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How Health Insurance Design Affects Access To Care And Costs, By Income, In Eleven Countries

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ABSTRACT This 2010 survey examines the insurance-related experiences of adults in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United States, and the United Kingdom. The countries all have different systems of coverage, ranging from public systems to hybrid systems of public and private insurance, and with varying levels of cost sharing. Overall, the study found significant differences in access, cost burdens, and problems with health insurance that are associated with insurance design. US adults were the most likely to incur high medical expenses, even when insured, and to spend time on insurance paperwork and disputes or to have payments denied. Germans reported spending time on paperwork at rates similar to US rates but were well protected against out-of-pocket spending. Swiss out-of-pocket spending was high, yet few Swiss had access concerns or problems paying bills. For US adults, comprehensive health reforms could lead to improvements in many of these areas, including reducing differences by income observed in the study.

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In 2010 the Commonwealth Fund conducted its thirteenth annual health policy survey with a broad focus on access, cost, and care experiences. To gain insights into how the coverage designs of various countries affect access to health care, financial protection when sick, and the complexity of health insurance, this study focused on experiences in these areas. Adults in eleven countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—were surveyed.

The eleven countries have diverse insurance and care systems.[1] For example, in the United Kingdom, coverage as well as much of the care is provided through the public National Health Service. The United States has a mixed system of private coverage, generally employment based, along with substantial publicly funded coverage through Medicare, Medicaid, and other programs. Germany has Europe's oldest system of universal coverage, in which competing insurers offer a standard comprehensive benefit package and higher-income households are allowed to opt out of statutory "sickness funds" to purchase private coverage (10 percent of the population chose to do so in 2009). Switzerland and the Netherlands require residents to purchase a standard, comprehensive health insurance package, offered by nonprofit private insurers in Switzerland and by a mix of nonprofit and for-profit insurers in the Netherlands. All of the countries in the study allow some role for private insurance either for extra benefits or to cover some portion of patients' cost sharing.

Benefits And Cost Sharing

Among the eleven countries, the structure of insurance coverage varies greatly in terms of core benefits, financial protection afforded consum-

ers, levels of required cost sharing, income-related provisions for premiums or benefits, and the roles of private insurance in each country. For example, all but Canada, the Netherlands, and the United Kingdom include cost sharing for primary care and often for other medical services as well (Exhibit 1). Only in the United States, Switzerland, and the Netherlands does health insurance carry deductibles on core benefits. In nationally defined benefits, all Swiss and Dutch health plans have a deductible, with higher deductibles offered in exchange for lower premiums. The Dutch deductible does not apply to primary care.[2]

COST SHARING Among the eleven countries, the United Kingdom goes furthest to protect its citizens from out-of-pocket medical spending. There is little or no cost sharing for medical care and benefits are comprehensive, including dental care and prescription drugs.

Canada's national health insurance program, Medicare, has no cost sharing for primary care or other covered benefits. However, core benefits under Canada's Medicare do not include outpatient prescription drugs or dental or home health care. Most Canadian provinces cover part of the cost of medications for elderly and low-income patients, although the generosity of this coverage varies across provinces.

New Zealand, which has a publicly funded system, has historically included significant cost sharing for primary care. However, recent reforms have lowered or eliminated these out-of-pocket costs to promote access and support primary care teams.

France includes significant cost sharing in its public health insurance system, but this is generally covered by supplemental private insurance that most residents buy and that the government provides for low-income citizens. In addition, France has a special program that eliminates cost sharing for people with any of thirty specified chronic conditions. French health insurance also covers medications with a "value-based" design for prescription drugs, featuring tiers that eliminate or lower cost sharing for highly effective medications, regardless of price.[3]

Germany has income-related out-of-pocket maximums that limit annual costs for patients and families to 1–2 percent of income. Switzerland, Sweden, and Norway have cost sharing for most services. Each of these three countries caps annual expenses, with annual caps ranging from less than US$300 in Sweden and Norway to nearly US$700 in Switzerland, in addition to the deductible (Exhibit 1).

PRIVATE INSURANCE Germany is unique among countries that have universal coverage in allowing higher-income households to opt out of social insurance and buy market-based private coverage. In contrast, France and Australia rely on private insurance to supplement cost sharing and expand benefits. Private insurers play a less prominent role in New Zealand, mainly to pay for care in private hospitals.

The Dutch and Swiss rely on private insurers to provide required core benefits in a tightly regulated marketplace. Additionally, most adults in both countries buy extra coverage. The Dutch usually purchase extra coverage for physical therapy and dental benefits. Many Swiss purchase extra coverage for some cost sharing, care outside local cantons, and extra benefits such as dental care.

In Canada, private insurance supplements public-coverage benefits not covered by Canada's Medicare, including prescription drugs, physical therapy, home care, and dental care. Private insurance in Sweden and Norway purchases faster access as well as access to private providers; it accounts for a small share of total health care expenses.

