THE U.S. HEALTH CARE DIVIDE: DISPARITIES IN PRIMARY CARE EXPERIENCES BY INCOME

FINDINGS FROM THE COMMONWEALTH FUND 2004 INTERNATIONAL HEALTH POLICY SURVEY

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April 2006

ABSTRACT: In analyzing findings from the Commonwealth Fund 2004 International Health Policy Survey, which studied adults in the United States, the United Kingdom, Australia, Canada, and New Zealand, this report finds a wide health care divide by income. There is health care gap not only separating the U.S. from the other four countries, but also one standing between lower-income and higher-income Americans. Among the countries surveyed, the U.S. stands out for income-based disparities in patient experiences, with below-average-income U.S. adults reporting the worst experiences—compared with their counterparts in the other four countries—on most measures of primary care access, coordination, and doctor-patient relationships. Although a lack of health insurance intensified the disparities, with uninsured U.S. adults often forgoing needed care, insurance coverage does not level the playing field. Even when insured, below-average-income Americans under the age of 65 were more likely to report access problems and delays than insured, above-average-income adults.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 900.

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ACKNOWLEDGMENTS

The authors thank the editors and reviewers for many thoughtful comments that improved this paper. The authors also gratefully acknowledge the substantial contribution of Michelle M. Doty, Ph.D., M.P.H., for her work in analyzing the data.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

Given the strong correlation worldwide between low income and poor health—including disability, chronic disease, and acute illness—it is especially critical for people with limited incomes to have ready access to medical care. Inequities in access can contribute to and exacerbate existing disparities in health and quality of life, creating barriers to a strong and productive life.

Low-income patients in any country are likely to be particularly vulnerable to policies related to health insurance. Gaps in coverage, patient cost-sharing, and limited benefits can all act as barriers to care. To the extent that higher income enables patients to avoid waiting lists, complex administrative processes, or community shortages, nonfinancial barriers may also contribute to inequities in care experiences.

Cross-national comparisons of health care experiences by income can help in the assessment of relative performance and can provide guidance to policymakers seeking to reduce health and health care disparities. To compare experiences in countries with different health insurance and care delivery systems, The Commonwealth Fund 2004 International Health Policy Survey interviewed adults in Australia, Canada, New Zealand, the United Kingdom, and the United States about their primary care experiences. A 2004 report based on the survey found shortfalls in the delivery of timely, effective, safe, or patient-centered care, with significant differences across all five countries.[1] Although country rankings varied, on average the U.S. often ranked low, particularly with regard to stability of physician–patient relationships, concerns with coordination of care, and cost-related barriers.

This report goes beyond the averages to compare experiences within and across the five countries by income. The study examines how adults with below-average incomes fare within each country's health system and how their experiences compare with those of adults with above-average incomes.[2]

Overall, the report finds a health care divide separating the U.S. from the other four countries. The U.S. stands out for income-based disparities in patient experiences—particularly for more negative primary care experiences for adults with below-average incomes. On most measures of primary care access, coordination, and doctor–patient relationships, below-average-income adults in the U.S. had the worst experiences compared with their counterparts in the other four countries. Only on selective

preventive care measures did below-average-income adults in the U.S. fare better than in the other countries.

In the U.S., disparities—many of them wide—between below-average- and above-average-income adults' experiences were evident on 21 of 30 measures. At the other end of the spectrum, the U.K. was the most equitable in terms of reported care experiences. Compared with the U.S., there were also relatively few disparities by income in Australia, Canada, and New Zealand; in these countries, significant differences arose most often for access to services not fully covered by public insurance.

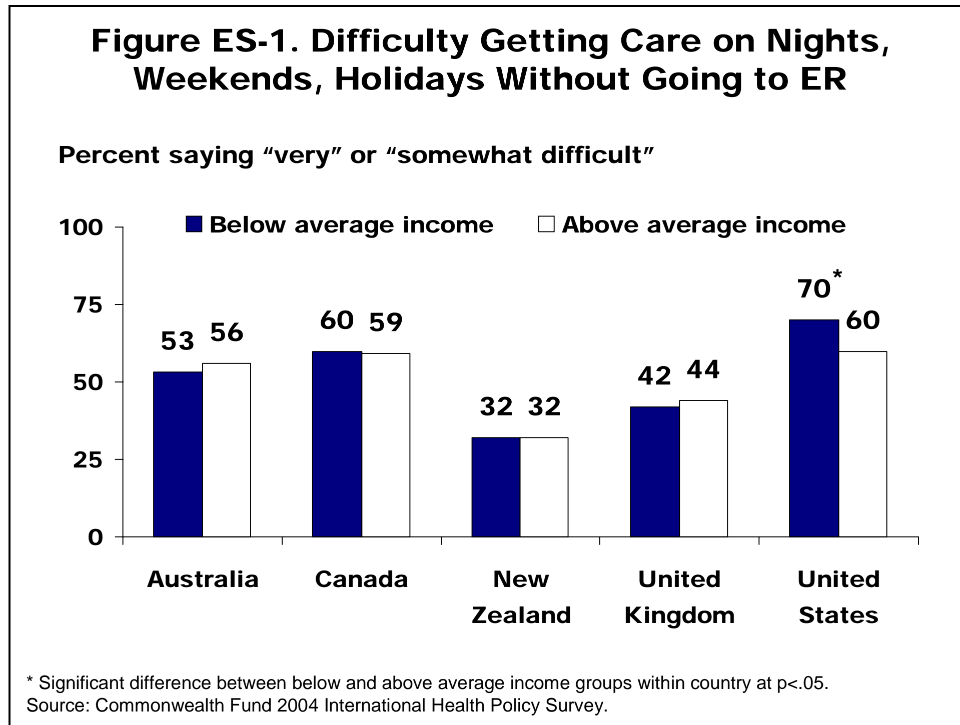
Among the five countries, the U.S. was unique in the extent to which differences by income extended to patient–physician care relationships and ratings. In the other four countries, lower-income and higher-income adults tended to report similar physician experiences.

The study also finds that uninsured adults in U.S. are at sharply elevated risk for access barriers, coordination gaps, and other primary care deficiencies. Yet, being uninsured is only part of the story: even when insured, below-average-income American adults under age 65 were more likely to report access problems and delays than insured, above-average-income adults.

Following are some key highlights from the study.

Low-Income Adults Across Five Countries

- Below-average-income adults in the U.S. ranked last on 16 of 30 measures of health care experiences. The more negative experiences spanned primary care access, coordination, and care ratings.
- Compared with below-average-income adults in the other countries, those in the U.S. were:
  - ➢ the most likely to have difficulty getting care at night, during weekends, or on holidays without going to the emergency room (70% vs. 32%–60% in the other countries) (Figure ES-1);



- ➢ the most likely to go without care because of costs (57% vs. 12%–44% in the other countries);[3]
- ➢ the most likely to report duplication of medical tests (17% vs. 5%–8% in the other countries); and
- ➢ the most likely to rate their doctor as fair/poor (22% vs. 9%–12% in the other countries).

- The U.S. performs comparatively well on clinical preventive care measures, regardless of income level. In these indicators, U.S. below-average-income adults tended to lead rather than lag their counterparts in other countries.

Disparities by Income

- The U.S. stands out for pervasive disparities by income. On 21 of 30 measures, there were significant and often wide gaps between below-average- and above-average-income adults' experiences, with the former more likely to report negative experiences.
  - ➢ In the U.S., significant gaps by income were seen across all but one access question, (i.e., did not have a regular doctor or place of care). Compared with above-average-income adults, those with below-average incomes were more likely to wait six days or more for an appointment with a doctor when sick (24% vs. 13%) and to go without needed care because of costs (57% vs. 25%). They were

also more likely to have gone to an emergency room for care and to report difficulty getting care after hours.

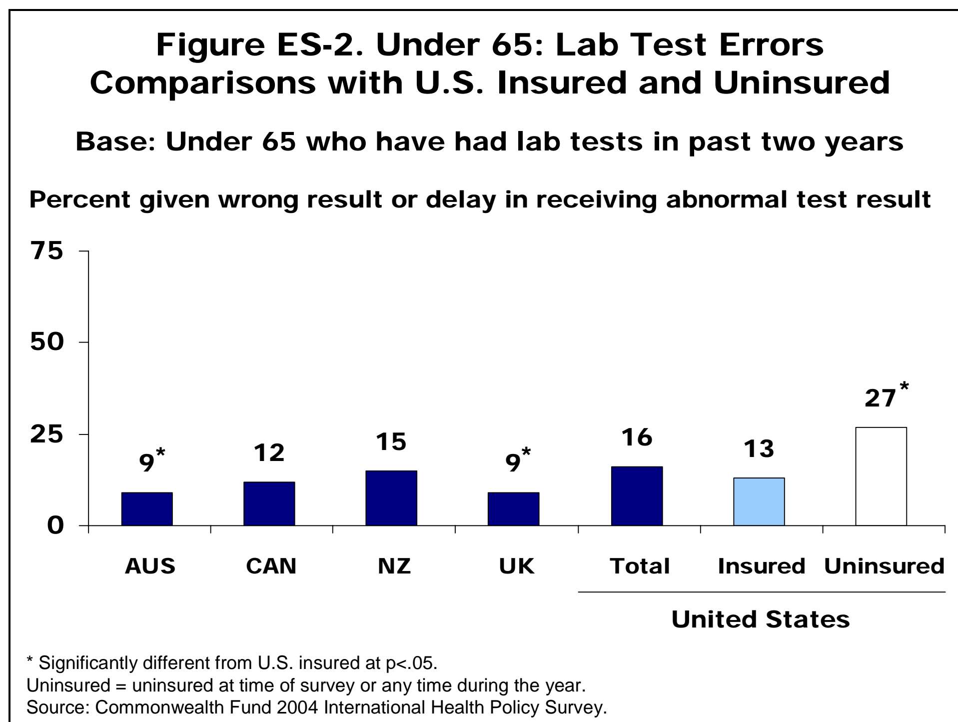
- ➢ There were also significant disparities for coordination of care—including duplicate tests and delays in receipt of lab tests. Compared with above-average-income adults, those with below-average incomes were more likely to report duplication of medical tests (17% vs. 9%), lab test errors (19% vs. 10%), or delays in receiving test results (25% vs. 17%).

- The U.S. was the only country among the five in which below-average-income patients often reported more negative doctor–patient care experiences, including physicians' failure to listen or to explain or make goals of care clear.

- Lack of health insurance intensified disparities. In the U.S., uninsured adults often went without needed care and also experienced more fragmented and disconnected care.

  - ➢ Uninsured adults were most at risk for access barriers and lack of a regular source of care: three of four reported going without care because of costs (76%) and difficulty getting care after hours (74%).

  - ➢ Uninsured adults were also significantly more likely than those with insurance to report duplication of tests (23% vs. 10%), experience medical record delays (26% vs. 15%), not receive test results or have results clearly explained (31% vs. 19%), and report lab test errors (27% vs. 13%) (Figure ES-2).



    - ➢ The survey findings also reveal that lack of insurance can undermine doctor–patient relationship and communication. Compared with insured U.S. adults, uninsured adults were significantly more likely to report negative experiences on all six key measures of doctor–patient relationship. They were also significantly more likely to leave the doctor's office without getting important questions answered (35% vs. 23%) and to rate their doctor as fair or poor (27% vs. 11%).
    - ➢ Although gaps narrow with insurance, the study finds that below-average-income insured adults under 65 continued to report access problems at twice the rate of insured adults with above-average incomes.
    - ➢ Even when insured, U.S. nonelderly adults still faced heightened access problems compared with nonelderly adults in the other four countries.

