Canadian Community-Dwelling Young-Old and Old-Old: Determinants of Satisfaction with Health Care

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RÉSUMÉ

Cette étude visait à déterminer les facteurs de satisfaction à l'égard des soins de santé chez les aîné(e)s canadien(ne)s vivant dans la communauté. On a utilisé un concept corrélationnel pour examiner les relations entre les facteurs socio-démographiques, les variables psychosociales, l'utilisation des services de santé et la satisfaction à l'égard des soins de santé chez les jeunes aîné(e)s et chez les aîné(e)s plus âgés. On a analysé un sous-échantillonage (N = 2 413) de l'*Enquête nationale sur la santé de la population* de 1994/95. Des analyses de régression hiérarchique ont révélé que les variables socio-démographiques constituaient les meilleurs prédicteurs de satisfaction à l'égard du système de santé national chez les jeunes aîné(e)s. La consultation des professionnels de la santé était le meilleur prédicteur de satisfaction à l'égard du système de soins de santé canadien chez les aîné(e)s âgé(e)s et des soins de santé reçus dans les deux groupes. La consultation des praticiens de médecines parallèles indiquait l'insatisfaction envers les soins de santé canadiens et des soins reçus par les aîné(e)s âgé(e)s. La détermination des plus importants facteurs de satisfaction à l'égard des soins de santé peut fournir des indices utiles aux responsables des politiques, aux planificateurs de

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Key Words: National Population Health Survey, Health Services Utilization, Alternative Practitioners, Client-Professional Relationships.

Mots clés: Enquête nationale sur la santé de la population, utilisation des services de santé, praticiens de médecines parallèles, relations clients-spécialistes.

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programmes et aux praticiens de sorte que l'on puisse offrir des services plus appropriés et plus efficaces à ce groupe de population.

ABSTRACT

The purpose of the study was to identify the determinants of satisfaction with health care for Canadian community-dwelling older adults. A correlational design was used to examine the relationships between socio-demographic indicators, psychosocial variables, health services utilization, and satisfaction with health care in the young-old and old-old. A subsample (N = 2,413) from the 1994/95 National Population Health Survey Supplement was analysed. Hierarchical regression analyses revealed that socio-demographic variables were the best predictors of satisfaction with the national health care system in the young-old. Consultation with health care professionals was the best predictor of satisfaction with the Canadian health care system in the old-old and of health care personally received in both cohorts. Consultations with *alternative* practitioners was negatively related to satisfaction with health care in Canada and to care personally received in the old-old. The identification of the best determinants of satisfaction with health care can provide useful direction to policy makers, program planners, and practitioners so that more appropriate and effective services can be made available to this population.

Canada has an aging population. In 1996, 3.53 million Canadians (12.2%) were aged 65 and older and the number of those aged 80 years and over had grown to 787,700 (5.1%), a 19.3 per cent increase from the previous census (Moore & Rosenberg, 1997). By 2031, the proportion of the Canadian population aged 65 and older is expected to rise to 25 per cent (Marshall & McPherson, 1994). Not only is the Canadian population aging steadily, the internal composition of the 65-plus age group contains a progressively greater proportion of people 80 years of age and older (Moore & Rosenberg, 1997).

As well, health care restructuring is occurring throughout Canada. Decreased spending and shifting resources from acute care to community care has resulted in the closure of acute-care and long-term care beds. Greater numbers of those over 80 years of age will remain within their communities rather than be institutionalized (Moore & Rosenberg, 1997). Although provinces have increased their community care budgets to some extent, there is no evidence that there has been a significant reallocation of funds to the community sector (Canadian Home Care Association, 1998; National Advisory Council on Aging, 1995). Costs and individuals requiring care are being off-loaded by all levels of government to families and communities (Rosenthal, 1994). As early as 1990, 15 per cent of older adults reported that the lack of community services was problematic for them (National Advisory Council on Aging, 1990). Further, 40 per cent of family caregivers of persons with dementia claimed that the availability of at least one additional community service would have delayed the nursing home placement of their relative (Collins, King, & Kokinakis, 1994). Recently,

the *NACA Position on Community Services in Health Care for Seniors: Progress and Challenges* (National Advisory Council on Aging, 1995) revealed the existence of gaps in the continuum of service that have resulted in inappropriate care for elderly persons and their caregivers that lowers the quality of life and increases health care costs. Confidence in the Canadian health care system is declining. The percentage of Canadians who rated their health care system as fair, poor, or very poor rose from 12 per cent in 1991 to 31 per cent in 1999 (Anderson & Parent, 1999). As health care reform unfolds and increased pressures are being placed on health care systems, it is especially important to measure and examine older adults' satisfaction with the health care systems.