Germany, the Netherlands, and Switzerland include insurance mandates and operate exchanges that offer consumers a choice of competing plans. In Switzerland and the Netherlands, these are private plans operating under local and national oversight. In Germany, regional "sickness funds" compete for members, who are allowed to switch funds if they choose.

Germany, the Netherlands, and Switzerland all include risk-adjustment features that compensate health plans for the varying levels of health risk that their enrollees represent. This risk adjustment seeks to focus competition on performance, rather than on signing up the healthiest enrollees. All three of these countries also employ joint negotiations between health insurers and providers, multipayer fee schedules, and common methods of paying hospitals, yet they also seek to give insurers flexibility to innovate and integrate care.[4–5]

Switzerland and the Netherlands require their citizens to pay premiums toward their coverage. In these countries, income-related premium assistance is provided to 30–40 percent of the population. Germany finances insurance by requiring participants to pay a percentage of income as contributions to sickness funds.

Germany and the Netherlands include employer as well as individual contributions, supplemented by general revenues. Switzerland does not require employers to contribute.

Even after health reform, the United States will remain unique for splitting the population into different insurance programs according to age and income. In the other countries, insurers cover people of all ages and income levels.

EXHIBIT 1

Health Insurance Profiles Of Eleven High-Income Countries, 2010

Country (2008 per capita spending on health care; population)[a]	Benefit package				Role of private insurance	Provisions for low-income patients
	Deductible	Annual out-of-pocket maximum	Medication: core benefit	Cost sharing for primary care visits		
Australia (US$3,353 in 2007; 21.4 million)	No	80% out-of-pocket subsidy if exceeds AUS$1,126 (US $1,033)	Yes	Yes[b]	50% buy coverage for suppl. cost sharing and access to private facilities	Lower cost sharing; lower out-of-pocket maximum before 80% subsidy
Canada (US$4,079; 33.1 million)	No	No	No[c]	No	Approx. 67% buy coverage for extra benefits	Some cost-sharing exemptions; varies by province[c]
France (US$3,696; 61.8 million)	No	No	Yes	Yes	90% buy coverage for suppl. cost sharing and some extra benefits	Supplements cost sharing; exemption for chronic disease
Germany (US$3,737; 82.1 million)	No	2% of income; 1% for patients with chronic diseases and low incomes	Yes	Yes	Approx. 20% buy coverage for suppl. cost sharing and amenities; 10% buy a substitute and opt out of social insurance	Income-related contribution for insurance; out-of-pocket maximum 1% of income
Netherlands (US$4,063; 16.4 million)	€165–665 (US $219–$883)	No	Yes	No	Private plans provide core benefits; 80% buy extra benefits	Income-related premium assistance (approx. 40% receive)
New Zealand (US$2,683; 4.3 million)	No	Subsidies after 12 doctor visits or 20 prescriptions in previous year	Yes	Yes	Approx. 33% buy coverage for suppl. cost sharing, private facilities, and specialists; small share of total spending	Lower cost sharing
Norway (US$5,003; 4.8 million)	No	NOK 1,615 (US$271)	Yes	Yes	Fewer than 5% buy coverage for faster access and use of private providers	None
Sweden (US$3,470; 9.2 million)	No	SEK 900 (US$127) for health services; SEK 1,800 (US$254) for pharmaceuticals	Yes	Yes	Fewer than 5% buy coverage for faster access and use of private providers	None
Switzerland (US$4,627; 7.6 million)	300–2,500 CHF (US $289–$2,405)	700 CHF (US$673) maximum after deductible	Yes	Yes	Private plans provide core benefits; 70% buy extra benefits	Income-related premium assistance (30% receive); deductible exemption
United Kingdom (US$3,129; 60.5 million)	No	No	Yes	No	Approx. 10% buy coverage for benefits and private facilities	Cost-sharing exemption
United States[d] (US$7,538; 304.5 million)	Yes, no limit	No	Yes for Medicaid, Medicare w/ supplement	Yes	66% have private primary insurance; supplements and substitutes for Medicare	Medicaid separate; 2010 reforms lower premium and cost sharing starting in 2014

SOURCES Note 1 in text; and Organization for Economic Cooperation and Development. OECD health data 2010: statistics and indicators. Paris: OECD; 2010 Jun 29. For percentage with private coverage: 2010 Commonwealth Fund international survey in eleven countries. **NOTES** Currency converted to US dollars using http://oanda.com on August 9, 2010. [a]Spending adjusted for cost of living. [b]To make services free or low cost to patients, the majority of Australian primary care providers directly bill the government for the covered amount (referred to as "bulk billing"). [c]Varies by province; there is no national requirement for core Canadian Medicare benefits. [d]Before passage of the Affordable Care Act.