- Among the five countries, the U.K. health care system appears to provide the most equitable access. Differences by income across primary care measures were typically small, with few significant disparities. The U.K is also notable for protecting low-income adults, as well as high-income adults, against financial burdens.
    - ➢ However, both below-average- and above-average-income adults in the U.K. lag behind other countries on clinical preventive care measures.
- Compared with the U.S., Australia, Canada, and New Zealand provide relatively equitable access to primary care. The income differences that emerged were associated with cost-sharing features or benefit gaps in national health insurance.

Summary

Despite health care spending that far outstrips that of the other four countries, the U.S. lags behind in provision of timely, patient-centered, and efficient care for its below-average-income population. The U.S. also stands out for systemic differences in access to care and primary care experience by income.

In the U.S., health insurance coverage is associated with access to care and better care experiences. Uninsured adults were the most likely of adults in all five countries to go without care because of costs and to experience coordination problems that put their health at risk and undermine the efficiency of care. The cross-country findings further indicate that below-average income adults are likely to be particularly sensitive to insurance design, including cost-sharing and benefits. In Australia and New Zealand, disparities by income level emerged for services less well covered by national plans, despite fees that would be considered modest by U.S. standards. Within the U.S., the persistence of access problems among below-average-income adults with insurance coverage likely reflects the shift in insurance design toward higher deductibles and cost-sharing.

Finding policy solutions to extend coverage and improve primary care for lower-income adults is a critical step toward improving the performance of the U.S. health care system. The experiences of other countries indicate that it is possible to do better.

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INTRODUCTION

Given the strong correlation worldwide between low income and poor health—including disability, chronic disease, and acute illness—it is especially critical for people with limited incomes to have ready access to medical care, particularly well-coordinated primary care. Inequities in access can contribute to and exacerbate existing disparities in health and quality of life, creating barriers to a strong and productive life.

Cross-national comparisons of health care experiences by income can help in the assessment of relative health system performance and can provide guidance to policymakers seeking to reduce health and health care disparities. To compare experiences in countries with different health insurance and care delivery systems, The Commonwealth Fund 2004 International Health Policy Survey examined the primary care experiences of adults in Australia, Canada, New Zealand, the United Kingdom, and the United States.[4] The initial study compared country averages across all adults participating in the survey. In each country, adults with below-average income were significantly more likely than those with above-average income to report health problems.

To determine how low-income individuals fare under different health systems, this report examines differences in experiences by income within each country and compares below-average-income adults' experiences across countries. First, the report describes the health insurance systems in each country. Then, it compares adults' primary care experiences by income. Using a series of measures, the study examines how adults with below-average incomes (i.e., below the country median) fare within each country's system and how their experiences compare with those of adults with above-average incomes (i.e., above the country's median). Appendix tables provide country averages (Tables 1a and 1b) and compare experiences by income groups (Tables 2–7).

BACKGROUND: HEALTH INSURANCE SYSTEM VARIATIONS, BY COUNTRY

Health insurance coverage is a major factor in facilitating patients' access to primary care and providing financial protection. The five countries vary on the scope of government-sponsored insurance they provide and how well their citizens are protected from out-of-pocket medical costs. The U.S. is unique among the countries surveyed for its lack of

universal coverage for adults under age 65. In addition, as a result of ongoing erosion in private health insurance coverage for the working population, the number of uninsured individuals in the U.S. reached 46 million (16% of the total population) in 2004, an increase of 6 million over the past four years.[5] Millions more have sporadic coverage (i.e. frequent gaps in their insurance coverage), resulting in an estimated 79.6 million people under age 65 uninsured for a month or longer during 2002.[6] Even when people are insured continuously, rising deductibles and cost-sharing appear to be increasing the ranks of the "underinsured" in the U.S.[7]

The other four countries in the study have universal coverage (Figure 1). Yet, coverage schemes vary in benefit design, patient cost-sharing, and the role of private insurance. In the U.K., health coverage is provided under the National Health Service, where citizens generally have access to a broad array of medical care services for which payment at point of service is not required. Private insurance plays a minor role, accounting for only 4 percent of health care expenditures.

Figure 1. Insurance and Cost-Sharing Policies in Four Countries with Universal Public Coverage

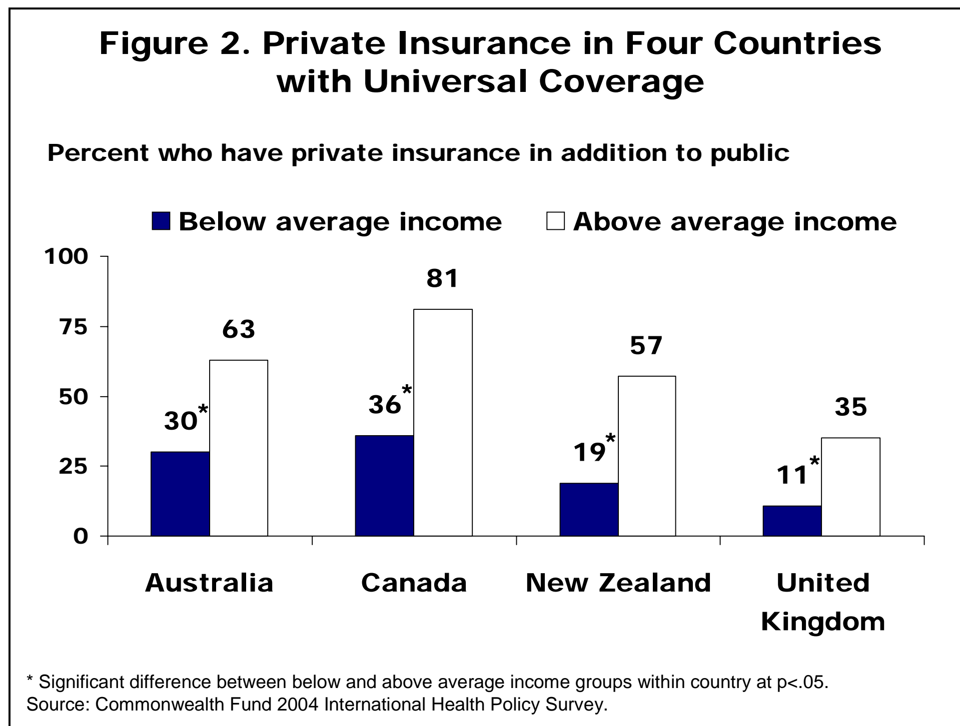
	AUS	CAN	NZ	UK
Private insurance for services covered by public	Permitted only for hospital services	Prohibited for core services in most provinces	Permitted	Permitted
Percent with private coverage	49%	79.9% (to cover benefits excluded from 'free-of charge' public plan)	33%	12%
Public Plan Patient Cost-Sharing	Variable depending on service type and provider	None for core services	Copayments for many services	None for basic services (except Rx and optical)
Prescription Drugs	Covered	Publicly covered for social assistance beneficiaries and in most provinces for seniors	Covered	Covered

Source: B. K. Frogner and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2005* (New York: The Commonwealth Fund, Apr. 2006).

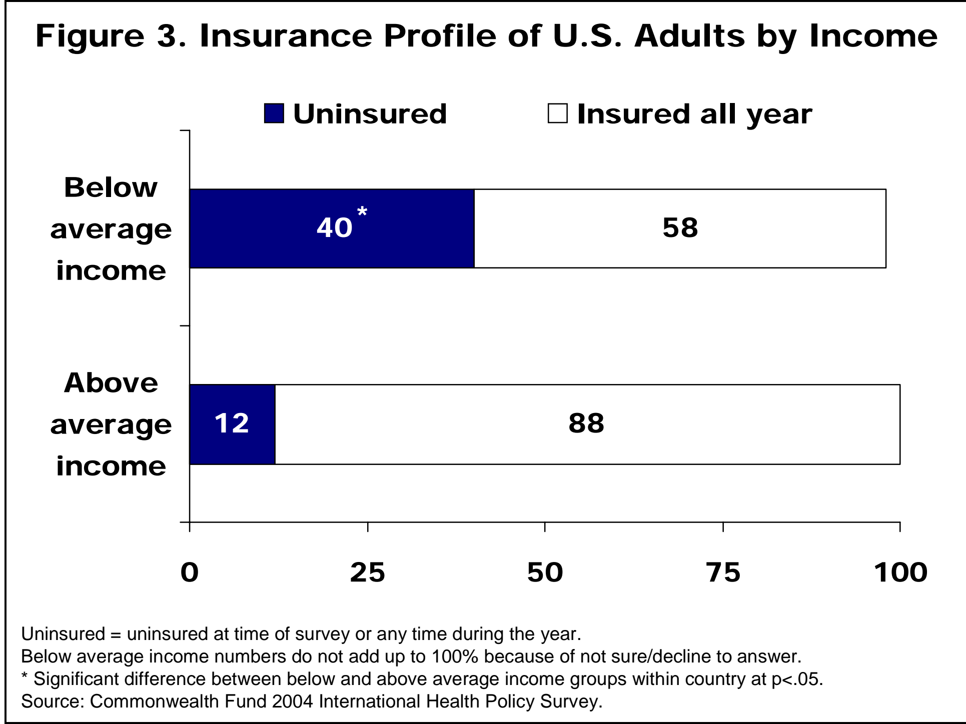
New Zealand's and Australia's national insurance benefits include patient cost-sharing for physician visits as well as for other care. Australia actively encourages individuals to purchase private insurance to supplement public coverage. In New Zealand, a high percentage of the population also purchases private insurance to supplement public coverage. In both countries, private insurance can be used to pay patient fees and provide access to private physicians, specialists, and hospitals.

Canada has a universal public insurance plan (Canadian Medicare), which prohibits the use of private insurance to pay for services covered by the plan. Canadian Medicare generally covers medical costs in full for included benefits. However, Canada's benefit package is less comprehensive than that of the U.K.—particularly for drugs and dental care. As a result, most Canadians have supplemental private insurance to cover services such as dental care, prescription drugs, rehabilitation services, and private care nursing.[8]

In the four countries with universal coverage, the survey finds that adults with above-average incomes were significantly more likely than those with below-average incomes to have private insurance in addition to public coverage (Figure 2). With the exception of those in the U.K., a vast majority of above-average-income adults had private coverage to supplement public insurance.

