

# Primary Care And Health System Performance: Adults' Experiences In Five Countries

Differing performance levels among countries highlight the potential for improvement and cross-national learning.

by **Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Karen Davis, Kinga Zapert, and Jordon Peugh**

**ABSTRACT:** This paper reports on a 2004 survey of primary care experiences among adults in Australia, Canada, New Zealand, the United Kingdom, and the United States. The survey finds shortfalls in delivery of safe, effective, timely, or patient-centered care, with variations among countries. Delays in lab test results and test errors raise safety concerns. Failures to communicate, to engage patients, or to promote health are widespread. Aside from clinical preventive care, the United States performs poorly on most care dimensions in the study, with notable cost-related access concerns and short-term physician relationships. Contrasts across countries point to the potential to improve performance and to learn from international initiatives.

PRIMARY CARE STANDS AT THE CENTER of medical care systems. Key functions include providing an entry point, delivering core medical and preventive care, and helping patients coordinate and integrate care.<sup>1</sup> When working well, each of these dimensions is instrumental in improving health outcomes and cost performance.<sup>2</sup> Ready access to effective primary care also offers the potential to reduce disparities in care, increasing citizens' opportunities to live healthy, productive lives. Internationally, a shared challenge in the twenty-first century is how to redesign primary care to make care more accessible, continuous, coordinated, and patient-centered. Calls to redesign care systems include an emphasis on promoting health and engaging patients in their own care.<sup>3</sup>

This paper presents findings from the 2004 Commonwealth Fund International Health Policy Survey in Australia, Canada, New Zealand, the United Kingdom, and the United States—the seventh in a series of annual international surveys.<sup>4</sup> The 2004 survey focuses on primary care and ambulatory care experiences.

---

*Cathy Schoen (CS@cmwf.org) is vice president, Health Policy, Research, and Evaluation, at the Commonwealth Fund in New York City. Robin Osborn is vice president, International Health Policy and Practice, there; Phuong Trang Huynh, a program officer; Michelle Doty, a senior analyst; and Karen Davis, president. Kinga Zapert is vice president of Harris Interactive in New York City, where Jordon Peugh is a senior research manager.*

In each of these countries, the quest to improve system performance has sparked an array of primary care initiatives. These operate within varying country contexts.<sup>5</sup> The United States is unique for its high percentage of specialists (60 percent or more, depending on definition), mix of primary care doctors, cost sharing, and high rates of uninsurance. Australia, Canada, New Zealand, and the United Kingdom rely on general practitioners (GPs) and family practice doctors for primary care; less than half of all physicians are specialists. The United Kingdom is unique among the five countries for requiring that patients register with a GP clinic and that GPs have arrangements for after-hours care. It is also the only country that pays for care based on capitation, with performance incentives. The other four countries all pay predominantly fee for service, although New Zealand is moving toward capitation.<sup>6</sup> The United Kingdom also provides the most comprehensive coverage, with few or no patient costs. Canada also covers physician care in full but leaves gaps in pharmacy care. Australia's and New Zealand's universal insurance systems include provisions for cost sharing for doctor visits as well as for other care.

■ **Survey methods.** The survey explores recent experiences with access to care, emergency care, coordination, continuity, and doctor-patient interactions. The survey also sought adults' views of choice, access to medical records, e-mail communication with physicians, and care systems overall. By identifying areas of shared concern and contrasting country differences from the patient perspective, the study seeks to inform policy efforts. Findings indicate substantial room for improvement in all five countries on key dimensions of care quality and missed opportunities to communicate, coordinate care, and engage patients. Country variations point to the potential to learn from cross-national experiences.

The survey consisted of telephone interviews with random, representative samples of people age eighteen and older in each of the five countries. The questionnaire was designed by researchers at the Commonwealth Fund and Harris Interactive, with the advice of and review by experts in each country, and it drew from concepts and modified scales in surveys developed for primary care.<sup>7</sup> Except for minor wording changes to reflect terminology differences, the same instrument was used in each country. Harris Interactive and country affiliates conducted telephone interviews between 29 March and 17 May 2004. Interviews lasted an average of seventeen minutes. The survey was conducted in English, with a French option in Canada and a Spanish option in the United States.

The final samples of adults were 1,400 in Australia, 1,410 in Canada, 1,400 in New Zealand, 3,061 in the United Kingdom, and 1,401 in the United States. The Commonwealth Fund provided support for random samples of 1,400 in each country. The Health Foundation partnered with the fund to expand the U.K. sample in specific regions, to enable future analysis by U.K. country.<sup>8</sup>

All surveys are subject to sampling error. The margin of sampling error is approximately plus or minus three percentage points for differences between coun-

tries and plus or minus two percentage points for country averages at the 95 percent confidence level. Poststratification weights were applied in each country to adjust for variations between the sample demographics and known population parameters. Analysis compared responses between or within countries using t-tests and chi-square tests. Text and exhibits indicate where differences were significant at the .05 level. The exhibits compare each country, indicating where country pairs differ significantly.<sup>9</sup>

## Survey Findings

■ **Views of the health system.** The survey asked about system views, confidence, and general cost experiences. Based on a question also asked in 1998 and 2001, the United States stands out as the most negative in overall public views and the United Kingdom as the most positive, repeating a pattern observed across the six years. One-third of U.S. adults called for rebuilding in 2004, with public discontent up since 2001, returning to 1998 levels (Exhibit 1). In contrast, U.K. system views have improved since 2001. In New Zealand and Canada, views have grown more positive across the six-year period, with a marked decline in the vote to rebuild. Australia has fluctuated over time. Yet in all of the countries, majorities continue to call for major reforms. Moreover, in all five countries, only a minority of adults are “very confident” that they will get high-quality, safe medical care when needed.

When respondents were asked about total out-of-pocket costs during the past year, wide differences emerged. The United States stands out for the greatest exposure to costs, and the United Kingdom for the least. More than one-quarter of U.S. adults (both insured and uninsured) spent more than \$1,000 out of pocket on health care in the past year, far exceeding expense burdens in the other countries. Reflecting national insurance designs that include patient cost sharing or benefit gaps, adults in Australia, Canada, and New Zealand were more exposed to costs than their U.K. counterparts but less so than U.S. adults.

■ **Access.** Having a usual doctor or place for care with a relationship over time provides a critical foundation for primary care. The vast majority of adults in all five countries reported having either a regular doctor or place of care, such as a clinic, health center, or group practice (Exhibit 2). The United States was notable, with about one in ten adults having no usual person or place and nearly one in five, no usual doctor. Except in the United States, these relationships tended to be long-term. Nearly two thirds of U.K. adults had been with the same doctor or place of care for more than five years, as had the majority of adults in Australia, Canada, and New Zealand. In contrast, only 37 percent of U.S. adults had such long-term relationships.

