MIRROR, MIRROR ON THE WALL: LOOKING AT THE QUALITY OF AMERICAN HEALTH CARE THROUGH THE PATIENT'S LENS

Karen Davis, Ph.D., Cathy Schoen, M.S., Stephen C. Schoenbaum, M.D., M.P.H.,
Anne-Marie J. Audet, M.D., M.Sc., S.M., Michelle M. Doty, Ph.D., M.P.H.,
and Katie Tenney

The Commonwealth Fund

January 2004

Copies of this report are available from The Commonwealth Fund by calling its toll-free publications line at **1-888-777-2744** and ordering publication number **683.** The report can also be found on the Fund's website at **www.cmwf.org.**

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ABOUT THE AUTHORS

Karen Davis, Ph.D., president of The Commonwealth Fund, is a nationally recognized economist with a distinguished career in public policy and research. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment*; *Medicare Policy*; *National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*.

Cathy Schoen, M.S., is vice president for health policy, research, and evaluation at The Commonwealth Fund and has oversight responsibilities for survey work and programs on health care coverage and access. She also serves as the executive director of the Fund's Task Force on the Future of Health Insurance. Previously, Ms. Schoen was director of special projects at the University of Massachusetts Labor Relations and Research Center and on the research faculty of the UMass School of Public Health. During the 1980s, she directed the Service Employees International Union's Research and Policy Department in Washington, D.C. Earlier, she served as a member of the staff of President Carter's national health insurance task force and as a senior health advisor during the 1988 presidential campaign. Prior to federal service, she was a research fellow at the Brookings Institution. She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College. She is the author and coauthor of many publications on health care coverage and quality issues.

Stephen C. Schoenbaum, M.D., M.P.H., is senior vice president of The Commonwealth Fund with responsibility for coordinating the development and management of the Fund's quality improvement programs and is a member of the Fund's executive management team. Prior to joining the Fund in February 2000, he was president of Harvard Pilgrim Health Care of New England and senior vice president of Harvard Pilgrim Health Care, responsible for delivery system operations in a mixed staff and network model HMO with approximately 150,000 members. Prior to joining Harvard Community Health Plan in 1981, Dr. Schoenbaum was a member of the Department of Medicine at Brigham and Women's Hospital and did epidemiologic research in obstetrics and infectious diseases. He is a lecturer in the Department of Ambulatory Care and Prevention, Harvard Medical School, the author of more than 125 scientific articles and papers, and the editor of a book on measuring clinical care. Dr. Schoenbaum received an A.B. from Swarthmore College with honors, an M.D. from Harvard Medical School (cum laude), and an M.P.H. from Harvard School of Public Health. He also completed the Program for Management Development at Harvard Business School.

Anne-Marie J. Audet, M.D., assistant vice president for quality improvement at The Commonwealth Fund, is responsible for the Fund's program to improve the quality of health care services. Dr. Audet has worked in the field of quality improvement for over a decade and brings to the Fund a deep understanding of the science of quality improvement, as well as an appreciation of the barriers and enablers that come into play when having to translate knowledge into real-world situations. At the national level, Dr. Audet worked in policy analysis at the American College of Physicians. At the state level, she led the implementation of the Medicare Health Care Quality Improvement Program in Massachusetts while working at the Massachusetts Peer Review Organization. More recently, she worked at the level of a health care institution and an integrated network of care with CareGroup. Prior to joining the Fund, Dr. Audet served as director of the Office for Clinical Effectiveness/Process Improvement at Beth Israel Deaconess Medical Center in Boston, where she was responsible for development of quality measurement systems, educational programs, and institution-wide medication safety initiatives. She was coeditor of "Clinical Crossroads," a series published monthly in *JAMA*. Dr. Audet holds a B.Sc. in cell and molecular biology and an MDCM and M.Sc. from McGill University and an S.M. in health policy and management from Harvard University.

Michelle McEvoy Doty, Ph.D., M.P.H., a senior analyst for the Health Policy, Research, and Evaluation department at The Commonwealth Fund, conducts research examining health care access and quality among vulnerable populations and the extent to which lack of health insurance contributes to barriers to health care and inequities in quality of care. Dr. Doty is the coauthor of several Commonwealth Fund reports and briefs, including, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk; Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans;* and *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility.* She received her M.P.H. and Ph.D. in public health from the University of California, Los Angeles.

Katie Tenney, the former special assistant to the president at The Commonwealth Fund, is a law student at Georgetown University.

EXECUTIVE SUMMARY

U.S. health care leaders often say that American health care is the best in the world. However, recent studies of medical outcomes and mortality and morbidity statistics suggest that the United States—despite spending more per capita on health care and devoting to it a greater percentage of its national income than any other country—is not getting commensurate value for its money. The Commonwealth Fund's cross-national surveys of patients' experiences in and views of their health care systems offer the opportunity to assess U.S. performance relative to other countries through the patients' perspective—a dimension often missing from other international comparisons.

Using data from two recent surveys conducted in five English-speaking nations—Australia, Canada, New Zealand, the United Kingdom, and the United States—this report ranks the countries in terms of patients' reports on care experiences and ratings on various dimensions of care.[1] While the surveys focused on an admittedly limited slice of the quality equation—patient perceptions of care received—as well as a limited number of countries, there are valuable insights to be gained from the data obtained.

We organized patient-reported experiences and assessments according to the Institute of Medicine's framework for quality, outlined in the six bulleted points below. Overall, the findings indicate that the U.S. health care system often performs relatively poorly from the patient perspective. With the exception of timeliness for hospital admissions and elective surgery, the U.S. system rarely ranked first and often ranked last or second-to-last. It performed particularly poorly in terms of providing care equitably, safely, or efficiently. On measures of patient-centeredness (which assess the quality of physician care as perceived by patients and whether patients felt included in decisions about their care), the U.S. system lagged behind some of the other countries and rarely received top scores. In all five countries, responses indicate room for improvement, with minor differences among countries on specific questions. Yet, the other four countries spend considerably less on health care per person and as a percent of gross domestic product than the United States. These findings indicate that, from the perspective of the patients it serves, the U.S. health care system could do much better in returning high-quality performance for the nation's substantial investment in health.

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[1] In each of the past five years The Commonwealth Fund has performed a survey in these five countries, and in each year the ministers of health have met to review the findings.

Key findings include:

- **Patient safety:** Among sicker adults, U.S. patients were the most likely to report a medical or medication error with serious health consequences.[2] Twice as many sicker adults in the U.S. as in the U.K. reported a medication or medical error that had a serious health consequence (18% vs. 9%). On four of five measures of safety, the U.S. system ranked last or second-to-last among the five countries.