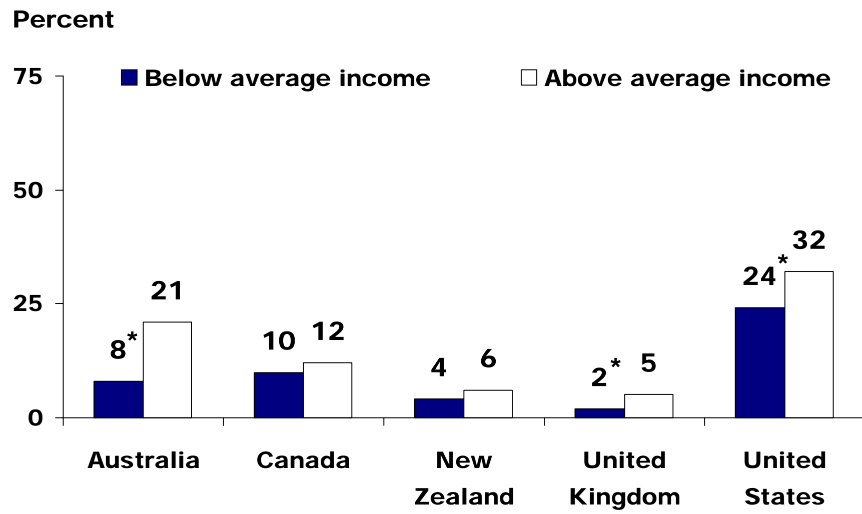


In the U.S., below-average-income adults were at high risk of having no insurance coverage at all (Figure 3). Two of five below-average-income adults said they were uninsured when surveyed or had a time when they were uninsured during the year. Because of this lack of coverage, below-average-income adults are at a serious disadvantage compared with their counterparts in the other four countries. In the other four countries, below-average-income adults have the protection of public coverage, and may also have the extra advantage of private insurance.



The U.S. started the decade with high out-of-pocket costs by international standards. Per capita out-of-pocket costs were $793 in the U.S. in 2003 compared with $448 in Canada and $296 in New Zealand.[9] In addition, five years of double-digit increases in insurance premium rates have sparked widespread growth in cost-sharing for private health insurance for the under-65 population.[10]

Due to these increased costs, U.S. adults faced potentially high medical bills at the time of the 2004 survey, even if they were insured. Reflecting this upward trend, both above-average- and below-average-income U.S. adults were significantly more likely than their counterparts in the other four countries to report high out-of-pocket costs of more than $1,000 dollars during the year (Figure 4). Above-average-income adults in Australia were also at relatively high risk for out-of-pocket costs, when compared with their counterparts in the other three countries with national insurance. Adults in the U.K. and New Zealand appeared relatively well protected, with only a small share (6% or less) of adults in either the below-average- or above-average-income groups reporting high out-of-pocket expenses.



INCOME AND HEALTH

Below-average-income adults in all five countries were among the most vulnerable in terms of medical care needs due to reasons of poor health and age.[11] Adults with below-average incomes were significantly more likely than those with above-average-incomes to rate their health as fair or poor and to report at least one of six chronic conditions included in the survey (Figure 5).

Figure 5. Health Status by Income

Percent:	AUS	CAN	NZ	UK	US
Fair/Poor Health:					
Below Average	22*	19*	22*	24*	30*
Above Average	7	7	6	8	6
Any of 6 Chronic Illnesses:^					
Below Average	63*	58*	62*	64*	62*
Above Average	41	42	40	39	42

^ Chronic illnesses include: hypertension, heart disease, diabetes, arthritis, lung problems, and depression.
* Significant difference between below and above average income groups within country at p<.05.
Source: Commonwealth Fund 2004 International Health Policy Survey.

Given the strong correlation between low income and poor health, it is especially critical for adults with limited incomes to have ready access to primary care. Inequities in access to medical care by income can otherwise contribute to and exacerbate disparities in health and quality of life.

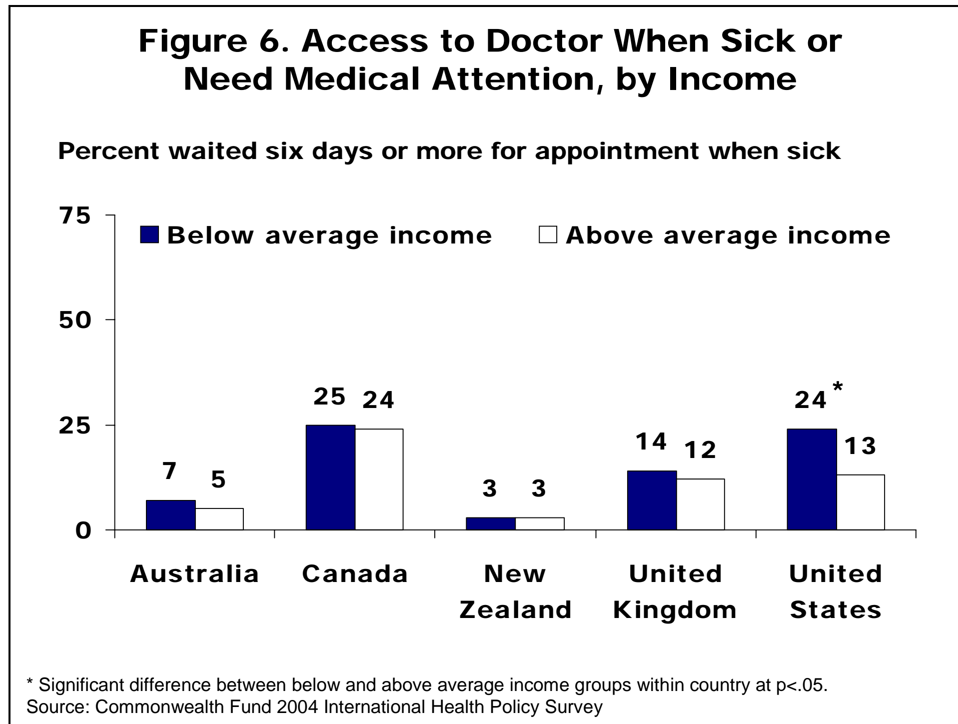
ACCESS TO CARE

Having a regular doctor or place for care is a critical factor to ensuring entry into the health care system. When surveyed, the majority of adults in all five countries said they had a regular doctor or place of care.

Looking across countries, below-average-income adults in the U.S. were significantly more likely to report not having a regular doctor or place of care compared with their counterparts in the other four countries. Rates of below-average-income adults in the U.S. without a regular source of care were double those reported in the other four countries (Table 2).

When they were asked how long it took to see a doctor the last time they were sick, below-average-income adults in the U.S. and Canada were the least likely to report same-day access. They were also the most likely to wait six days or more for an appointment—one of four adults in both Canada and the U.S. reported this problem (Figure 6). In contrast, adults in Australia and New Zealand across income levels were

most likely to have rapid access to a doctor when sick. More than half in both income groups in these countries said they were able to get a same-day appointment when sick.



* Significant difference between below and above average income groups within country at p<.05.
Source: Commonwealth Fund 2004 International Health Policy Survey

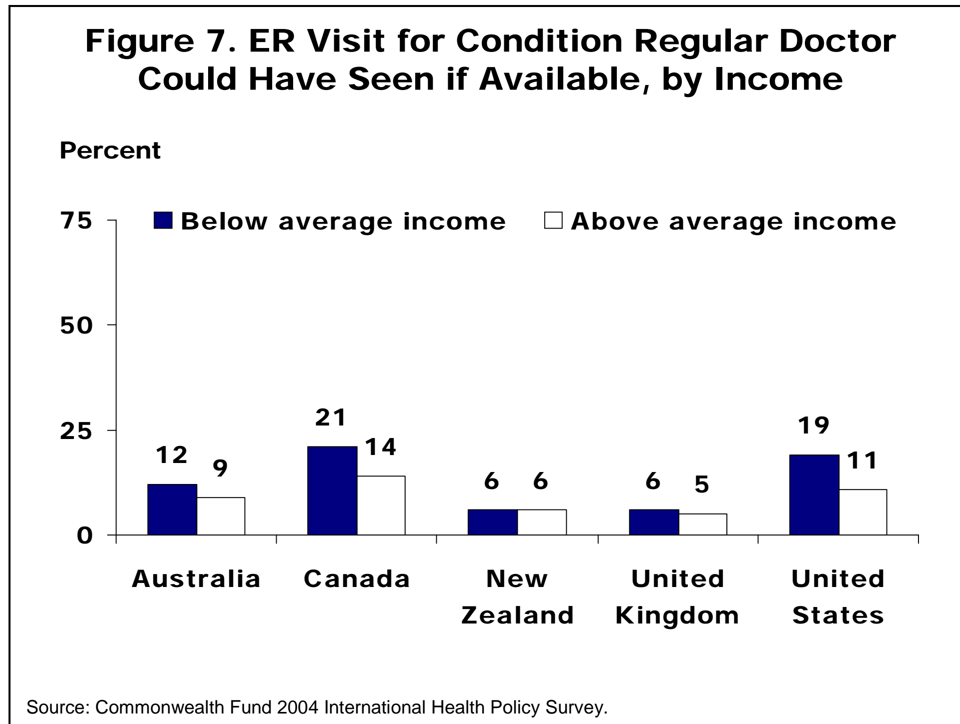
Among the five countries, the U.S. was the only country where waiting times to see a doctor when sick varied significantly by income. Nearly one of four below-average-income adults in the U.S. said they waited six days or more, a rate nearly double that reported by above-average-income adults. In Canada, income level was not associated with wait times—one of four adults in either income category was likely to encounter long waiting times to see a doctor when sick.

Emergency Room Care

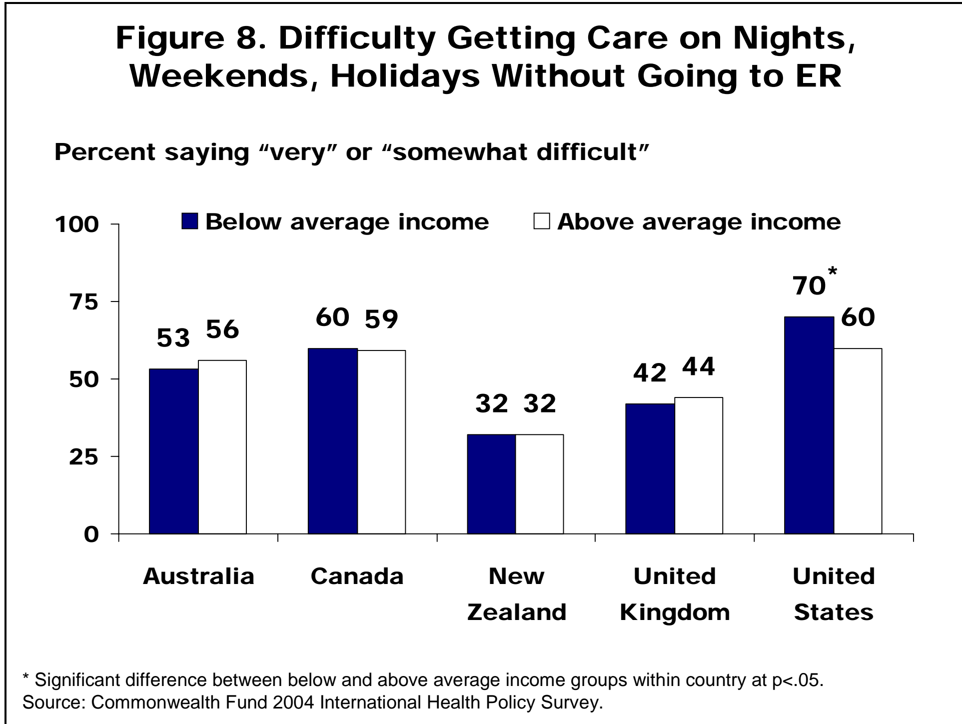
The emergency room (ER) serves as a sensitive indicator for how well systems respond to patients' needs. When care is not available in the community, the ER fills in the gap, acting as a safety-net care source. If this occurs frequently, the result can be longer waits or delays for those with urgent care needs. In all five countries except the U.K., below-average-income adults were significantly more likely than those with above-average income to have used the ER in the past two years.

