The most recent Commonwealth Fund International Health Policy Survey asked hospital executives in five countries—Australia, Canada, New Zealand, the United Kingdom, and the United States—for their views of their nation’s health care system, the level and quality of hospital resources, and efforts to improve quality of care. Findings show that half of hospital executives in the United States are dissatisfied with the health care system, a significantly higher proportion than in the other four nations surveyed.

U.S. Hospitals: A Current Snapshot
“U.S. hospitals operate within highly decentralized, competitive insurance and delivery systems in which revenues depend on volume and patient mix. U.S. hospitals stand out for high costs (three times the OECD median cost per day and twice the OECD cost per capita), low rates of hospital admissions, and short lengths-of-stay. Reimbursement incentives have encouraged and supported a migration of care to freestanding centers and emergence of niche hospitals. National health spending has risen sharply over the past several years, fueled by rapid increases in hospital costs.”

From R. J. Blendon et al., “Confronting Competing Demands to Improve Quality,” Health Affairs, May/June 2004

The survey found a higher rate of dissatisfaction among U.S. hospital executives even though they were more likely than their counterparts to report a strong financial situation, excellent facilities, resources available to expand or improve current services, and short waiting times, or none at all, for elective surgery.

U.S. hospital executives also stood out as being the most concerned about market competition, the expense of providing care to the uninsured, and the cost of malpractice insurance. Furthermore, U.S. hospital executives were the most reluctant to disclose quality-of-care data to the public.

Staffing shortages, poor-quality emergency room facilities, and long waits for emergency department care were problems shared by all five countries. Still, patient safety efforts appear to be gaining traction: hospital executives in each nation strongly endorsed recognized strategies to improve quality of care, such as treatment guidelines, computerized ordering of drugs, and electronic medical records. Hospital executives in each country named information technology and electronic medical records as their top priorities for a one-time capital investment to improve quality of care.

The Commonwealth Fund survey, conducted in 2003, is the sixth in a series of surveys designed to provide a comparative perspective on health policy issues in these five countries. The newest survey consisted of interviews with a sample of hospital chief operating officers or top administrators of the larger hospitals in each country. The findings were reported in the May/June 2004 issue of Health Affairs.
Overall System Views
U.S. hospital executives are more dissatisfied with the health care system than their counterparts in Australia, Canada, New Zealand, and the U.K. Inadequate funding or reimbursement and staffing shortages were named as major challenges in all five countries.

- Half of hospital executives in the U.S., compared with 12 percent or less in the other countries, were not very satisfied, or not satisfied at all, with the health care system (Figure 1).
- Hospital executives across all five countries named inadequate funding, staffing shortages, and inadequate or outdated facilities as major problems facing their hospitals. One of six U.S. respondents also named the cost of caring for the uninsured as a top problem, while 11 percent cited malpractice insurance costs (Figure 2).

Financial Health, Competition, Quality of Facilities, and Capacity to Expand or Improve Services
According to the survey, hospitals in the U.S. are in better financial health than those in Australia, Canada, New Zealand, or the U.K. At the same time, U.S. hospital executives feel the most threatened by market competition. When asked about the quality of their hospital facilities, U.S. respondents gave the highest ratings. However, across all five countries, emergency department facilities were rated relatively poorly, a finding consistent with physicians’ ratings in the Fund’s 2000 International Health Policy Survey.²

- Seventy-one percent of U.S. hospital executives reported having a surplus or profit in the last year, while one-quarter said that they operated at a deficit. These findings contrast with those for the other four countries, where one-third or fewer of hospitals reported profits (Figure 3).

- Profitability of U.S. hospitals was associated with ownership status. Private, for-profit hospitals were significantly more likely to report that they had a surplus in the past year (93%) compared with not-for-profit (72%) and public (54%) hospitals. Thirty-seven percent of U.S. public hospitals reported running a deficit in the past year.
- The U.S. was the only country of the five with a substantial percentage of hospitals reporting that their current financial situation allowed for some improvements or expansions of health care services (Figure 3).

- U.S. hospital executives were significantly more likely than those in the other countries to rate the quality of their facilities, including intensive care units, operating rooms, and diagnostic equipment, as excellent.
- Across all countries, respondents were critical of their hospital’s emergency department. At most, a third of hospital executives rated their emergency departments as excellent, while about one-fifth to one-half rated them as

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only fair or poor (Canada, 48%; New Zealand, 30%; Australia, 21%; U.S., 19%; U.K., 17%) (Figure 4).