Study Design And Methods

The survey consisted of computer-assisted telephone interviews of random samples of adults age eighteen or older in eleven countries, using a common questionnaire that was translated and adjusted for country-specific wording as needed. Harris Interactive and country subcontractors conducted the interviews from March though June 2010 (the field times varied by country). The final country samples, shown in Exhibit 2, ranged from 1,000 to more than 3,500.[6,7]

The analysis weighted final samples to reflect the distribution of the adult population in each country.[9] The margin of sample error for country averages is approximately plus or minus 2 percent for Australia, Canada, Sweden, and the United States, and plus or minus 3 percent for the other countries, at the 95 percent confidence level. Exhibits 2–4 display the country results and are repeated in the Technical Appendix with statistical tests that compared each country to the other ten. In the text, the discussion focuses on differences that were statistically significant (see the Technical Appendix for full results).[8]

To examine experiences within countries by income, we told respondents what the median household income in their country was and asked them if their income was much or somewhat above the country "average" (referring to median), close to the average, or somewhat or much below the average. We refer hereafter to the median as the average, the term we used with respondents.

We used responses to create three groups: below average, about average, and above average. This method did not result in equal groups, because respondents were the judge of what was about average. Our analysis compared the below-average and the above-average groups, omitting the middle group.

Given that low-income adults in all countries were more likely than their higher-income peers to be elderly and to have multiple chronic conditions, we conducted country-specific logit multivariate regressions to examine whether income differences persisted after we controlled for health, age, and—in the United States—insurance status. Exhibits 5 and 6 display adjusted percentages for above- and below-average income groups. The Technical Appendix provides demographics and regression results.[8]

Confidence, Affordability, And Costs

The survey asked adults about how confident they were in their ability to afford health care if they became seriously ill. It also asked about their experience with cost-related access problems and cost burdens. US adults were the most negative about affordability (Exhibit 2). They were significantly less likely than adults in all other countries to have confidence in their ability to afford care. They were also significantly more likely than adults in other countries to have

EXHIBIT 2

Adults' Confidence In And Cost-Related Experiences With Health Care In Eleven High-Income Countries, 2010

	Percent of adults who							
	Were confident/very confident that if seriously ill they would		Had problems with access because of cost in previous year			Had out-of-pocket medical spending in previous year		
Country (sample size)	Receive most effective treatment, including drugs, diagnostic tests	Be able to afford care needed	Did not see doctor when sick or did not get recommended care	Did not fill Rx or skipped doses	Had either access problem	$200 or less	$1,000 or more	Had serious problem paying or were unable to pay medical bills in previous year
AUS (3,552)	76	64	18	12	22	35	21	8
CAN (3,302)	76	68	8	10	15	51	12	6
FRA (1,402)	85	73	9	7	13	47	4	9
GER (1,005)	82	70	23	6	25	41	8	3
NETH (1,001)	88	81	4	3	6	39	9	4
NZ (1,000)	84	75	12	7	14	61	7	6
NOR (1,058)	70	69	8	6	11	33	16	5
SWE (2,100)	67	70	6	7	10	50	2	5
SWI (1,306)	89	78	9	4	10	20	25	6
UK (1,511)	92	90	5	2	5	76	1	2
US (2,501)	70	58	28	21	33	31	35	20

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. **NOTE** Significance tests are available in the Technical Appendix, which can be accessed by clicking on the Technical Appendix link in the box to the right of the article online.

EXHIBIT 3

Adults' Experiences With Access To Health Care In Eleven High-Income Countries, 2010

	Percent of adults who							
	Saw a doctor or nurse last time they needed care		Needed after-hours care or used the ED and reported		Waited to see specialist[a]		Waited for elective surgery[b]	
Country	Same or next day	Waited 6 days or more	Somewhat/very difficult to obtain care after hours[c]	ED use in past 2 years	Less than 4 weeks	2 months or more	Less than 1 month	4 months or more
AUS	65	14	59	33	54	28	53	18
CAN	45	33	65	44	41	41	35	25
FRA	62	17	63	27	53	28	46	7
GER	66	16	57	22	83	7	78	0
NETH	72	5	33	26	70	16	59	5
NZ	78	5	38	29	61	22	54	8
NOR	45	28	45	26	50	34	44	21
SWE	57	25	68	35	45	31	34	22
SWI	93	2	43	22	82	5	55	7
UK	70	8	38	25	72	19	59	21
US	57	19	63	37	80	9	68	7

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. **NOTES** Sample sizes for each country are reported in Exhibit 2. Significance tests are available in the Technical Appendix, which can be accessed by clicking on the Technical Appendix link in the box to the right of the article online. ED is emergency department. [a]If they needed to see a specialist within the two previous years. [b]If they had elective surgery within the two previous years. [c]If they answered the question and had needed after-hours care.

gone without care because of cost, to have spent $1,000 or more out of pocket on medical care, and to have had serious problems paying medical bills during the previous year.

A lower proportion of adults in the United States than in all other countries except Sweden and Norway were confident that they would receive the most effective treatment when needed. UK, Swiss, and Dutch adults were the most confident (Exhibit 2).