Rates of ER use were highest in Canada and the U.S.—the two countries with the longest waits to see physicians and where individuals had the most difficulties getting after-hours care. One of five below-average-income respondents in these two countries said

they used the ER for regular care that could have been provided by a doctor, if available (Figure 7).

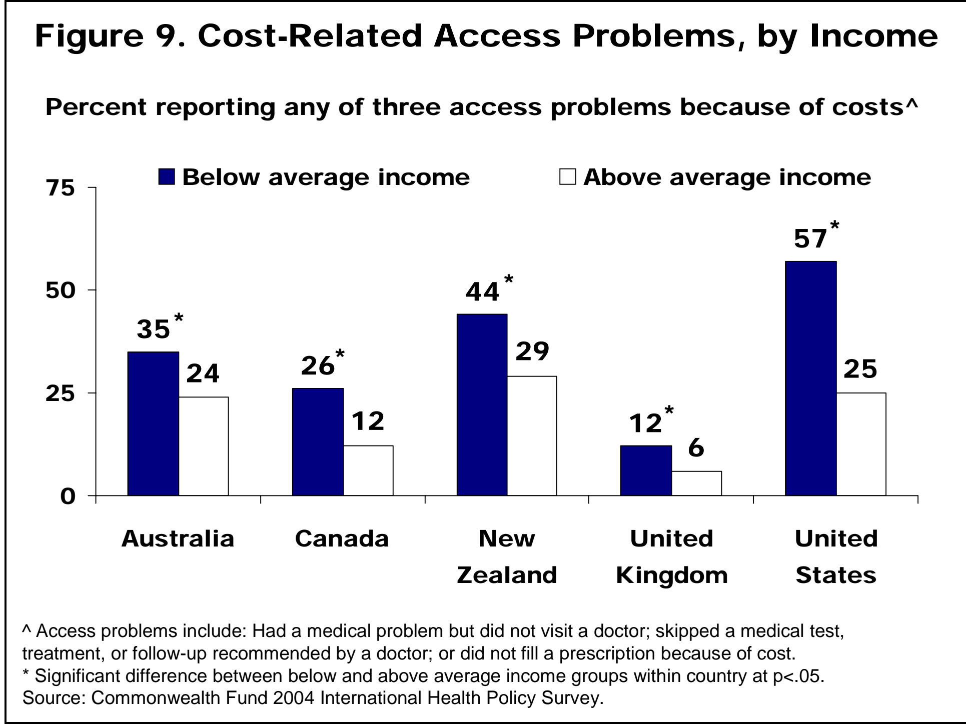


Difficulty getting care after hours without going to the ER was a concern in all five countries, but rates varied widely. Problems appeared most widespread in Australia, Canada, and the U.S., where majorities of adults in both income groups reported it was very or somewhat difficult getting care after hours without going to the ER. This problem was especially troublesome for below-average-income American adults. Seven of 10 reported difficulty, a rate significantly greater than that of above-average-income Americans. Only one-third of New Zealand adults in either income group and less than half of U.K. adults said getting care after hours was difficult (Figure 8).



Cost Barriers

Among the five countries, below-average-income adults in the U.S. were the most likely to have gone without care because of costs, with nearly three of five reporting a time they did not fill a prescription, did not go to a doctor when sick, or skipped recommended care or treatment (Figure 9). Yet, despite universal coverage, below-average-income adults in Australia, Canada, and New Zealand also reported often high levels of cost-related access problems. U.K. adults were the most financially protected, with few below-average- or above-average-income adults reporting cost-related access concerns.



In the four countries with higher rates of cost concerns, adults with below-average incomes were significantly more likely than those with above-average incomes to report access problems because of costs on each of three medical care services and to report they did not get needed dental care because of costs.

In the U.S, the spread on each of the four services (including dental care) between below-average- and above-average-income adults was typically wide (23 percentage points or more), as well as significant. In contrast, in the U.K, except for dental care, a small percentage of adults reported cost-related access barriers, with only a 1–4 percentage point spread between below-average- and above-average-income groups.

In the countries with cost-sharing, rates of cost-related access problems tended to track the country's insurance benefit designs and cost-sharing provisions. The percent of adults reporting access-cost problems was lowest in countries with comprehensive coverage for specific services and highest in countries with cost-sharing or benefit gaps.

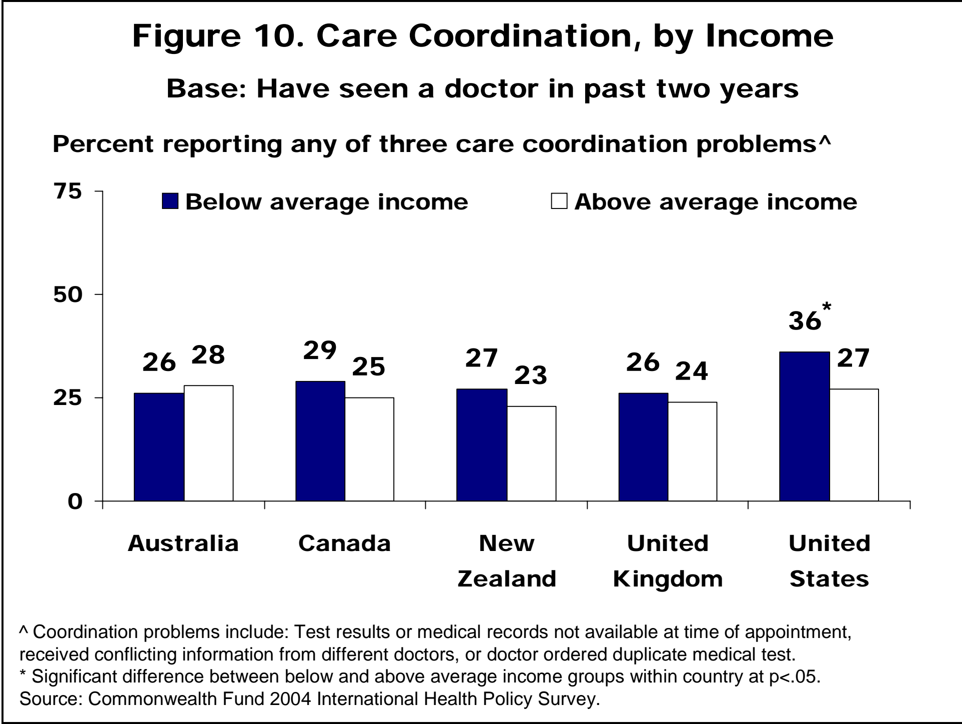
Despite high rates of forgone care, below-average-income adults in the U.S. were also the most likely to report high levels of out-of-pocket costs. One of four reported paying more than $1,000 out-of-pocket for medical costs in the past year. Above-average-income Americans also reported high costs; nearly one of three paid more than $1,000 out-of-pocket. The high out-of-pocket cost findings held for insured as well as uninsured

U.S. adults (Table 6). In the other four countries, the insurance systems were more protective than the U.S. system. However, one of five above-average-income Australians also paid more than $1,000 for medical costs (Table 2).

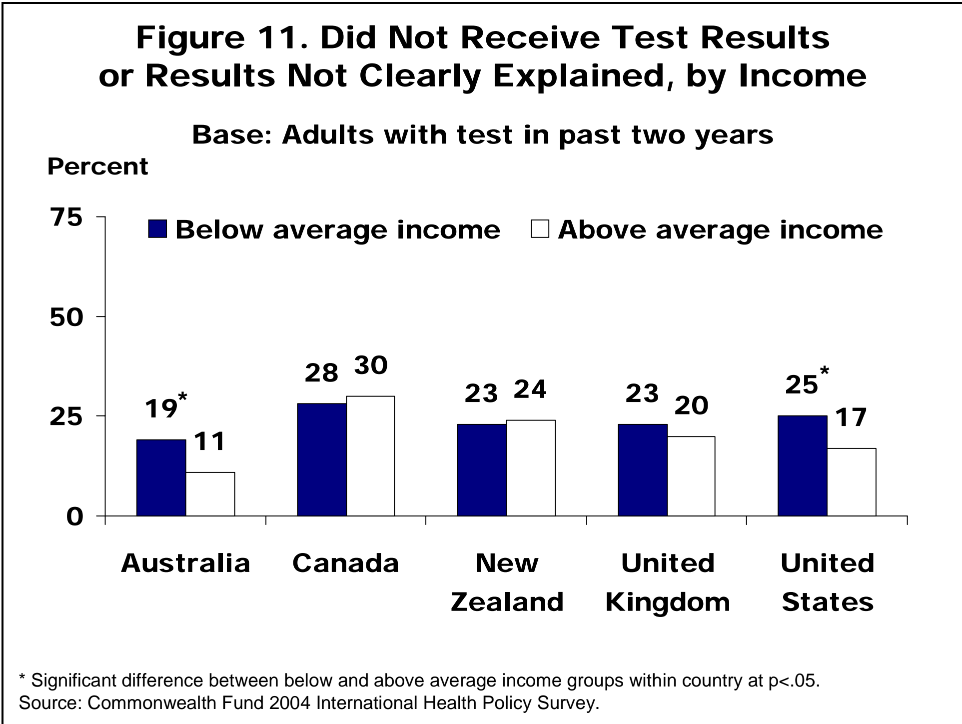
COORDINATION OF CARE

Coordination of care—between providers and across sites of care—poses challenges for the health systems in all five countries, with failures in coordination translating into delays in treatment, potential medical errors, poor doctor–patient communication, and wasted resources (Table 3). Yet, again, the U.S. stands out among the countries for income-related inequalities around coordination of care. Below-average-income adults in the U.S. fared significantly worse than those with above-average incomes on five of nine coordination measures, placing these individuals at higher risk for poorer quality care and medical errors.

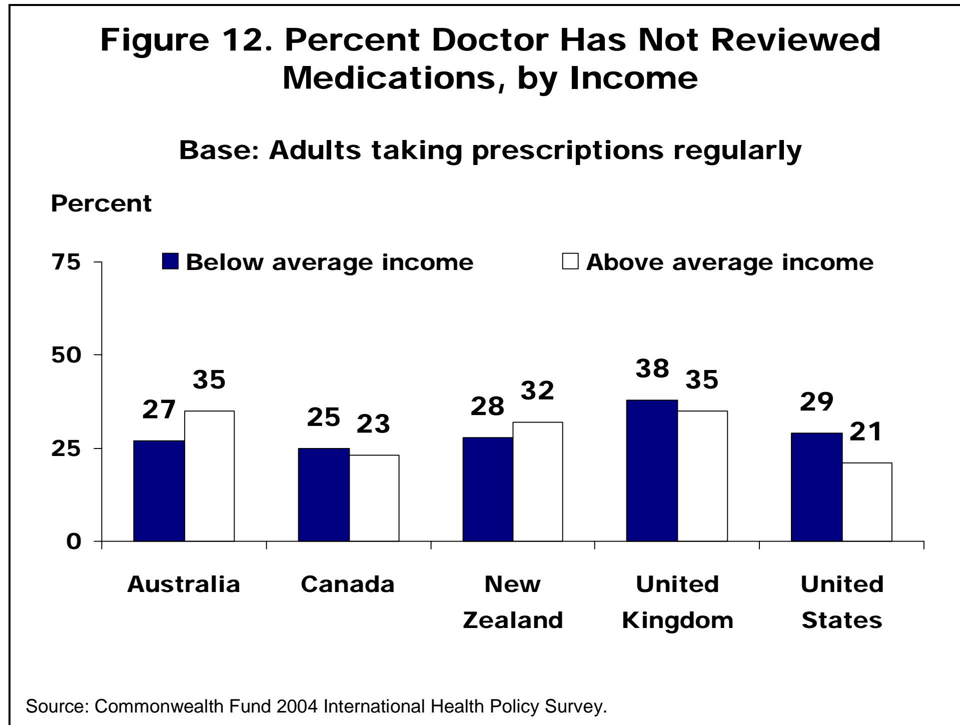
On three measures of coordination (test results or medical record not available at time of scheduled appointment, patients received duplicate tests or procedures, or patients received conflicting information from different doctors), below-average-income adults in the U.S. experienced more problems than below-average-income adults in the other countries (Figure 10). Disparities existed within the U.S. on all three indicators. On the duplication of tests and receiving conflicting information measures, below-average-income Americans were significantly more likely to have problems than above-average-income Americans. Particularly, below-average-income adults in the U.S. reported significantly more problems with unnecessary duplication of medical tests compared with their counterparts in the other four countries. In the other four countries, there were no significant income differences in coordination indicators.