- **Patient-centeredness:** Survey questions asked patients to rate the quality of their physician care and asked whether physicians involved them in care decisions. Patients in the U.S. and U.K. had the lowest rankings on patient ratings of physician–patient interactions. U.S. and U.K. patients also were less likely than patients in Australia, Canada, or New Zealand to rate their physician care as excellent or very good. Across four measures of patient-centeredness, New Zealand generally was highest, followed by Australia and Canada.

- **Timeliness:** The U.S. stands out among the five countries in terms of patients reporting the least difficulty waiting for hospital admission and for elective or non-emergency surgery. Yet U.S. patients, along with Canadian and U.K. patients, were much more likely to say they waited five days or more for an appointment with a doctor than were adults in Australia or New Zealand (18 percent in U.S., 23 percent in Canada, and 16 percent in U.K., compared with 5 percent in Australia and 1 percent in New Zealand). On measures of timeliness, the U.K. and Canada generally ranked last. New Zealand and Australia outperformed the U.S. in terms of ambulatory care. As a result, based on six measures of timeliness, the U.S. ranked in the middle of the five countries.

- **Efficiency:** The survey included three questions on the coordination of care that serve as indicators of health care system efficiency. Compared with sicker patients in other countries, U.S. patients more often reported that they were sent for duplicate tests and that the results of the tests failed to reach their doctor's office in time for appointments. More than one of five U.S. patients reported these concerns. U.S. patients also were the most likely to say that they had to repeat their medical history multiple times. On these three measures of efficiency, the U.S. ranked last among the five countries, with Australia and New Zealand vying for top slots.

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[2] The 2002 survey of "sicker" adults included those who rated their health as fair or poor or who in the past two years had a serious illness, been hospitalized for care other than a normal delivery, or had major surgery.

- **Effectiveness:** The primary indicators of effectiveness in the surveys related to patients' ability to follow up on recommended care and whether physicians reviewed patients' course of treatment with them. Compared with the other four countries, U.S. patients were most likely to report they went without recommended care due to costs. Across the indicators of effectiveness, the U.K. ranked first, Canada and New Zealand were next, and Australia and the U.S. tied for last.

- **Equity:** Seven measures gauged to what extent patients' income affected their ability to access care. The U.S. scored worst on every measure of low-income patients not receiving needed care and had the greatest disparities in terms of access to care between those with below-average and above-average incomes. With lowest rankings on all seven measures, the U.S. ranked last among the five countries in terms of equity in the health care system. The U.K. ranked first, with no or negligible differences in terms of patients' access to care by income. The U.S. is the only country surveyed with large numbers of uninsured, and this contributed to its low rating for equity in the health care system. However, disparities persisted between lower-income and higher-income insured patients surveyed in the U.S. and other countries, with the exception of the U.K. Moreover, comparing the responses of insured Americans only to responses of patients in the other four countries had little effect on the U.S. rankings for patient-reported quality measures.

Summary and Implications

These rankings summarize evidence on measures of quality as perceived or experienced by patients. Unlike medical records or administrative data, patient surveys have few direct measures of effectiveness or efficiency. Patients' assessments of timeliness and patient-centered care are likely to be affected by their experiences and expectations, which may differ by country and culture. Yet, reports from the World Health Organization (WHO) that compare health care system performance using measures such as life expectancy, infant mortality, or preventable years of life lost as well as health expenditures also suggest that the U.S. achieves the least for its population among these five countries. A working group—supported by The Commonwealth Fund and with experts from each of the five countries, the Organization for Economic Cooperation and Development (OECD), and WHO—is currently developing a set of indicators that will provide objective measures of clinical effectiveness. It is possible that these indicators will yield a more complete picture of health care systems in which the U.S. performs more favorably.

On five of the six domains of quality of care included in the Institute of Medicine framework, the U.S. performs relatively poorly from the patients' perspective. Timeliness was the only measure on which the U.S. system performed better than the four other countries, due largely to patients reporting the shortest waiting times for hospital admission and elective surgery. Even on this measure, however, New Zealand outperformed the U.S. in terms of prompt access to primary care physicians and specialists.

The findings suggest that, if the health care system is to perform according to patients' expectations, the U.S. will need to remove financial barriers to care and improve the delivery of care. Disparities in terms of access to services signal the need to expand insurance to cover the uninsured and to ensure that the system works well for all Americans. Based on these patient reports, the U.S. should improve the delivery, coordination, and equity of the health care system.

MIRROR, MIRROR ON THE WALL: LOOKING AT THE QUALITY OF AMERICAN HEALTH CARE THROUGH THE PATIENT'S LENS

Health care leaders in the United States often say that the U.S. health care system is the best in the world, despite the absence of consistent scientific evidence on its performance. Like the queen in *Snow White*, Americans too often look only at our own reflection in the mirror—failing to include international experience in assessments of our health care system. With U.S. per capita spending on health more than double the average among Organization for Economic Cooperation and Development (OECD) industrialized nations, and with the percentage of national income devoted to health care exceeding all other nations, Americans should expect commensurate value and superior performance. Cross-national studies provide an opportunity to focus on areas where the U.S. performs poorly or well and to set goals for improving the return on the nation's substantial investment.

In the first major attempt to rank health care systems, the World Health Organization's *World Health 2000* report placed the U.S. health system 37th in the world.[3] This calls into question the value Americans receive for their country's investment in health care. The U.S. ranked 24th in terms of "health attainment," even lower (32nd) in terms of "equity of health outcomes" across its population, and lower still (54th) in terms of "fairness of financial contributions" toward health care. In the same report, the U.S. ranked first in terms of "patient responsiveness." Some experts have criticized the report's measures, methods, and data, including the fact that the data did not include information derived directly from patients.[4]

Cross-national surveys of patients offer a unique dimension that has been missing from international studies of health care system performance, including the WHO analysis. When such surveys include a common set of questions, they can overcome differences among national data systems and definitions that frustrate cross-national comparisons.

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[3] World Health Organization, *The World Health Report 2000, Health Systems: Improving Performance* (Geneva: WHO, 2000). Available at http://www.who.int/whr2001/2001/archives/2000/en/contents.htm.

[4] R. J. Blendon, M. Kim, and J. M. Benson, "The Public Versus the World Health Organization on Health System Performance," *Health Affairs* 20 (May/June 2001): 10–20; C. Murray, K. Kawabata, and N. Valentine, "People's Experience Versus People's Expectations," *Health Affairs* 20 (May/June 2001): 21–24; J. Mulligan, "Measuring the Performance of Health Systems," *British Medical Journal* 321 (2000): 191–192; V. Navarro, "Assessment of the World Health Report 2000," *The Lancet* 358 (2000): 1598–601; C. Almeida et al., "Methodological Concerns and Recommendations on Policy Consequences of the World Health Report 2000," *The Lancet* 357 (2001): 1692–97; D. B. Evans et al., "Comparative Efficiency of National Health Systems: Cross National Econometric Analysis," *British Medical Journal* 323 (2001): 307–310; P. Braveman, B. Starfield, and H. J. Geiger, "World Health Report 2000: How It Removes Equity from the Agenda for Public Health Monitoring and Policy," *British Medical Journal* 323 (2001): 678–81.

