States (15 percent) and Canada (11 percent) were the most likely to report going to the ED for a condition that could have been treated by a regular doctor or place of care had those been available. In contrast, rates of avoidable ED visits were no more than 8 percent in all of the other countries. In the Netherlands and Norway, where respondents reported the least difficulty getting after-hours care and the lowest rates of avoidable ED visits, primary care doctors have a statutory or contractual responsibility to provide after-hours care and do so through a variety of arrangements from walk-in centers to nurse triage telephone lines.

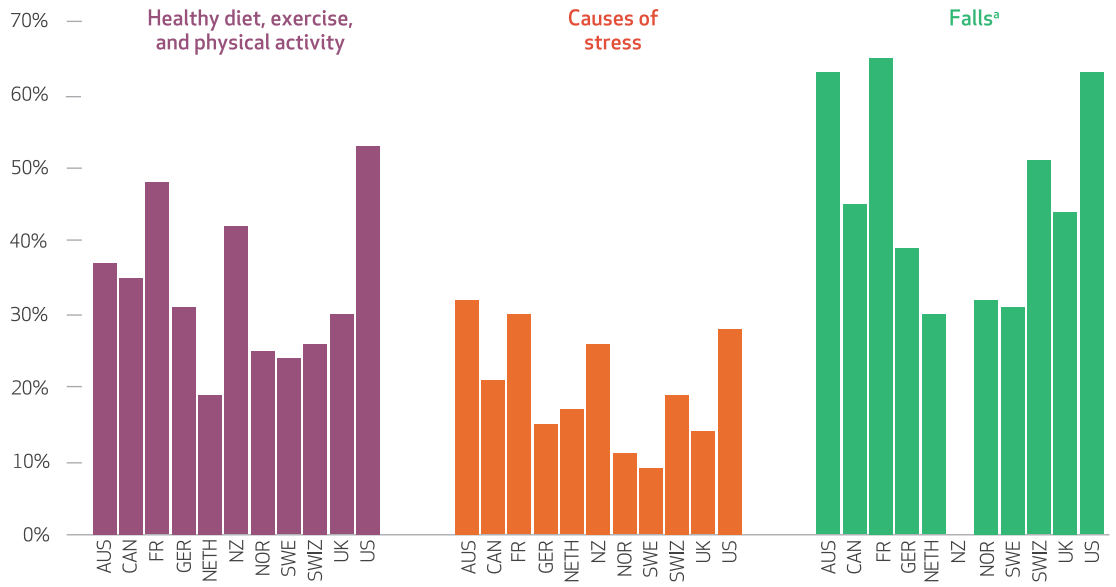
HEALTH PROMOTION Although over 95 percent of older adults across the eleven countries reported having a regular doctor or place of care (Appendix A5),[12] there were shortfalls related to health promotion. Only 19–53 percent of respondents reported having discussions about healthy diet, exercise, and physical activity with their doctor or other clinical staff in the past two years (Exhibit 3).

Asking patients about stress and anxiety to help flag mental health concerns is also an important aspect of health promotion, yet few older adults in any of the eleven countries reported discussing these issues with their clinicians. At best, one in three respondents in Australia and France (32 percent and 30 percent, respectively) did; at worst, one in ten in Norway and Sweden (11 percent and 9 percent, respectively) did.

Falls among the elderly, which can have serious health and economic consequences, are often preventable with risk management by health care providers.[18] Still, there was a wide variation—from 65 percent in France (and 63 percent in the United States and Australia) to 30 percent in the Netherlands (and 31 percent in Sweden and 32 percent in Norway)—in whether respondents who identified themselves as at high or moderate risk for falling talked to their

EXHIBIT 3

Percentages of adults ages 65 and older in eleven countries who had a regular doctor or place of care and discussed health promotion topics with their doctor, 2017



SOURCE 2017 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** All discussions were within the past two years, except for discussions of falls (which had no time frame). Country abbreviations are explained in the Notes to Exhibit 2. More detailed findings and significance indicators are in Appendix A5 (see Note 12 in text). [a]The sample is adults ages seventy-five and older who had a regular doctor or place of care and whose self-perceived risk of falling was "high" or "moderate." Data for New Zealand are not shown because the sample size was less than 100.

doctor about falling and ways to prevent it.