Patterns regarding affordability, cost-related access, and problems with medical bills in the eleven countries tended to track insurance coverage design. With comprehensive benefits and nominal cost sharing, UK and Dutch adults were the most confident that they would be able to afford care and the least likely to have gone without care because of costs.

Out-of-pocket spending of US$1,000 or more was rare in Germany and France, probably reflecting German income-related limits and French provisions for people with chronic conditions.

New Zealand and Swedish coverage also protects people from substantial out-of-pocket spending. Half or more of adults paid less than US$200 out of pocket during the year, and few incurred high expenses or had problems paying medical bills. The percentage of New Zealanders going without care because of costs has dropped significantly since 2004, when it was 34 percent. The drop suggests that the country's policies to lower patients' primary care costs have been effective.[10]

At the other end of the spectrum, 21 percent of adults in Australia, one-fourth in Switzerland, and one-third in the United States spent US $1,000 or more. Norwegian adults were also more likely to incur high out-of-pocket spending than adults in the remaining seven countries.

The United States is the only country in which one-fifth of adults reported serious problems paying health care bills. In contrast, at most 9 percent of adults in other countries (8 percent Australia and 9 percent France) reported serious problems paying bills.

US adults' exposure to costs results from insurance benefit gaps as well as a high percentage of adults without insurance. Adults who had been insured the entire previous year were about as likely to spend US$1,000 or more as were those who had been uninsured. Among US adults under age sixty-five, 38 percent of those insured all year and 35 percent of those who were uninsured at some point during the year spent $1,000 or more during the year (see the Technical Appendix).[8] Reflecting prescription cost sharing or benefit gaps, Australian, Canadian, and US adults were the most likely to skip medications because of cost.

The contrast between the United States and Switzerland is notable for cost-related concerns. Both countries allow deductibles, yet Swiss insurance caps annual spending and offers a choice of relatively low deductibles, and premiums are subsidized for low-income people. When

EXHIBIT 4

Adults' Difficulty Dealing With Health Insurance In Eleven High-Income Countries, 2010

	Percent of adults in past year who		
Country	"Spent a lot of time on paperwork or disputes" for medical bills or insurance	Reported "insurance denied payment" or "did not pay as much as you expected"	Had either difficulty or both difficulties
AUS	6	11	14
CAN	6	12	15
FRA	11	18	23
GER	16	11	23
NETH	8	15	20
NZ	4	4	6
NOR	8	2	9
SWE	3	2	4
SWI	6	10	13
UK	3	2	5
US	17	25	31

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. NOTE Significance tests are available in the Technical Appendix, which can be accessed by clicking on the Technical Appendix link in the box to the right of the article online.

surveyed, more than half of very-low-income Swiss respondents had opted for the low deductible (data not shown). The combination of subsidized premiums and low deductibles for people facing budget constraints probably contributes to the comparatively low rates of Swiss who went without care because of costs or were unable to pay bills.

Waiting Times

To assess the responsiveness of the health care system, the survey asked about waiting times. Although a significant majority of adults in all eleven countries had a regular doctor or place of care, experiences varied widely in terms of timely visits to providers when sick, wait times for specialists or elective surgery, and after-hours access to care (Exhibit 3).

Switzerland stands out for rapid access: 93 percent of the Swiss respondents had received a same- or next-day appointment the last time they were sick. Swiss adults, along with German and US adults, were more likely than adults in the other countries to report quick access to specialists (Exhibit 3). In all three countries, long waits for specialists or elective surgery were rare.

Majorities of New Zealand, Dutch, and UK adults also receive timely primary care: 70 percent or more reported that they received care the same or the next day.[11] In contrast, one-fourth or more of Canadian, Swedish, and Norwegian adults reported having to wait six days or more to see a doctor or nurse when sick (Exhibit 3).

Adults in those three countries were also the most likely to report having to wait two months or more for specialists, and—along with UK adults—to wait four months or more for elective surgery. Although the share of UK adults waiting four months or more was high, the majority of UK adults received care within a month—a significant increase from earlier surveys.[12]

The countries varied in their capacity to provide care twenty-four hours a day, seven days a week, outside of hospital emergency departments (EDs). About two-thirds of adults in Canada, France, Sweden, and the United States said it was difficult to get after-hours care without going to the emergency department—nearly twice the rate reported in the Netherlands, New Zealand, and the United Kingdom (Exhibit 3). One-third or more Australian, Canadian, Swedish, and US adults said that they had gone to the emergency department in the previous two years—higher rates than reported in the other countries. Half of those with ED use had two or more visits (data not shown).

Insurance Complexity

Adults' responses varied widely by country in terms of the amount of time spent on insurance paperwork or disputes, and of lack of certainty about what insurance would cover (Exhibit 4). Overall, US adults were the most likely to report spending a lot of time on paperwork or disputes (17 percent), followed closely by adults in Germany (16 percent).

