

# A Survey Of Primary Care Physicians In Eleven Countries, 2009: Perspectives On Care, Costs, And Experiences

Doctors say problems exist across all eleven countries, although some nations are doing a better job than others.

**by Cathy Schoen, Robin Osborn, Michelle M. Doty, David Squires, Jordon Peugh, and Sandra Applebaum**

**ABSTRACT:** This 2009 survey of primary care doctors in Australia, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom, and the United States finds wide differences in practice systems, incentives, perceptions of access to care, use of health information technology (IT), and programs to improve quality. Response rates exceeded 40 percent except in four countries: the United States, Canada, France, and the United Kingdom. U.S. and Canadian physicians lag in the adoption of IT. U.S. doctors were the most likely to report that there are insurance restrictions on obtaining medication and treatment for their patients and that their patients often have difficulty with costs. We believe that opportunities exist for cross-national learning in disease management, use of teams, and performance feedback to improve primary care globally. *Health Aff (Millwood)*. 2009;28(6):w1171-83 (published online 5 November 2009; 10.1377/hlthaff.28.6.w1171)]

PRIMARY CARE CLINICIANS IN MOST COUNTRIES provide the foundation for health care systems and serve as the linchpin that improves access, connects care, and provides continuity for patients and families. Research shows that strong primary care is associated with good outcomes and lower costs.<sup>1-3</sup> Aging populations, prevalence of chronic disease, and increasing ability to deliver complex care outside the hospital have prompted international efforts to redesign primary care to improve outcomes and efficiency. Consequently, primary

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care practices often face new requirements for accountability as well as incentives to improve.

To varying degrees, health systems are investing in information technology (IT), round-the-clock access, providers working in teams, integration, and quality improvement. Reforms in delivery systems and payment policies seek to spur innovations for managing chronic conditions and supporting frail elderly or disabled people living in the community.

Primary care physicians' experiences and perspectives in a period of rapid change offer a unique view from the front lines. To track developments in countries with diverse health systems, this 2009 study surveyed primary care physicians in eleven countries: Australia, Canada, France, Germany, Italy, New Zealand, the Netherlands, Norway, Sweden, the United Kingdom, and the United States. This survey, the twelfth in a series that informs a symposium of health ministers and policy experts, focused on access, chronic care management, health IT, and financial and information incentives—key areas that have been targets of reforms.

### **Eleven-Country Context**

The countries studied represent a mix of primary care and insurance systems (Exhibit 1). The United States is distinct in its reliance on internal medicine and pediatrics for primary care and its highly decentralized referral systems. The other countries rely extensively on general or family practice (GP/FP) physicians, often augmented by use of primary care nurses for preventive or chronic care and counseling.<sup>4</sup> In Australia, Italy, the Netherlands, New Zealand, Norway, and the United Kingdom, patients register with primary care physicians, who typically serve as “gatekeepers” for referral for more specialized care. Other countries encourage registration through financial incentives for patients or providers, or both.<sup>5</sup>

Primary care practices, except in Sweden, generally operate as private practices. A majority of Swedish doctors work as public employees (local health centers), but reforms have been moving to private contracts and a mix of prepayment, or capitation, and fees.<sup>4</sup> Insurers in Australia, Canada, France, Germany, and the United States generally pay fee-for-service (FFS). The other countries use a blend of capitation and fees for visits, targeted care, or performance incentives. The U.S. system includes examples of salary, mixed FFS and capitation, and integrated systems.<sup>6</sup>

Insurance systems differ across countries in patient cost sharing. In contrast to the United States, Canada, the Netherlands, and the United Kingdom have no or little cost sharing for medical care. France requires no cost sharing for specific chronic illnesses. Germany limits costs as a share of income. Norway and Sweden limit annual out-of-pocket costs. In Australia, primary care visits are often “bulk-billed” with no patient charge, and ceilings limit overall cost exposure. New Zealand has been reducing patient fees. Italy's national benefits cover primary care in full, with copayments for outpatient drugs and specialists.<sup>4</sup>

**EXHIBIT 1**  
**Country Information, Survey Sample, And Practice Size Among Primary Care Physicians In Eleven Countries, 2009**

	Country information			Survey sample and practice size				
	Primary care doctor role and payment <sup>a</sup>			Sample		Practice size <sup>b</sup>		
	Required to register	Gatekeeper for referrals	Payment	Unweighted N	Response rate	<2 FTE doctors	2 to <5 FTE doctors	5 or more FTE doctors
ITA	Yes	Yes	Mix capitation/fees/incentives	844	61%	48%	33%	19%
NOR <sup>c</sup>	Yes	Yes	Mix FFS/capitation	774	56	10	64	26
AUS	No	Yes	FFS	1,016	52	11	47	41
GER <sup>d</sup>	No	National incentives	FFS	715	50	50	46	2
NET	Yes	Yes	Mix capitation/FFS	614	50	56	39	4
NZ	Yes	Yes	Mix capitation/FFS	500	50	16	59	25
SWE <sup>d</sup>	No	National incentives	Most salary; private: mix capitation/FFS	1,450	48	7	34	57
US	No	No	FFS	1,442	39	27	32	38
CAN <sup>d</sup>	No	National incentives	FFS	1,401	35	24	32	41
UK	Yes	Yes	Mix capitation/incentives	1,062	20	12	57	30
FRA <sup>d</sup>	No	National incentives	FFS	502	7	72	26	2

**SOURCES:** See below.

**NOTES:** Countries are listed in descending order by response rate. FTE is full-time equivalent. FFS is fee-for-service.

