

The Elderly In Five Nations: The Importance Of Universal Coverage

Surveys of elderly persons indicate that these nations' policies to protect the elderly are functioning well.

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ABSTRACT: This paper reports 1999 survey results on the population age sixty-five and older in five nations—Australia, Canada, New Zealand, the United Kingdom, and the United States. The majority of respondents were generally satisfied with the quality, affordability, and availability of health services in their nations. In many measures of access to and cost of care, the United States looks much like the other nations surveyed. However, as the elderly view their health systems, the direction they have taken in recent years with respect to caring for the elderly, and the future affordability of care in old age, U.S. respondents tended to be more pessimistic than were those in other nations.

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FIVE NATIONS**

THE SUCCESSES OF PUBLIC HEALTH and medicine over the past 100 years are perhaps most evident in the lives of the elderly. Today, people over age sixty-five live longer, healthier, and more productive lives. Increased life expectancies have made the elderly a growing share of the population of many nations.¹ However, with this demographic change has come the challenge of making continued improvements in social systems that were developed in a different era.

In 1998 the Commonwealth Fund launched the International Program in Health Policy, designed to provide comparative views of major health policy issues in the United States, Australia, New Zealand, the United Kingdom, and Canada. Focusing on the population age sixty-five and older in these five nations, the Commonwealth Fund 1999 International Health Policy Survey of the Elderly pro-

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vides insights into how well nations are doing in meeting the health and other basic needs of the elderly and the challenges that lie ahead. Of special relevance to the debate about prescription drug coverage under Medicare in the United States, the survey also offers a view of the elderly's experiences getting and paying for medications. These data have international relevance in an era when drug costs are becoming an increasing challenge to health budgets worldwide.

■ **Survey methods.** The data reported here are derived from telephone surveys of nationally representative cross-sectional samples of households in each country in which a randomly selected, noninstitutionalized adult age sixty-five or older was interviewed. Surveys were conducted from April to June 1999, during the International Year of the Aging. Sample sizes were 701 in Australia, 700 in Canada, 700 in New Zealand, 714 in the United Kingdom, and 700 in the United States. Harris Interactive Inc. (formerly Louis Harris and Associates) and its international affiliates collected the data.

Researchers from the Harvard School of Public Health, Harris Interactive, and the Commonwealth Fund collaborated in the design of the survey instrument that was administered in all five countries. Several measures were taken or adapted from prior instruments developed for prior international health surveys, including questions asked in the 1998 Commonwealth surveys of adults age eighteen and older in the same five countries.² Instruments were reviewed by health care experts in all nations. The average length of survey administration was twelve minutes.

All surveys are subject to both sampling and nonsampling error. The margin of error for the national populations of 1,000 persons is ± 3 percent. Responses of smaller groups have higher margins of sampling error. Statistical tests included the *t*-test for differences in proportions with each country tested versus the United States as a referent group.

In cross-national surveys the principal concern is the cross-cultural interpretation, and therefore the validity, of common survey measures. Although we attempted to maximize the comparability of survey findings, in the end these survey responses must be viewed in the context of the individual cultures of each country. Differences in standard practice in measuring and reporting sample disposition and response rate information make the publication of one common response rate unadvisable.³

Survey Findings

■ **Overall system view.** The study used a measure of consumers' satisfaction with their nation's health system performance that has been tracked in prior studies. Views were the most negative in the

United States and New Zealand, as they were in the 1998 survey, and the most positive in Canada and the United Kingdom (Exhibit 1). Nearly four in ten Canadians and Britons believe that their system works well, and fewer than 20 percent favor the most negative of the response items—completely rebuilding their system. The elderly in all five countries were more likely to say that their systems need only minor changes than were the general adult populations who were surveyed in 1998.⁴ At the other extreme, no significant differences were measured in any country but the United States on the response that the system needs to be completely rebuilt.