US adults were also more likely to report that they were denied insurance reimbursement or were reimbursed less than they expected (25 percent), followed by adults in France (18 percent).

25%

Of US Adults

US adults (25 percent) were the most likely to report that they were denied insurance reimbursement or received less than they expected.

EXHIBIT 5

Adults' Views Of Health Care And Costs, By Income Level, In Eleven High-Income Countries, 2010

Country, income level (sample size)	Percent who were confident or very confident that they would receive most effective treatment	Percent who were confident or very confident that they would be able to afford needed care	Percent who experienced at least one access barrier due to cost	Percent who had out-of-pocket spending of $200 or less	Percent who had out-of-pocket spending of $1,000 or more	Percent who had serious problems paying or were unable to pay medical bills
AUSTRALIA						
Above average (855)	79[a]	77[a]	12[a]	23[a]	31[a]	5[a]
Below average (1,649)	73	56	22	44	16	10
CANADA						
Above average (1,155)	80[a]	79[a]	6[a]	48	17[a]	2[a]
Below average (1,161)	71	51	18	51	12	9
FRANCE						
Above average (619)	88	78[a]	8[a]	41[a]	5	2[a]
Below average (508)	85	67	17	53	5	13
GERMANY						
Above average (289)	82	77[a]	17[a]	40[a]	10[a]	1[a]
Below average (223)	78	62	27	52	5	7
NETHERLANDS						
Above average (488)	88[a]	87[a]	3[a]	37	11	2[a]
Below average (224)	81	65	13	42	7	11
NEW ZEALAND						
Above average (296)	87[a]	85[a]	8[a]	56[a]	11[a]	2[a]
Below average (419)	78	67	15	68	6	6
NORWAY						
Above average (638)	72[a]	79[a]	4[a]	30[a]	16	1[a]
Below average (201)	63	57	21	39	15	10
SWEDEN						
Above average (917)	70[a]	79[a]	5[a]	52	2	2[a]
Below average (598)	58	61	14	49	2	9
SWITZERLAND						
Above average (354)	91[a]	86[a]	7[a]	19[a]	34[a]	2[a]
Below average (569)	86	67	12	26	20	9
UNITED KINGDOM						
Above average (342)	95	93[a]	4	88	0	2
Below average (274)	92	87	4	86	0	3
UNITED STATES						
Above average (853)	82[a]	74[a]	20[a]	24[a]	45[a]	9[a]
Below average (861)	65	50	39	38	29	24

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. **NOTES** Percentages were adjusted based on logistic regression to control for health status, age, and—in the United States—insurance status. Average is the median. [a]Indicates significant within-country differences with below-average income ($p < 0.05$).

The comparatively high rates may reflect insurance complexity or recent changes in coverage. Including both questions about spending time on paperwork or insurance not paying as expected, 31 percent of US adults encountered some type of insurance concern in the past two years—the highest rate in the survey.

US adults under age sixty-five were significantly more likely to report insurance paperwork, disputes, or insurance surprises than were those sixty-five and older and covered by Medicare (35 percent compared to 16 percent). The high rates of insurance concerns among younger adults may stem from unstable coverage as well as complex benefit designs. One-third said that they had changed plans in the past three years, often more than once (see the Technical Appendix for contrasts between groups under age sixty-five and age sixty-five and older).[8]

In addition to adults in the United States, French, German, and Dutch adults were more likely than adults in other countries to report one of the two types of insurance concerns. The higher rates may reflect either complexity

EXHIBIT 6

Access To Care And Insurance Complexity, By Income, In Eleven High-Income Countries, 2010

Country, income level	Percent who saw doctor or nurse last time they needed care: Same or next day	Percent who saw doctor or nurse last time they needed care: Waited 6 days or more	Percent who needed after-hours care or used ED: Somewhat/very difficult to obtain care after hours[a]	Percent who needed after-hours care or used ED: ED use in past 2 years	Percent who waited to see specialist[b]: Less than 4 weeks	Percent who waited to see specialist[b]: 2 months or more	Percent who experienced insurance difficulty[c]
AUSTRALIA							
Above average	64	13[d]	60	31	57[d]	26[d]	20[d]
Below average	60	18	63	33	50	31	13
CANADA							
Above average	45[d]	32[d]	64[d]	37[d]	44[d]	40	16
Below average	37	43	72	43	36	45	15
FRANCE							
Above average	59	15	59[d]	23	56[d]	29	25
Below average	60	17	67	26	49	30	25
GERMANY							
Above average	70	14	56	19	81	8	19
Below average	62	18	55	21	82	9	19
THE NETHERLANDS							
Above average	76[d]	5	31[d]	25	68	15[d]	21
Below average	66	7	44	22	64	24	22
NEW ZEALAND							
Above average	81	6	34	25	69[d]	14[d]	9[d]
Below average	77	6	37	27	53	26	4
NORWAY							
Above average	45	27	40[d]	23	51	35	5
Below average	45	31	52	29	48	35	7
SWEDEN							
Above average	56	21[d]	67	31	45	32	3
Below average	51	28	70	35	45	31	5
SWITZERLAND							
Above average	91	3	43	21	79[d]	7[d]	11
Below average	93	3	42	22	89	3	15
UNITED KINGDOM							
Above average	65	11	31[d]	26	68	18	4
Below average	61	10	47	26	66	28	5
UNITED STATES							
Above average	65[d]	13[d]	55[d]	30[d]	83[d]	7	29
Below average	54	22	68	38	76	10	31