<sup>a</sup> Commonwealth Fund. Description of health care systems: Australia, Canada, Denmark, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. New York (NY): Commonwealth Fund; forthcoming, 2009 Nov.

<sup>b</sup> Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

<sup>c</sup> Norway does not require registration but strongly encourages and offers incentives; 98 percent are registered.

<sup>d</sup> Canada does not require referral but has provider incentives to discourage self-referrals. France, Germany, and Sweden use incentives for patients and providers.

In recent years, all but the United States have initiated national reforms, including financial and information incentives, focused on primary care to strengthen or transform the capacity to provide a foundation for high-quality, efficient care.

**Study Design And Methods**

■ **Sampling.** Primary care physicians in each country were sampled and surveyed using a common questionnaire that builds on a 2006 primary care physician survey conducted in seven countries.<sup>7</sup> The definition of *primary care* included GP and FP physicians in all countries and also general internists and pediatricians in Ger-

many and the United States.<sup>8</sup> Practicing physicians were chosen randomly from public and private lists.<sup>9</sup> Exhibit 1 shows final sample sizes and response rates.

Harris Interactive Inc. and subcontractors in each country collected data by a combination of mail, online, and telephone during February–July 2009.<sup>10</sup> Mail surveys were conducted in Canada, Germany, Netherlands, Norway, Sweden, and the United States. Australia and New Zealand used phone recruitment and surveys by mail. Italy recruited by mail and completed surveys online. French and U.K. interviews were by phone.<sup>11</sup> The low response rates in the latter two of these countries, as well as in the United States and Canada, indicate the need for caution in interpreting results as representative of all physicians.

In general, final samples closely matched initial characteristics available from lists of physicians. However, differences in data collection and response rates introduce an unknown bias.

The analysis weighted final samples to reflect the distribution of physicians by age, country region, sex, and primary care specialty.<sup>12</sup> For samples of 1,000 and 500, the margin of sample error is 3–4 percent at the 95 percent confidence level. Exhibits indicate where differences are significant ( $p < 0.05$ ).

■ **Practice size.** The countries differ significantly in practice size (Exhibit 1). Group practice is more the norm in Sweden, the United Kingdom, Norway, and Australia; groups tend to be largest in Sweden. Italian and French doctors were the least likely and Swedish doctors the most likely to say that they include nonphysician clinicians in their practices.<sup>13</sup>

## Study Findings

■ **Health IT.** The survey asked about basic electronic medical records (EMRs) and thirteen other computerized functions (Exhibit 2). To assess multifunctional capacity, we created a summary variable counting the number of functions and categorized systems as low (0–3), middle (4–8), or high (9–14).<sup>13</sup>

The survey found a striking spread across countries in the adoption of EMRs and the range of electronic functions (Exhibit 2). In Australia, Italy, the Netherlands, New Zealand, Sweden, and the United Kingdom, EMRs are nearly universal, and half or more practices reported at least nine functions surveyed. Physicians in Canada, the United States, and France lag behind in basic EMRs as well as multifunctional support, following patterns observed in other studies.<sup>14</sup> Even though EMR use is nearly universal in Norway, its functional capacity is low, as is that of Germany.

The varied responses indicate different emphases in building capacity. For example, among the seven countries with near-universal EMRs, the majority of physicians reported electronic access to lab results, yet fewer than half of Dutch, Norwegian, and U.K. doctors can order tests electronically. Across countries, most doctors with EMRs reported electronic clinical notes, routine electronic prescribing, and computerized alerts about potential problems with drug doses or interac-

**EXHIBIT 2**  
**Health Information Practice Capacity Among Primary Care Physicians In Eleven Countries, 2009**

	Use EMR in practice (% yes)	Electronic information functions (0–14) in practice			Percent high functionality (9–14) by practice size (no. of FTE doctors)		
		Low (0–3)	Middle (4–8)	High (9–14)	<2	2 to <5	5 or more
AUS	95 <sup>b,c,d,f,k</sup>	3%	6%	91% <sup>b,c,d,e,f,h,i,j,k</sup>	82%	90% <sup>l</sup>	94% <sup>l</sup>
CAN	37 <sup>c,d,e,f,g,h,i,j,k</sup>	65	21	14 <sup>c,d,e,f,g,h,i,j,k</sup>	6	18 <sup>l</sup>	17 <sup>l</sup>
FRA	68 <sup>e,f,g,h,i,j,k</sup>	39	47	15 <sup>d,e,f,g,h,i,j,k</sup>	14	16	– <sup>m</sup>
GER	72 <sup>e,f,g,h,i,j,k</sup>	14	50	36 <sup>e,f,g,h,i,j,k</sup>	31	41 <sup>l</sup>	– <sup>m</sup>
ITA	94 <sup>f,h,k</sup>	4	30	66 <sup>f,g,h,i,j,k</sup>	65	64	72
NET	99 <sup>g,h,i,j,k</sup>	1	45	54 <sup>g,h,i,j,k</sup>	53	55	– <sup>m</sup>
NZ	97 <sup>i,k</sup>	2	6	92 <sup>h,i,j,k</sup>	83	92 <sup>l</sup>	98 <sup>l</sup>
NOR	97 <sup>i,k</sup>	15	66	19 <sup>i,j,k</sup>	15	19	21
SWE	94 <sup>j,k</sup>	4	47	49 <sup>j,k</sup>	20	49 <sup>l</sup>	52 <sup>l</sup>
UK	96 <sup>k</sup>	0	11	89 <sup>k</sup>	83	89	92 <sup>l</sup>
US	46	51	23	26	7	25 <sup>l</sup>	40 <sup>l</sup>