To explore accessibility to patients, the survey asked about timeliness, twenty-four-hour availability, and financial access. Reports revealed striking between-country differences. The majority of adults in New Zealand and Australia said that they received appointments the same day the last time they were sick and needed medical attention. In contrast, only one-third or less of Canadian or U.S. adults re-

**EXHIBIT 1**  
**Health System Views And Cost Experiences Among Adults In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Overall system views, trend 1998–2004					
Only minor changes needed, system works well					
2004	21% <sup>d,e</sup>	21% <sup>d,e</sup>	19% <sup>d,e</sup>	26% <sup>e</sup>	16%
2001	25 <sup>a</sup>	21	18	21 <sup>a</sup>	18
1998	19	20	9 <sup>a</sup>	25	17
Fundamental changes needed					
2004	55 <sup>b,c,d,e</sup>	63 <sup>d,e</sup>	60 <sup>e</sup>	59 <sup>e</sup>	47
2001	53	59	60	60	51
1998	49	56	57	58	46
Rebuild completely					
2004	23 <sup>b,c,d,e</sup>	14 <sup>c,e</sup>	19 <sup>d,e</sup>	13 <sup>e</sup>	33
2001	19 <sup>a</sup>	18 <sup>a</sup>	20	18 <sup>a</sup>	28 <sup>a</sup>
1998	30 <sup>a</sup>	23 <sup>a</sup>	32 <sup>a</sup>	14	33
Confidence and costs in 2004					
Confident will get quality and safe medical care when needed					
Very confident	28	25 <sup>d,e</sup>	27	30	30
Somewhat confident	46 <sup>b</sup>	54 <sup>c,d,e</sup>	47	47	44
Not very or not at all confident	25 <sup>b</sup>	20 <sup>c,e</sup>	25	23	24
Out-of-pocket medical expenses in the past year, in U.S. dollar equivalent <sup>f</sup>					
None	10 <sup>b,c,d</sup>	22 <sup>c,d,e</sup>	7 <sup>d,e</sup>	57 <sup>e</sup>	11
\$1–\$100	14 <sup>b,c,e</sup>	19 <sup>d,e</sup>	21 <sup>d,e</sup>	15 <sup>e</sup>	7
\$101–\$1,000	44 <sup>b,c,d</sup>	39 <sup>c,d</sup>	50 <sup>d,e</sup>	21 <sup>e</sup>	42
More than \$1,000	14 <sup>c,d,e</sup>	12 <sup>c,d,e</sup>	5 <sup>d,e</sup>	4 <sup>e</sup>	26

**SOURCES:** Commonwealth Fund International Health Policy Surveys, 1998, 2001, and 2004.

**NOTE:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below.

<sup>a</sup> Within country,  $p < .05$  for difference from 2004.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

<sup>f</sup> Out-of-pocket expenses do not add to 100 percent because of "don't know"/missing.

ported such rapid access. Canadian and U.S. adults also reported long waits, with 20–25 percent waiting at least six days to get an appointment when sick, a waiting time rare in Australia or New Zealand.

Difficulty in getting care nights, weekends, or holidays was of significant concern in all five countries. Although problems were most widespread in the United States, majorities of adults in Australia and Canada also said that after-hours access was difficult. Even in New Zealand, where the rate of difficulty was lowest, one-third of adults viewed after-hours access as difficult.

Telephone help lines provide a potential source for primary care access after hours. In the United Kingdom, NHS Direct operates a twenty-four-hour telephone nurse advice and information service. When respondents were asked about any use of such assistance in the past two years, help lines were used most frequently in Canada and the United Kingdom, followed by the United States.<sup>10</sup>

**EXHIBIT 2**  
**Access To Care And To Physicians In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Do you have a doctor or GP you regularly see?					
Yes	88% <sup>c,d,e</sup>	86% <sup>c,d</sup>	91% <sup>e</sup>	91% <sup>e</sup>	83%
No, but usual place of care	6 <sup>b</sup>	9 <sup>c</sup>	6 <sup>d,e</sup>	8	8
No usual doctor or place	5 <sup>c,d,e</sup>	5 <sup>c,d,e</sup>	3 <sup>d,e</sup>	1 <sup>e</sup>	9
Length of time with doctor or usual place					
No regular doctor/place of care	5 <sup>c,d,e</sup>	5 <sup>c,d,e</sup>	3 <sup>d,e</sup>	1 <sup>e</sup>	9
2 years or less	22 <sup>d,e</sup>	20 <sup>e</sup>	21 <sup>e</sup>	18 <sup>e</sup>	29
3-5 years	22 <sup>d</sup>	21 <sup>d,e</sup>	20 <sup>d,e</sup>	17 <sup>e</sup>	25
More than 5 years	50 <sup>c,d,e</sup>	53 <sup>d,e</sup>	56 <sup>d,e</sup>	63 <sup>e</sup>	37
Last time you were sick or needed medical attention, how quickly can you get an appointment to see a doctor?					
Same day	54 <sup>b,c,d,e</sup>	27 <sup>c,d,e</sup>	60 <sup>d,e</sup>	41 <sup>e</sup>	33
Next day	21 <sup>b,d,e</sup>	15 <sup>c,d</sup>	24 <sup>d,e</sup>	18	18
2 to 5 days	17 <sup>b,c,d,e</sup>	27 <sup>c</sup>	11 <sup>d,e</sup>	26	24
6 or more days	7 <sup>b,c,d,e</sup>	25 <sup>c,d,e</sup>	2 <sup>d,e</sup>	13 <sup>e</sup>	19
How difficult is it to get care on nights, weekends, or holidays without going to the ER?					
Very or somewhat easy	25 <sup>c,d</sup>	29 <sup>c,e</sup>	46 <sup>d,e</sup>	30 <sup>e</sup>	23
Very or somewhat difficult	54 <sup>b,c,d,e</sup>	59 <sup>c,d,e</sup>	33 <sup>d,e</sup>	43 <sup>e</sup>	63
Never needed care in evenings, weekends, holidays	15 <sup>b,d,e</sup>	8 <sup>c,d,e</sup>	18 <sup>d,e</sup>	21 <sup>e</sup>	11
Have you called a help line for medical or health advice in past 2 years? (percent answering yes)	8 <sup>b,d,e</sup>	24 <sup>c,d,e</sup>	8 <sup>d,e</sup>	28 <sup>e</sup>	17
Access problems because of costs during past 12 months					
Did not get medical care because of cost of doctor's visit	17 <sup>b,c,d,e</sup>	6 <sup>c,e</sup>	28 <sup>d</sup>	4 <sup>e</sup>	29
Skipped medical test, treatment, or follow-up because of cost	18 <sup>b,d,e</sup>	8 <sup>c,d,e</sup>	20 <sup>d,e</sup>	2 <sup>e</sup>	27
Did not fill Rx or skipped doses because of cost	12 <sup>d,e</sup>	9 <sup>d,e</sup>	11 <sup>d,e</sup>	4 <sup>e</sup>	21
Yes to at least one of the above	29 <sup>b,c,d,e</sup>	17 <sup>c,d,e</sup>	34 <sup>d,e</sup>	9 <sup>e</sup>	40