Consumer satisfaction with the health care they have received is a measure of patient/client outcomes and an indicator of quality of care (Donabedian, 1988). A paucity of satisfaction research exists from a national or provincial perspective. A notable exception is the recent analysis of data from the 1991 Canadian Study on Health and Aging that identified potential predictors of informal caregivers' dissatisfaction with community long-term care services. The sample was comprised of caregivers of seniors with dementia. Some of the predictors of dissatisfaction with care received were found to be related to the senior's impairment in daily living activities, disruptive behaviours, dementia, and higher levels of education (Durand, Krueger, Chambers, Grek, & Charles, 1995).

The majority of satisfaction research has been conducted in acute care settings, primarily in the United States. A paucity of satisfaction research exists which pertains to community settings in Canada. The few studies that have been conducted focussed on clients' satisfaction with a type of program (Forbes, 1996) and care providers (Martin Matthews & Wakefield, 1992).

Although many socio-demographic characteristics have been examined as determinants of satisfaction, few trends have been found. Hall and Doran (1990) performed a meta-analysis of 221 studies and concluded that greater satisfaction with medical care was significantly associated with increased age and less education and marginally associated with being married and of higher social status. No overall relationship was found for ethnicity, gender, income, or family size. Contrary findings were revealed in a recent examination of data from the 1991 Medicare Current Beneficiary Survey on 8,859 community-dwelling older adults. Lee and Kasper (1998) revealed that those 80 years of age or over, with less education and lower income were less likely to be satisfied with medical care. Positive correlations have been reported between client/patient satisfaction and size of support network (Carmel, 1985), perceived social support (Rabiner, 1992), and perceived health status (Carmel, 1985; Lee & Kasper, 1998).

Satisfied clients are more likely to use the service, to co-operate with health care professionals by disclosing relevant information, to participate in their own care, to comply with medication regimes, and to follow

preventive care practice guidelines (Newcomer, Preston, & Harrington, 1996; Weingarten et al., 1995). Therefore, it is important to assess clients' satisfaction with the care that they received, especially when major restructuring is being undertaken within the health care systems, to ensure that more appropriate and effective services are made available to community-dwelling older adults and their caregivers.

Design and Sample

A correlational design was used to examine the relationships between socio-demographic indicators, psychosocial variables, health services utilization, and satisfaction with the national and provincial health care systems and with health care personally received in Canadian community-dwelling young-old and old-old. Data from the Health Canada Supplement to the 1994/95 National Population Health Survey (NPHS) were analysed.

The NPHS was designed to collect information related to the health of the Canadian population. The questionnaire included questions related to socio-demographic characteristics, informal support, use of health care services, and perceived health (rated from poor to excellent). Scales or subscales were also incorporated into the NPHS. These included: (a) the Sense of Coherence Scale (Antonovsky, 1987); (b) the Mastery Index (Pearlin & Schooler, 1978); (c) the Self-Esteem Scale (Rosenberg, 1979); and (d) the Health Utility Index Mark 3 (Feeny, Furlong, Boyle, & Torrance, 1995). All of these scales have been used in health science research and have acceptable reliability and validity. In addition, the Health Canada Supplement Survey covered topics in relation to: (a) satisfaction with health care in Canada, with provincial health care systems, and with care personally received; (b) main strengths and weaknesses of the Canadian health care system; (c) misuse of the national health care system; and (d) availability of health care.

The number of respondents to the Supplement represented a 90.6 per cent response rate. The sample for this study included all of those aged 65 to 79 (young-old, n = 2,006) and those who were 80 years of age and over (old-old, n = 406) who responded to the Supplement survey. This sample represented the core sample of respondents targeted for the longitudinal study and generalizes to approximately 3.3 million Canadians aged 65 and over (Statistics Canada & Health Canada, 1996).