Since 1998, The Commonwealth Fund has supported surveys about patients' experiences with their health care system in Australia, Canada, New Zealand, the United Kingdom, and the United States.[5] Focusing on health care access, costs, and quality, these surveys enable assessment of important dimensions of health system performance. However, they have limitations. In addition to lacking clinical data on effectiveness of care and economic data on efficiency, the surveys focus on an admittedly limited slice of the quality equation—patient perceptions of the care they received. They also include a limited number of countries.

But while not a complete cross-national sample, the five countries represent a range of health care systems charged with serving diverse populations in industrialized nations that have had to address similar cost and quality issues. Comparing patient-reported experiences in these countries, therefore, can inform the ongoing debate over how to make the U.S. health care system more effective and responsive to patient needs.

To add to our understanding of overall health system performance, as well as illustrate the utility of including patient reports in health system assessments, this report summarizes what has been learned from the Fund's international surveys regarding the six dimensions of quality set forth by the Institute of Medicine (IOM) in *Crossing the Quality Chasm*.[6] Although health care system evaluations can focus on a number of dimensions, including health status, coverage, financial sustainability, and political viability, this report focuses on just one dimension: quality, as it is perceived and experienced by patients.[7] Quality itself is a multifaceted concept, taking into account measures of safety, effectiveness, access, and equity and ideally looking at them from a number of different angles, including those of providers, purchasers, and patients. This report provides patients' perspectives, without which an understanding of how the U.S. performs on these dimensions of quality would not be complete.

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[5] Commonwealth Fund 1998 International Health Policy Survey, Commonwealth Fund 1999 International Health Policy Survey of the Elderly, Commonwealth Fund 2000 International Health Policy Survey of Physicians, Commonwealth Fund 2001 International Health Policy Survey, Commonwealth Fund 2002 International Health Policy Survey of Adults with Health Problems.

[6] Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001).

[7] World Health Organization, *The World Health Report 2000, Health Systems: Improving Performance* (Geneva: WHO, 2000).

METHODS

The IOM's six dimensions of quality are the framework for this assessment. These include: safety, patient-centeredness, timeliness, efficiency, effectiveness, and equity. Patient-reported care experiences are particularly well suited to assessing patient-centeredness, timeliness, equity, and safety. Some patient-reported measures also lend insight into selected aspects of efficiency and effectiveness.

Data are drawn from the Commonwealth Fund 2001 International Health Policy Survey and the 2002 International Health Policy Survey of Sicker Adults, both conducted by telephone in Australia, Canada, New Zealand, the United Kingdom, and the United States. The 2001 survey is a nationally representative, cross-sectional sample of noninstitutionalized adults in the five countries. The 2002 survey is a nationally representative survey of "sicker adults," defined as those who rated their health status as fair or poor, had a serious illness in the past two years, or had been hospitalized for something other than a normal delivery or had undergone major surgery in the past two years.[8] Approximately 1,400 adults in each of the countries were included in 2001, and approximately 750 sicker adults were included in 2002. The 2001 survey focused on patients' experiences getting and using health care services, as well as their opinions on health system structure and recent reforms. The 2001 survey, which had a larger sample, also enabled analysis of differential experiences by income groups. The 2002 survey examined sicker patients' views of the health care system, quality of care, care coordination, medical errors, patient–physician communication, waiting times, and access problems. Further details of the survey methodology are described elsewhere.[9]

For this report, we selected and grouped measures from these two surveys according to IOM's six dimensions of quality. The dimensions of safety and effectiveness were measured by four items, patient-centeredness by five items, timeliness by seven items, and efficiency by three items. For the measure of equity, we compared experiences of adults with incomes above or below national median incomes to examine low-income experiences across countries and differences between those with lower and higher incomes. For each item, we ranked countries by calculating means and ranking these scores from highest to lowest (where 1 equals the highest score) across the five countries. For ties in means, the tied observations were assigned the average of the ranks that would be assigned if there were no ties. For each IOM domain of quality, a summary ranking

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[8] The 2002 survey identified "sicker" adults using screening questions. For a description of the methodology, see R. J. Blendon et al., "Common Concerns Amidst Diverse Health Care Systems: Sicker Adults' Views and Health Care Experiences in Five Nations," *Health Affairs* 22 (May/June 2003): 106–21.

[9] R. J. Blendon et al., "Inequities in Health Care: A Five-Country Survey," *Health Affairs* 21 (May/June 2002): 182–91; R. J. Blendon et al., "Common Concerns Amidst Diverse Health Care Systems: Sicker Adults' Views and Health Care Experiences in Five Nations," *Health Affairs* 22 (May/June 2003): 106–21.

was calculated by summing the individual ranked scores and ranking these totals from highest (value=1) to lowest (value=5) score.[10]

RESULTS

Safety

The IOM defines safety as "avoiding injuries to the patients from the care that is intended to help them." Survey measures of patient safety were primarily related to patient-reported perceptions of medication and medical errors. The 2002 survey asked sick adults about their experiences with medication or medical errors by a doctor, hospital, or pharmacist, and further inquired whether the error caused serious health consequences.[11] In addition, the survey asked patients if they had been taking a medication that caused serious side effects about which the doctor did not tell them. Exhibit 1 summarizes country findings on each of these measures of safety. In each of the five countries, at least 10 percent of the surveyed population reported receiving wrong medications or doses and at least 13 percent reported experiencing a medical error in the prior two years. Although there was not a large variation across the five countries for two of the measures related to medication errors, overall the U.K.'s sicker population reported the lowest rate of errors while the U.S. population reported the highest rate. Twice as many adults in the U.S. as in the U.K. reported a medication or medical error that caused a serious health consequence (18% vs. 9%). Adults in the U.S. were much more likely to be taking multiple medications, and those taking more medications were more likely to report medication or medical errors, suggesting that the increased error rate might be a result of increased opportunities for error.[12]

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[10] We also looked at other ways often used to rank countries, including an index used by the United Nations Human Development Index and the Fraser Institute Index of Human Progress to rank countries' performances: $\text{Index}_{\text{Max}}=W=[(\text{country value}-\text{maximum value}) / (\text{minimum value}-\text{maximum value})] \times 100$. We found that the simple ranking method used in this report and the method described here produced comparable results across these five countries and indicators.