**SOURCE:** Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

**NOTES:** Count of fourteen functions includes the following: electronic ordering of medications and tests, computer access to test results and medication lists, computer alerts/prompts, and decision support; computerized reminder systems for prevention and follow-up care; computerized ability to list patients by diagnosis, lab results, and medications; and electronic entry of notes and medical histories. For details by function, see Technical Appendix Table 2, online at <http://content.healthaffairs.org/cgi/content/full/hlthaff.28.6.w1171/DC2>. Significant differences between countries for low/high functionality indicated for distribution of summary variable rather than individual responses. Underlined row headings indicate a response rate below 40 percent. Reading from top to bottom starting with Australia, the letter indicates significant differences with countries below at  $p < 0.05$ , as indicated: <sup>b</sup>Different from CAN. <sup>c</sup>Different from FRA. <sup>d</sup>Different from GER. <sup>e</sup>Different from ITA. <sup>f</sup>Different from NET. <sup>g</sup>Different from NZ. <sup>h</sup>Different from NOR. <sup>i</sup>Different from SWE. <sup>j</sup>Different from UK. <sup>k</sup>Different from US.

<sup>l</sup>Indicates significant within-country differences with <2 full-time-equivalent (FTE) doctors ( $p < 0.05$ ).

<sup>m</sup>Very small sample size (under 30) of practices with 5 or more FTE doctors.

tions (except in Norway). Answers varied for other functions.<sup>13</sup>

Decision support appears generally less well developed. Computerized reminders for treatment guidelines, tracking laboratory tests, and prompts to provide patients with test results were the least frequently reported, including in countries with multifunctional capacity.

Notably, the seven countries with near-universal EMRs have succeeded in spreading multifunctional capacity to smaller as well as larger practices (Exhibit 2). Their national policies and standards have supported spread of multifunctional capacity.<sup>15</sup> In contrast, U.S. multifunctional capacity remains concentrated in larger practices. Half of U.S. practices with high-function capacity were associated with integrated care systems such as Kaiser (data not shown).

■ **Access.** Primary care practices provide an entry point into the health care system as well as a key source of prevention, essential care, and continuity. Asked whether their practice had an arrangement where patients could be seen after hours without going to an emergency room (ER), nearly all Dutch, New Zealand, and U.K. doctors said “yes,” compared to just 29 percent of U.S. physicians—the lowest in the

**EXHIBIT 3**  
**Access And Insurance Barriers Among Primary Care Physicians In Eleven Countries, 2009**

	<b>Practice accessibility</b>	<b>Doctors' perception of access barriers: how often do your patients experience the following</b>			<b>Insurance barriers to needed care</b>
	<b>After-hours arrangement to see doctor/nurse without going to ER (% yes)</b>	<b>Difficulty paying for medications or other out-of-pocket costs (% often)</b>	<b>Difficulty getting specialized diagnostic tests (% often)</b>	<b>Long waiting times to see a specialist (% often)</b>	<b>Amount of time physician or staff spend getting patients needed drugs or treatments due to coverage restrictions (% major problem)</b>
AUS	50 <sup>b,c,e,f,g,h,j,k</sup>	23 <sup>b,c,d,e,f,h,i,j,k</sup>	21 <sup>b,c,d,e,f,g,h,j</sup>	34 <sup>b,c,d,e,g,h,i,j,k</sup>	13 <sup>b,d,e,h,i,j,k</sup>
CAN	43 <sup>c,d,e,f,g,h,i,j,k</sup>	27 <sup>c,e,f,h,i,j,k</sup>	47 <sup>d,e,f,g,h,i,j,k</sup>	75 <sup>c,d,f,g,h,i,j,k</sup>	19 <sup>d,e,f,i,j,k</sup>
FRA	78 <sup>d,f,g,h,i,j,k</sup>	17 <sup>d,e,f,g,h,i,k</sup>	42 <sup>d,e,f,g,h,i,j,k</sup>	53 <sup>d,e,f,g,i,j,k</sup>	16 <sup>d,e,f,i,j,k</sup>
GER	54 <sup>e,f,g,h,j,k</sup>	28 <sup>e,h,i,j,k</sup>	26 <sup>e,f,g,h,i,j</sup>	66 <sup>e,f,g,h,j,k</sup>	34 <sup>e,f,g,h,i,j,k</sup>
ITA	77 <sup>f,g,h,i,j,k</sup>	37 <sup>g,h,i,j,k</sup>	52 <sup>f,g,h,i,j,k</sup>	75 <sup>f,g,h,i,j,k</sup>	42 <sup>f,g,h,i,j,k</sup>
NET	97 <sup>g,h,i,j,k</sup>	33 <sup>g,h,i,j,k</sup>	15 <sup>g,h,i,k</sup>	36 <sup>g,h,i,j,k</sup>	10 <sup>g,h,j,k</sup>
NZ	89 <sup>h,i,k</sup>	25 <sup>h,i,j,k</sup>	60 <sup>h,i,j,k</sup>	45 <sup>h,i,j,k</sup>	16 <sup>j,k</sup>
NOR	38 <sup>i,j,k</sup>	5 <sup>i,k</sup>	11 <sup>i,j,k</sup>	55 <sup>i,j,k</sup>	17 <sup>i,j,k</sup>
SWE	54 <sup>i,k</sup>	6 <sup>i,k</sup>	22 <sup>i</sup>	63 <sup>j,k</sup>	10 <sup>j,k</sup>
UK	89 <sup>k</sup>	14 <sup>k</sup>	16 <sup>k</sup>	22 <sup>k</sup>	6 <sup>k</sup>
US	29	58	24	28	48