Data Analyses

The planned data analyses entailed a multi-stage process consisting of data description, univariate, and multivariate analyses. Analyses were completed separately for the young-old (Y-O) and old-old (O-O) using SPSS® 7.5 for WindowsTM (Norusis, 1994). The independent variables included

gender, marital status, income, education, province of residence, immigrant status, health status, sense of coherence (SOC), mastery, self-esteem, perceived support, frequency of support, social involvement, perceived health, hospitalizations, use of home care services, consultations with health care professionals, and consultations with alternative practitioners. The dependent variables included satisfaction with the national and provincial health care systems and with health care personally received.

Description of the Canadian Community-Dwelling Young-Old and Old-Old

The similarities and differences between the young-old and old-old cohorts in relation to the independent variables and the dependent variables are initially described. Because of the similarities in the results of satisfaction with the national and provincial health care systems, only the results related to the Canadian health care system are reported. When differences were found between the two systems, these are reported. A presentation of the results of the regression analyses for the two cohorts follows.

Socio-demographic Variables

The old-old cohort had a statistically significant greater percentage of: females ($\chi^2 = 7.742$, $p = .005$); widowed, divorced, or separated individuals ($\chi^2 = 95.167$, $p = .000$); those living alone ($\chi^2 = 111.720$, $p = .000$); those in the lowest and lower-middle income brackets ($U = 303683.5$, $p = .000$); those with lower education levels ($U = 342941.5$, $p = .000$); immigrants ($\chi^2 = 23.548$, $p = .000$); and those in poorer overall health ($F[1,2407] = 55.706$, $p = .000$) than the young-old cohort. The cohorts were not found to differ significantly on province of residence. These findings lend support to the belief that there are two distinct groups among older persons, the young-old and the old-old. Any examination of the predictors of satisfaction with health care of older adults should take into consideration the differences between these two cohorts.

Psychosocial Variables

The SOC scores were found to be similar for the young-old (mean = 63.48, $SD = 10.99$) and old-old cohorts (mean = 63.92, $SD = 11.01$). Likewise, the Mastery scores were similar for the young-old (mean = 19.02, $SD = 4.36$) and old-old (mean = 18.62, $SD = 4.17$). However, a difference was found between the groups in relation to the Self-Esteem scores with the young-old reporting greater Self-Esteem than the old-old (F [1, 2350] = 9.356, $p = .002$). The old-old cohort reported higher Perceived Social Support (F [1, 2368] = 8.937, $p = .003$) than the young-old, specifically in perceiving that support would be available in a crisis ($\chi^2 = 7.648$, $p = .006$) and when making personal decisions ($\chi^2 = 6.983$, $p = .008$). The old-old cohort also scored significantly higher than the young-old cohort in Aver-

age Frequency of Contact (F [1, 2369] = 6.616, p = .010), suggesting that the old-old have greater frequency of contact with a smaller informal support network than the young-old. A large percentage of both the young-old and old-old had daily contact with close friends (Y-O: 26.9%; O-O: 36.3%), neighbours (Y-O: 35.4%; O-O: 40.5%), daughters or daughters-in-law (Y-O: 26.9%; O-O: 27.5%), and sons or sons-in-law (Y-O: 20.5%; O-O: 21.1%). The young-old and old-old cohorts did not differ significantly on their total Social Involvement scores or on how they perceived their health.

Health Care Services Utilization

The vast majority of young-old (95.8%) and old-old (96.7%) had consulted with a health care professional in the previous year. Approximately one-fifth of the old-old had been hospitalized overnight in the previous year and one-fifth had received home care services. One-seventh of the young-old had been hospitalized overnight and few (7.8%) had received home care services. These findings underscore the fact that this population, especially the old-old are important consumers of health care services.

Few respondents reported consulting with alternative practitioners (e.g., homeopaths, naturopaths, massage therapists, and acupuncturists) in the past 12 months. Only 2.7 per cent of the young-old and 3.6 per cent of the old-old replied in the affirmative. Additionally, the percentages of young-old (37.1%) and old-old (35.8%) who use selected health care products such as ointments, vitamins, and herbs were not significantly different.

Satisfaction with Health Care

The vast majority of young-old and old-old respondents rated health care in Canada (Y-O: 90.8%; O-O: 91.8%), and the care they personally received (Y-O: 86.6%; O-O: 87.1%) as either excellent or good. However, the old-old (92.8%) reported significantly greater satisfaction and the young-old (12.2%) reported more dissatisfaction with their provincial health care system (U = 368691.5, p = .001).