[11] Two U.S. surveys have used similar questions to measure patient safety: R. J. Blendon et al., "Views of Practicing Physicians and the Public on Medical Errors," *New England Journal of Medicine* 347 (2002): 1933–40; and K. Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care* (New York: The Commonwealth Fund, April 2002).

[12] Thirty-six percent of sicker American adults reported taking four or more medications, compared with 22 to 25 percent in the other countries. R. J. Blendon et al., "Common Concerns Amidst Diverse Health Care Systems: Sicker Adults' Views and Health Care Experiences in Five Nations," *Health Affairs* 22 (May/June 2003): 106–21.

Exhibit 1. Patient Safety Measures: Frequency and Country Rankings,*
Sicker Adults, 2002

Percent reporting:	AUS	CAN	NZ	UK	US
Given the wrong medication or wrong dose by a doctor, hospital, or pharmacist in past 2 years	11% (2.5)	11% (2.5)	13% (5)	10% (1)	12% (4)
Believed a medical mistake was made in your treatment or care in past 2 years	19 (3)	20 (4)	18 (2)	13 (1)	23 (5)
Medication or medical mistake that caused serious health consequences in past 2 years	13 (2)	15 (4)	14 (3)	9 (1)	18 (5)
Have been taking medication that caused serious side effects that the doctor didn't tell you about	11 (4.5)	9 (2)	9 (2)	11 (4.5)	9 (2)
Within-Country Sum of Rankings	12	12.5	12	7.5	16
Overall Ranking	**2.5**	**4**	**2.5**	**1**	**5**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Source: 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Due to higher rates of patient-reported medical and medication errors, the U.S. ranked last on the summary score of the five safety measures, and the U.K. ranked first.

Differences in education and cultural norms, media attention, as well as the subjective nature of communication between doctors and patients, may influence patients' perceptions of error. Therefore, caution must be used in relying only on patients' perceptions to rank safety. Nevertheless, these findings indicate that U.S. patients have serious concerns about medical errors.

Patient-Centeredness

The IOM defines patient-centeredness as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." The 2002 survey of sicker adults probed respondents about physician care and communication. Measures of physicians' responsiveness to patients included: percent reporting that their regular doctor does not ask patients for ideas and opinions about treatment and care and does not make clear the specific goals of treatment, as well as percent of patients rating their physician as fair or poor in terms of spending enough time with them, being accessible by phone or in person, or listening carefully to their health concerns. As shown in Exhibit 2, about one-half (in U.S., 47%) to two-thirds (in U.K., 67%) of sicker adults reported that their regular doctor does not ask for ideas and opinions about their treatment and care. Twenty percent (in U.S.) to 38 percent (in U.K.) of sicker adults reported that their regular doctor does not make clear the specific goals for treatment. The U.S. rankings were in the same range as three other countries on these two measures, while the U.K. stood out. More U.K. patients than patients in the four other countries reported that their doctor does not ask for ideas and opinions about their treatment or make clear the specific goals for treatment.

Exhibit 2. Patient-Centeredness Measures: Frequency and Country Rankings,* Sicker Adults, 2002

Percent reporting:	AUS	CAN	NZ	UK	US
Regular doctor does not ask for ideas and opinions about treatment and care	51 (4)	49 (3)	47 (1.5)	67 (5)	47 (1.5)
Regular doctor does not make clear the specific goals for treatment	23 (3)	21 (2)	25 (4)	38 (5)	20 (1)
Physician fair or poor on spending enough time with patient	15 (2)	17 (3)	10 (1)	21 (4.5)	21 (4.5)
Physician fair or poor on being accessible by phone or in person	17 (2)	20 (3)	9 (1)	26 (5)	23 (4)
Physician fair or poor on listening carefully to patient's health concerns	9 (2)	10 (3)	8 (1)	14 (4)	17 (5)
Within-Country Sum of Rankings	13	14	8.5	23.5	16
Overall Ranking	**2**	**3**	**1**	**5**	**4**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Source: 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.

On three measures that asked patients to rate physician care in terms of time, accessibility, or listening carefully to their concerns, sicker adults in the U.S. and the U.K. reported negative experiences (fair or poor ratings) at twice the rate of patients in New Zealand. U.S. and U.K. adults also were the least likely to give physician care an excellent or very good rating on time, accessibility, or listening (not shown).

Across the five countries, one of 10 to more than one of five sicker adults gave their physicians a negative rating on measures of time or accessibility by phone or in person. In general, New Zealanders were least likely to report that their physicians did not spend enough time with them or that they had poor communication with their doctors. By contrast, the U.S. and U.K. had higher rates of reported problems with time, accessibility, and listening to patient's health concerns. U.K. physicians appear to involve patients less actively in care decisions than do physicians in other countries.

In the summary rankings, across all the measures of patient-centeredness, New Zealand ranked first, followed by Australia and Canada. The U.S. and U.K. ranked lowest.

Timeliness

The IOM defines timely care as "reducing waits and sometimes harmful delays for both those who receive and those who give care." Measures of timeliness included in the 2001 and 2002 surveys asked patients about waiting times for admission for elective surgery, days waiting for appointments with a regular physician, perceived problems in admission to a hospital, waits for emergency care, and difficulty seeing specialists when needed.

In 2001, survey respondents were asked to report actual waiting times for any elective/non-emergency surgery in the past two years and for an appointment with a physician when medical attention was last needed. The 2002 survey of sicker adults included more subjective questions, such as whether long waits for hospital admission or in emergency departments had been a big problem in the past two years.

Different country patterns surface for different measures of timeliness, depending on the particular health care service. Rankings on particular measures also at times switched between countries, depending on whether the survey used more objective measures of waiting time (days or months) or more subjective measures (big or serious problems).

The U.S. stands out for patients' reports of the shortest waiting time for elective or non-emergency surgery in 2001. Elective surgery waiting times were longest in the U.K., and long waits were reported in the other three countries (Exhibit 3). U.S. patients also were much less likely than patients in the other countries to report problems with long waits for hospital admission. In 2001, Canadians were the most likely to report a major problem with timely admission to hospitals.

For care outside the hospital, including waiting times to see a doctor, the U.S. did less well. Nearly one of five U.S. adults in 2001 said they waited five days or more for an appointment—a much higher rate than reported in either Australia or New Zealand. Australians and New Zealanders were notably more likely than U.S., Canadian, or U.K. patients to report that the last time they were sick or needed medical attention they were able to get an appointment on the same day. Thirty-seven percent of Australians, 61 percent of Canadians, 29 percent of New Zealanders, 55 percent of Britons, and 59 percent of Americans reported that they could not get a same-day appointment.