**SOURCE:** Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

**NOTES:** Underlined row headings indicate a response rate below 40 percent. Reading from top to bottom starting with Australia, the letter indicates significant differences with countries below at  $p < 0.05$ , as indicated: <sup>b</sup>Different from CAN. <sup>c</sup>Different from FRA. <sup>d</sup>Different from GER. <sup>e</sup>Different from ITA. <sup>f</sup>Different from NET. <sup>g</sup>Different from NZ. <sup>h</sup>Different from NOR. <sup>i</sup>Different from SWE. <sup>j</sup>Different from UK. <sup>k</sup>Different from US.

survey (Exhibit 3).

U.S. physicians were by far the most likely to say that their patients often have difficulty paying for medications or other medical care (Exhibit 3): more than half reported this concern. U.S. doctors' reports of limited access after hours and high cost barriers mirror experiences reported by chronically ill U.S. patients in a 2008 eight-country survey.<sup>16</sup>

Primary care doctors' perceptions of access to specialized care varied significantly across countries. Dutch, Norwegian, and U.K. physicians were the least likely to report that patients had difficulty getting specialized diagnostic tests; Canadian, Italian, and New Zealand doctors were the most likely (Exhibit 3).

Regarding waits to see specialists, a majority of Canadian, German, Italian, and Swedish primary care doctors said that their patients often faced long waits. By contrast, less than 30 percent of U.S. and U.K. doctors reported long waits—the lowest rates in the survey. Notably, German and U.K. physicians' perceptions diverged from those of their patients. In the 2008 survey, German patients, along with U.S. and Dutch patients, were the most likely to cite short waits for specialists. U.K. patients, along with New Zealanders and Canadians, were the most likely to report long waits.<sup>16</sup>

Insurance and coverage restrictions can also limit access. Further, recent reports within the United States find that insurance provisions to limit or control medication or treatment absorb substantial physician time.<sup>17</sup> For a cross-national perspective, the survey asked physicians whether the amount of time they or their staffs spent getting patients needed medications or treatment because of coverage restrictions was of concern. Half of U.S. physicians reported that time spent in this way was a major problem—the highest in the survey (Exhibit 3).

■ **Chronic care.** An increasing share of primary doctors' time is spent caring for patients with complex chronic conditions. Thus, improving outcomes requires transforming primary care to focus on prevention and health and engaging patients and families to manage conditions over time. Such transformation has been a priority in all eleven countries.

The vast majority of doctors in all countries surveyed reported caring for patients with diabetes, asthma or chronic obstructive pulmonary disease (COPD), hypertension, and depression. Yet reports varied by country in the extent to which practices use evidence-based written guidelines, routinely provide patients with instructions to manage their care, or include teams of nonphysician clinicians (Exhibit 4). In all countries except France, 75 percent or more of doctors reported routinely using written guidelines for diabetes, asthma/COPD, and hypertension. Within each country, doctors were the least likely to report using guidelines for depression. Fewer than half of physicians reported such guidelines except in the United Kingdom and Australia.

U.K. doctors' overall reports of frequent use of guidelines reflect national incentives and targets for managing chronically ill patients. Australia's high rate of guideline use for depression reflects its national efforts to improve the ability of primary care to manage depression.<sup>18</sup> Notably, physicians in these two countries were also the most likely to report that their EMR systems include computer prompts for guidelines.

Patients with chronic conditions require physician time; education about their illness; and coaching to cope with treatment, diet, and medication regimens. A growing body of evidence indicates that the use of care teams, including nurses, can improve outcomes.<sup>19</sup> Physician reports indicate that use of such teams is widespread in most of the countries surveyed (Exhibit 4). The French doctors who participated in the survey stand out on the low end.<sup>12</sup>

For patients living with chronic illnesses, effective control of their conditions depends on a collaborative relationship and understanding of care plans, including written instructions. Yet Italy was the only country in which a majority of doctors reported routinely giving such patients written instructions on how to manage their care at home (Exhibit 4).

The extent to which doctors routinely provide patients with written lists of all medications is also limited. Fewer than half of physicians in all but three countries reported providing medication lists to patients (Exhibit 4). The patterns only