The survey does find signs that not all is as it could be in these nations. Fewer than one-quarter of the elderly in these countries said that medical care for the elderly has improved over the past five years (Exhibit 1). In all nations except the United Kingdom, significantly more respondents perceived that health care for the elderly has declined rather than improved during this period. The biggest gaps are seen in Canada and New Zealand.

■ **Access to and costs of care.** We asked respondents about their ability to get and pay for the health care services they needed, as well as other cost-of-living issues. On two access measures—getting needed care and getting specialty care—there is strong evidence that the universal systems in place in these countries provide financial protection to the older, sicker populations and reasonable access to care (Exhibit 2). In all five countries fewer than 10 percent of the elderly said that it is extremely or very difficult to get these services. Waiting times for elective surgery were longest in Canada and the United Kingdom, but relatively few complained that waiting times were a serious problem for them. Across all five nations only 6 percent or fewer reported a problem paying their medical

EXHIBIT 1
Elderly Consumers' Views Of Their Health Care System, In Australia, Canada, New Zealand, The United Kingdom, And The United States, 1999

Percent of respondents who said	AUS	CAN	NZ	UK	US
On the whole the system works pretty well, and only minor changes are necessary to make it work better	34%**	38%**	22%	39%**	25%
There are some good things in our health care system, but fundamental changes are needed to make it work better	38	40	45	44	44
Our health care system has so much wrong with it that we need to completely rebuild it	24	18	31	15	26
Medical care for the elderly in our country is					
Better than five years ago	14	12	8**	24**	15
About the same	40	41	30	42	46
Worse than five years ago	29	36	48	21	26

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

** $p < .05$ for differences with the United States.

EXHIBIT 2**Elderly Consumers' Reports On Access To And Cost Of Care, In Australia, Canada, New Zealand, The United Kingdom, And The United States, 1999**

Cost: percent who reported	AUS	CAN	NZ	UK	US
Difficulties in meeting basic living costs	20%	15%**	26%**	26%**	21%
Having problems paying medical bills last year	4	3	5	1	6
Access: percent who reported					
Difficulties in getting needed medical care					
Extremely difficult	2	1	2	1	1
Very difficult	2	2	2	2	2
Somewhat difficult	3	10	6	12	8
Not too difficult	28	26	29	34	21
Not at all difficult	66	58**	60**	49**	66
Difficulties in seeing specialists and consultants when they needed to					
Extremely difficult	2	3	3	3	2
Very difficult	2	6	3	8	3
Somewhat difficult	6	14	7	13	9
Not too difficult	28	22	25	28	20
Not at all difficult	59**	40**	25**	28**	52
Waiting times for nonemergency surgery for themselves or a family member					
No waiting	47**	21**	25**	18**	41
Less than 1 week	7	5	13	6	10
1-2 weeks	16	11	14	8	30
3-4 weeks	10	19	10	12	11
5 weeks or more	19**	40**	34**	51**	7
Of those who needed elective surgery, waiting a long time for surgery was a serious problem	9	11**	16**	13**	4

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

** $p < .05$ for differences with the United States.

bills (Exhibit 2). The financial protections afforded by U.S. Medicare are evident by comparison of this measure with 1998 data for the nonelderly uninsured in the United States: More than 40 percent of the nonelderly uninsured in 1998 reported problems paying medical bills.⁵

However, in all nations except Canada 20 percent or more of elderly persons reported difficulty paying for the basic costs of daily living. This factor underscores the importance of the financial protection of health coverage for this older, sicker, and potentially more vulnerable population.