The main strengths of Canada's health care systems were perceived as: (a) no cost (Y-O: 54.9%; O-O: 52.8%); (b) universality (Y-O: 51.5%; O-O: 43.4%); (c) quality of care (Y-O: 38.3%; O-O: 44.9%); (d) being free to choose their physician and location of treatment (Y-O: 39.9%; O-O: 34.9%); and (e) having access to the health care systems (Y-O: 32.0%; O-O: 29.9%). A significantly greater percentage of the young-old (51.5%) identified universality (χ^2 = 9.436, p = .002) as a strength of the health care systems.

The groups did not differ significantly on the identified weaknesses of Canada's health care systems. The most frequently reported weaknesses were: (a) misuse or abuse of the systems (Y-O: 53.5%; O-O: 44.0%); (b) too long between their call and the time that their appointment or visit was arranged (Y-O: 24.0%; O-O: 19.5%); and (c) cost of the health care systems (Y-O: 16.1%; O-O: 10.9%). Although 9.1 per cent of the young-old and 6.2 per cent of the old-old group considered lack of available services a main

weakness, only 2.9 per cent of the young-old and 3.8 per cent of the old-old responded positively when asked if they had needed health care or advice but did not receive it. This finding complements the work of Millar and Beaudet (1996) who found that 4 per cent of Canadians had been unable to receive the health care required during the previous year. In the present research, the primary reason the young-old (19.8%) and old-old (24.5%) gave for not receiving care was "difficulty getting access to the health professional".

Most young-old (86.0%) and old-old (81.7%) reported that there was misuse of Canada's health care systems. The greatest areas of misuse were: (a) the number of physician visits for minor ailments (Y-O: 77.8%; O-O: 75.2%); (b) the number of drugs prescribed (Y-O: 38.8%; O-O: 35.4%); (c) the number of diagnostic tests (Y-O: 16.8%; O-O: 12.6%); and (d) overnight hospitalizations instead of using outpatient or home care services (Y-O: 12.1%; O-O: 8.4%). The groups did not differ significantly in their report of the areas in which there is misuse.

Both groups considered individuals using the health care systems (Y-O: 51.9%; O-O: 48.4%), followed by governments (Y-O: 48.8%; O-O: 42.9%), and physicians (Y-O: 43.3%; O-O: 33.1%) to be responsible for reducing or stopping the misuse. However, significantly more respondents in the young-old cohort than in the old-old group considered physicians responsible for reducing misuse ($\chi^2 = 6.962$, $p = .008$).

Multivariate Relationships

Hierarchical (sequential) regression analyses were employed to determine if SOC, mastery, self-esteem, informal social support (perceived social support, social involvement, and frequency of contacts), and perceived health, and then health services utilization (hospitalizations, use of home care services, consultations with health care professionals, and consultations with alternative practitioners) improved prediction of satisfaction beyond that afforded by the socio-demographic indicators (age, gender, marital status, education, income, province of residence, and immigrant status) and health status. Thus, the first model included only the socio-demographic variables. In the second model the psychosocial variables and perceived health were added, and in the third model the health services utilization variables were added. Since the influence of all the independent variables on the dependent variables is of interest, the results of model three are reported. Variables that were marginally significant (e.g., $p < .2$) in the correlation analyses and theoretically appropriate were retained for inclusion in multivariate analyses. Significance was set at the more stringent alpha level of .01.

Table 1
Hierarchical regression analyses for significant variables predicting satisfaction with health care in Canada and with health care personally received (Model 3)

	Satisfaction with Health Care in Canada				*Satisfaction with Health Care Personally Received*			
	Young-Old		*Old-Old*		*Young-Old*		*Old-Old*	
Variables	*B*	β	*B*	β	*B*	β	*B*	β
Gender (Male)	.112	.085*	–	–	–	–	–	–
Education	2.55E-02	.118*	–	–	3.32E-02	.091*	–	–
Immigrant	.105	.065*	–	–	.153	.056*	–	–
Marital Status	–	–	.226	.178*	–	–	–	–
British Columbia	.259	.132*	–	–	–	–	–	–
Ontario	.237	.176*	–	–	.363	.159*	.313	.137*
Saskatchewan	-.330	-.098*	–	–	–	–	–	–
SOC**	4.62E-03	.077*	–	–	–	–	–	–
Health Profess.	–	–	.670	.182*	2.472	.431*	2.848	.457*
Home Care	–	–	–	–	.252	.062*	.292	.109*
Alternative Prof.	–	–	-.440	-.144*	–	–	-.772	-.131*

Notes: * $p < .01$, two-tailed.
**SOC = Sense of Coherence.