Not getting test results back or not having results clearly explained was a common problem in all countries, reflecting a missed opportunity to engage patients in their care. Canadians in both income groups reported the highest rates on this measure. In Australia and the U.S., below-average-income adults were significantly more likely than those with above-average incomes to report this shortfall in coordination of care (Figure 11).



In the U.K., below-average-income adults were most likely to say that their doctor had not reviewed all their medications with them or explained the side effects of any prescribed medications. With patients typically seeing multiple doctors and often taking multiple medications, failures in coordination can put them at greater risk for medication problems and adverse drug interactions (Figure 12).



While most of the attention in patient safety has focused on medication errors, the survey findings point to another area of concern—laboratory tests and x-rays. Seven percent to 21 percent of all patients reported they were given incorrect test results or experienced a delay in getting abnormal results. This was a particular problem for below-average-income adults in New Zealand and the U.S., with one of five reporting diagnostic test errors, almost twice the percentage of those with above-average incomes.

It is also important for patients' regular doctors to be informed about care they have received from other providers. The survey asked two questions about care following an ER visit or hospitalization. In four of the five countries, between one-fourth and one-third of the respondents, regardless of income level, reported that after visiting the ER, their regular doctor did not seem informed and up-to-date about the care they had received. In Canada, the rate was somewhat higher, with about two of five reporting this problem. Canadians were also more likely to report that after being hospitalized, their doctor did not seem informed and up-to-date on their follow-up care plan. In contrast, only one of 10 American respondents had this experience after hospitalization (Table 3).

DOCTOR–PATIENT RELATIONSHIP AND COMMUNICATION

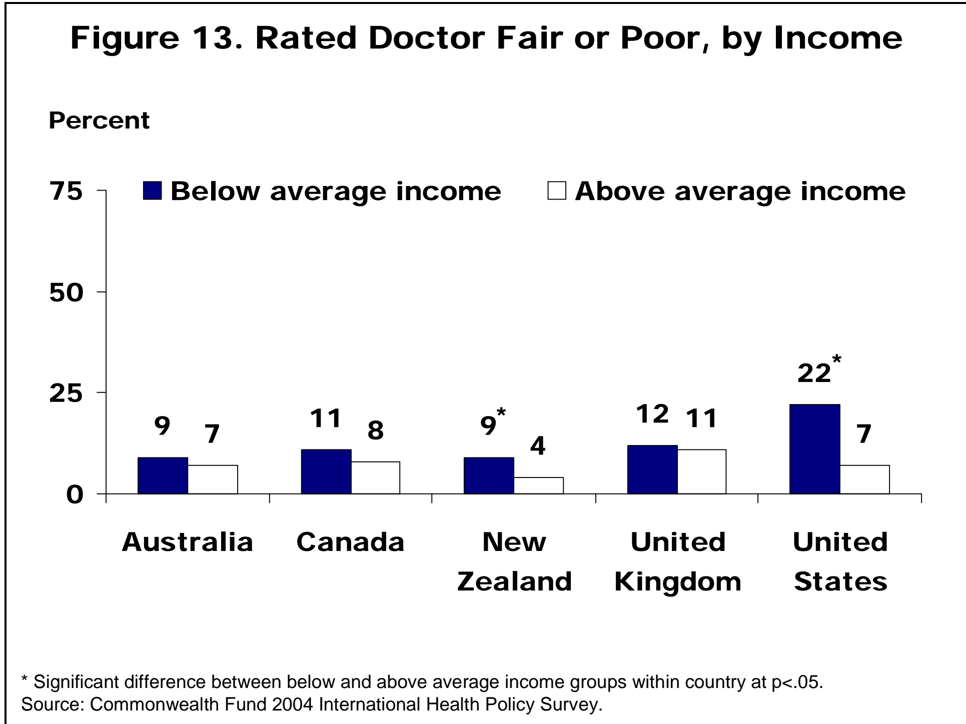
Shortfalls in doctor–patient communication were common in all countries and represent missed opportunities to identify patients' preferences or concerns, to communicate effectively, or to involve patients in decision-making. These failures potentially undermine care and may contribute to lack of adherence to medical advice (Table 4).

Experiences of below-average-income adults in the U.S. were striking when compared with their counterparts in the other countries. On five of six key dimensions of patient-centered care,[12] below-average-income adults in the U.S. reported more negative experiences than did below-average-income adults in the other countries. The U.S. also stands out for the greatest income-related inequities in patients' experiences with care, with below-average-income adults reporting significantly lower quality ratings than those with above-average income on five of six measures. These differences by income were rare in the other four countries.

Across six questions about doctor–patient communications and physician efforts to engage patients in care decisions, adults in New Zealand and Australia with below-average and above-average income tended to be the most positive, while adults in the U.K. and U.S. were most negative. In all five countries, doctors are less likely to tell below-average-income patients about treatment choices and engage patients in care decisions. One-third of below-average- and above-average-income adults in Australia, Canada, and New Zealand said their doctor did not usually tell them about treatment choices or ask for their ideas or opinions. Adults in the U.K. and the U.S. were the least likely to report discussion about care options, with about half of below-average- and above-average-income adults reporting these conversations sometimes, rarely, or never occurred.

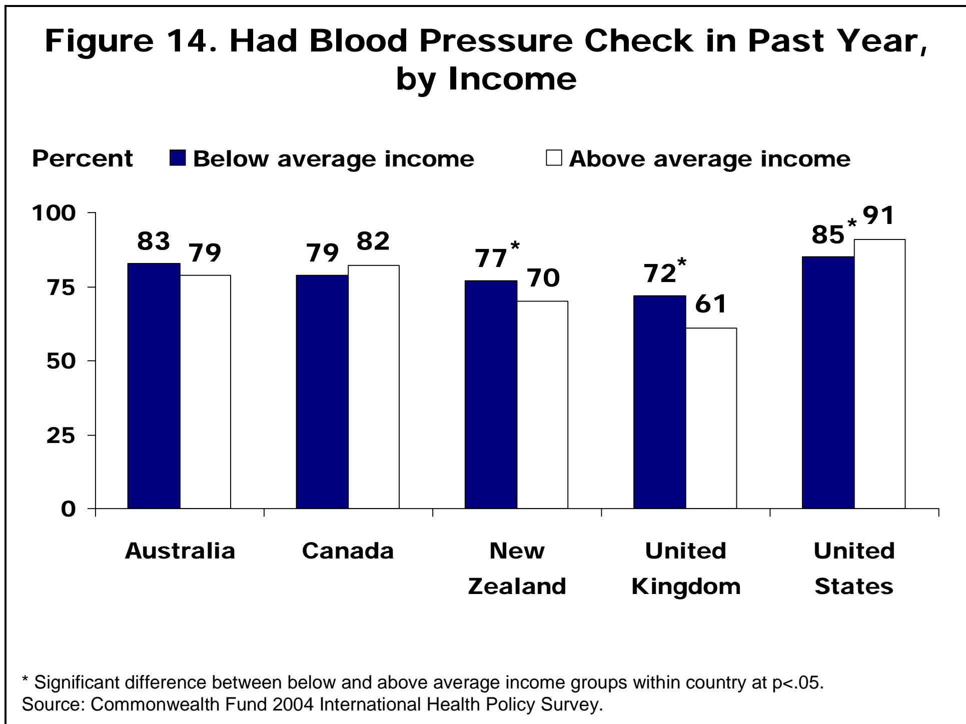
In all five countries, below-average-income adults were somewhat more likely to have left their doctor's office in the past two years without getting important questions answered than were those with above-average income. Differences by income were significant only in New Zealand.

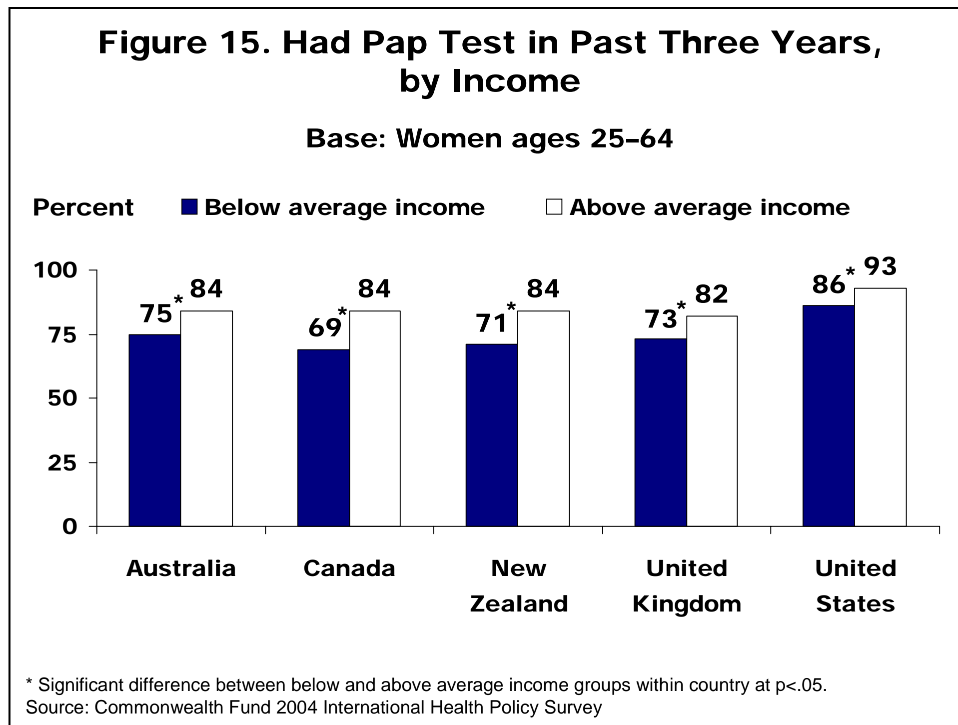
Compared with their counterparts in the other four countries, below-average-income adults in the U.S. were notably more negative about their experiences with doctors overall. More than one of five rated their doctor fair or poor—double the percentages in other countries (Figure 13). In both New Zealand and the U.S., adults with below-average incomes were significantly more likely than were those with above-average incomes to rate their doctor fair or poor, although the gap between income groups in the U.S. was notably wider.