■ **Variations in prescription drug coverage.** Compared with the other nations, the United States has a significantly greater proportion of its elderly population who have no drug coverage at all and a significantly higher proportion of elderly persons with high uncovered prescription drug costs (Exhibit 3). Fully 32 percent of the U.S. elderly reported having no coverage at all for prescription drug costs; 20 percent paid \$50–\$100 per month out of pocket for

EXHIBIT 3

Elderly's Prescription Drug Coverage And Costs, In Australia, Canada, New Zealand, The United Kingdom, And The United States, 1999

Percent reporting	AUS	CAN	NZ	UK	US
Coverage for the cost of prescription drugs					
No public or private coverage	8%**	10%**	16%**	1%**	32%
Some public or private coverage	80	69	71	1	53
Complete public or private coverage	9	18	5	97	13
Monthly out-of-pocket expenses for prescription drugs					
None	10**	24	16	92**	20
Less than \$50	85	59	69	7	41
\$50-\$100	3	10	8	0	20
More than \$100	0**	4**	2**	0**	16
Did not fill a prescription for financial reasons (among those who needed to)	1**	4**	2**	3**	7

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

** $p < .05$ for differences with the United States.

drugs, and 16 percent paid more than \$100 per month. By contrast, fewer than 5 percent of the elderly in the other four nations experienced costs of more than \$100 per month.

Probably the most dramatic contrast in the survey is between the elderly's out-of-pocket payments for medicines in the United Kingdom and in the United States. Nine out of ten British elderly paid nothing out of pocket for their monthly prescription medicines in 1999, whereas only two out of ten elderly Americans made this claim. Nevertheless, we found no significant differences between the U.S. elderly and those in the other nations in financial barriers to filling prescriptions or in problems paying medical bills.

However, of elderly Americans who incurred high out-of-pocket drug expenses in 1999, 15 percent reported not filling a prescription because they could not afford it, 18 percent reported having problems paying medical bills, and 29 percent reported having problems meeting daily living expenses (Exhibit 4).

■ **Perceptions of quality of care.** Basic information on the use of health services in all countries reveals that hospitalization rates and physician office visits are similar, although Australians had many more frequent physician visits, and only 2 percent of Australia's elderly population went without physician care in 1999. Consistent with 1998 survey findings for the total populations of these countries, considerable variation is seen across nations in the availability of home visits by physicians or nurses.⁶ Of note, one in four elderly in the United Kingdom had a health professional visit at home when someone was ill, while in the United States only one in twenty had such a home visit.

Only those elderly who received services were asked to rate their

EXHIBIT 4 Elderly Americans And Prescription Drug Coverage, 1999

Percent who reported	Monthly out-of-pocket spending on drugs		
	Less than \$50	\$50-\$100	More than \$100
Not filling prescription for financial reasons (among those who needed to)	3%	10%**	15%**
Having problems paying medical bills	3	7	18**
Difficulties in meeting basic living costs	17	29**	29**
Being very worried that they will have large medical expenses and not be able to pay for needed care	17	27**	28**

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

** $p < .05$ for differences with less than \$50.

quality. The elderly in Australia and New Zealand were most likely to rate their care as excellent in most categories; Canadians and Britons were more negative (Exhibit 5). The United States, which spends the most for health care, ranked in the middle. In all countries, in general, very small proportions of the elderly population rated their care as fair or poor, although Canadians were much more

EXHIBIT 5 Elderly Consumers' Views On Quality Of Care, In Australia, Canada, New Zealand, The United Kingdom, And The United States, 1999

Quality: percent who reported	AUS	CAN	NZ	UK	US
Overall care over past 12 months was					
Excellent	36%	27%**	39%**	25%**	32%
Very good	39	34	36	46	33
Good	17	26	14	17	22
Fair/poor	6	8	5	6	10
Care received at most recent doctor visit was					
Excellent	44	38	51**	31**	40
Very good	36	35	31	46	37
Good	16	21	13	16	17
Fair/poor	4	5	4	5	5
Hospital care^a: percent who reported					
Overall care experience was					
Excellent	30	25	39**	31	27
Very good	36	36	37	41	34
Good	22	24	17	15	25
Fair/poor	10	13	5	12	13
Availability of nurses was					
Excellent	35	21**	44**	29**	34
Very good	36	32	30	39	29
Good	17	21	14	17	21
Fair/poor	11	24	10	14	15
Length-of-stay was too short	9	13	10	9	9
Did not have enough input about treatment during hospitalization	17	22**	18	22**	16

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

^a Hospital care ratings were reported only by those who had been hospitalized in the past two years.