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. **NOTES** Percentages were adjusted based on logistic regression to control for health status, age, and—in the United States—insurance status. Average is the median. ED is emergency department. [a]If they answered the question and had needed after-hours care. [b]If they needed to see a specialist within the two previous years. [c]Spent a lot of time on insurance paperwork or received less from insurance than expected. [d]Indicates significant within-country differences with below-average income ($p < 0.05$).

or changes in coverage in recent years. Notably, the percentage of Dutch adults who cited paperwork concerns has dropped substantially (from 31 percent to 8 percent) since 2007, the year after the Netherlands switched to competing insurers and a time of high rates of switching plans.[12] The rate at which Dutch adults changed from one plan to another has now returned to pre-2006 levels of 3–5 percent a year (data not shown).

Reports of excessive paperwork or disputes about insurance were rare in New Zealand, Norway, Sweden, and the United Kingdom (less than 10 percent). These four—unlike the other countries—operate unified health systems in which patients pay user fees when they access care providers, instead of requiring insurance claims for patients to be reimbursed.

Experiences By Income

In all countries, adults with below-average incomes were significantly more likely than adults with above-average incomes to have multiple chronic conditions and to be older (Technical

Poorer adults are more likely to need health care and less likely to have the resources to afford it on their own.

Appendix 2).[8] This puts poorer adults doubly at risk: They are more likely to need health care and less likely to have the resources to afford it on their own. Lower-income US adults under age sixty-five are also at high risk of being uninsured. Of these adults, 27 percent either were uninsured at the time of the survey or had been uninsured earlier in the year.

To examine the extent to which confidence, access, cost, and insurance experiences differ by income, Exhibits 5 and 6 compare adults with above-average incomes to those with below-average incomes, controlling for health, age, and—in the United States—whether they were insured all year (Technical Appendix).[8,13] The results of the regression analyses reveal some shared but also some distinct country patterns. Although experiences varied by income in several countries, overall, the United States stands out for persistent and wide differences by income, with more negative experiences for those with below-average incomes.

CONFIDENCE, ACCESS, AND COSTS BY INCOME High out-of-pocket spending ($1,000 or more) was rare for both low- and high-income adults in France, Sweden, and the United Kingdom (Exhibit 5). In the other countries, with the exception of Norway, adults with below-average incomes were much less likely than adults with above-average incomes to report high out-of-pocket spending. Although Swiss and US lower-income adults were less exposed to such spending than those with higher income, poorer adults in those countries had rates of high out-of-pocket spending well above the rates of above-average-income adults in all the other countries except Australia.

The income differences on cost-related access barriers and problems paying medical bills were significant in all countries except the United Kingdom. The gap was widest in the United States, even after health, age, and insurance status were adjusted for.

In all countries, lower-income adults were less likely than higher-income adults to be confident that they would be able to afford the care they need. UK low-income adults were the most confident about affording care and receiving the most effective treatment, with little to no significant income differences. Confidence in getting high-quality care was also relatively high among low-income adults in France, Germany, the Netherlands, New Zealand, and Switzerland.

WAITS AND INSURANCE COMPLEXITY, BY INCOME Income differences also emerged in the time spent waiting to see a doctor and access to after-hours care in several countries (Exhibit 6). Rapid access to health care when sick varied significantly by income in Canada, the Netherlands, and the United States. The widest income gap was in the United States.

Waiting-time patterns by income group generally tracked country averages. Canadian low-income adults were the least likely to get same- or next-day appointments and most likely to wait six days or longer. Low-income Swiss were the most likely to get rapid access to care when sick and when they needed to see specialists. Indeed, Switzerland was the only country where lower-income adults were significantly more likely than higher-income adults to report short waits to see specialists.

There were significant differences by income for waits to see specialists in Australia, Canada, France, New Zealand, the Netherlands, and the United States. However, waits to see specialists in the United States were relatively short for both income groups.

After-hours and ED use patterns by income may reflect differences in local community resources as well as in income. Lower-income adults were significantly more likely than higher-income adults to report difficulty getting after-hours care in Canada, France, the Netherlands, Norway, the United Kingdom, and the United States, but not in the other countries. Canada and the United States were the only countries where significant income differences in ED use persisted after health status was controlled for, and rates were high for both income groups.