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below. GP is general practitioner. ER is emergency room.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

Access concerns were also related to costs. As found in past surveys, the percentage of adults who went without care because of costs correlated closely with countries' insurance systems. With a system characterized by high uninsurance rates and cost sharing for the insured, U.S. adults were the most likely to say that they did not see a doctor when sick, did not get recommended tests or follow-up care, or went without prescription medications because of costs in the past year. New Zealand rates of not seeing a doctor rivaled U.S. rates and were significantly higher than rates in the other three countries. The United Kingdom and Canada stand out for having negligible cost-related access problems. Australia stands midway between the country extremes.

Lower-income adults' access to care was particularly sensitive to costs, with problems again the most acute in the United States. Among adults with incomes

below countries' national medians, the share going without any of the three services because of cost ranged from a low of 12 percent in the United Kingdom, 26 percent in Canada, 35 percent in Australia, and 44 percent in New Zealand to a high of 57 percent in the United States (data not shown in Exhibit 2).

■ **Emergency room care.** The emergency room (ER) serves as a sensitive indicator for how well care systems are responding to patients' needs. ER use rates during the past two years were significantly higher in Canada and the United States than the other three countries (Exhibit 3). Canadian and U.S. adults were also more likely to have gone to the ER for care that their regular source could have provided if available. In these two countries, such ER visits accounted for about half of recent ER use. The survey also found use of the ER substituting for regular physician care in the other three countries, but to a lesser extent. Notably, adults in Canada and the United States were less likely than adults in the other countries to report rapid access to doctors when sick and more likely to say that after-hours access was difficult. In combination, these indicators signal widespread patient concerns about

**EXHIBIT 3  
Hospital Emergency Room (ER) Use And Experiences In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Number of times respondent has gone to ER in past 2 years					
Yes, any visit	29% <sup>b,e</sup>	38% <sup>c,d,e</sup>	27% <sup>e</sup>	29% <sup>e</sup>	34%
1	16 <sup>b</sup>	20 <sup>c</sup>	16 <sup>d</sup>	19	18
2 or more	13 <sup>b,d,e</sup>	18 <sup>c,d</sup>	11 <sup>e</sup>	10 <sup>e</sup>	16
Went to ER for a condition that could have been treated by regular doctor or source of care if available	9 <sup>b,c,d,e</sup>	18 <sup>c,d</sup>	7 <sup>e</sup>	6 <sup>e</sup>	16
Base: Used the ER at least once (n)	357	530	331	911	449
Rating of emergency care services					
Excellent or very good	55% <sup>b</sup>	45% <sup>d</sup>	51%	53%	47%
Good	22	27 <sup>e</sup>	22	22	18
Fair or poor	23 <sup>e</sup>	27 <sup>e</sup>	27	23 <sup>e</sup>	34
Waiting time in ER before being treated					
Less than 30 minutes	40% <sup>b,d</sup>	22% <sup>c,d,e</sup>	41% <sup>d</sup>	33%	37%
30 minutes to less than 1 hour	15	11 <sup>d</sup>	14	16	16
1 hour to less than 2 hours	13	17 <sup>d,e</sup>	17	12	11
2 hours or more	29 <sup>b,d,e</sup>	48 <sup>c,d,e</sup>	27 <sup>d,e</sup>	36	34
Respondent was in pain while in ER	68	64 <sup>e</sup>	62 <sup>e</sup>	62 <sup>e</sup>	73
Hospital staff did everything they could to help control pain					
Base: Said yes, was in pain (n)	243	336	199	586	308
Yes, definitely	50% <sup>b,c,e</sup>	31% <sup>d</sup>	37% <sup>d</sup>	48% <sup>e</sup>	33%
Yes, to some extent	20 <sup>b,e</sup>	34 <sup>d</sup>	27	27	29
No	30	34 <sup>d</sup>	33 <sup>d</sup>	24 <sup>e</sup>	36
After ER visit, regular doctor did not seem informed and up-to-date about care received in the ER	30	36 <sup>c</sup>	28	32	30

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

timely primary care access in both countries.

The quality of ER care was of concern in all countries. Long waiting times (two hours or more) were common. ER waits appear to be a particular concern in Canada, but waits were also often long in the United Kingdom and United States. Lack of effective ER response to pain emerged as a shared concern across countries. Among those in pain when they went to the ER, at most half of adults in any country thought that the ER staff did everything they could to help control pain. Australian and U.K. ERs received the highest marks for pain relief, but even in these countries substantial shares of patients thought that the staff could have done more. In all countries, reports of follow-up care after ER visits indicate frequent gaps in continuity with primary care doctors. Among those with a usual care source and an ER visit, 28–36 percent said that their doctor did not seem informed or up-to-date about care received in the ER.

■ **Coordination.** Improving coordination and continuity of care are key goals of primary care initiatives. Failure to coordinate care across sites of care or capture episodes of care in patients' medical histories can lead to medical errors, undermine quality and outcomes, increase duplication and other inefficiencies, and frustrate and overwhelm patients. The survey found coordination concerns in all five countries.

Seeing multiple doctors and other health professionals was the norm, with little variation by country (Exhibit 4). Among those with a recent doctor visit, one in four or more adults in each country reported a problem with coordination of care based on three indicators: Test results or medical records were not available at the time of a scheduled appointment; patients received duplicate tests or procedures; patients received conflicting information; or some combination. U.S. rates were significantly higher than at least three of the other four countries on each measure.

About two of five adults said that they take prescription drugs regularly, with the majority of these taking multiple medications. Among those taking prescription drugs regularly, failures by physicians to review medications were frequent, raising risks of drug interactions. High proportions also said that their doctor had not explained medication side effects. On these indicators, U.K. adults were significantly more likely to cite failures to review or explain side effects of medications, but rates were high in all countries.

Timely receipt and accuracy of lab and diagnostic results emerged as a coordination and safety risk. Among those with a recent test, 16–28 percent said that there was a time when they did not receive results or that results were not clearly explained. Rates of results delayed or not explained were significantly lower in Australia and higher in Canada than in the other countries.