**EXHIBIT 4**  
**Providing Chronic Care Among Primary Care Physicians I Eleven Countries, 2009**

	Practice routinely uses written guidance to treat these conditions (% yes)				Care management		
	Diabetes	Asthma or COPD	Hyper-tension	Depres-sion	Practice uses non-physician staff to manage care (% yes)	Gives chronically ill patients written instructions on managing care at home (% yes, routinely)	Gives patients written list of their medications (% yes, routinely)
AUS	87 <sup>b,c,d,e,f,g,i,j,k</sup>	86 <sup>b,c,d,e,h,j,k</sup>	83 <sup>c,d,e,f,g,i,j,k</sup>	71 <sup>b,c,d,e,f,g,h,i,j,k</sup>	88 <sup>b,c,d,e,h,i,j,k</sup>	24 <sup>b,c,e,g,h,i,j,k</sup>	12 <sup>b,c,d,e,f,g,h,i,j,k</sup>
CAN	82 <sup>c,d,e,f,g,h,i,j</sup>	76 <sup>c,d,e,f,g,i,j</sup>	81 <sup>c,d,e,f,g,i,j</sup>	45 <sup>c,d,e,f,g,i,j</sup>	52 <sup>c,d,f,g,h,i,j,k</sup>	16 <sup>c,d,e,f,h,i,j,k</sup>	16 <sup>c,d,e,f,g,h,i,j,k</sup>
FRA	62 <sup>d,e,f,g,h,i,j,k</sup>	46 <sup>d,e,f,g,h,i,j,k</sup>	50 <sup>d,e,f,g,h,i,j,k</sup>	30 <sup>e,g,h,i,j,k</sup>	11 <sup>d,e,f,g,h,i,j,k</sup>	9 <sup>d,e,f,g,j,k</sup>	43 <sup>d,e,f,g,h,i,j,k</sup>
GER	77 <sup>e,f,g,h,i,j,k</sup>	74 <sup>e,f,g,h,i,j</sup>	75 <sup>e,f,h,i,j</sup>	26 <sup>e,g,h,i,j,k</sup>	73 <sup>e,f,g,i,j,k</sup>	23 <sup>e,g,h,i,j,k</sup>	66 <sup>e,f,g,h,i,j,k</sup>
ITA	94 <sup>f,h,j,k</sup>	89 <sup>h,i,j,k</sup>	94 <sup>f,g,h,i,j,k</sup>	39 <sup>f,g,h,i,j,k</sup>	54 <sup>f,g,h,i,j,k</sup>	63 <sup>f,g,h,i,j,k</sup>	59 <sup>f,g,h,i,j,k</sup>
NET	98 <sup>g,h,i,k</sup>	87 <sup>h,j,k</sup>	90 <sup>g,h,j,k</sup>	31 <sup>g,h,i,j,k</sup>	91 <sup>h,i,j,k</sup>	22 <sup>g,h,i,j,k</sup>	4 <sup>h,i,j,k</sup>
NZ	93 <sup>h,j,k</sup>	87 <sup>h,j,k</sup>	75 <sup>h,i,j</sup>	65 <sup>h,j,k</sup>	88 <sup>h,i,j,k</sup>	15 <sup>h,i,j,k</sup>	5 <sup>h,i,j,k</sup>
NOR	86 <sup>i,j,k</sup>	81 <sup>i,j</sup>	81 <sup>i,j</sup>	49 <sup>i,j</sup>	73 <sup>i,j,k</sup>	9 <sup>i,k</sup>	20 <sup>i,j,k</sup>
SWE	94 <sup>i,k</sup>	84 <sup>j,k</sup>	91 <sup>j,k</sup>	63 <sup>i,k</sup>	98 <sup>k</sup>	11 <sup>j,k</sup>	29 <sup>j</sup>
UK	96 <sup>k</sup>	97 <sup>k</sup>	96 <sup>k</sup>	80 <sup>k</sup>	98 <sup>k</sup>	33	83 <sup>k</sup>
US	82	78	78	49	59	30	30

**SOURCE:** Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

**NOTES:** Underlined row headings indicate a response rate below 40 percent. COPD is chronic obstructive pulmonary disease. Reading from top to bottom starting with Australia, the letter indicates significant differences with countries below at  $p < 0.05$ , as indicated: <sup>b</sup>Different from CAN. <sup>c</sup>Different from FRA. <sup>d</sup>Different from GER. <sup>e</sup>Different from ITA. <sup>f</sup>Different from NET. <sup>g</sup>Different from NZ. <sup>h</sup>Different from NOR. <sup>i</sup>Different from SWE. <sup>j</sup>Different from UK. <sup>k</sup>Different from US.

partially correlate with electronic capacity to generate such lists. Doctors in some countries that reported such capacity, such as Australia, apparently do not routinely provide the information to patients.

■ **Quality incentives.** All eleven countries face the challenge of how to improve responsiveness and quality while improving efficiency. Each is working to improve primary care and encourage innovation, especially for care of chronic conditions.

The survey asked doctors about the availability of incentives for six aspects of care (Exhibit 5). Overall, U.K. doctors were the most likely to report receiving or having the potential to receive incentive payments, likely the result of recent reforms including the GP contract implemented in 2004 that included a “quality and outcomes framework.” These reforms provided rewards for GP performance on more than 100 indicators of clinical outcomes, preventive care, patient experiences, and organization.<sup>4</sup>

Financial incentives are embedded in primary health organizations in New Zealand, part of national GP performance incentives in Australia, and an integral element of the Dutch and Italian mix of capitation and fees for specific services or team capacity.<sup>20</sup> Swedish primary care doctors were the least likely to report extra