THE EXPERIENCE OF HIGH-NEED OLDER ADULTS

A significant number of elderly people have multiple chronic conditions and diminished capacity for performing activities of daily living without assistance, defined above as high-need older adults. Across all eleven countries, at least one in four of the elderly population were categorized as high-need (Exhibit 4). The United States and Australia stood out as having significantly higher rates of high-need elderly adults (43 percent and 39 percent, respectively), yet high need was driven by different factors in these two countries. The United States had the highest proportion of all elderly respondents who reported multiple chronic conditions, whereas Australia had the highest prevalence of older adults with functional limitations (Exhibit 1).

High-need elderly people are vulnerable to depression, anxiety, and social isolation (Appendix A6).[12] At least one in four of these people in all eleven countries except Sweden (where the share was 15 percent) reported experiencing emotional distress, such as anxiety or depression, in the past year (Exhibit 4). Australia and the Netherlands (40 percent and 37 percent, respectively) were at the top of the range. At least one in eight of the high-need elderly in all of the study countries said that they lived alone and felt isolated often or some of the time, with the highest rates in the Netherlands (24 percent), France (22 percent), and Norway (21 percent) (Appendix A7).[12]

In terms of vulnerability, high-need elderly people are also significantly more likely than other elderly people to say that they have a moderate or high risk of falling (55–70 percent versus 28–41 percent) (Appendix A7).[12] The United States, Australia, and Germany stood out for having large shares of high-need elderly people who reported economic vulnerability. In Australia and Germany, about a quarter of the high-need elderly reported worrying about having enough money to buy nutritious meals and pay for housing, utilities, or medical needs (Exhibit 4). This figure jumped to about one-third in the United States.

High-need elderly Americans also faced serious cost-related barriers to care: The proportion of Americans who skipped care because of costs was more than fifteen times that of Swedes (31 percent versus 2 percent, respectively). US seniors experience comparatively high cost sharing and out-of-pocket expenses in the Medicare program, with copayments and deductibles for many medical services and for pharmaceuticals. Medicare also does not cover commonly used durable medical equipment, such as hear-

EXHIBIT 4

Percentages of adults ages 65 and older in eleven countries who were high-need and who reported selected problems, 2017

Country	Respondents defined as high-need	High-need respondents who: Had economic vulnerability	Had cost-related access problem	Had emotional distress such as anxiety or depression in past year	Had care coordination problem[a]	Were somewhat or not at all satisfied with quality of care received in past year[b]
AUS	39%	26%	19%	40%	36%	41%
CAN	33	17	14	29	35	38
FR	31	11	4	24	13	35
GER	29	23	14	34	43	27
NETH	29	14	8	37	26	32
NZ	24	13	14	24	—[c]	23
NOR	24	7	6	23	—[c]	26
SWE	28	6	2	15	28	24
SWIZ	24	14	14	24	36	21
UK	34	11	7	23	30	29
US	43	32	31	30	41	26

SOURCE 2017 Commonwealth Fund International Health Policy Survey of Older Adults. **NOTES** *High-need respondents* were defined as those who had three or more chronic conditions or who reported that because of a health problem, they needed someone to help them with housework, preparing meals, managing daily medications, or shopping. Appendix A2 presents for a detailed definition and numbers of high-need adults by category, and Appendix A7 presents descriptive statistics for the high-need and other adults (see Note 12 in text). Country abbreviations are explained in the Notes to Exhibit 2. *Economic vulnerability* is defined in Exhibit 1, note c. *Cost-related access problem* is defined in Exhibit 2, note a. [a]Test results or records were not available at an appointment or duplicate tests were ordered; a specialist lacked medical history or a regular doctor was not informed about specialist care; or the respondent received conflicting information from different doctors or health care professionals in the past two years. Excludes adults who did not see two or more doctors in the past year. [b]Excludes adults who did not receive care in the past year. Possible responses were "completely satisfied," "very satisfied," "somewhat satisfied," and "not at all satisfied." [c]Not shown because the sample size was less than 100.

ing aids.[4]

The high-need elderly, who see multiple providers and often receive care in many different settings, reported high rates of care coordination problems. Only in France (13 percent), the Netherlands (26 percent), and Sweden (28 percent) were reported rates of coordination problems below 30 percent.

Finally, in all countries, many high-need elderly people expressed low levels of satisfaction with their quality of care. One in five (21 percent) in Switzerland reported being somewhat or not at all satisfied with the quality of the care they had received in the past year, and twice as many respondents (41 percent) in Australia gave their care low marks.

Discussion

The survey findings illustrate strengths and deficits of the eleven health care systems in caring for older adults. Across the countries, elderly respondents reported a high prevalence of multiple chronic conditions and functional limitations, both of which are associated with more doctor visits, more hospitalizations, and higher costs.[19] In addition, many elderly people experience financial hardship (struggling to pay for necessities, including housing, food, and electricity) and have problems such as social isolation, both of which have been shown to contribute to poorer health and outcomes.[20]

As health care systems face unprecedented demographic changes, with increases in the elderly population and rising rates of chronic disease and disability, they will need to better address the complex, cross-sectoral problems that characterize this population.