Regression Analyses for Variables Predicting Satisfaction with Health Care in Canada

In the young-old, the first two models revealed significant F changes (F ratio for change in R^2). The first model accounted for 14.7 per cent of the variance in satisfaction with health care in Canada (F_{change} [12,1760] = 25.336; $p = .000$), the second model accounted for an additional 2.0 per cent of the variance (F_{change} [5,1755] = 8.489; $p = .000$), while the third model only accounted for another .4 per cent of the variance (F_{change} [3,1752] = 2.994; $p = .030$). The total variance accounted for was 17.1 per cent.

In the old-old cohort, all three models revealed significant F changes with the first model accounting for 4.5 per cent of the variance in satisfaction with health care in Canada (F_{change} [5,344 = 3.259; $p = .007$), the second model explaining an additional 6.6 per cent of the variance (F_{change} [6,338] = 4.188; $p = .000$), and the third model accounting for another 6.1 per cent of the variance (F_{change} [3,335] = 8.191; $p = .000$). The total variance accounted for was 17.2 per cent.

It is noteworthy that the independent variables contributing to the prediction of satisfaction with health care in Canada were different for the two groups. The significant predictors in the old-old group were marital status, consultations with health care professionals, and consultations with alternative practitioners while the predictors in the young-old group were primarily socio-demographic variables (living in Ontario, British Columbia, and Saskatchewan, education, gender, and immigrant status), and SOC (Table 1).

Regression Analyses for Variables Predicting Satisfaction with Health Care Personally Received

In the young-old, the first and third models revealed significant F changes. The first model accounted for 8.7 per cent of the variance in satisfaction with health care personally received (F_{change} [8,1738] = 20.702; $p = .000$), the second model only accounted for an additional .6 per cent of the variance (F_{change} [4,1734] = 3.053; $p = .016$), and the third model accounted for another 19.1 per cent of the variance (F_{change} [3,1731] = 154.504; $p = .000$). The total variance accounted for was 28.4 per cent.

In the old-old cohort, only two models were used as no psychosocial indicators were marginally significant. Both models revealed significant F changes. The first model accounted for 7.0 per cent of the variance in satisfaction with health care personally received (F_{change} [5,395 = 5.997; $p = .000$) and the second model accounted for an additional 23.3 per cent of the variance (F_{change} [3,392] = 43.672; $p = .000$). The total variance accounted for was 30.3 per cent.

The difference between the correlation coefficients for the young-old and old-old cohorts was not significant. In both groups, consultations with health care professionals made the greatest contribution to the prediction of satisfaction with health care personally received. Additionally, living in Ontario and use of home care services were significant predictors in both

groups. Consultation with alternative practitioners was a significant predictor in the old-old and education and immigrant status were significant predictors of satisfaction with care personally received in the young-old (Table 1).

Policy, Program, and Practice Implications

The Canadian context is changing with the aging of the population and with health care restructuring that has resulted in the closure of acute care and long-term care beds and cuts in social programs. The present research demonstrates the significant determinants of satisfaction with health care for the young-old and old-old. Strategies that will assist policy makers, program planners, and practitioners in ensuring that the significant determinants of satisfaction are addressed and supported are suggested in the following discussion.

Most older adults rated health care in Canada and the health care that they personally received as either excellent or good. However, the old-old were significantly more satisfied with their provincial health care system than the young-old. It was interesting to note that the main strengths of Canada's health care system identified by the respondents reflected the principles of the *Canada Health Act*. Indeed, the majority of respondents considered no cost or *public administration* to be the most important strength. *Universality* (available to rich and poor), *accessibility* (urban/rural and free to choose their physician and location of treatment), *comprehensibility* (range of services), and *portability* were considered important strengths. An additional identified strength was quality of care. These findings underscore the fact that the principles of the *Canada Health Act* are important to older adults and support the recommendation of the National Forum on Health (1997) that the five principles of the *Canada Health Act* must be preserved and protected.

Additionally, addressing the identified weaknesses of the health care system (e.g., misuse of the systems, long waiting time for an appointment, and too costly) may enhance older adults' satisfaction with health care. Rather than physicians treating minor ailments, administering immunizations, and routine examinations, nurses could be providing these services at less cost to the system. Reducing the number of prescription drugs, diagnostic tests, and hospitalizations were also suggested as remedies for decreasing the misuse of the system.