Exhibit 3. Timeliness Measures: Frequency and Country Rankings,* 2001 and Sicker Adults, 2002

	2001				
Percent reporting:	**AUS**	**CAN**	**NZ**	**UK**	**US**
Waiting time of four months or more for elective/nonemergency surgery (base: those needing elective surgery in past year)	23% (2)	27% (4)	26% (3)	38% (5)	5% (1)
Last time need medical attention had to wait 5 or more days for an appointment	5 (2)	23 (5)	1 (1)	16 (3)	18 (4)
	2002				
Percent reporting:	**AUS**	**CAN**	**NZ**	**UK**	**US**
Long waits to be admitted to the hospital were a big problem (base: respondent or family member hospitalized in past 2 years)	19 (2)	32 (5)	24 (4)	21 (3)	13 (1)
Delays or problems while discharge arrangements were being made (base: respondent or family member hospitalized in past 2 years)	9 (1.5)	9 (1.5)	11 (3)	15 (5)	12 (4)
Waiting time for emergency care was a big problem (base: used an emergency room in past 2 years)	31 (2.5)	37 (5)	28 (1)	36 (4)	31 (2.5)
Very difficult or somewhat difficult to see a specialist	41 (4)	53 (5)	36 (1)	38 (2)	40 (3)
Within-Country Sum of Rankings	14	25.5	13	22	15.5
Overall Ranking	**2**	**5**	**1**	**4**	**3**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Sources: 2001 Commonwealth Fund International Health Policy Survey; 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.

On other measures—waits for emergency care, delays at discharge, difficulty getting to see specialists—U.S. responses generally were in the middle of the range on timeliness. New Zealanders were the least likely to report that waiting for emergency care was a big problem, while Canadians were the most likely to report that it was a big problem. Canadians also were most likely to report difficulty seeing a specialist (53 percent of sicker adults in 2002).

Despite the comparatively greater supply of specialists in the U.S., 40 percent of sicker American adults in 2002 reported that it was somewhat or very difficult to see a specialist, roughly comparable to rates in Australia, New Zealand, and the U.K. But survey respondents' explanations for the problems they experienced in getting to see a specialist varied across countries. Americans were less likely than those in other countries to cite long waiting times for appointments, but markedly more likely to say that being denied a referral or having to wait for a referral was the reason they experienced this difficulty (data not shown).

Given the variation in timeliness scores by type of services, an overall ranking on timeliness is problematic. In particular, although U.S. outperformed the other nations in terms of quick access to hospital care, it scored in the mid-range on other measures of timeliness. In the overall ranking of timeliness, Canada and the U.K. vied for last place, depending on the source of care and type of measure. New Zealand and Australia performed particularly well on measures of timely access to physicians, placing their overall ranking among the five nations as one and two, respectively.

Efficiency

The IOM defines efficient care as "avoiding waste, including waste of equipment, supplies, ideas, and energy." Microeconomic efficiency means producing a given service at the lowest possible cost. Other than asking patients about their perceptions of waste or duplication, asking them to report on efficiency in the health care system is difficult. As a result, the surveys included only a few measures of care coordination that, taken together, can be indicators of efficiency from the patients' perspective. In the 2002 survey of sicker adults, adults were asked if they were sent for duplicate tests by different health care professionals, if they had to tell the same story to multiple health professionals, and if medical records or test results did not reach a physician's office in time for an appointment.

As shown in Exhibit 4, the U.S. had the highest percentage of sicker adults reporting these inefficient practices, although differences between the U.S. percentages and the next-highest percentages were minor on two of the three indicators. On all three indicators, U.S. rates of duplication or failure to coordinate care were substantially higher than three or more of the other four countries. Australia generally had the lowest reported instances of duplication or inefficiency. For example, one of seven Australians reported that medical records or test results did not reach a physician's office in time for an appointment, compared with one of four Americans. One of eight Australians reported being sent for duplicate tests by different health care professionals, compared with more than one of five Americans. In the summary ranking, Australia ranked first and the U.S. ranked last.

Exhibit 4. Efficiency Measures: Frequency and Country Rankings,*
Sicker Adults, 2002

Percent reporting:	**AUS**	**CAN**	**NZ**	**UK**	**US**
Sent for duplicate tests by different health care professionals, in past 2 years	13% (1.5)	20% (4)	17% (3)	13% (1.5)	22% (5)
Had to tell the same story to multiple health professionals, in past 2 years	49 (2.5)	50 (4)	47 (1)	49 (2.5)	57 (5)
Medical records/test results did not reach MD office in time for appointment, in past 2 years	14 (1)	19 (3)	16 (2)	23 (4)	25 (5)
Within-Country Sum of Rankings	5	11	6	8	15
Overall Ranking	**1**	**4**	**2**	**3**	**5**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Source: 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Effectiveness

Effectiveness is defined by the IOM as "providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit." Since patients are not reliable reporters of the scientific basis of the care they have received, the surveys could not directly assess clinical care or care effectiveness based on a strict IOM definition. A patient survey is probably less useful in assessing effectiveness than any of the other IOM dimensions of quality.

In the analysis, we thus used a proxy for effectiveness by assessing the extent to which patients understood and were able to follow up on physician care recommendations. These are measures of effectiveness, given that physicians are able to make recommendations for care based on available scientific evidence and patient non-adherence prevents the application of that evidence. The 2002 survey included three questions about whether patients received recommended care: whether or not patients got a recommended test, treatment, or follow-up care; filled a prescription; or skipped doses of medications to make them last longer.

The 2002 survey of sicker adults also included one question on whether in the past two years doctors had reviewed or discussed all of a patient's medications. Explaining medications is related both to effectiveness and safety. If physicians do not explain, patients may not know what beneficial effects to expect (e.g., for medications to treat hypertension, it is a difference in blood pressure, something that patients cannot "feel"). This may result in decreased adherence and, consequently, a decrease in the intended effectiveness of the therapeutic plan. Further, if physicians do not explain medications, patients may discontinue a medication prematurely because they experience unexpected side effects.

The results in Exhibit 5 indicate considerable variation across countries. The one measure where the U.S. did relatively well was whether physicians reviewed or discussed all medications taken by their patients in the past two years. Thirty percent of American patients said physicians did not do this, compared with 41 percent of Australian and 46 percent of British patients.

Exhibit 5. Effectiveness Measures: Frequency and Country Rankings,* Sicker Adults, 2002

Percent reporting:	**AUS**	**CAN**	**NZ**	**UK**	**US**
Did not get a recommended test, treatment, or follow-up due to cost, in past 2 years	16% (4)	10% (2)	15% (3)	5% (1)	26% (5)
Did not fill a prescription due to cost in past 2 years	23 (4)	19 (2)	20 (3)	10 (1)	35 (5)
Skipped doses to make medicine last longer	9 (4)	8 (3)	7 (2)	6 (1)	16 (5)
Doctor has not reviewed/discussed all of the medications they take in past 2 years	41 (4)	37 (3)	34 (2)	46 (5)	30 (1)
Within-Country Sum of Rankings	16	10	10	8	16
Overall Ranking	**4.5**	**2.5**	**2.5**	**1**	**4.5**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Source: 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.