Raising safety concerns, 8–15 percent of patients said that they were given incorrect test results (either false positive or negative) or had experienced delays in being notified about abnormal results. Test error rates were highest in Canada, New Zealand, and the United States. Also, as seen with the ER, continuity and coordination gaps with primary care also occurred after hospitalization.

**EXHIBIT 4**  
**Use Rates And Coordination: Medical Care, Prescription Drugs, And Diagnostic Tests**  
**In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Number of different doctors and other health professionals seen in past 2 years					
None	2% <sup>b,c,d,e</sup>	4%	3%	4%	3%
One	20 <sup>c</sup>	22	26 <sup>d</sup>	22	23
Two	28 <sup>b</sup>	33 <sup>d</sup>	30	28 <sup>e</sup>	32
Three or more	50 <sup>b,c,d,e</sup>	40 <sup>d</sup>	40 <sup>d</sup>	45 <sup>e</sup>	41
In the past 2 years (base: have seen at least one doctor in past 2 years) (n)					
	1,373	1,345	1,351	2,911	1,361
Test results or medical records were not available at time of scheduled appointment	12% <sup>e</sup>	14%	13% <sup>e</sup>	13% <sup>e</sup>	17%
Doctors ordered a medical test that you felt was unnecessary because the test had already been done	7 <sup>d,e</sup>	6 <sup>d,e</sup>	7 <sup>d,e</sup>	4 <sup>e</sup>	14
Received conflicting information from different doctors	18 <sup>b,c,d</sup>	14 <sup>e</sup>	14 <sup>e</sup>	14 <sup>e</sup>	18
Percent who said yes to at least one of the above	28	26 <sup>e</sup>	25 <sup>e</sup>	24 <sup>e</sup>	31
Prescription medication					
Percent taking prescription medications on regular or ongoing basis	39% <sup>d,e</sup>	43%	39% <sup>d,e</sup>	44%	46%
Number of different prescription medications					
None	60 <sup>d,e</sup>	57 <sup>c</sup>	61 <sup>d,e</sup>	56	54
Taking 1 prescription	14 <sup>e</sup>	14 <sup>e</sup>	14 <sup>e</sup>	14 <sup>e</sup>	11
Taking 2 or more different prescriptions	26 <sup>d,e</sup>	29 <sup>e</sup>	25 <sup>d,e</sup>	30	34
In past 2 years (base: taking prescriptions regularly) (n)					
	555	623	638	1,407	715
Your doctor has not reviewed the medications you take, including those prescribed by other doctors	29 <sup>d</sup>	25 <sup>c,d</sup>	31 <sup>d,e</sup>	37 <sup>e</sup>	25
Your doctor has not explained the side effects of any medication that was prescribed	25 <sup>d</sup>	28 <sup>d</sup>	27 <sup>d</sup>	39 <sup>e</sup>	30
Percent who indicated yes to at least one of the above	42 <sup>d</sup>	39 <sup>d</sup>	42 <sup>d</sup>	55 <sup>e</sup>	41
Lab, x-ray, and diagnostic tests					
Percent with blood tests, x-rays, or any other tests in the past 2 years	83 <sup>d</sup>	84 <sup>d</sup>	82 <sup>d</sup>	71 <sup>e</sup>	84
Base: had tests in past 2 years (n)					
	1,161	1,181	1,165	2,209	1,212
Last time had tests did not find out results	8% <sup>b,c,d</sup>	20% <sup>c,d,e</sup>	13% <sup>e</sup>	12%	10%
Received results but results were not clearly explained	8	10	10	10	11
Percent who did not find out results or to whom results were not clearly explained	16 <sup>b,c,d,e</sup>	28 <sup>c,d,e</sup>	22	21	20
In past 2 years					
You have been given incorrect results for diagnostic or lab test	4%	5% <sup>d</sup>	5% <sup>d</sup>	3% <sup>e</sup>	6%
You have experienced delays in being notified about abnormal results	6 <sup>b,c,e</sup>	9 <sup>d</sup>	11 <sup>d</sup>	6 <sup>e</sup>	11
Percent who been given incorrect results for test results or who had delays in being notified about abnormal results	9 <sup>b,c,e</sup>	12 <sup>d,e</sup>	14 <sup>d</sup>	8 <sup>e</sup>	15
Percent hospitalized overnight in the past 2 years (excluding normal delivery)					
	19 <sup>b,d,e</sup>	13 <sup>c</sup>	17 <sup>d</sup>	14	15
Among those hospitalized past 2 years: regular doctor did not seem informed and up-to-date about plans for follow-up care after you left the hospital	19	21	23 <sup>e</sup>	23 <sup>e</sup>	13

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.



■ **Missed opportunities: doctor-patient communications and interactions.**

A key goal of efforts to improve performance and primary care is to make care more patient-centered. On this dimension, the study reveals missed opportunities to identify patients' preferences or concerns, to communicate well, or to engage patients in care decisions. Across countries, most adults rated their doctors positively, and the majority said that their doctor always listens carefully and explains things clearly (Exhibit 5). In each country, adults were much less positive about physicians'