**EXHIBIT 5**  
**Quality Improvement Incentives Among Primary Care Physicians In Eleven Countries, 2009**

**Doctor receives or has potential to receive extra financial support or incentive based on**

	<b>High patient satisfaction ratings (% yes)</b>	<b>Achieving clinical care targets (% yes)</b>	<b>Managing patients with chronic disease or complex needs (% yes)</b>	<b>Enhanced preventive care activities (% yes)</b>	<b>Adding nonphysician clinicians to your practice team (% yes)</b>	<b>Non-face-to-face interactions with patients (% yes)</b>	<b>Any incentives (% yes to any)</b>
<u>AUS</u>	29 <sup>b,c,d,e,f,g,h,i,j,k</sup>	25 <sup>b,c,d,e,g,h,i,j</sup>	53 <sup>c,f,h,i,j,k</sup>	28 <sup>c,d,f,g,h,i,j,k</sup>	38 <sup>b,c,d,e,f,g,h,i,j,k</sup>	10 <sup>b,c,f,g,h,i,j,k</sup>	65 <sup>c,d,e,f,g,h,i,j,k</sup>
<u>CAN</u>	1 <sup>d,e,f,i,j,k</sup>	21 <sup>c,d,e,g,h,i,j,k</sup>	54 <sup>c,d,f,h,i,j,k</sup>	26 <sup>c,f,g,h,i,j,k</sup>	21 <sup>c,d,e,f,h,i,j,k</sup>	16 <sup>c,d,f,g,h,i,k</sup>	62 <sup>c,e,f,g,h,i,j,k</sup>
<u>FRA</u>	2 <sup>d,e,f,i,j,k</sup>	6 <sup>e,f,g,h,j,k</sup>	42 <sup>e,f,g,h,i,j,k</sup>	14 <sup>d,e,g,i,j</sup>	3 <sup>d,e,f,g,h,j,k</sup>	3 <sup>d,f,h,j,k</sup>	50 <sup>d,e,f,g,h,i,j,k</sup>
<u>GER</u>	4 <sup>e,h,j,k</sup>	6 <sup>e,f,g,h,j,k</sup>	48 <sup>e,f,g,h,i,j,k</sup>	23 <sup>e,f,g,h,i,j,k</sup>	17 <sup>e,f,h,i,j,k</sup>	7 <sup>f,h,i,j</sup>	58 <sup>e,f,g,h,i,j,k</sup>
<u>ITA</u>	19 <sup>f,g,h,i,j</sup>	51 <sup>f,g,h,i,j,k</sup>	56 <sup>f,h,i,j,k</sup>	28 <sup>f,g,h,i,j,k</sup>	44 <sup>f,g,h,i,j,k</sup>	— <sup>l</sup>	70 <sup>f,g,h,i,j,k</sup>
<u>NET</u>	4 <sup>h,j,k</sup>	23 <sup>g,h,i,j,k</sup>	61 <sup>h,i,j,k</sup>	17 <sup>g,h,i,j,k</sup>	60 <sup>g,h,i,j,k</sup>	35 <sup>g,i,j,k</sup>	81 <sup>h,i,j,k</sup>
<u>NZ</u>	2 <sup>j,k</sup>	74 <sup>h,i,j,k</sup>	55 <sup>h,i,j,k</sup>	38 <sup>h,i,k</sup>	19 <sup>h,i,j,k</sup>	5 <sup>h,j</sup>	80 <sup>h,i,j,k</sup>
<u>NOR</u>	1 <sup>i,j,k</sup>	1 <sup>i,j,k</sup>	9 <sup>i,j,k</sup>	12 <sup>i,j</sup>	7 <sup>i,j</sup>	30 <sup>i,j,k</sup>	35 <sup>i,j</sup>
<u>SWE</u>	4 <sup>j,k</sup>	5 <sup>j,k</sup>	2 <sup>j,k</sup>	2 <sup>j,k</sup>	2 <sup>j,k</sup>	4 <sup>j,k</sup>	10 <sup>j,k</sup>
<u>UK</u>	49 <sup>k</sup>	84 <sup>k</sup>	82 <sup>k</sup>	37 <sup>k</sup>	26 <sup>k</sup>	17 <sup>k</sup>	89 <sup>k</sup>
<u>US</u>	19	28	17	10	6	7	36

**SOURCE:** Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

**NOTES:** Underlined row headings indicate a response rate below 40 percent. Reading from top to bottom starting with Australia, the letter indicates significant differences with countries below at  $p < 0.05$ , as indicated: <sup>b</sup>Different from CAN. <sup>c</sup>Different from FRA. <sup>d</sup>Different from GER. <sup>e</sup>Different from ITA. <sup>f</sup>Different from NET. <sup>g</sup>Different from NZ. <sup>h</sup>Different from NOR. <sup>i</sup>Different from SWE. <sup>j</sup>Different from UK. <sup>k</sup>Different from US. <sup>l</sup>Italy survey did not ask question.

payments, perhaps reflecting the fact that they are primarily paid by salary and supported by systems including nurse-led clinics for chronic illnesses.<sup>21</sup>

Two-fifths of physicians or more from all but three countries reported targeted payments for managing patients with chronic diseases—the most widely implemented incentive (Exhibit 5). Incentives to expand teams were reported most frequently in the Netherlands and Italy.

Among countries with FFS payment systems, U.S. doctors were the least likely to report incentives or targeted payments—including low rates for managing chronic disease. Although “pay for performance” is a concept advocated in the United States, U.K., Italian, and New Zealand physicians were the most likely to report financial incentives to meet clinical targets, and the United Kingdom was the only country where half of doctors indicated potential rewards for high patient ratings.

■ **Information feedback.** Information that peers have met with success is often instrumental to guide and drive innovation.<sup>22</sup> Such information is beginning to be available in several countries (Exhibit 6).