The U.S. population fared much worse than other populations surveyed on the three questions that asked patients about going without needed care due to cost. On all three measures, Americans were the most likely to say they went without recommended care. U.K. patients were the least likely to report not filling a prescription due to costs. Americans reported skipping doses of medications at twice the rate and not filling prescriptions at three times the rate of Britons.

Across the adherence measures of effectiveness, the U.K. ranked first, Canada and New Zealand ranked next, and Australia and the U.S. tied for last.

Equity

The IOM defines equity as "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status." The 2001 survey's larger sample size enables contrasts among adults grouped by three income categories: those who reported their incomes as above the country median, those who reported incomes as about average relative to median, and those who reported their incomes as below the country median. In all five countries, adults reporting below-average incomes were more likely to report chronic health problems (not shown). Thus, reports from these lower-income adults provide particularly sensitive measures for how well each country performs in terms of meeting the needs of its most vulnerable population.

In Exhibit 6, we compare patient reports on various measures of access to care for adults reporting their incomes as below average and those reporting their incomes as above average. The exhibit ranks responses within each income group and displays percentage-point differences within countries for the two income groups. We include survey access measures expected to be sensitive to health care barriers for financial or geographic reasons, including difficulty getting care when needed; not getting needed or recommended care due to costs, including dental care; and having difficulty getting care because it is not available where one lives.

Exhibit 6. Equity Measures: Frequency and Country Rankings,* 2001

	Below-Average Income					Above-Average Income					Percentage-Point Difference Between Below-Average and Above-Average Income				
Percent reporting:	**AUS**	**CAN**	**NZ**	**UK**	**US**	**AUS**	**CAN**	**NZ**	**UK**	**US**	**AUS**	**CAN**	**NZ**	**UK**	**US**
Had medical problem but did not visit doctor due to cost in the past year	14% (3)	9% (2)	24% (4)	4% (1)	36% (5)	10% (3)	3% (2)	18% (5)	2% (1)	15% (4)	4% (2)	6% (3.5)	6% (3.5)	2% (1)	21% (5)
Did not get recommended test, treatment, or follow-up due to cost in the past year	17 (3)	9 (2)	18 (4)	4 (1)	36 (5)	14 (4.5)	4 (2)	11 (3)	1 (1)	14 (4.5)	3 (1.5)	5 (3)	7 (4)	3 (1.5)	22 (5)
Did not fill prescription due to cost in the past year	21 (3)	22 (4)	20 (2)	7 (1)	39 (5)	18 (4.5)	7 (1.5)	11 (3)	7 (1.5)	18 (4.5)	3 (2)	15 (4)	9 (3)	0 (1)	21 (5)
Had problem paying medical bills in past year	17 (3)	14 (2)	20 (4)	4 (1)	35 (5)	8 (4)	3 (2)	7 (3)	2 (1)	11 (5)	9 (2)	11 (3)	13 (4)	2 (1)	24 (5)
Often or sometimes unable to get care because it is not available where you live	19 (2)	23 (3)	24 (4)	14 (1)	28 (5)	14 (2)	17 (5)	16 (4)	11 (1)	15 (3)	5 (2)	6 (3)	8 (4)	3 (1)	13 (5)
Last time need medical attention had to wait 5 or more days for an appointment	6 (2)	27 (5)	2 (1)	15 (3)	21 (4)	3 (2)	20 (5)	1 (1)	17 (4)	16 (3)	3 (3)	7 (5)	1 (2)	-2 (1)	5 (4)
Extremely or very difficult to see a specialist when needed	14 (1)	20 (3)	21 (4)	16 (2)	30 (5)	11 (4)	14 (5)	6 (1)	9 (3)	8 (2)	3 (1)	6 (2)	15 (4)	7 (3)	22 (5)
Needed dental care but did not see dentist in past year	38 (2)	42 (4)	40 (3)	20 (1)	51 (5)	31 (4)	15 (1)	36 (5)	19 (2)	24 (3)	7 (3)	27 (4.5)	4 (2)	1 (1)	27 (4.5)
Within-Country Sum of Rankings	19	25	26	11	39	28	23.5	25	14.5	29	16.5	28	26.5	10.5	38.5
Overall Ranking	**2**	**3**	**4**	**1**	**5**	**4**	**2**	**3**	**1**	**5**	**2**	**4**	**3**	**1**	**5**

Note: Country ranking for each item indicated in parentheses.

* Average rankings are assigned to tied observations; "1" equals highest positive score.

Source: 2001 Commonwealth Fund International Health Policy Survey.

The U.S. had the greatest percentage-point disparities by income for each measure and, as a result, ranked a clear last on all measures of equity. Moreover, Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick, not getting a recommended test, treatment or follow-up care, not filling a prescription, or not seeing a dentist when needed due to costs. On all of these indicators, one-third or more of lower-income adults in the U.S. said they went without needed care due to costs in the past year. Americans with below-average incomes also were more likely to report difficulty getting care because of where they lived and more likely to say it is extremely or very difficult to get specialist care when needed. Even among the higher-income population, U.S. respondents often were more likely than their counterparts in other countries to report difficulty obtaining needed care due to costs.

The U.K. scored highest on equity, with only small differences between lower- and higher-income adults on most measures. Compared with lower-income adults in other countries, lower-income Britons were the least likely to report problems obtaining care because of cost. In the other three countries, differences by income most often emerged for services covered least well in universal national insurance programs, namely prescription drugs and dental care.