**EXHIBIT 5**  
**Doctor-Patient Relationship And Communication In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Overall, how do you rate the quality of care received from your doctor in past 12 months?					
Excellent or very good	71% <sup>d,e</sup>	68% <sup>c,d,e</sup>	74% <sup>d,e</sup>	64%	61%
Good	19 <sup>c</sup>	20 <sup>c</sup>	15 <sup>d,e</sup>	21	22
Fair or poor	8 <sup>d,e</sup>	9 <sup>c,e</sup>	6 <sup>d,e</sup>	11 <sup>e</sup>	14
How often does the doctor					
Listen carefully to you?					
Always	71 <sup>b,e</sup>	66 <sup>c,e</sup>	74 <sup>d,e</sup>	68 <sup>e</sup>	58
Usually	19 <sup>e</sup>	21 <sup>e</sup>	19 <sup>e</sup>	20 <sup>e</sup>	25
Sometimes/rarely or never	9 <sup>b,c,d,e</sup>	12 <sup>c,e</sup>	7 <sup>d,e</sup>	11 <sup>e</sup>	15
Explain things in a way you can understand?					
Always	73 <sup>e</sup>	70 <sup>e</sup>	73 <sup>d,e</sup>	69 <sup>e</sup>	58
Usually	18 <sup>e</sup>	21 <sup>e</sup>	19 <sup>e</sup>	19 <sup>e</sup>	26
Sometimes/rarely or never	9 <sup>e</sup>	9 <sup>e</sup>	7 <sup>d,e</sup>	11 <sup>e</sup>	15
Spend enough time with you?					
Always	63 <sup>b,d,e</sup>	55 <sup>c,d,e</sup>	66 <sup>d,e</sup>	58 <sup>e</sup>	44
Usually	23 <sup>b,e</sup>	27 <sup>c,d</sup>	21 <sup>e</sup>	23 <sup>e</sup>	28
Sometimes/rarely or never	14 <sup>b,c,d,e</sup>	17 <sup>c,e</sup>	12 <sup>d,e</sup>	17 <sup>e</sup>	25
When you need care or treatment, how often does the doctor					
Make clear the specific goals and plans for your treatment?					
Always	61 <sup>b,d,e</sup>	55 <sup>e</sup>	59 <sup>d,e</sup>	52 <sup>e</sup>	45
Usually	22 <sup>b,e</sup>	27 <sup>c,d,e</sup>	23 <sup>e</sup>	21 <sup>e</sup>	31
Sometimes/rarely or never	14 <sup>d,e</sup>	15 <sup>d,e</sup>	13 <sup>d,e</sup>	19	20
Give you clear instructions so that you know what to do or what symptoms to watch for?					
Always	70 <sup>b,d,e</sup>	62 <sup>c</sup>	71 <sup>d,e</sup>	64	60
Usually	19 <sup>b,e</sup>	25 <sup>c,d</sup>	20 <sup>e</sup>	20 <sup>e</sup>	24
Sometimes/rarely or never	10 <sup>c,e</sup>	12 <sup>c</sup>	8 <sup>d,e</sup>	13	13
Tell you about treatment choices and ask for your ideas/opinions?					
Always	43 <sup>b,d,e</sup>	36 <sup>c,d,e</sup>	41 <sup>d,e</sup>	27	29
Usually	19 <sup>b,d</sup>	26 <sup>c,d</sup>	22 <sup>d</sup>	15 <sup>e</sup>	23
Sometimes/rarely or never	35 <sup>c,d,e</sup>	35 <sup>c,d,e</sup>	30 <sup>d,e</sup>	50 <sup>e</sup>	44
In the past 2 years					
Was there a time that you left the doctor's office without getting important questions answered?	22 <sup>d</sup>	19 <sup>d,e</sup>	20 <sup>d,e</sup>	13 <sup>e</sup>	24
Was there a time you did not follow the doctor's advice or treatment plan?	28 <sup>b,d</sup>	22 <sup>c,d,e</sup>	26 <sup>d,e</sup>	14 <sup>e</sup>	31

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

spending adequate time with them. New Zealand and Australia adults were the most positive on these measures, repeating patterns observed in earlier surveys.<sup>11</sup> On each of these measures, U.S. adults were significantly less likely to score their doctors highly and the most likely among the five countries to report concerns.

Asked to consider times when they needed care or treatment, the majority of patients in all countries except the United States think that their doctors always make goals and plans clear, with Australia and New Zealand being the most positive; one in five U.K. and U.S. adults responded negatively to this item.

Failure to engage patients in treatment or care plans was frequent in all countries. One-third to half of respondents said that their doctors sometimes, rarely, or never tell them about choices or involve them in care decisions. Survey findings further indicate failure to solicit questions from patients. In four of five countries, at least one in five adults reported a recent time when they left the doctor's office without getting important questions answered.

A significant share of adults in each country also reported a time when they did not follow their doctor's advice, with nonadherence rates highest in the United States. Repeating patterns observed in a survey of sicker adults, one of the leading reasons for nonadherence was disagreement with the recommendation.<sup>12</sup> In the United States and New Zealand, costs were also named as one of the top three reasons. Not taking medications as prescribed was the advice most commonly disregarded in all countries (data on nonadherence reasons or type are not shown).

■ **Preventive care and health promotion.** A hallmark of high-quality primary care is an emphasis on preventive care, counseling, and awareness of patients' health concerns. Findings indicate shortfalls in promoting health in all five countries (Exhibit 6). On provisions of clinical preventive care, however, the United States tended to lead or rank high among countries. The survey reveals a failure to routinely make sure patients are up-to-date on recommended preventive care. In all countries the percentage of the elderly receiving a flu shot in the past year fell short of guidelines, with rates lowest in Canada and New Zealand.

Country guidelines vary for Pap test (cervical cancer screen) and mammograms for both frequency and age ranges.<sup>13</sup> To compare rates, we calculated the percentage of women meeting country-specific guidelines and also compared screening rates for an age range shared in common. On Pap tests, U.S. women were the most likely and Australian women the least likely to be screened within guidelines. Mammography within guidelines varied more narrowly, with about three of four women reporting a screen within the recommended time period. Both measures indicate that sizable shares of women are not being screened as recommended. Comparing frequency rates for a fixed age range shows wider variation across countries on both measures. Within the 25–64 (Pap test) and 50–64 (mammogram) age ranges, rates for Pap tests and mammograms within the past two years were lowest in the United Kingdom and highest in the United States.

The study findings indicate an overall lack of emphasis on prevention. At least

**EXHIBIT 6  
Preventive Care And Health Promotion In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Any doctor visit in past year	92% <sup>b,c,d,e</sup>	87% <sup>c,d</sup>	86% <sup>d,e</sup>	83% <sup>e</sup>	88%
Blood pressure check in past year, all ages	78% <sup>c,d,e</sup>	80% <sup>c,d,e</sup>	72% <sup>d,e</sup>	68% <sup>e</sup>	86
Flu shot in past year, age 65 and older	77% <sup>b,c</sup>	66% <sup>d</sup>	67% <sup>d</sup>	74	72
<b>Women</b>					
Percent of women receiving Pap test or mammogram at intervals recommended in each country for age group <sup>a</sup>					
Received Pap test at recommended interval/age	65%	74%	77%	79%	87%
Received mammogram at recommended interval/age	73	73	77	77	73
<b>Pap test or cervical smear, women ages 25–64</b>					
In past two years	68	70	69	58	85
In past 3 years	78	77	81	77	89
In past 5 years	82	83	85	85	92
<b>Mammogram, women ages 50–64</b>					
In past two years	71	71	77	63	84
In past 3 years	80	79	81	77	86
<b>Doctor does not send reminders for preventive care</b>					
In past 2 years your doctor has not	62% <sup>c,d,e</sup>	61% <sup>c,d,e</sup>	55% <sup>d,e</sup>	50%	49%
Provided advice or counseling on weight, nutrition, or exercise	62% <sup>b,c,d,e</sup>	55% <sup>c,d,e</sup>	67% <sup>d,e</sup>	72% <sup>e</sup>	48
Asked if there are any emotional issues that may be affecting your health	67% <sup>b,d</sup>	62% <sup>c,d</sup>	71% <sup>e</sup>	72% <sup>e</sup>	63
<b>Doctor diagnosis of chronic disease</b>					
Hypertension	20% <sup>e</sup>	20% <sup>e</sup>	18% <sup>d,e</sup>	22%	24%
Heart disease, including heart attack	5	6	6	7	7
Diabetes	6	6	5% <sup>e</sup>	5% <sup>e</sup>	8
Arthritis	21% <sup>c,e</sup>	20% <sup>c,e</sup>	15% <sup>d,e</sup>	21% <sup>e</sup>	25
Lung problems (such as asthma, emphysema)	15% <sup>b,e</sup>	12% <sup>c</sup>	17% <sup>e</sup>	14	12
Depression	13% <sup>e</sup>	13% <sup>d,e</sup>	12% <sup>d,e</sup>	16	17
Percent with at least one of 6 chronic conditions	50	48% <sup>d</sup>	47% <sup>d,e</sup>	52	51
Base: adults with diagnosis of at least 1 chronic condition (n)	691	690	729	1,616	752
Doctor has not given you a plan to manage your care at home	43% <sup>d,e</sup>	40% <sup>d</sup>	37% <sup>d</sup>	55% <sup>e</sup>	36%