The strongest predictor of satisfaction with the national health care system in the old-old and of satisfaction with care personally received in both cohorts was consultation with health care professionals. This finding exemplifies the importance of seniors' consultations with health care professionals in predicting satisfaction with health care not only at the individual level but also at the national level. Use of home care services was also found to be a significant predictor of satisfaction with care

personally received. This supports the position of the National Forum on Health which recommended that home care be an integral part of the publicly funded health care system (National Forum on Health, 1997).

The findings from the present research also revealed that those in the old-old cohort who consulted with alternative practitioners tended to be more dissatisfied with the national health care system and with care personally received. Millar (1997) reported that the demand for alternative and complementary services will increase as the population ages and the prevalence of multiple chronic diseases increases with age. Thus, it will become increasingly important to examine the reasons why individuals who are dissatisfied with the traditional provision of health care seek services elsewhere. Perhaps the use of alternative health care modalities is related to the greater emphasis on holistic health care, health promotion, disease prevention, and self-care (Furnham & Forey, 1994).

There is variation in the funding of various alternative health care services under provincial health care plans. For example, the western provinces include some form of payment for chiropractic services while the provincial insurance in Quebec and some Atlantic provinces does not extend to chiropractic services (Millar, 1997). To assist policy makers in their decisions related to which services to fund and to promote a greater consensus across Canada, the effectiveness of alternative practices needs to be evaluated and monitored over time with the same criteria used for evaluating treatments in conventional practice.

In the young-old cohort, gender, education, and immigrant status were significant predictors of satisfaction with the national health care system and with care personally received. The findings revealed that young-old males, those who have achieved higher levels of education, and those who have immigrant status are more likely to be satisfied. Those with higher levels of education have greater ability to access health care information and services. Immigrants may value the Canadian health care systems as they compare it with the health care system in their countries of origin.

The findings that young-old residents of Ontario and British Columbia were more likely to be satisfied with the health care systems while those living in Saskatchewan were more likely to be dissatisfied and that young-old and old-old residents of Ontario were more likely to be satisfied with the care they personally received require further examination. These results may reflect the fact that residents in Ontario and British Columbia have on average a higher education, a higher family income, a lower rate of risky behaviours, such as heavy drinking, more health promotion programs, higher provincial health spending per person, and longer average length of stays in hospital than do residents of Saskatchewan (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996). However, further research needs to be conducted to understand why residents in particular jurisdictions are more satisfied than others. Analysing satisfaction at the national or provincial level may conceal factors

that are important in determining satisfaction with health care, such as patterns of provincial health care spending, the model of delivery of health care, the professional credentials of the providers, and length of residence, among other factors.

SOC was a significant predictor of satisfaction with the Canadian health care system in the young-old cohort. Those with a strong SOC, which includes a belief that the resources are available to meet their needs, were more likely to be satisfied with the Canadian health care system.

In summary, it is important to note that the best predictors of satisfaction with the national health care system in the young-old were the socio-demographic variables (especially education). However, in the old-old cohort three different variables predicted satisfaction with the Canadian health care system. Those who were married or had a partner and those who had consulted with health care professionals tended to be more satisfied with the national health care system, while those who had consulted with alternative practitioners were more likely to be dissatisfied. Lee and Kapser (1998) also reported that older adults with higher education were more likely to be satisfied. However, Hall and Doran's (1990) conclusions following a meta-analysis of 221 satisfaction studies were contrary. They found a negative association between education and satisfaction. The findings from the present study lend support to the notion that the predictors of satisfaction for older adults are different than the predictors in other age groups. This illustrates the importance of studying successive groups of older adults as each new cohort will have different expectations that may influence their satisfaction with health care.

Conclusion

With the aging of the Canadian population and with health care restructuring occurring across Canada, older adults' evaluations of their satisfaction with the care they personally receive and with the national health care system will continue to be important outcome measures. Additionally, determining the best predictors of outcomes such as satisfaction with health care for the young-old and old-old cohorts provides useful direction to policy makers, program planners, and practitioners so that more appropriate and effective services can be offered to community-dwelling older adults and their caregivers. Some of the findings of the present research will contribute to the knowledge required to make sound policies and sensible resource allocation decisions that are needed to maintain older adults in their communities.

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