Reports of insurance complexity varied little by income within countries, with the exception of Australia. There, high-income adults were more likely to report being denied payment or not receiving what they expected from insurance plans. The concerns may stem from private insurance interactions with public insurance: 72 percent of above-average-income Australians said that they had purchased private coverage in addition to public coverage (data not shown). Australia permits higher charges and the use

of private hospitals for those with private insurance.

Overall, across countries (Exhibits 5 and 6), the United Kingdom had the fewest significant differences in access and affordability by income, and the United States had the most. Differences by income, with low-income adults more at risk, also emerged on cost-related measures in several other countries. Strikingly, however, these did not always translate into disparities in waiting times or after-hours use.

US income differences were generally the widest, even after health, age, and insurance status were controlled for. US adults with above-average income also tended to report more cost-related concerns and experiences with insurance hassles than their counterparts in most of the other countries.

US ADULTS UNDER AGE SIXTY-FIVE In the United States, negative experiences were concentrated in adults under age sixty-five. Coverage was especially uncertain and unstable for adults with below-average incomes. In this group, 50 percent either were uninsured at the time of the survey (28 percent) or had been uninsured earlier in the year (22 percent; data not shown). Adults under age sixty-five with average incomes also faced gaps: 24 percent were uninsured when surveyed or said they that were uninsured earlier in the year.

Although US adults who had been uninsured at some point were at greatest risk for cost or access concerns, US adults under age sixty-five who had been insured all year but who had below-average incomes also reported high rates of concern. In fact, they were more likely to report going without care because of costs or medical bill problems than adults of all ages in the other countries and than US low-income adults age sixty-five and older (Technical Appendix Table 1).[8]

Discussion And Implications

Overall, the study indicates that insurance design can affect access and cost, as well as patients' experiences interacting with insurers. A general population survey such as ours is limited by the extent to which adults can provide accurate estimates of their spending, and by the extent to which it misses hard-to-reach vulnerable populations and thus may understate areas of concern.

However, the survey method's strength is in providing information on current patient experiences to help monitor efforts to improve quality and access and reduce costs. The variations across countries provide insights and point to challenges ahead for the United States as it implements health reform.

ACCESS AND COSTS Among the countries with cost sharing, adults with annual limits or exemptions reduced cost burdens, especially for those with lower incomes, and made it less likely that patients would go without care because of its cost. Still, there were significant income differences on cost-related concerns about access and problems paying bills in all countries except the United Kingdom, which has negligible user fees. The gaps we found support the results of other studies that find that low-income patients, especially those with chronic diseases, are highly sensitive to price for both essential and less-essential care.[14,15]

At the same time, the contrasts among countries indicate that it is possible to design cost sharing to protect access and reduce income disparities. Switzerland has relatively high deductibles and cost sharing. Yet annual limits and exemptions, combined with transparent pricing and billing, appear to allow the Swiss to budget for health care costs and avoid insurance disputes or surprises. Swiss fee-for-service payments by insurers to doctors are the same within a geographic area, regardless of patients' incomes, which promotes equity.

Insurance is clearly only part of the access story. Significant country differences in getting care when needed and waits to see specialists highlight variable success in organizing easy access. Adults in Sweden, Norway, and Canada reported waits to see primary care providers as well as to see specialists that exceeded those reported in other countries.[16] Efforts to address these issues are under way in these countries.

The high percentage of Dutch and New Zealanders reporting rapid access when sick and finding it easy to get after-hours care points to the potential benefits of primary care teams and community-based shared services.[17,18] The Swiss also reported rapid access to primary care. Swiss physicians are required to organize round-the-clock coverage and are paid extra for after-hours care (personal communication to Robin Osborn from Thomas Zeltner, the former Swiss secretary of health, August 6, 2010).

INSURANCE COMPLEXITY Complex and changing US benefit designs plus the lack of transparency in what insurance will pay or what providers will charge contribute to the high percentage of US adults reporting disputes or surprises having to do with reimbursements. Lack of uniformity, even for lists of covered drugs, consumes patients' and clinicians' time and adds to insurance overhead. In the Commonwealth Fund's 2009 international survey of primary care practices, US doctors were by far the most likely to report major problems with the amount of time they

and their staff spent getting drugs or treatment for their patients because of insurance restrictions.[19] A recent study estimated that US practice staff members' time devoted to insurance amounts to $68,000 per physician, or $31 billion a year.[20]

US Insurance Reforms: Challenges Ahead

Concerns expressed by US respondents were concentrated in the working-age population that is the target of insurance reforms. In this age group, wide disparities by income for those insured throughout the year underscore the importance of the Affordable Care Act's emphasis on benefits with income-related provisions. The law will expand eligibility for Medicaid to those earning 133 percent of the federal poverty level. It will also provide subsidies for premiums for people up to 400 percent of poverty and for cost sharing for people up to 250 percent of poverty.[21]

However, by international standards, the United States will remain an outlier for cost sharing. The annual limits for the least expensive benefit option will range from $2,000 per person ($4,000 per family) for those with incomes just above 133 percent of poverty, to $6,000 per person above subsidy thresholds. Families can opt for lower cost exposure, but only if they can pay higher premiums.