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below. Significance tests were not performed for responses to Pap test/cervical smear questions.

<sup>a</sup> Recommended standards for Pap test and mammogram vary by country for both intervals and age ranges. For Pap test/mammography guidelines, see Note 13 in text.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

half of adults in each country said that their doctor does not send reminders, has not recently provided advice or counseling on weight or exercise, or has not asked if there were any emotional issues affecting their health. Lack of discussions on weight or exercise is particularly notable, given emerging epidemics of obesity and diabetes in the five countries. Physician outreach may also be particularly important for mental health. Studies indicate that primary care physicians frequently fail to detect depressive symptoms despite the fact that screening can improve care outcomes.<sup>14</sup>

The lack of patient-centered care extends to those with chronic illnesses. Despite studies indicating that self-management plans are a critical component to improving or maintaining health for people with a chronic illness, one-third or more of those with a chronic condition diagnosis said “no” when asked if their doctor had given them a plan to manage their care at home.<sup>15</sup>

■ **Provider choice, medical records, and e-mail access.** Assuring that patients have a choice of providers has emerged as a policy priority in the five countries to varying degrees. The study finds, however, that most adults are somewhat or very satisfied with their current amount of choice (Exhibit 7).

Respondents reported varying access to their medical records, ranging from a low of 28 percent in the United Kingdom to a high of 51 percent in the United States. There appears to be broad interest in spreading this access.

Interest in e-mail communication with physicians exists but appears less widespread than the desire for access to medical records. Among those with Internet access but without e-mail access to doctors, less than half in any country wanted

**EXHIBIT 7**  
**Choice, Information, And Communication In Five Countries, 2004**

	AUS	CAN	NZ	UK	US
Unweighted N	1,400	1,410	1,400	3,061	1,401
Satisfaction with choice of doctors					
Very satisfied	40% <sup>b,c,d</sup>	30% <sup>c,d,e</sup>	48% <sup>e</sup>	44% <sup>e</sup>	39%
Somewhat satisfied	40% <sup>d</sup>	40% <sup>d</sup>	37	35	39
Not very or not at all satisfied	17% <sup>b,c</sup>	27% <sup>c,d,e</sup>	12% <sup>d,e</sup>	18	20
Do you have access to your own medical record? <sup>a</sup>					
Yes	40% <sup>b,c,d,e</sup>	34% <sup>c,d,e</sup>	45% <sup>d,e</sup>	28% <sup>e</sup>	51
No	33% <sup>b,c,d</sup>	43% <sup>c,e</sup>	29% <sup>d</sup>	44% <sup>e</sup>	31
Among those without current access: Would you like to have access to your own medical record? (n)	844	919	737	2,184	616
Yes	67% <sup>b,d,e</sup>	73% <sup>c,d</sup>	64% <sup>d,e</sup>	59% <sup>e</sup>	75%
No	29% <sup>b,d,e</sup>	22% <sup>c,d</sup>	27% <sup>d,e</sup>	35% <sup>e</sup>	19
Base: has regular doctor/place of care (n)	1,326	1,338	1,372	3,033	1,293
Are you able to communicate with your doctor/GP by e-mail? <sup>a</sup>					
Yes	16% <sup>b,c,d</sup>	10% <sup>c,d,e</sup>	22% <sup>d</sup>	13% <sup>e</sup>	20%
No	35% <sup>b,c</sup>	50% <sup>c,d,e</sup>	27% <sup>d,e</sup>	34	37
No, do not have access to Internet	24% <sup>c</sup>	21	19	21	21
Among those with Internet access and who cannot e-mail doctor: Would you like to communicate with regular doctor/GP by e-mail? (n)	819	924	751	1,982	781
Yes	25% <sup>b,c,d,e</sup>	41% <sup>c</sup>	30% <sup>d,e</sup>	40%	42%
No	72% <sup>b,d,e</sup>	56% <sup>c</sup>	68% <sup>d,e</sup>	56	56

**SOURCE:** Commonwealth Fund International Health Policy Survey, 2004.

**NOTES:** Reading from left to right, the letter indicates  $p < .05$  for differences with countries to the right, as below. GP is general practitioner.

<sup>a</sup> Missing percentages are adults who did not know if they had medical record or e-mail access. For each question, those who did not know were asked the follow-up question about preferences.

<sup>b</sup> For difference with CAN.

<sup>c</sup> For difference with NZ.

<sup>d</sup> For difference with UK.

<sup>e</sup> For difference with US.

to be able to communicate by e-mail with their doctor. Notably, about one in five adults in each country did not have Internet access.

## Discussion And Policy Implications

Primary care is fundamental to a high-performance health care system and plays an important role in health care quality, costs, and outcomes. As the entry point and the setting where the general public is most likely to experience the health care system, primary care also influences public confidence in the system. In all five countries, the study found shortfalls in delivering safe, effective, patient-centered, timely, efficient, and equitable care, although performance varies among countries. For patients, deficits in accessibility, continuity, and coordination add up to poor quality-of-care experiences. The findings indicate opportunities to take policy action and to learn from countries' initiatives.

While most of the attention on safety has focused to date on hospitals, adults' experiences in primary care settings indicate a further set of challenges. Lab and test error rates and delays were notably high, given that this was a random survey of adults rather than a subset of sicker patients. These reports signal a need to improve test information flow and systems to lower error rates. The risk of medication errors, drug interactions, or complications in ambulatory settings also appears high, given the substantial share of adults reporting that their doctors failed to review medications or alert them to potential side effects.