PREVENTIVE CARE

A hallmark of high-quality primary care is an emphasis on preventive care, counseling, and awareness of patients' health concerns. The survey included several measures of preventive care, including doctors providing advice or counseling on weight, nutrition, or exercise; asking about emotional issues such as depression or stress; sending reminders for preventive care; and performing blood pressure checks and pap tests (Figures 14 and 15, Table 5).





In the U.S., on all five preventive care measures, below-average-income adults did less well than above-average-income adults, although the difference was significant on only two measures (blood pressure test in the past year and pap test in past three years for women ages 25–64). Even though the pattern in the U.S. favored above-average-income adults, in general, Americans were more or as likely to report receiving preventive care compared with their international counterparts, regardless of income level. On clinical measures, the U.S. performs particularly well, especially for above-average-income adults; below-average-income adults were at least on par with the other four countries.

Rates of preventive care tend to be lower in the U.K. than in the other countries. On most measures there was little significant difference between below-average- and above-average-income adults in any of the five countries (except for pap test in past three years for women ages 25–64). In Australia and the U.K., however, the pattern was for below-average-income adults to fare better. In New Zealand and the U.K., below-average-income adults were significantly more likely to have received a blood pressure check in the past year than were above-average-income adults. In general, below-average- and above-average-income Canadians receive a similar amount of preventive care. Compared with the average, the U.S. is a leader in providing preventive care for its citizens while the U.K. lags behind.

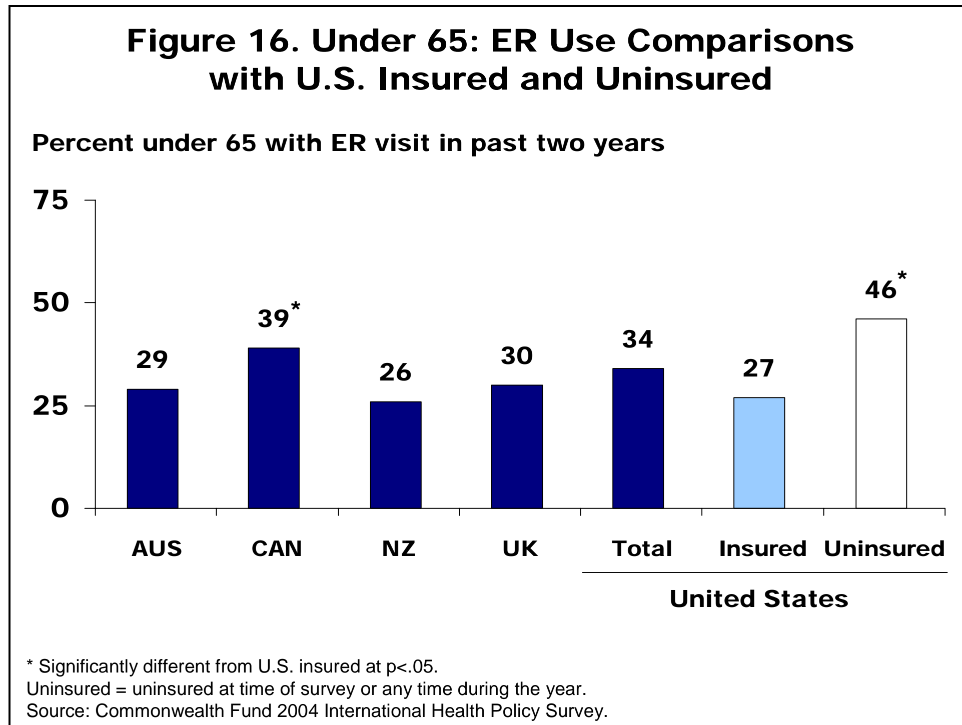
INSURANCE AND INEQUITIES IN THE UNITED STATES

Experiences by Insurance Coverage Status

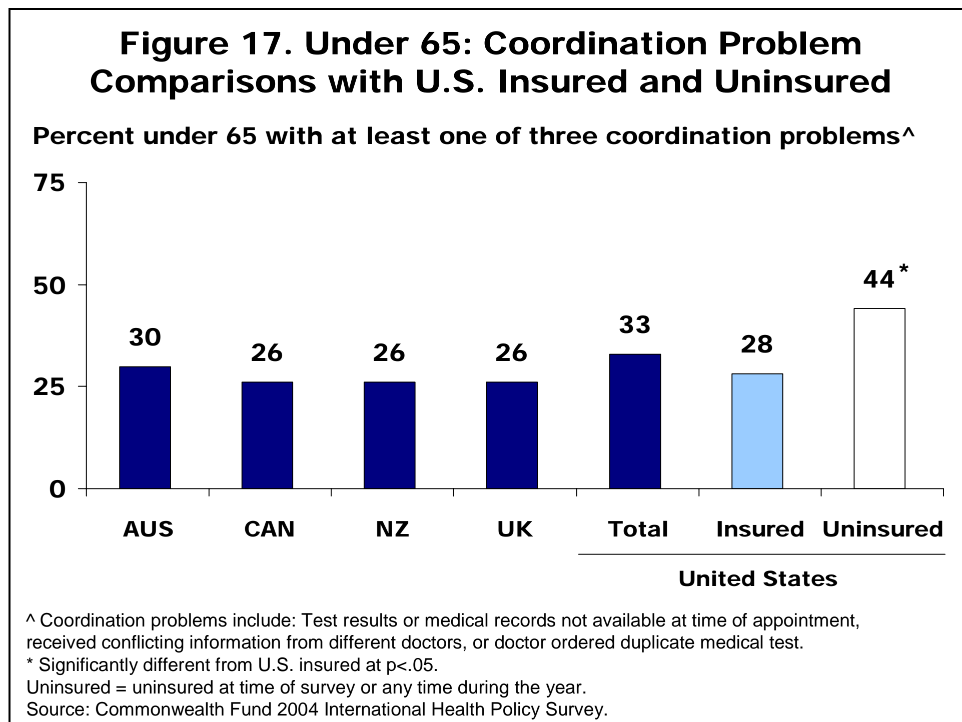
Although the U.S. spends more per person on health care than any other country,[13] lack of adequate insurance coverage undermines access and quality for those with below-average incomes. Americans in the survey with below-average incomes were notably more likely to be uninsured than those with above-average incomes, with four of 10 below-average-income adults uninsured. Furthermore, those with above-average income were more likely than those with below-average income to be insured all year.

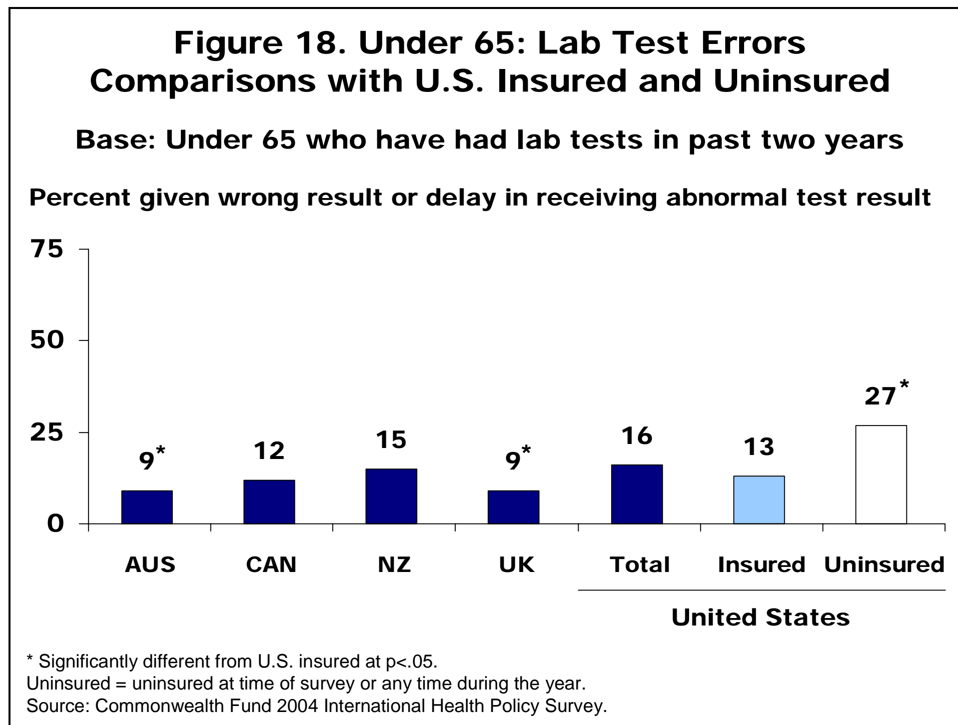
To compare experiences of insured and uninsured U.S. adults with each other and those in the other four countries, we restricted the sample to nonelderly (i.e. under age 65) adults (Table 6). The comparison reveals the extent to which lack of insurance undermines access to primary care and erodes care experiences for working adults in the United States.

On seven of eight access measures, uninsured U.S. adults under age 65 were significantly more likely than insured U.S. adults to report problems, including forgoing care because of costs, lack of timely access to care, and resorting to the ER for care (Table 6, Figure 16). The gaps between insured and uninsured Americans' experiences were wide and significant. For example, 76 percent of uninsured U.S. adults reported at least one of three access problems because of costs, compared with only 30 percent of insured U.S. adults. However, both insured and uninsured U.S. adults under age 65 were just as likely to spend more than $1,000 on out-of-pocket medical expenses, indicating the effects of rising deductibles and cost-sharing among the privately insured.



The survey further revealed the extent to which insurance gaps can erode coordination of care and expose patients to medical errors. The uninsured were significantly more likely to report receiving duplicate tests, conflicting information, visits when medical records were not available, not receiving test results or not having results clearly explained, and lab errors or delays in receipt of abnormal test results (Figures 17 and 18). The findings indicate that lack of insurance undermines the efficiency, safety, and effectiveness of care.





The survey findings also reveal that lack of insurance can undermine doctor–patient relationship and communication. Compared with insured U.S. adults, uninsured U.S. adults were significantly more likely to report negative experiences on all six key measures of doctor–patient relationship included in the study. They were also significantly more likely to leave their doctor's office without getting important questions answered and to rate their doctor as fair or poor.

Even when insured, U.S. nonelderly adults still were at risk for more access problems compared with nonelderly adults in the other four countries. Insured U.S. nonelderly adults were significantly less likely to get a same-day appointment when sick compared with nonelderly adults in Australia, New Zealand, and the U.K.; significantly more likely to wait six days or more for an appointment compared with adults in Australia and New Zealand; significantly more likely to visit the ER for a condition their regular doctor could have seen compared with adults in Australia, New Zealand, and the U.K.; significantly more likely to report difficulty getting care after-hours compared with adults in the other four countries; and significantly more likely to report access problems because of costs compared with adults in Canada, New Zealand, and the U.K.