- Competition with other medical facilities is a far greater concern for U.S. hospital executives than it is for others. More than half reported that they were very concerned about losing patients to freestanding diagnostic or treatment centers or freestanding ambulatory or primary care centers. Both U.S. and Australian executives also were more likely to cite the potential loss of patients to other hospitals as a serious concern (19% and 16%, respectively) (Figure 5).

- Two years after the September 11th terrorist attacks and the anthrax attacks, the survey found that no more than 28 percent of U.S. hospital executives felt they were very prepared for a terrorist attack, compared with 43 percent in the U.K., 25 percent in Canada and New Zealand, and 18 percent in Australia.

- Only 1 percent of U.S. hospital executives reported that patients often or very often have to wait six months or more for elective surgery, a far lower percentage than reported for Australia (26%), Canada (32%), New Zealand (42%), or the U.K. (57%). While the U.S. is an outlier in this regard, its short waits may not reflect indigent and uninsured patients who are discouraged from seeking elective surgery altogether.

- Short waiting times were reported by U.S. respondents for two specific procedures: a breast biopsy for a 50-year-old woman with an ill-defined mass, but no adenopathy, and routine hip replacement for a 65-year-old man (Figure 6).

- U.S. hospitals resembled hospitals in other nations with regard to emergency department waiting times: four of 10 (39%) reported that, on average, their patients wait two hours or more to be seen (compared with U.K., 58%; Canada, 46%; Australia, 23%; New Zealand, 17%).

- One-fourth of U.S hospital executives reported that patients are often or very often diverted to other hospitals. This is a significantly less common practice in the other countries (U.S. 24%; Canada, 19%; Australia, 14%; U.K., 11%, New Zealand, 0%).
• Frequent delays or problems in discharging patients from the hospital due to a lack of post-hospital care were a common concern in all countries except New Zealand. More than four of 10 hospital executives said patients experienced discharge delays often or very often (Canada and U.K., 58%; Australia, 43%; U.S., 40%; New Zealand, 7%).

• New Zealand hospitals reported the fewest diversions to other hospitals because of a lack of emergency department or inpatient capacity. They also reported the least discharge delays due to limited post-hospital care, suggesting better coordination among primary, emergency, and community-based care providers.

Patient Safety: Medical Errors

The 2002 Commonwealth Fund International Health Policy Survey found that a significant number of adults with health problems experienced medical errors. While the 2003 survey found that the U.K. and U.S. appear to be the leaders in patient safety efforts, in no country were a majority of hospital executives very confident in their hospital’s ability to identify and address preventable errors or in physician support for such efforts.

• Three-fourths or more of U.S. and U.K. hospital executives reported that their hospitals have a written policy to inform patients or their families if a preventable medical error resulting in serious harm had been made in their care. No more than six of 10 in Australia, Canada, and New Zealand reported such a policy (Figure 7).

• Although virtually all hospitals in the five nations have some type of system for identifying and addressing medical errors, only one of four hospital executives in the U.S., U.K., and Australia were likely to respond that their system was very effective. Even fewer in Canada and New Zealand reported this.

• Hospital executives in the U.S. and U.K. were significantly more likely than their counterparts in Australia, Canada, and New Zealand to say that physicians in their hospital were very supportive of reporting and addressing medical errors.

Quality Improvement and Public Disclosure of Data

Across all five countries, the majority of hospital executives agreed that a number of recognized strategies to improve quality of care were at least somewhat effective, and that provider performance data should be reported to the public.

• Eight of 10 hospital executives in all five countries endorsed the use of electronic medical records, computerized ordering of drugs, treatment guidelines for common conditions, and comparisons of medical outcomes with other hospitals, rating them as at least somewhat effective in improving quality of care.

• Of the quality improvement strategies presented, computerized ordering of drugs garnered the most support from U.S. respondents. Sixty percent thought the initiative would be very effective (compared with New Zealand, 64%; U.K., 61%; Australia, 55%; Canada, 51%).

• The majority of hospital administrators in all the countries approved of public disclosure of quality data on hospital performance. In general, U.K. hospital executives were the most consistently supportive of disclosing quality-of-care information.

• More than 80 percent of U.S. hospital executives supported disclosing the frequency of specific procedures and publicly releasing patient satisfaction ratings. But nearly 30 percent or more of U.S. hospital executives said that medical error rates, mortality rates for elective medical conditions, average waiting times for specific procedures, and nosocomial infection rates should not be reported to the public. Australian executives similarly opposed disclosure for these measures, a likely reflection of shared malpractice concerns and a more competitive market environment (Figure 8).