■ **Widespread deficiencies.** The study found deficiencies in delivery of effective care as measured by widespread failure to give patients plans to manage chronic conditions at home and gaps in receipt of recommended preventive tests. The fact that the United States performed relatively well on clinical preventive measures suggests that policy leadership, clear guidelines, and market pressures could make a difference. For the past decade, the Health Plan Employer Data and Information Set (HEDIS), a U.S. private-sector quality initiative, has targeted clinical preventive care as a core indicator, pressuring health plans to measure and improve outcomes.<sup>16</sup> This pressure, in combination with national policies, likely contributed to high U.S. screening rates. Yet in the United States as well as other countries, only a minority of patients report having had discussions with their physicians about emotional health, despite recommendations by the U.S. Preventive Services Task Force that primary care clinicians ask a few simple questions to screen for depression. Moving from policy to action and accountability in this area could make a difference.

Deficiencies in patient-centered care cut across countries, based on patients' reports of widespread failure to involve them in treatment decisions and to make goals clear or answer their questions. These communication failures potentially undermine care and contribute to lack of adherence to medical advice.

Access to care is central to a high-performing care system and efforts to redesign primary care. The marked variations in timely access to physicians and variations in ER use point to gaps in each country but also signal the potential to do

better. The high rates of same-day access in Australia and New Zealand show that it is possible to design systems to enable rapid response. The fact that these countries also had lower ER use rates and shorter ER waiting times suggests that more timely access to primary care could help ease demands on ERs and improve the continuity of care. Opportunities thus exist for cross-national learning.<sup>17</sup>

The study underscores the extent to which patient cost sharing for primary care can undermine accessibility, deter patients from getting recommended care, and contribute to inequities. Access barriers were particularly acute in the United States, where uninsurance rates are high and insured patients face growing cost sharing. U.S. income disparities persist across primary care and quality dimensions and disproportionately affect racial and ethnic minorities.<sup>18</sup>

Adults' experiences indicate that failure to coordinate care can lead to inefficiencies as measured by delays in care, duplication, lack of information flow, conflicting advice, or wasted time. Coordination failures also undermine effective care, especially when information fails to move from the hospital, ER, or diagnostic sites to where patients see their regular doctors.

■ **Poor U.S. performance.** Across multiple dimensions of care, the United States stands out for its relatively poor performance. With the exception of preventive measures, the U.S. primary care system ranked either last or significantly lower than the leaders on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences. These findings stand in stark contrast to U.S. spending rates that outstrip those of the rest of the world. The performance in other countries indicates that it is possible to do better. However, moving to a higher-performing health care system is likely to require system redesign and innovative policies.<sup>19</sup>

■ **Policy implications.** A number of tools are available to policy leaders in the five countries we studied as they seek to improve primary care. These countries differ in the extent to which they are pursuing these strategies, offering rich opportunities to inform policy cross-nationally.

Redesign efforts include innovative payment systems that reward high-quality performance and team-based approaches to care. For example, New Zealand's new Primary Health Organizations, an interdisciplinary model of care for an enrolled population, are based on a population needs-based funding formula, with a focus on increased payments to care for Maori, Pacific Islander; and other low-income, disadvantaged populations.<sup>20</sup> A new incentive-based contract for GPs in the United Kingdom explicitly rewards achieving quality targets.<sup>21</sup>

Countries are also looking to learning collaboratives to redesign care. The United Kingdom has an extensive primary care collaborative network to expand same-day access and improve outcomes for chronic conditions.<sup>22</sup> ER collaboratives in Australia are under way to improve pain control and reduce waiting times. Australia's comparatively positive reports on ER waits and pain relief suggest that this collaborative may offer insights for other countries.<sup>23</sup>

*“Perhaps the most powerful health care policy tool that countries are pursuing is investment in information technology.”*

.....

Policy efforts to improve after-hours coverage could at once respond to patients' concerns, ease ER stress, and improve links to primary providers. National initiatives offer multiple examples. Australia has implemented several after-hours primary care demonstration projects and recently announced plans to facilitate after-hours GP clinics colocated with emergency departments.<sup>24</sup> Canada recently instituted a Primary Health Care Transition Fund to encourage models of round-the-clock, team-based care, which are integrated across services and settings and are focused on health promotion and management of chronic disease.<sup>25</sup> The United Kingdom has set up a twenty-four-hour nurse-staffed hotline and NHS Walk-In Centres to improve after-hours care.<sup>26</sup> In addition to countries in this study, Denmark has developed evening clinics and physician telephone-triage systems to make care more accessible during off hours.<sup>27</sup>

A key policy lever is lowering cost barriers to make preventive and primary care more accessible. New Zealand is reducing cost sharing for low-income, child, elderly, and minority populations as part of its primary care initiative, with an endpoint of universal low-cost access for all. In contrast, in the United States, policy pushes toward plans with high front-end deductibles could exacerbate access disparities.<sup>28</sup> Affordability concerns likely contribute to the mixed U.S. performance on a range of quality indicators.<sup>29</sup>

Insurance systems could also encourage continuity with physicians over time. This is a particular challenge in the United States, given the short-term nature of physician-patient relationships reported in our survey. Yet past studies indicate that these frequent changes in the United States are less a matter of patient choice than of switching because of plan changes or network instability.<sup>30</sup> Efforts to improve insurance stability as well as coverage could improve continuity. The challenge for the United States is how to redirect the system's market and competitive orientation to encourage continuity and more patient-centered care.<sup>31</sup>

Perhaps the most powerful health care policy tool that countries are pursuing is investment in information technology (IT).<sup>32</sup> Electronic medical records and electronic prescribing systems can reduce medical errors, remind patients and physicians about preventive and follow-up care, and facilitate the sharing of integrated records and information across sites of care. The United Kingdom has made a major investment in moving to an integrated uniform information system encompassing both primary and acute care.<sup>33</sup>

■ **Challenges ahead.** Wide variations observed among the five countries surveyed suggest that individual countries' policies make a difference. Although it is beyond the limits of this study to attribute performance to particular policy initiatives, promising initiatives under way in each country warrant further study and

tracking over time. The challenge in all five countries is finding the right combination to improve primary care and move to a high-performance care system. The lack of a strong patient-centered or primary care orientation in the United States emerges throughout the survey and underscores the importance of examining international strategies that could be adapted and instituted at home.<sup>34</sup>

.....  
 This study was supported by the Commonwealth Fund. The authors thank the editors and four anonymous reviewers for many thoughtful comments that improved this paper. They also gratefully acknowledge the substantial contributions of an expert panel for its advice on the questionnaire. The views expressed are those of the authors and should not be attributed to the Commonwealth Fund or its directors or officers.