In addition to access barriers, insured U.S. adults encountered heightened gaps in care coordination. Compared with nonelderly adults in Australia, Canada, and the U.K., insured nonelderly adults in the U.S. were significantly more likely to experience

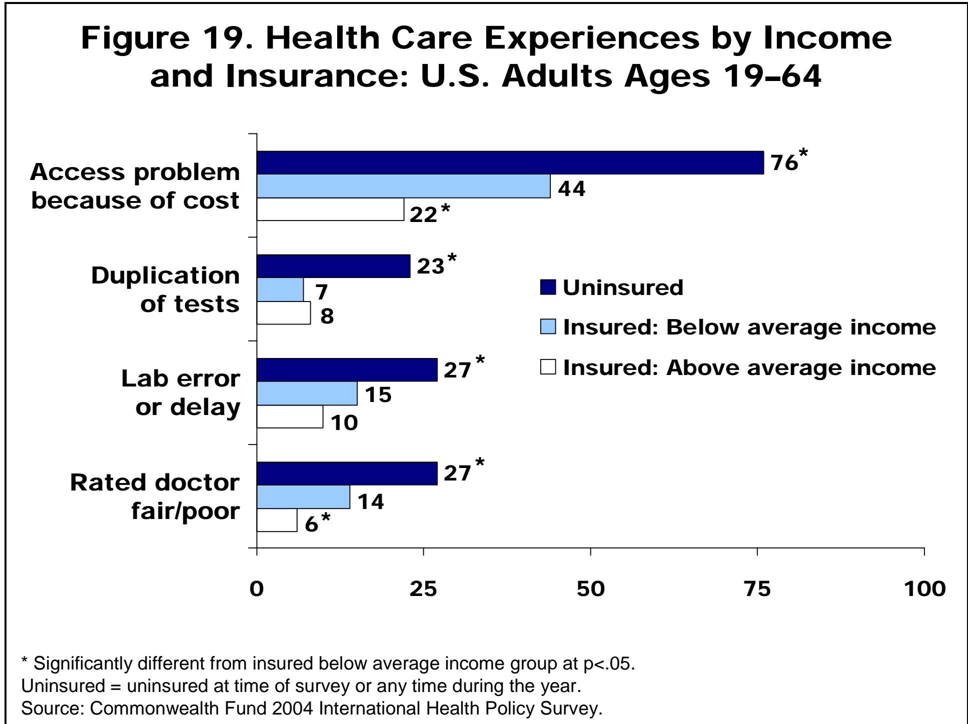
unnecessary duplication of medical tests. In addition, insured nonelderly adults in the U.S. were significantly more likely to report that their doctor sometimes, rarely or never spends enough time with them or makes clear the specific treatment goals and plans, compared with nonelderly adults in Australia and New Zealand.

U.S. Insurance Coverage Status and Income Divide

In the U.S., being insured helps mitigate access and cost problems regardless of income, which, in turn, reduces income-related access and quality of care disparities. Uninsured adults were more likely than insured adults, regardless of income, to report problems with access and coordination, and experience more negative doctor–patient relationships and communication.

Yet, even with insurance, below-average-income Americans still report greater rates of access barriers and coordination concerns than above-average-income Americans with insurance. As detailed in Table 7, insured adults with below-average incomes were significantly more likely than above-average-income insured adults to wait for an appointment when sick, to visit the ER for a condition that their regular doctor could have seen if available, and to go without care because of costs.

Insured adults with below-average-income were also significantly more likely than above-average-income adults with insurance to report that their doctor did not review all medications; their doctor did not spend enough time with them; to leave the doctor's office without getting important questions answered; and to rate their doctor as fair or poor. This suggests that below-average-income adults have insurance that is less comprehensive and less likely to provide affordable access to care, and policies that may offer a more limited network of providers (Figure 19). These findings indicate that, in the U.S., not all insurance is equally protective. Insurance does not guarantee access or cost protection, and can leave many low-income insured adults at risk of being "underinsured" because of benefit gaps and cost-sharing.[14] Being "underinsured" or lacking insurance entirely can undermines not only access to care, but also the quality of care received.



SUMMARY

Primary care stands at the center of medical care, serving as an entry point to the health system. Primary care physicians deliver core medical and preventive services and help patients coordinate and integrate the sum of their health care.[15] When working well, each dimension of primary care is instrumental in improving health outcomes and cost performance.[16] Ready access to effective primary care also offers the potential to reduce disparities in care, enhancing opportunities for patients to live healthy, productive lives.

Despite the importance of primary care, below-average-income adults in the U.S. ranked last—that is, they had the worst experiences—among the five countries surveyed on 16 of 30 measures studied (Figure 20). These measures included most indicators of getting and paying for needed care, The notable exception to this trend is clinical preventive measures, where below-average-income Americans do as well or better than both below-average- and above-average-income adults in the other four countries.

Figure 20. Ranking of Below Average Income Adults′ Experiences by Country

Number of Measures Where Below Average Income Adults′ Experiences in Country Was the Worst Compared with Below Average Income Adults in the Other Four Countries

	General access (4)	Access because of cost (4)	Coordination (9)	Doctor-Patient (8)	Prevention (5)	Total (30)
AUS	0	0	0	0	1	1
CAN	2	0	3	0	1	6
NZ	0	0	1	1	0	2
UK	0	0	2	1	3	6
US	2	4	3	7	0	16

Source: Commonwealth Fund 2004 International Health Policy Survey.

The health care system in the U.S. stands out for its striking disparities in experiences between above-average- and below-average-income adults. Overall, the study reveal a health divide with significant differences by income on 21 of the 30 measures studied (Figure 21).

Figure 21. Inequity Summary: Number of Measures Where Below Average Income Adults Have More Negative Experiences

	General access (4)	Access because of cost (4)	Coordination (9)	Doctor-Patient (8)	Prevention (5)	Total (30)
AUS	0	3	1	0	0	4
CAN	0	4	1	0	0	5
NZ	0	4	1	3	0	8
UK	0	1	0	0	0	1
US	3	4	5	7	2	21

* Inequity counted when significant difference between income groups where $p \leq .05$ and gap of $\geq 5\%$; for U.S. $p \leq .05$ and gap>5%, or gap>5%.
Source: Commonwealth Fund 2004 International Health Policy Survey.

The U.K., which has the most comprehensive insurance coverage of the countries surveyed, leads the group in lack of financial burdens placed on patients and equality between adults with below-average- and above-average-incomes, with few and narrow differences. Australia and New Zealand rank in the middle of the countries on issues of cost-related access inequity, indicating that experiences of below-average-income adults are likely to be sensitive to even modest cost-sharing levels.

Uninsured adults in the U.S. were at the highest risk for problems relating to access, care coordination and delays, or errors that put their health at risk. While being insured in the U.S. improves access and care experiences, below-average-income adults with insurance were also at relatively high risk for having primary care access concerns.

An earlier study using data from the Commonwealth Fund 2001 International Health Policy Survey found that differences by income in access and care experiences in the U.S. remain even when controlling for insurance.[17] This study confirms these earlier findings. Below-average-income Americans face cost-related problems even when they have insurance coverage—a fact that likely reflects cost-sharing obligations and benefit gaps in coverage. Shifts in private insurance to plans with even higher deductibles and cost-sharing, combined with federal budget cuts in Medicaid, may further contribute to the income divide. A recent study warns that steady upward pressure on costs of health care in the U.S. could make health care services unaffordable for even more Americans, increasing income inequities.[18]

The study reveals that below-average-income adults' experiences are particularly sensitive to insurance design, including factors relating to cost-sharing and benefits. In Australia and New Zealand, income differences emerged for services less well covered by national plans despite fees that would be considered modest by U.S. standards. Within the U.S., the persistence of access problems among below-average-income adults with insurance likely reflects the shift toward higher deductibles and cost-sharing.

Clinical preventive measures emerge as the one area in which the U.S. performs comparably well, extending even to the experiences of adults with below-average income. This performance may reflect public and private policy efforts to promote and publicize clinical guidelines for preventive care and to use public health campaigns to encourage patients to seek care. For the past decade, the Health Plan Employer Data and Information Set, a private-sector quality initiative, has targeted clinical preventive care as a core indicator, pressuring health plans to measure and improve outcomes.[19] The combination

of clear guidelines plus efforts to hold delivery systems accountable and engage the public likely contribute to the U.S.'s performance on this aspect of care.

The survey also focuses on access and doctor–patient communications and interactions when receiving care. Access to care is a critical element in reducing disparities in health care. However, clinical studies have shown that disparities in health care, including differences in who receives appropriate care or high-quality care, can persist even for those with access to primary care.[20] Therefore, it is important not only to improve access to care, but also to address disparities relating to quality of care..

Finding policy solutions to extend coverage and enhance primary care for lower-income adults is a critical step toward improving the performance of the U.S. health care system. The experiences in other countries indicate that it is possible to do better. For the U.S., the challenge will lie in building consensus around methods to bridge the growing health divide.

METHODS

The Commonwealth Fund 2004 International Health Policy Survey consisted of telephone interviews with 1,400 adults ages 18 and over in Australia, Canada, New Zealand, and the United States, with an expanded sample of 3,061 in the United Kingdom. The Commonwealth Fund provided support for random samples of 1,400 in each country. The U.K. Health Foundation partnered with the Fund to expand the U.K. sample in specific regions, to enable future analysis by U.K. countries. Harris Interactive and associates conducted the survey between March and May 2004.

To compare experiences among lower- and higher-income adults, the survey cited the national median household income in 2004 in each country and asked whether the person's own income was much or somewhat below, about average, or much or somewhat above the national average. In U.S. dollars, the country median incomes were $30,000 in Australia, $37,800 in Canada, $25,000 in New Zealand, $41,600 in the U.K., and $42,400 in the U.S. The percent of adults identifying their income as below average income was: 32 percent in Australia, 30 percent in Canada, 22 percent in New Zealand, 36 percent in the U.K., and 35 percent in the U.S. The percent who identified their incomes as above average income was: 41 percent in Australia, 44 percent in Canada, 56 percent in New Zealand, 38 percent in the U.K., and 39 percent in the U.S. Roughly one of five respondents in each country said their incomes were "about average." Adults with average income were included in the country totals but not shown separately when comparing those with below-average and above-average income. Four percent to 8 percent of adults did not report their relative incomes. Tables indicate where differences by income are significant at the 95 percent confidence level or better.

NOTES

[1] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (Oct. 28, 2004):W4-487–W4-503.

[2] The study asked each adult to compare their income to the median income in the country. Median, average income in U.S. dollars was $42,400 at the time of the study.

[3] Access questions included: in the past year, did not fill a prescription or skipped doses; had a medical problem but did not visit a doctor; skipped a recommended test or follow-up because of costs.

[4] Schoen et al., "Primary Care," 2004.

[5] C. DeNavas-Walt, B. D. Proctor, and C. H. Lee, *Income, Poverty and Health Insurance Coverage in the United States: 2004,* Current Population Reports, U.S. Census Bureau (Washington, D.C.: U.S. Government Printing Office, Aug. 2005).

[6] J. A. Rhoades, *The Long-Term Uninsured in America, 2002–2003: Estimates for the U.S. Population Under Age 65,* MEPS Statistical Brief #104 (Rockville, Md.: Agency for Healthcare Research and Quality, Dec. 2005).

[7] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):W5-289–W5-302.

[8] B. K. Frogner and G. F. Anderson, "Multinational Comparisons of Health Systems Data 2005" (New York: The Commonwealth Fund, forthcoming).

[9] Ibid.

[10] J. Gabel, G. Claxton, I. Gil et al., "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage," *Health Affairs,* Sept./Oct. 2004 23(5):200–09.

[11] L. A. Aday, *At Risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States* (San Francisco: Jossey-Bass, 1993).