Routine reviews of clinical outcomes and patient experiences, comparative information, and annual assessments relative to targets were most frequently re-

**EXHIBIT 6**  
**Performance Reviews, Benchmarks, And Physicians' Concerns With Time Spent On Reporting, 2009**

	Practice routinely receives and reviews data on patient care		Doctor's clin. perf. reviewed against targets at least annually (% yes)	Practice's clin. perf. comp. with other practices (% yes, routinely)	Practice has process for identifying adverse events and taking follow-up action			Time spent reporting clin. inform. or meeting regulations (% major problem)
	Clinical outcomes	Patient satis. and exper.			% yes, works well	% yes, needs improvement	% no	
AUS	24 <sup>b,c,d,e,f,g,h,i,j,k</sup>	52 <sup>b,c,d,e,f,g,h,i,j</sup>	52 <sup>b,c,e,f,g,h,i,j,k</sup>	14 <sup>b,c,d,e,f,g,h,i,j,k</sup>	32 <sup>b,c,d,e,f,h,i,j,k</sup>	53 <sup>b,c,d,e,f,h,i,j,k</sup>	15 <sup>b,c,d,e,f,h,j,k</sup>	26 <sup>b,c,d,e,f,h,i,j</sup>
<u>CAN</u>	17 <sup>c,d,e,f,g,h,i,j,k</sup>	15 <sup>c,d,f,g,h,i,j,k</sup>	32 <sup>d,f,g,h,i,j,k</sup>	11 <sup>c,d,e,f,g,h,i,j,k</sup>	10 <sup>c,d,f,g,i,j,k</sup>	31 <sup>c,e,f,g,h,i,j,k</sup>	55 <sup>d,e,f,g,h,i,j,k</sup>	15 <sup>c,d,e,f,g,h,i,j,k</sup>
FRA	12 <sup>d,e,f,g,h,i,j,k</sup>	2 <sup>d,e,f,g,h,i,j,k</sup>	30 <sup>d,f,g,h,i,j,k</sup>	38 <sup>d,e,f,g,h,j,k</sup>	18 <sup>e,f,g,h,i,j</sup>	23 <sup>d,e,g,h,i,j,k</sup>	58 <sup>d,e,f,g,h,i,j,k</sup>	38 <sup>d,e,f,g,h,i,k</sup>
GER	41 <sup>f,g,h,i,j</sup>	24 <sup>e,g,h,i,j,k</sup>	55 <sup>e,f,g,h,i,j,k</sup>	23 <sup>e,h,i,j</sup>	18 <sup>e,f,g,h,i,j</sup>	30 <sup>e,g,h,i,j,k</sup>	48 <sup>f,g,h,i,j,k</sup>	67 <sup>e,f,g,h,i,j,k</sup>
ITA	40 <sup>f,g,h,i,j</sup>	12 <sup>f,g,h,i,j,k</sup>	29 <sup>f,g,h,i,j,k</sup>	24 <sup>l</sup>	13 <sup>f,g,i,j,k</sup>	37 <sup>f,g,h,i,k</sup>	48 <sup>f,g,h,i,j,k</sup>	50 <sup>f,g,h,j,k</sup>
NET	65 <sup>h,i,j,k</sup>	23 <sup>g,h,i,j,k</sup>	41 <sup>g,h,i,j,k</sup>	25 <sup>h,i,j</sup>	5 <sup>g,h,i,j,k</sup>	25 <sup>g,h,i,j,k</sup>	68 <sup>g,h,i,j,k</sup>	19 <sup>g,i,j,k</sup>
NZ	68 <sup>h,j,k</sup>	65 <sup>h,i,j,k</sup>	81 <sup>h,i,j,k</sup>	26 <sup>h,i,j</sup>	32 <sup>h,i,j,k</sup>	52 <sup>i,j,k</sup>	15 <sup>h,j,k</sup>	29 <sup>h,i</sup>
NOR	25 <sup>i,j,k</sup>	5 <sup>i,j,k</sup>	18 <sup>i,j,k</sup>	3 <sup>h,i,j</sup>	12 <sup>i,j,k</sup>	47 <sup>l</sup>	37 <sup>i,j,k</sup>	20 <sup>l,j,k</sup>
SWE	71 <sup>j,k</sup>	78 <sup>j,k</sup>	46 <sup>i,k</sup>	39 <sup>j,k</sup>	41 <sup>j,k</sup>	44 <sup>l</sup>	12 <sup>j,k</sup>	49 <sup>j,k</sup>
UK	89 <sup>k</sup>	96 <sup>k</sup>	92 <sup>k</sup>	65 <sup>k</sup>	56 <sup>k</sup>	38 <sup>k</sup>	5 <sup>k</sup>	32 <sup>k</sup>
US	43	55	61	28	20	45	31	27

**SOURCE:** Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009.

**NOTES:** Underlined row headings indicate a response rate below 40 percent. Reading from top to bottom starting with Australia, the letter indicates significant differences with countries below at  $p < 0.05$ , as indicated: <sup>b</sup>Different from CAN. <sup>c</sup>Different from FRA. <sup>d</sup>Different from GER. <sup>e</sup>Different from ITA. <sup>f</sup>Different from NET. <sup>g</sup>Different from NZ. <sup>h</sup>Different from NOR. <sup>i</sup>Different from SWE. <sup>j</sup>Different from UK. <sup>k</sup>Different from US.

<sup>l</sup>In Italy, asked "Yes" or "No." Responses are not comparable to other countries, which asked "yes, routinely," "yes, occasionally," or "no."

ported in the United Kingdom. In the Netherlands, New Zealand, and Sweden, two-thirds of doctors reported data on clinical outcomes. Strong majorities of New Zealand and Swedish doctors also reported patient experience information. These four countries have made systematic efforts to measure and compare outcomes and patient experiences, with feedback to physicians and the public. In the United Kingdom, public comparative data on primary care practices supports a policy to promote informed choices.

Collecting data on performance can consume physicians' time. When asked about time burden, half or more German, Italian, and Swedish doctors reported major time concerns (Exhibit 6). These concerns may indicate the need to streamline reporting or build reporting capacity in a way that avoids draining resources.