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U.S. and Canadian hospital executives were the least likely to rate current government policies to improve quality as effective. New Zealand, Australian, and U.K. respondents voiced greater confidence in their government's quality improvement efforts: three of five or more hospital executives rated them as somewhat or very effective (U.K., 75%; Australia, 68%; New Zealand, 61%; Canada, 46%; U.S., 40%).

**Staffing Issues**

Hospital staffing shortages were named a top concern in all five countries. The impact of staffing shortages and facility constraints is evidenced in cancellation rates for scheduled surgeries and procedures.

- When asked about staffing shortages, U.S. hospital executives were most concerned about nurse staffing levels, with almost one-third reporting a serious shortage of nurses (Figure 9).

- Across the five countries, at least eight of 10 hospital executives reported moderate or serious shortages of nurses. However, hospital executives in all five countries expressed guarded optimism about nurse staffing levels, with a majority reporting that they were better than or the same as two years ago.

- A majority of hospital executives in all countries reported a shortage of pharmacists. The percentage reporting a serious shortage ranged from 14 percent in the U.S. and New Zealand to 33 percent in Canada.

- Shortages of specialists were reported by all five countries. Serious shortages ranged from a low of 7 percent in New Zealand to 26 percent in Canada.

- Staffing shortages or lack of capacity were responsible for one of seven U.S. hospital directors having to cancel 10 percent or more of scheduled surgeries or procedures. Significantly higher cancellation rates were found in Canada and the U.K. (U.S. and Australia, 14%; New Zealand, 21%; U.K., 24%; Canada, 26%).

**Priorities for Improving the Quality of Care**

When hospital executives in the five countries were asked what their top priority would be for a one-time capital investment to improve quality of care for patients, information technology (IT) was the dominant choice.

- Information technology and electronic medical records were the top priorities for 62 percent of U.S. hospital executives as a one-time capital investment to improve quality of care (Figure 10).

- While one-third or more of chief executives in Australia, Canada, New Zealand, and the U.K. named IT as their top priority, one of five or more said they would direct a one-time capital investment toward upgrading emergency and operating rooms or patient facilities.
Across all five countries, the majority of hospital administrators named high startup costs as a major barrier to expanding the use of computer technology (New Zealand, 93%; Australia and Canada, 84%; U.S., 71%; U.K., 69%). Projected maintenance costs, insufficient technical staff, and lack of uniform industry standards also were seen as major barriers (Figure 11).

### United States Figure 11

**Major Barriers to Greater Use of Computer Technology in Hospitals**

<table>
<thead>
<tr>
<th>Percent saying major barrier</th>
<th>AUS</th>
<th>CAN</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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<tr>
<td>High startup costs</td>
<td>84%</td>
<td>84%</td>
<td>93%</td>
<td>69%</td>
<td>71%</td>
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<tr>
<td>Projected maintenance costs/ insufficient technical staff</td>
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<td>42</td>
<td>32</td>
<td>52</td>
<td>27</td>
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<tr>
<td>Lack of uniform standards within industry</td>
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<td>35</td>
<td>50</td>
<td>31</td>
<td>44</td>
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<tr>
<td>Doctors’ resistance to change</td>
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<td>18</td>
<td>8</td>
<td>39</td>
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<tr>
<td>Privacy concerns</td>
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<td>7</td>
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<tr>
<td>Lack of staff training or knowledge</td>
<td>11</td>
<td>12</td>
<td>4</td>
<td>9</td>
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Survey Methods

The Commonwealth Fund 2003 International Health Policy Survey consisted of interviews with hospital executives of the larger hospitals in Australia, Canada, New Zealand, the United Kingdom, and the United States. The survey drew random samples from lists of the largest general or pediatric hospitals in each country, excluding specialty hospitals. The largest hospitals surveyed in Australia and Canada had 100 or more beds, and in the United Kingdom and United States had 200 or more beds. In New Zealand, the study included hospitals in the country’s 34 District Health Boards regardless of bed size. Final survey hospital sample sizes were: AUS 100; CAN 102; NZ 28; UK 103; and US 205. Harris Interactive, Inc., and country affiliates conducted the interviews by telephone with the chief operating officer or top administrator of hospitals between April and May 2003. The May/June 2004 *Health Affairs* article based on the survey provides tests for statistical differences between countries.