** $p < .05$ for differences with the United States.

critical of nursing services in their hospitals.

Also, a substantial minority of the elderly population in each country who had been hospitalized reported not having enough of a say in treatment decisions during their recent hospital stay.

■ **Caregiving and home care.** Given the frail health of the elderly population, we asked if elderly respondents in each of the five countries had provided care for a frail or disabled person in the past two years, or if respondents themselves had needed assistance. Findings in Exhibit 6 show somewhat consistent proportions of these populations providing such care to others, although the British were somewhat less likely than Americans or Canadians were to say that they provided this kind of informal care. Rather dramatic differences are seen across the countries in informal caregivers' perception that they could not get the assistance they needed to care for their loved one. Elderly Britons were most likely and elderly Americans least likely to have experienced a time without needed assistance. Proportions of respondents who said that they themselves needed assistance range from 9 percent to 16 percent. Of those who received paid help, U.S. respondents were least likely to report that it was paid for by family members and most likely to report that they had received government help with these costs. The British elderly were most likely to rely on family help and least likely to report receiving public assistance for these costs.

■ **Future concerns.** We asked respondents to voice their concerns about several issues, including the costs of their future care and their needs for long-term care financial assistance (Exhibit 7). The elderly in New Zealand worry more about their health care-related financial problems than respondents in the other countries do. On all measures shown in the exhibit, 19–25 percent of New Zealanders reported being very concerned about affording medical and long-term care and becoming a burden to their families. In the United States similar proportions expressed concerns about affording long-term care and other medical care. These findings are notable, given the higher levels of dissatisfaction with these health sys-

EXHIBIT 6**Caregiving And Home Health Care For Persons Age Sixty-Five And Older, 1999**

	AUS	CAN	NZ	UK	US
Percent who were a caregiver for a frail/disabled person in the past two years	21%**	25%	25%	19%**	27%
Percent of caregivers with unmet need for assistance	15	19**	20**	32**	10
Percent who themselves needed help	10	14**	16**	12	9
Percent with paid help for which the family paid	19	14	14	23**	10
Percent with paid help for which the government paid	51**	62**	67	40**	75

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

** $p < .05$ for differences with the United States.

EXHIBIT 7

Elderly Consumers' Concerns About Their Future Health Care, In Australia, Canada, New Zealand, The United Kingdom, And The United States, 1999

Percent "very concerned" that they	AUS	CAN	NZ	UK	US
Will have to leave their present abode because of a health problem	10%**	13%	19%	11%**	16%
Will not have enough money or insurance for needed long-term care services	12%**	14%**	24	12%**	22
Will become a burden to the family	13%**	13%**	25%**	13%**	19
Will not be able to pay for needed care	11	14	25	10	21

SOURCE: Commonwealth Fund/Harvard/Harris 1999 International Health Policy Survey of the Elderly.

NOTE: Persons age sixty-five and older.

** *p* < .05 for differences with the United States.

tems, but also because the elderly in these two nations who receive home health assistance are most likely to get it from the government or some public insurance plan. Elderly Americans also were least likely to report unmet need for assistance for informal caregivers. While the conclusions we can draw from these data are limited because of small sample subgroup size, given the small proportions of persons needing and using home and long-term care services, the combination of public- and private-sector financing seems to be providing important protections.

Summary And Policy Implications

As we enter the new century, this survey finds that the majority of the elderly in all five countries are generally satisfied with the quality, affordability, and availability of their health services. In many measures of access to and costs of care, the United States looks much like these other nations—a testament to the protections offered by Medicare. However, as the elderly view their health systems, the direction they have taken in recent years in caring for the elderly, and the future affordability of care in old age, more problems can be seen, particularly in the United States and New Zealand.