■ **Safety tracking.** Previous surveys found high rates of medical errors reported by chronically ill patients, and patients often reported that adverse events occurred outside the hospital.<sup>16</sup> Corroborating patients' concerns, nearly half or more doctors in Germany, Italy, Canada, France, and the Netherlands said that their practices have no process for identifying adverse events and taking action (Exhibit 6). Among countries where a majority of doctors reported a process, U.K. and Swedish doctors

were the most likely to say that their process works well.

### Summary And Implications

The survey highlights diverse international initiatives to invest in primary care and to incorporate incentives to innovate. Variations in access, information systems, use of teams, and payment incentives reflect policy choices and the extent to which countries rely on national frameworks or local action to drive change.

■ **National policies make a difference.** A response rate of just 20 percent from the U.K. primary care practices makes it difficult to generalize. Nonetheless, the practices that responded stand out throughout the survey for information capacity, a systemic approach to chronic care, and incentives to support improved performance. The most recent round of efforts to transform the U.K. National Health Service (NHS) began in 1998; a decade later, policies to invest and improve access, quality, and health outcomes have been put in place. Recent studies indicate that the reforms have improved outcomes.<sup>23</sup> Current initiatives further promote the use of patient-centered care teams and system integration.<sup>18</sup>

The advanced health IT capacity, extensive quality incentives, and team use reported by Australian, Dutch, and New Zealand doctors also reflect national payment and information system policies focused on primary care. Indeed, in all countries with widespread adoption and use of health IT, a combination of national financial incentives, standards, and technical support has been instrumental. All countries in the study are developing the capacity to exchange information across sites of care to enhance safety, avoid duplication, and improve health outcomes. Attesting to the importance of information in efforts to improve, physicians reporting high-function health IT capacity within each country were also significantly more likely than others to have a system to track adverse events.<sup>15, 24</sup>

■ **Access.** The Netherlands is notable for legislation that created physician-run after-hours cooperatives that operate on nights and weekends—a system that patients and doctors indicate provides accessible care. New Zealand also uses a cooperative model, while the United Kingdom has invested in national call centers that respond after hours. Cooperatives, where feasible, offer the potential for access, continuity, and coordination that would not exist outside of fully integrated care systems, and they reduce time demands on physicians.<sup>25</sup>

Insurance benefit designs are also instrumental for access and support of primary care. Here U.S. physicians stand out for concerns that their patients often have difficulty paying for care and for reports of time spent confronting insurance restrictions on medications or treatment decisions. Both responses make it more difficult to provide timely access.

■ **The U.S. in perspective.** Although the United States spends far more than the other countries do,<sup>26</sup> U.S. primary care physicians continue to lag well behind in health IT capacity, are the least likely to have arrangements for after-hours care, and report few incentives or targeted support for improving primary care. The patient-

centered chronic care model originated in the United States, yet U.S. physicians have not led in implementing features of the model such as the use of teams. Without systemwide health IT support for small practices or payment for time to manage chronic conditions, advances in U.S. primary care have depended on integrated care systems or local initiatives. Innovative primary care developments exist, but their spread has been slow.

Overall, the survey highlights the lack of national policies focused on U.S. primary care. Unless primary care practices are part of more integrated care systems, they are on their own facing multiple payers with uncoordinated policies. In contrast, other countries with multiple payers seek coherent payment and coverage policies. As the United States looks to develop new primary care models that could work well for patients and physicians, policymakers can learn a great deal from diverse initiatives under way in other countries.

■ **New models.** Increasingly, primary care physicians and care teams are expected to serve as a bridge between hospitals and community care. Each country is emphasizing information systems, teams, continuity during transitions, and patient and family engagement to help manage health in an aging population. All face the question of how to transform existing primary care into more integrated care systems to improve outcomes and reduce inefficiency

Internationally, there is conceptual agreement but also a search for new models to advance primary care.<sup>27</sup> The variations in payment incentives, information systems, use of teams, and guidelines demonstrated in the survey reveal a rich basis for cross-national learning to inform and develop primary care models that use twenty-first-century technologies and skills creatively to yield better health outcomes and value.

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8. The U.S. survey oversampled pediatricians. The U.S. weighted sample includes 40 percent internal medicine, 35 percent family practice, 20 percent pediatrics, and 6 percent general practice. German ratios are 90 percent internal medicine and 9 percent pediatrics.
9. The lists included the American Medical Association (AMA) Physician Masterfile and similar lists in other countries. Lists are particularly current in countries with registration.
10. The Commonwealth Fund provided core support and partnered with the Health Foundation (U.K.), Australian Commission on Safety/Quality in Health Care, Health Council of Canada, Ontario Quality Council, and Québec Health Commission for expanded country samples. Support for other country samples was funded by German Institute for Quality and Efficiency in Health Care; Haute Autorité de Santé and Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (France); Italian Association of Primary Care Doctors; Dutch Ministry of Health, Welfare, and Sport and Scientific Institute for Quality of Healthcare, Radboud University; Norwegian Knowledge Centre for the Health Services; and Swedish Ministry of Health.
11. The French survey was taken during 23 April–May 11, with 1,782 physicians (or 28 percent of contacts) agreeing to participate. The survey firm stopped interviews at the quota of 500.
12. Data weights included sex, age, and region in all countries except the Netherlands, which was weighted by sex and age. U.S. and German data included weights by specialty and Australia, by urbanicity.
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