The U.S. is the only country surveyed without a universal health insurance system. On all measures included in Exhibit 6, uninsured adults were more likely than insured adults to report difficulties getting needed care or going without care due to costs. However, disparate experiences by income persist even after taking insurance status into account. Compared with insured Americans with above-average incomes, insured Americans with below-average incomes were more likely to report going without care due to costs and difficulties seeing a specialist when needed. In multivariate analyses, the U.S. was the only one of the five countries in which many more lower-income adults reported negative experiences in terms of the quality of their physicians' care, after controlling for health, insurance status, and other demographic characteristics.[13]

DISCUSSION

This examination provides evidence of deficiencies in terms of the quality of care in the U.S. health system, as reflected in the patients' mirror. Although the U.S. spends more on health care than any other country, has the highest ratio of specialist physicians per capita, and performs the most technological procedures per capita, survey findings indicate that

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[13] C. Schoen and M. M. Doty, "Inequities in Access to Medical Care in Five Countries: Findings from the 2001 Commonwealth Fund International Health Policy Survey," *Health Policy* (forthcoming).

from the patients' perspective the quality of American health care is less than optimal.[14] The nation's substantial investment in health care is not yielding returns in terms of public satisfaction with the health care system. In fact, in 2002, 44 percent of sicker adults in the U.S. reported being very or somewhat dissatisfied with the country's health care system.[15]

Based on these surveys of patients, the U.S. rarely outperforms the other nations surveyed; on most measures of the quality of care, it ranked last or second-to-last. Among the five countries surveyed, the U.S. performed particularly poorly on measures of equity and meeting the health care needs of its vulnerable populations. The U.S. also ranked last on patient perceptions of safety, efficiency, and effectiveness (measured in terms of ability to adhere to recommended care). Only on timeliness for admission to hospitals or for elective surgery did the U.S. rank highest among the five nations. In terms of timeliness for other services, including ready access to physicians, the U.S. was not the leader. New Zealand outperformed the U.S. in terms of providing prompt access to primary care physicians and specialists.

There are, of course, limits to reliance on patient perspectives to assess quality of care. Patient surveys are perhaps most useful when assessing timeliness and physician–patient communication. Unlike medical records or administrative data, such surveys typically contain few direct measures of effectiveness or efficiency, since patients are not usually in a position to report on these dimensions of care. Yet, reports from the World Health Organization (WHO) that compare health care system performance using measures such as life expectancy, infant mortality, or preventable years of life lost as well as health expenditures also suggest that the U.S. achieves the least for its population among these five countries.[16] A working group—supported by The Commonwealth Fund and with experts from each of the five countries, the Organization for Economic Cooperation and Development (OECD), and WHO—is currently developing a set of indicators that will provide objective measures of clinical effectiveness. It is possible that these indicators will yield a more complete picture of health care systems in which the U.S. performs more favorably.

It also is difficult to disentangle the effects of health insurance coverage from the quality of care experiences reported by U.S. patients. Comprehensiveness of insurance and stability of coverage are likely to factor in to access to care and interactions with

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[14] G. F. Anderson, V. Petrosyan, and P. S. Hussey, *Multinational Comparisons of Health Systems Data, 2002* (New York: The Commonwealth Fund, October 2002).

[15] R. J. Blendon et al., "Common Concerns Amidst Diverse Health Care Systems: Sicker Adults' Views and Health Care Experiences in Five Nations," *Health Affairs* 22 (May/June 2003): 106–21.

[16] World Health Organization, *The World Health Report 2000, Health Systems: Improving Performance* (Geneva: WHO, 2000).

physicians. We find that insured Americans and higher-income Americans are more likely than their counterparts in other countries to report problems such as not getting recommended tests, treatments, or prescription drugs. This may be a reflection of the lack of comprehensive health insurance coverage and the high out-of-pocket costs for care in the U.S., even among persons with insurance and above-average incomes. More fragmented insurance sources and discontinuous coverage also undermine efforts in the U.S. to improve care coordination, including the sharing of information among providers.

Like those used in the WHO report, the measures, methods, and data used in this analysis are far from perfect. Different measures, moreover, are not weighted based on independent evidence of what patients value most highly.

Cultural differences and patient expectations also may influence findings. Americans may have higher expectations of care and be less willing to tolerate delays or perceived barriers to care than patients in other countries. Individual reports may be influenced by survey respondents' attitudes (such as an unwillingness to complain), past history, or expectations. Patients' perceptions of medical errors, for example, likely depend on their level of education and awareness of potential risks as well as their past interactions with doctors.

One definition of "quality" health care is health services that meet or exceed consumer expectations. Even if the expectations of U.S. patients are higher than patients in other countries, the U.S. health care system should be held to the standard of meeting its consumers' needs. Thus, while patient perspectives are but one lens from which to view the U.S. care system, the overall conclusion remains: the U.S. health care system is not the "fairest of them all"—at least from the viewpoint of those who use it to stay healthy, get better or manage their chronic illness, or who are vulnerable because of low income and poor health.

Why does the American public consistently rank our health care system so low? What can be done to improve this situation? U.S. patients report that they face a number of barriers in getting high-quality care. Inadequacies of insurance coverage certainly contribute to these problems and to the inequities between insured and uninsured patients, and between high-income and low-income patients that are reported here. The U.S. is the only country among the five—indeed, among all major industrialized countries—not to have a universal system of health coverage. In 2002, the number of uninsured rose to 43.6 million people, a 4 million person or 10 percent increase over the past two years.[17]

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[17] U.S. Census, Current Population Survey, available at http://www.census.gov.

Patients in the U.S. also pay a much higher percentage of health care expenses out-of-pocket than do patients in the four other countries.[18]

But, beyond financial barriers, patients in the U.S. and the other four countries surveyed who do get care report that it is not always safe, patient-centered, timely, or efficient. Many patient reports correspond with reports by physicians in these five countries. The Commonwealth Fund 2000 International Health Policy Survey of Physicians found that U.S. physicians were more likely than physicians in the other four countries to report major problems, such as patients who cannot afford necessary prescription drugs and limitations on drugs one can prescribe. They also were more likely to indicate that their patients have difficulty affording out-of-pocket costs or are not able to afford the care they need.[19] Only U.K. physicians were more likely than U.S. physicians to view as a major problem for their own medical practice not having enough time with patients. However, U.S. physicians were more likely than physicians in the other four countries to report that their hospitals were excellent or good at finding and addressing medical errors and having adequate nursing staff, emergency room facilities, and the latest medical and diagnostic equipment. U.S. physicians also were least likely to report long waits for specialist referrals and long waiting times for surgical or hospital care.

Improving on patient-reported dimensions of quality in the U.S. will undoubtedly require a sustained effort to improve coordination of care and promote the adoption of systems that support better transfer of information across multiple providers of care and that assist clinicians in providing safe and effective care. The 2000 International Health Policy Survey of Physicians found that physicians in the U.K. and New Zealand make much more extensive use of electronic medical records and electronic prescribing than do physicians in the U.S.[20] Twenty-four percent of Australian physicians, 14 percent of Canadian physicians, 49 percent of New Zealand physicians, 58 percent of U.K. physicians, and 17 percent of U.S. physicians reported frequent use of electronic medical records.[21]

A number of recent developments may help to accelerate the rate of adoption of information technologies in this country. About 20 government agencies have agreed to adopt health information interoperability standards that will enable them to "speak the

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[18] C. Schoen and M. M. Doty, "Inequities in Access to Medical Care in Five Countries: Findings from the 2001 Commonwealth Fund International Health Policy Survey," *Health Policy* (forthcoming).