**NOTES**

1. B. Starfield, *Primary Care* (New York: Oxford University Press, 1998).
2. J. Macinko, B. Starfield, and L. Shi, "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998," *Health Services Research* 38, no. 3 (2003): 831–865.
3. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001); and Organization for Economic Cooperation and Development, *Towards High Performing Health Systems* (Paris: OECD, 2004).
4. Recent articles in the series include R.J. Blendon et al., "Inequities in Health Care: A Five-Country Survey," *Health Affairs* 21, no. 3 (2002): 182–191; R.J. Blendon et al., "Common Concerns amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* 22, no. 3 (2003): 117–121; and R.J. Blendon et al., "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23, no. 3 (2004): 119–135.
5. G.F. Anderson, V. Petrosyan, and P.S. Hussey, *Multinational Comparisons of Health Systems Data* (New York: Commonwealth Fund, October 2002); and Starfield, *Primary Care*.
6. The Hon. Annette King, minister of health, New Zealand, *The Primary Health Care Strategy* (Wellington: Ministry of Health, February 2001).
7. D.G. Safran et al., "Measuring Patients' Experiences with Individual Physicians," *Journal of General Internal Medicine* 19 Supp. (2004): 177; A. Coulter and H. Magee, *The European Patient of the Future* (Maidenhead, U.K.: Open University Press, 2003); and Healthcare Commission and Picker Institute Europe, "Patient Survey Report 2004: Primary Care," 2004, [www.healthcarecommission.org.uk/assetRoot/04/00/86/89/04008689.pdf](http://www.healthcarecommission.org.uk/assetRoot/04/00/86/89/04008689.pdf) (20 October 2004).
8. The Health Foundation is an independent charity based in London, [www.health.org.uk](http://www.health.org.uk). Interviews were conducted in London and in Wales, Scotland, and Ireland to assure at least 500 respondents in each area.
9. Differences in survey practices among the countries make calculation of response rates infeasible. Harris made extensive efforts to assure a representative sample. Adults age eighteen and older were selected randomly in households, up to ten attempts were made to make contact, and calls were made at different times and on both weekdays and weekends. Respondents could specify and schedule interview times.
10. In the United Kingdom, the survey named the national help line, NHS Direct or NHS-24.
11. Blendon et al., "Inequities in Health Care"; and Blendon et al., "Common Concerns."
12. Blendon et al., "Common Concerns."
13. Pap test guidelines: Australia, ages 18–70, every two years; Canada, ages 18–69, every three years; New Zealand, ages 20–69, every three years; United Kingdom, ages 25–49, every three years, and ages 50–64, every five years; and United States, ages 18–64, every three years. Mammogram guidelines: Australia, ages 50–69, every two years; Canada, ages 50–69, every two years; New Zealand, ages 50–64, every two years; United Kingdom, ages 50–64, every three years; and United States, age 40 and older, every two years.
14. M. Pignone et al., "Screening for Depression in Adults: A Summary of Evidence for the U.S. Preventive Services Task Force," *Annals of Internal Medicine* 136, no. 10 (2002): 765–776.
15. E.H. Wagner, "Managed Care and Chronic Illness: Health Services Research Needs," *Health Services Research* 32, no. 5 (1977): 702–714.
16. National Committee for Quality Assurance, *The State of Health Care Quality, 2003: Industry Trends and Analysis*



- (Washington: NCQA, 2003).
17. M. Murray et al., "Improving Timely Access to Primary Care: Case Studies of the Advance Access Model," *Journal of the American Medical Association* 289, no. 8 (2003): 1042–1046.
  18. C. Schoen and M. Doty, "Inequities in Access to Medical Care in Five Countries," *Health Policy* 67, no. 3 (2004): 309–322; and Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2003).
  19. T. Bodenheimer, "Innovations in Primary Care in the United States," *British Medical Journal* 326, no. 7393 (2003): 797–798; and A. Majeed and A.B. Bindman, "What Can Primary Care in the United States Learn from the United Kingdom?" *British Medical Journal* 326, no. 7393 (2003): 799.
  20. King, *The Primary Health Strategy*.
  21. P.C. Smith and N. York, "Quality Incentives: The Case of U.K. General Practitioners," *Health Affairs* 23, no. 2 (2004): 112–118.
  22. National Primary Care Development Team, "The National Primary Care Collaborative," [www.npdt.org/scripts/default.asp?site\\_id=5](http://www.npdt.org/scripts/default.asp?site_id=5) (27 September 2004).
  23. National Institute of Clinical Studies, *National Emergency Department Collaborative Report*, April 2004, [www.nicsl.com.au/knowledge\\_reports\\_detail.aspx?view=13](http://www.nicsl.com.au/knowledge_reports_detail.aspx?view=13) (20 October 2004).
  24. Philip Davies, deputy secretary, Australia Department of Health and Ageing, personal communication, 27 September 2004.
  25. Health Canada, "Primary Health Care Transition Fund," 19 November 2002, [www.hc-sc.gc.ca/phctf-fassp/english/index.html](http://www.hc-sc.gc.ca/phctf-fassp/english/index.html) (1 October 2004).
  26. NHS Direct Online, "About NHS Direct: NHS Direct Telephone Service," [www.nhsdirect.nhs.uk/innerpage.asp?Area=52](http://www.nhsdirect.nhs.uk/innerpage.asp?Area=52) (1 October 2004); and NHS England, "NHS Walk-In Centres," [www.nhs.uk/england/noAppointmentNeeded/walkinCentres/default.aspx](http://www.nhs.uk/england/noAppointmentNeeded/walkinCentres/default.aspx) (27 September 2004).
  27. K. Davis, "The Danish Health System through an American Lens," *Health Policy* 59, no. 2 (2002): 119–132.
  28. For cautions and critique, see K. Davis, "Consumer Directed Health Care: Will It Improve Health System Performance? Concluding Commentary," *Health Services Research* 39, no. 4, Part 2 (2004): 1219–1233.
  29. P.S. Hussey et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs* 23, no. 2 (2004): 89–99.
  30. K. Davis and C. Schoen, "Assuring Quality, Information, and Choice in Managed Care," *Inquiry* 35, no. 2 (1998): 104–114.
  31. K. Grumbach and T. Bodenheimer, "A Primary Care Home for Americans: Putting the House in Order," *Journal of the American Medical Association* 288, no. 7 (2002): 889–893.
  32. W.E. Hammond III, "Electronic Medical Records—Getting It Right and Going to Scale," January 2004, [www.cmwf.org/usr\\_doc/hammond\\_emedicalrecords\\_695.pdf](http://www.cmwf.org/usr_doc/hammond_emedicalrecords_695.pdf) (1 October 2004).
  33. NHS Confederation, *The National Strategy for IT in the NHS*, Briefing no. 88 (London: NHS Confederation, August 2003).
  34. Starfield, *Primary Care*; and K. Davis et al., *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care through the Patient's Lens* (New York: Commonwealth Fund, January 2004).