The elderly US population is already sicker than similar populations in other countries. Part of the cause is likely to be gaps in coverage and preventive care during Americans' working years, which results in an older population that ages into Medicare with unmanaged chronic illness.

HEALTH CARE COVERAGE AND DESIGN MATTER

The 2017 international survey highlights the striking importance of benefit design. Since 1965 Medicare has provided universal health insurance coverage to US adults ages sixty-five and older, but premium contributions and cost sharing continue to be a serious burden for many beneficiaries. Other systems that also provide universal coverage are more protective. For example, in Canada, the Netherlands, and the United Kingdom, there are no deductibles or cost sharing for primary care; France exempts adults with any one of thirty-two chronic conditions from cost sharing for primary care and prescription drugs; Sweden caps cost sharing for health

care visits at US$120 per year; and Germany limits cost sharing to 1 percent of income for the chronically ill.[4] In contrast, the US elderly face a "triple whammy," as they experience higher cost sharing, higher levels of economic vulnerability, and dramatically higher health care costs—with prescription drugs often two or three times as expensive in the United States as in the other countries studied.[21]

Survey findings indicate that older adults, especially in Australia, Canada, and the United States, face barriers to needed social care services because of costs, which may translate into more ED visits, higher rates of hospitalization, and poorer health outcomes.[3] There exist promising new initiatives that recognize the interaction between health and social care needs. For the lowest-income elderly people in the United States, who are dually eligible for Medicare and Medicaid, the Affordable Care Act funded new models to improve access to and integration of medical and behavioral health care and social services.[22] In Canada, where home care was not a mandated benefit under the Canada Health Act of 1984, the new administration of Prime Minister Justin Trudeau recently announced a significant investment in home and community-based care, including benefits for caregivers to help close the gap in access to services.[23] In Australia a single entry point and government portal to community-based care services was recently introduced to make it easier for the elderly to gain access to the full range of services and subsidies—ranging from home care and meals to palliative care.[24]

TIMELY ACCESS TO CARE As older adults manage their chronic conditions and often complex care regimens daily, health care systems often fail them. This point is vividly illustrated by the finding that in the countries in our study, up to one in three elderly people waited six days or more to see a doctor when sick. Failing to provide older patients with timely primary care and having the ED serve as the default provider increase the risk of fragmented care, unnecessary tests, and hospital admissions. Overall, these shortfalls in timely access (not hearing from a doctor on the same day, waiting six or more days for an appointment, and having difficulty getting after-hours care) were least likely to happen in the Dutch health care system, in part because of the system's strong primary care infrastructure (patients register with a practice, and multidisciplinary care teams and house visits are the norm) and the national network of after-hours cooperatives (led by general practitioners) that provide walk-in urgent care and home visits.

New approaches that realign incentives and change the way care is paid for may further help older patients get care when they need it. For example, value-based care models in the United States, in which providers are accountable for quality and costs, provide incentives to manage patients' care more efficiently and avoid ED visits. Similarly, bundled care models in Australia and the Netherlands that pay primary care practices a set fee for a year of care for chronically ill patients encourage providers to redesign protocols to enable easy access.[4]

PATIENTS AS PARTNERS IN THEIR CARE A growing body of evidence shows that activated patients who are partners in their own care have better adherence, better outcomes, and higher satisfaction.[25] Embedding patient engagement in practice has been more challenging, and the survey findings underscore the gaps related to health promotion and healthy lifestyle discussions.

One of the most striking findings of the survey is the failure to engage the elderly in conversations about mental health, despite compelling evidence that depression contributes to the development of chronic illness,[26] is associated with poorer adherence to treatment regimens,[27] and—as a comorbidity with other chronic conditions—may increase costs by 50 percent or more.[28]

As countries are working to increase patients' engagement in promoting better health and to better address mental health needs, they often use similar strategies. For example, Australia, Canada, the Netherlands, New Zealand, and the United States are experimenting with the use of community health workers to encourage better adherence and prevention for chronic conditions.[29–32] Similarly, the Netherlands (with the Ministry of Health's e-mental health tool kit) and England (with the "Big White Wall" of the National Health Service [NHS]) have rolled out nationwide e-health interventions for mental health that are being used in primary care.[33,34]

THE HIGH-NEED ELDERLY The real test of a health care system is how well it performs for its patients with the greatest need. While not a homogeneous group, the high-need elderly—defined by poorer health and functional status, as explained above—are more likely to suffer economic hardship, experience depression and anxiety, live alone and feel socially isolated, and be at greater risk for falls than their non-high-need counterparts (Appendix A7).[12] These markers of vulnerability put them at risk of further deterioration in health, increasing frailty, and declining ability to live independently in the community—each of which has implications for a trajectory of higher health care costs and poorer outcomes.[19] Not surprisingly, members of this group have rates of ED use that are two to three times the rates of their healthier counter-

parts and experience more care coordination problems and medical errors (data not shown).