[19] R. J. Blendon et al., "Physicians' Views on Quality of Care: A Five-Country Comparison," *Health Affairs* 20 (May/June 2001): 233–43.

[20] The Commonwealth Fund, *The Commonwealth Fund 2000 International Health Policy Survey of Physicians: Chartpack,* May 2001, http://www.cmwf.org/programs/international/2000_intl_chartpack.ppt.

[21] Ibid.

same language." The standards aim to: 1) improve care coordination in terms of ordering, scheduling appointments and tests, and admitting, discharge, and transfer of patients; 2) standardize ordering of drugs from retail pharmacies; 3) allow health care providers to monitor information from an intensive care unit or through telehealth services; 4) enable images and associated diagnostic information to be transferred from various devices as well as medical staff workstations; and 5) standardize the electronic exchange of clinical laboratory results.

In addition, the Department of Health and Human Services recently announced two steps toward achieving routine use of electronic medical records. The National Library of Medicine signed a $32 million five-year contract with the College of American Pathologists to license its compilation of standardized medical vocabulary, which is in use in 40 countries. The agreement will make it easy for doctors, hospitals, insurers, public health departments, and others to use uniform clinical terms. The Institute of Medicine will design a standardized model of an electronic health record, to be ready in 2004.

Other countries' experiences suggest models for the U.S. to explore in seeking to improve its health system performance. The U.K. ranked high on measures of equity and lack of financial barriers to care. New Zealand ranked high on measures of patient-centered care and responsiveness. Australia ranked high in terms of minimal duplication of tests and delays due to tests not reaching physicians' offices in time for patient visits, both of which are indicators of efficiency. Rather than focus solely on best practices within its borders, the U.S. would benefit from a systematic examination of models of care and best practices from other countries.

In addition to looking at models of care from other countries, we need to find better ways to diffuse models that have been shown to be effective locally, or within the context of demonstration projects. For example, there is evidence that an advanced access approach to scheduling office visits can enable patients to make appointments—even walk-in or same-day appointments—that match their needs.[22] But this practice is still not widely implemented. Wennberg and colleagues have developed a shared decision-making process that has proven to increase patients' satisfaction with the communication process, which the surveys identify as a major source of problems.[23] In this case, the benefits apply to many dimensions of quality, including patient-centeredness, effectiveness, and safety.

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[22] M. Murray and D. M. Berwick, "Advanced Access: Reducing Waiting and Delays in Primary Care," *Journal of the American Medical Association* 290 (July 16, 2003): 332–33.

[23] J. E. Wennberg, "Shared Decision-Making and the Future of Managed Care," *Disease Management and Clinical Outcomes* 1 (1997): 15–16.

Yet, such approaches and tools are not widely used by physicians and their patients, pointing to the need for more effective diffusion strategies.

These results indicate a consistent relationship between how a country performs in terms of equity and how patients then rate performance on other dimensions of quality: the lower the performance score for equity, the lower the performance on other measures. This suggests that, when a country fails to meet the needs of the most vulnerable, it will be judged most harshly by its citizens. Rather than disregarding its performance on equity as a separate and lesser concern, the U.S. should devote far greater attention to seeing that the health system works well for all Americans. These findings raise fundamental questions about the current trend in the U.S. to increase patients' out-of-pocket costs, and about the lack of action on the growing numbers of uninsured and underinsured. The U.S. needs to make a major commitment to improving health insurance coverage and quality of care. If it fails to act, not only will the U.S. standing among health systems continue to erode, but there will be a predictable rise in public dissatisfaction and significant economic and human costs.

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#654 *American Health Care: Why So Costly?* (June 11, 2003). Karen Davis, The Commonwealth Fund. In invited testimony before a Senate Appropriations subcommittee hearing on rising health care costs, the Fund's president outlined a number of steps that need to be taken to achieve a high-performing, accessible health system, including: public reporting of health care cost and quality data, establishment of quality standards, broad-scale demonstrations of new approaches to insurance coverage, investment in modern information technology and improved care processes, provider performance incentives, and elimination of waste and ineffective care.

#645 *Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries* (May/June 2003). Robert J. Blendon, Cathy Schoen, Catherine DesRoches, Robin Osborn, and Kinga Zapert. *Health Affairs,* vol. 22, no. 3 (*In the Literature* summary). In this article, based on the Commonwealth Fund 2002 International Health Policy Survey of adults with health problems in five industrialized countries, the authors point to widespread error, inefficiency, and missed opportunities in those health systems. They suggest that reforms targeted to populations with health problems could reap system-wide improved quality and cost savings.

#640 *The Australian Health Care System: Views and Experiences of Adults with Health Problems—Findings from the Commonwealth Fund 2002 International Health Policy Survey* (May 2003). This data brief is a companion to the *Health Affairs* article (see *In the Literature* **#645** above).

#641 *The Canadian Health Care System: Views and Experiences of Adults with Health Problems—Findings from the Commonwealth Fund 2002 International Health Policy Survey* (May 2003). This data brief is a companion to the *Health Affairs* article (see *In the Literature* **#645** above).

#642 *The New Zealand Health Care System: Views and Experiences of Adults with Health Problems—Findings from the Commonwealth Fund 2002 International Health Policy Survey* (May 2003). This data brief is a companion to the *Health Affairs* article (see *In the Literature* **#645** above).

#643 *The United Kingdom Health Care System: Views and Experiences of Adults with Health Problems—Findings from the Commonwealth Fund 2002 International Health Policy Survey* (May 2003). This data brief is a companion to the *Health Affairs* article (see *In the Literature* **#645** above).

#644 *The United States Health Care System: Views and Experiences of Adults with Health Problems—Findings from the Commonwealth Fund 2002 International Health Policy Survey* (May 2003). This data brief is a companion to the *Health Affairs* article (see *In the Literature* **#645** above).

#578 *Exploring Consumer Perspectives on Good Physician Care: A Summary of Focus Group Results* (January 2003). Donna Pillittere, Mary Beth Bigley, Judith Hibbard, and Greg Pawlson. Part of a multifaceted Commonwealth Fund-supported study, "Developing Patient-Centered Measures of Physician Quality," the authors report that consumers can understand and will value information about effectiveness and patient safety (as well as patient-centeredness) if they are presented with information in a consumer-friendly framework.

#582 *Multinational Comparisons of Health Systems Data, 2002* (October 2002). Gerard F. Anderson, Varduhi Petrosyan, and Peter S. Hussey, Johns Hopkins University. This chartbook uses data from the Organization for Economic Cooperation and Development to compare performance of health care systems in eight countries—Australia, Canada, France, Germany, Japan, New Zealand, the United Kingdom, and the United States.