As US reforms unfold, it will be important to monitor access and affordability. The Affordable Care Act will provide billions of dollars in subsidies for premiums and cost sharing to address affordability for individuals and families with low or modest incomes. Even so, it is still possible that some of the insured will remain at substantial financial risk for care they cannot afford when sick and bills they cannot pay.

Even after the enactment of health reform, the United States will also remain unique among countries in that it covers low-income people in a separate program. This poses the dual challenge of promoting equity across programs and ensuring continuity of insurance. In the other ten countries in our survey, providers were typically paid the same amount regardless of patients' incomes, which is not currently the case in the United States. Nor is it likely to be the case after full implementation of health reform. Avoiding coverage gaps as patients' circumstances change will require creative efforts to enable single portals of entry for people to enroll in publicly sponsored and private insurance, and smooth transitions as families gain or lose eligibility for insurance. To the extent that provider networks also differ for those low-income insurance programs, continuity of care as well as insurance will remain at risk after reforms take effect.

Tracking experiences by insurance and income will be key to successful implementation of US reforms. Although access, cost burdens, complexity concerns, and disparities by income may be ameliorated by reform, success will depend on focused state as well as federal action.

Tracking US experiences will also be useful for other countries, especially those contemplating less unified and more market-oriented approaches, with more extensive patient cost sharing.

The US experience to date provides a cautionary tale of complexity, with high overhead costs and disparities by income. Similarly, the United States has the opportunity to learn as countries with insurance-based systems incorporate incentives for patients and providers, including reference pricing and value-based benefit designs, and as countries with competing insurers develop risk adjustment to focus competition on value. ■

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NOTES

1 Commonwealth Fund. Description of health care systems: Australia, Canada, Denmark, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, 2010. New York (NY): Commonwealth Fund; forthcoming 2010 Dec.

2 The Swiss exempt some services, such as preventive care. The Affordable Care Act in the United States allows deductibles up to $5,950 per individual and $11,900 per family and exempts preventive care, with those provisions to take effect in 2014. The United States has no limit on deductibles.

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4 Schoen C, Helms D, Folsom A. Harnessing health care markets for the public interest: insights for US health reform from the German and Dutch multipayer systems [Internet]. New York (NY): Commonwealth Fund; 2009 Dec [cited 2010 Oct 22]. Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Dec/Schoen_German%20and%20Dutch%20Governance%20Report_1215_v2.pdf

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6 The Commonwealth Fund provided core support for the survey, with cofunding to expand the countries included provided by the German Institute for Quality and Efficiency in Health Care; Haute Authorité de Santé and Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (France); Dutch Ministry of Health, Welfare, and Sport and the Scientific Institute for Quality of Healthcare at Radboud University Nijmegen, in the Netherlands; Norwegian Knowledge Centre for the Health Services; Swedish Ministry of Health and Social Affairs; and the Swiss Federal Office of Public Health. In addition, support for expanded country samples was provided by the UK Health Foundation; Australian Commission on Safety and Quality in Health Care and the Bureau of Health Information; and the Health Council of Canada, Ontario Health Quality Council, and Québec Health Commission.

7 This was a rapid-response survey. The field times ranged from two weeks to two months in countries with extra samples; most field times were four weeks. Subjects were called at least eight times if they did not respond. Response rates were as follows: Australia, 26 percent; Canada, 29 percent; France, 21 percent; Germany, 20 percent; the Netherlands, 21 percent; New Zealand, 30 percent; Norway, 13 percent; Sweden, 42 percent; Switzerland, 54 percent; United Kingdom, 24 percent; and United States, 26 percent.

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

9 The weighted variables 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.

10 Schoen C, Osborn R, Huynh PT, Doty MM, Davis K, Zapert K, et al. Primary care and health system performance: adults' experiences in five countries. Health Aff (Millwood). 2004;23:w4-487–503. DOI:10.1377/hlthaff.var.487.

11 Same-day care was reported by 42 percent in Australia; 29 percent in Canada; 44 percent in France; 43 percent in Germany; 47 percent in Netherlands; 49 percent in New Zealand; 33 percent in Norway; 41 percent in Sweden; 88 percent in Switzerland; 31 percent in United Kingdom; and 38 percent in United States.

12 In 2007, about 40 percent of UK adults received elective surgery in less than one month. One-third waited four months or more. Schoen C, Osborn R, Doty MM, Bishop M, Peugh J, Murukutla N. Toward higher-performance health systems: adults' health care experiences in seven countries, 2007. Health Aff (Millwood). 2007;26(6):w717–34. DOI: 10.1377/hlthaff.26.6.w717.

13 We lacked sufficient sample sizes to compare elective surgery waits by income, because fewer than 20 percent of the respondents had had elective surgery in the previous two years.

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