A majority of the elderly in all countries (70 percent or more in the United States and New Zealand) would like to see major changes in their health care systems to make them work better. Serious concerns about not having enough money to pay for long-term care are also more pronounced in those two nations. In both countries, however, these system-level concerns do not translate into dissatisfaction with quality of care. Waiting times for care and barriers to seeing medical specialists were reported more frequently in Canada and the United Kingdom, and yet these are nations where health system ratings are highest.

The divide we have long observed in the United States between ratings of health systems and individual health care services can also

“In all five countries universal health coverage for the elderly has provided protection from most financial problems.”

be seen in these other countries. In general, in our prior studies these health system ratings tend to reflect public concerns with issues of affordability of care and access to services rather than the quality of personal health care services.⁷ The elderly in these five countries generally have good financial access but express concern that it will not last. Serious public debates about the financing and delivery of care are taking place in all of these countries and may be helping to shape future expectations and worry.

■ **Medicare drug coverage.** Given the current U.S. debate over Medicare prescription drug coverage, the survey data have special relevance. Elderly Americans clearly lag behind their counterparts in other nations. In all other countries surveyed the vast majority of the populations have at least some coverage and very low out-of-pocket spending for prescription drugs. Although in all countries, including the United States, there do not appear to be substantial financial barriers to filling prescriptions, Americans who lack a drug benefit and incur high out-of-pocket costs are also likely to have problems paying their medical bills, meeting daily living expenses, and affording needed prescriptions. It appears that the elderly without drug coverage, unlike the nonelderly without health insurance, are as likely as those with coverage to fill their needed prescriptions but bear the adverse burdens of the added cost.

■ **Universal health coverage.** Despite the variations in the responses of the elderly in these five nations, two final common themes are evident and important to highlight. First, in all five countries surveyed, universal health coverage for the elderly has provided protection from most problems of financial access to care and generally led to widespread contentment with the quality of available medical care. While we need to acknowledge that this is a survey of elderly persons living in noninstitutional settings and healthy enough to be surveyed, there is much good news in these data. The policies that these nations have put in place to protect older citizens from financial worries due to health costs are functioning well.

Second, there is reason for future concern about erosion of those protections in all countries as these populations age, the number of retirees grows, and health care costs increase. In all countries surveyed, large portions of the elderly have difficulty meeting living expenses. Future concerns include the prospect of not having enough money for retirement and worry about the future affordabil-

ity of acute and long-term care services. The current state of health system reform, the direction reform has taken in the recent past, and the future affordability of care appear to be the strongest forces driving dissatisfaction in the nations where discontent is highest.

■ **Future challenges.** In the future, all five nations will struggle to maintain income and health security, especially in times of economic downturn, with a growing share of elderly citizens and fewer working persons to support the retired populations. This picture could change as people live longer, more productive lives and retire at a later age. On a positive note, in the United Kingdom, where the proportion of the population age sixty-five and over is already as large as the U.S. share will be in another generation, the elderly do not see the need for major system change and experience few cost problems.⁸ The problems that are seen in perceptions of quality of care and access to home care services may presage the challenges to come in providing needed services for more elderly citizens. The question for the future is how policymakers can maintain public confidence while trying to strike a balance between fiscal reality and the growing needs of these populations.

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NOTES

1. G.F. Anderson and P.S. Hussey, "Population Aging: A Comparison among Industrialized Countries," *Health Affairs* (May/June 2000): 191-203.
2. K. Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* (May/June 1999): 206-216; K. Donelan et al., "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs* (Summer 1996): 254-265; and R.J. Blendon et al., "Who Has the Best Health Care System? A Second Look," *Health Affairs* (Winter 1995): 220-230.
3. For more details on survey procedures, contact Karen Donelan, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts, 02115.
4. Donelan et al., "The Cost of Health System Change."
5. *Ibid.*
6. *Ibid.*
7. *Ibid.*
8. Anderson and Hussey, "Population Aging."