In countries where the high-need elderly report the greatest economic vulnerability—the United States, Australia, and Germany—they are also more likely to experience financial barriers to care, which highlights the need for better aligning policy between sectors to ensure that older, sicker, and more economically vulnerable adults do not fall through the cracks.

The high levels of dissatisfaction with the health care system voiced by the survey's high-need elderly respondents reflect the reality that current health care systems, designed for acute episodic care, are not working for older patients with ongoing chronic conditions, functional limitations, and care that needs to be managed in the context of their daily lives.

Recognizing the challenges these high-need patients face, policy makers across the eleven countries are investing in innovative care models to improve quality and costs of care for them. Key to most of the models are risk prediction, stratification of patients and targeting of interventions, intense case management and care coordination, self-management support, and information systems that support better care management and clinical decision making.[35] As these innovative models are scaled and evaluated, countries have a unique opportunity for cross-national learning.

THE SOCIAL SAFETY NET The economic vulnerability of older adults emerged from this study as a key concern. Research shows that poverty, food insecurity, unstable housing, social isolation, and mental health problems contribute to higher rates of chronic illness, poorer health and outcomes, higher utilization of the health care system, and greater costs.[36–38] The United States stands out for disproportionately low spending on social care services compared to health. A previous analysis has shown that some countries in the Organization for Economic Cooperation and Development spend, on average, two dollars on social services for every one dollar on health care. In the United States, less than sixty cents is spent on social services for every health care dollar spent.[3]

The benefits of a strong safety net are demonstrated by the survey findings. In Sweden and France, the high-need elderly report low levels of economic vulnerability and are least likely to experience any cost barriers to health care, and the elderly who need help with activities of daily living experience few cost barriers. In contrast, the higher rates of self-reported social isolation in France, the Netherlands, and Norway, whose relative investments in social services versus health are high, suggests that as policy makers support "aging in place," there may be a need for more effective ways of reaching out to the elderly living alone in the community.

The real test of a health care system is how well it performs for its patients with the greatest need.

With a growing body of evidence demonstrating that interventions in housing, income support, nutrition, care coordination, and community outreach show positive health outcomes or spending reductions,[39] there is an increasingly compelling business case for policy makers to better align health and social care spending and address the challenge of frequently siloed health and social care programs, with governance for health at the national level and for social care at the local level.[40]

Some international examples show how countries are recognizing this opportunity to better improve health by aligning health and social service spending. In England, Integrated Care Pioneers funded in twenty-five communities combine budgets and join up health and social services,[41] and the NHS's experiment with combined personal health and social care budgets enables patients to tailor services to meet their needs.[42] Norway's more than four hundred municipalities both have the responsibility and hold the budgets for primary care and social services, and they have broken down the silos that traditionally contain the sectors and have created the incentive to provide a composite set of health and social services that meet their community's needs.[3,4] Similarly, in the United States, Medicare and Medicaid are experimenting nationally with Accountable Health Communities to bridge the gap between clinical and community services, while locally, health care systems in places as diverse as Portland, Oregon, and Hennepin County, Minnesota, are investing in low-income housing and employment opportunities to address the social determinants of health. Countries may want to watch these and other demonstrations for further evidence of how investments at the intersection of health and social services can have a positive impact on health and costs.

Conclusion

The 2017 survey findings highlight areas where health care systems can improve to meet the needs of a rapidly aging population whose members must manage multiple chronic illnesses and functional limitations. The findings also show why it is critical to get both health and social care right, so that systems that may already be stretched in terms of budget, workforce, and capacity can manage the increase in demand that is anticipated as the baby boomers join the ranks of older adults. ■

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NOTES

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11 Weighting procedures considered the sample design, probability of selection, and systematic nonresponse across known population parameters including region, sex, age, education, and other demographic characteristics consistent with country standards, which are shown in Appendix A1 (see Note 12 below).

12 To access the Appendix, click on the Details tab of the article online.

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