[12] The six measures of patient-centered care included doctor: listens carefully to you; explains things in a way you can understand; spends enough time with you; makes clear the specific goals and plan for your treatment; gives you clear instructions so you know what to do or what symptoms to watch for; and tells you about treatment choices and asks for your ideas/opinions.

[13] G. F. Anderson, P. S. Hussey, B. K. Frogner et al., "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs,* July/Aug. 2005 24(4):903–14.

[14] Schoen et al., "Insured But Not Protected," 2005.

[15] B. Starfield, *Primary Care* (New York: Oxford University Press, 1998).

[16] 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,* June 2003 38(3):831–65.

[17] C. Schoen and M. M. Doty, "Inequities in Access to Medical Care in Five Countries: Findings from the 2001 Commonwealth Fund International Health Policy Survey," *Health Policy*, Mar. 2004 67(3):309–22.

[18] R. E. Hurley, H. H. Pham, and G. Claxton, "A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities," *Health Affairs* Web Exclusive (Dec. 6, 2005):W5-566–W5-576.

[19] National Committee for Quality Assurance, *The State of Health Care Quality, 2003: Industry Trends and Analysis* (Washington, D.C.: NCQA, 2003).

[20] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2005* (Rockville, Md.: AHRQ, 2005), available at http://www.ahrq.gov/qual/nhdr05/nhdr05.pdf; E. van Doorslaer, X. Koolman, and A. M. Jones, "Explaining Income-Related Inequalities in Doctor Utilisation in Europe," *Health Economics,* July 2004 13(7):629–47; N. E. Adler and K. Newman, "Socioeconomic Disparities in Health: Pathways and Policies," *Health Affairs,* Mar./Apr. 2002 21(2):60–76; S. Dunlop, P. Coyte, and W. McIsaac, "Socio-Economic Status and the Utilization of Physicians' Services: Results from the Canadian National Population Health Survey," *Social Science and Medicine,* July 2000 51(1):123–33.

APPENDIX. TABLES

Table 1a. Adults' Care Experiences in Five Countries, 2004 (country averages)

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=	1400	1410	1400	3061	1401
Access					
No regular doctor or place of care	5%*	5%*	3%*	1%*	9%
Saw doctor same day when sick	54*	27*	60*	41*	33
Waited six days or more for appointment when sick	7*	25*	2*	13*	19
ER visit in past two years	29*	38*	26*	29	34
ER visit for condition regular doctor could have seen if available	9*	18	7*	6*	16
Somewhat or very difficult to get care on nights, weekends, or holidays without going to ER	54*	59*	33*	43*	63
Access problems because of costs during past year:					
Did not fill prescription or skipped doses	12*	9*	11*	4*	21
Had a medical problem, did not visit doctor	17*	6*	28	4*	29
Skipped recommended test or follow-up	18*	8*	20*	2*	27
At least one of three access problems because of costs	29*	17*	34*	9*	40
Did not get needed dental care because of costs	35	26*	37	21*	38
Spent more than US$1,000 on out-of-pocket costs in past year	14*	12*	5*	4*	26
Coordination					
In past two years a time when:					
Unnecessary duplication of medical tests	7*	6*	7*	4*	14
Received conflicting information from different doctors	18	14*	14*	14*	18
Test results or medical records not available at time of scheduled appointment	12*	14	13*	13*	17
Any of three coordination problems	28	26*	25*	24*	31
Had lab, x-ray or other test in past two years:					
Did not receive test results or results not clearly explained	16*	28*	22	21	20
Lab error or delay in receiving abnormal test results	9*	12*	14	8*	15
Those on medication, in past two years:					
Doctor did not review all medications taken, including those prescribed by other doctors	29	25	31*	37*	25
Doctor did not explain side effects of any prescribed medication	25	28	27	39*	30
After ER visit, regular doctor did not seem informed and up-to-date about care received in ER	30	36	28	32	30
After hospitalization, regular doctor did not seem informed and up-to-date about follow-up care plan	19	21	23*	23*	13

* Indicates the country differs from the United States at p<.05.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 1b. Adults' Care Experiences in Five Countries, 2004 (country averages)

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=	1400	1410	1400	3061	1401
Doctor–Patient Relationship					
Doctor only sometimes, rarely or never:					
Listens carefully to you	9%*	12%*	7%*	11%*	15%
Explains things in a way you can understand	9*	9*	7*	11*	15
Spends enough time with you	14*	17*	12*	17*	25
Makes clear the specific goals and plan for your treatment	14*	15*	13*	19	20
Gives you clear instructions so you know what to do or what symptoms to watch for	10*	12	8*	13	13
Tells you about treatment choices and asks for your ideas/opinions	35*	35*	30*	50*	44
Left doctor's office without getting important questions answered in past two years	22	19*	20*	13*	24
Rated doctor fair/poor overall	8*	9*	6*	11*	14
Prevention					
Blood pressure test in past year	78*	80*	72*	68*	86
Pap test, women ages 25–64, in past three years	78	77	81	77	89
Doctor does not send reminders for preventive care	62*	61*	55*	50	49
Base: Has regular doctor/place of care					
In past two years doctor:					
Did not discuss weight, nutrition, or exercise	62*	55*	67*	72*	48
Did not ask you about any emotional concerns that might be affecting your health	67	62	71*	72*	63

* Indicates the country differs from the United States at $p<.05$.

Significance tests were not performed for responses to pap test questions.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 2. Access to Care by Below and Above Average Income Adults in Five Countries, 2004

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=					
Below average	420	426	339	1120	452
Above average	633	626	742	1136	653
No regular doctor or place of care					
Below average	5%^	5%^	3%^	0%*^	10%
Above average	5	5	3	2	6
Saw doctor same day when sick					
Below average	56^	27	60^	43^	33
Above average	56	27	60	39	35
Waited six days or more for appointment when sick					
Below average	7^	25	3^	14	24*
Above average	5	24	3	12	13
ER visit in past two years					
Below average	34*^	43*	34*^	32^	40*
Above average	25	34	22	26	26
ER visit for condition regular doctor could have seen if available					
Below average	12^	21	6^	6^	19
Above average	9	14	6	5	11
Somewhat or very difficult to get after-hours care					
Below average	53^	60^	32^	42^	70*
Above average	56	59	32	44	60
Access problems because of costs during past year:					
Did not fill prescription or skipped doses					
Below average	13*^	16*^	15*^	6*^	33*
Above average	10	6	7	2	10
Had a medical problem, did not visit doctor					
Below average	20*^	10*^	39*	6*^	44*
Above average	14	3	24	3	16
Skipped recommended test or follow-up					
Below average	20*^	11*^	24*^	3*^	40*
Above average	13	6	16	2	17
At least one of three access problems because of costs					
Below average	35*^	26*^	44*^	12*^	57*
Above average	24	12	29	6	25
Did not get needed dental care because of costs					
Below average	43*^	39*^	41*^	24*^	52*
Above average	29	19	34	17	25
Spent more than US$1,000 on out-of-pocket costs					
Below average	8*^	10^	4^	2*^	24*
Above average	21	12	6	5	32

* Significant difference between below average and above average income groups within country at p<.05.

^ Indicates the country below average income group differs from the U.S. below average income group at p<.05.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 3. Coordination of Care by Below and Above Average Income Adults in Five Countries, 2004

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=					
Below average	420	426	339	1120	452
Above average	633	626	742	1136	653
In past two years a time when:					
Unnecessary duplication of medical tests					
Below average	6%^	8%*^	7%^	5%^	17%*
Above average	7	5	8	4	9
Received conflicting information					
Below average	16	19*	18	16^	21*
Above average	18	11	13	13	14
Test results or medical records not available at visit					
Below average	13^	12^	15	15	19
Above average	10	16	11	13	14
Any of three coordination problems					
Below average	26^	29	27^	26^	36*
Above average	28	25	23	24	27
Had lab, x-ray or other test in past two years:					
Did not receive test results or results not clearly explained					
Below average	19*	28	23	23	25*
Above average	11	30	24	20	17
Lab error or delay in receiving abnormal test results					
Below average	8^	14	21*	8^	19*
Above average	7	11	11	7	10
Those on medication, in past two years:					
Doctor did not review all medications taken					
Below average	27	25	28	38	29
Above average	35	23	32	35	21
Doctor did not explain side effects of any prescribed medication					
Below average	27	31	22^	39	32
Above average	28	27	30	36	27
After ER visit, regular doctor did not seem informed and up-to-date about care received in ER					
Below average	28	37	23	29	30
Above average	31	41	29	33	27
After hospitalization, regular doctor did not seem informed and up-to-date about follow-up care plan					
Below average	16	25^	24^	19	8
Above average	21	27	20	26	11

* Significant difference between below average and above average income groups within country at $p<.05$.

^ Indicates the country below average income group differs from the U.S. below average income group at $p<.05$.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 4. Doctor–Patient Relationship and Communication by Below and Above Average Income Adults in Five Countries, 2004

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=					
Below average	420	426	339	1120	452
Above average	633	626	742	1136	653
Doctor only sometimes, rarely or never:					
Listens carefully to you					
Below average	9%^	13%	8%*^	10%^	19%*
Above average	9	12	4	12	10
Explains things in a way you can understand					
Below average	9^	11^	9*^	11*	19*
Above average	7	7	5	9	7
Spends enough time with you					
Below average	13^	20^	13^	17^	31*
Above average	13	16	10	17	19
Makes clear the specific goals and plan for your treatment					
Below average	15^	18^	14^	20	25*
Above average	14	15	12	19	16
Gives you clear instructions so you know what to do or what symptoms to watch for					
Below average	11^	14	9^	13	16
Above average	9	11	6	12	12
Tells you about treatment choices and asks for your ideas/opinions					
Below average	33^	36^	36*^	53	48*
Above average	37	37	27	48	40
Left doctor's office without getting important questions answered in past two years					
Below average	24	23	27*	15^	27
Above average	19	19	16	12	21
Rated doctor fair/poor overall					
Below average	9^	11^	9*^	12^	22*
Above average	7	8	4	11	7

* Significant difference between below average and above average income groups within country at p<.05.

^ Indicates the country below average income group differs from the U.S. below average income group at p<.05.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 5. Preventive Care and Health Promotion by Below and Above Average Income Adults in Five Countries, 2004

	Australia	Canada	New Zealand	United Kingdom	United States
Unweighted N=					
Below average	420	426	339	1120	452
Above average	633	626	742	1136	653
Blood pressure test in past year					
Below average	83%	79%^	77%*^	72%*^	85%*
Above average	79	82	70	61	91
Pap test, women ages 25–64, in past three years					
Below average	75*^	69*^	71*^	73*^	86*
Above average	84	84	84	82	93
Doctor does not send reminders for preventive care					
Below average	61^	60^	55	49	52
Above average	62	61	52	53	48
Base: Has regular doctor/place of care					
In past two years doctor:					
Did not discuss weight, nutrition, or exercise					
Below average	57*	53	62*^	69^	50
Above average	66	53	69	74	45
Did not ask you about any emotional concerns that might be affecting your health					
Below average	62	62	67	70*	64
Above average	68	60	73	75	61

* Significant difference between below average and above average income groups within country at p<.05.

^ Indicates the country below average income group differs from the U.S. below average income group at p<.05.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 6. Nonelderly Adults' Care Experiences in Five Countries, with U.S. Insured and Uninsured, 2004 (base: adults ages 18–64)

	Australia	Canada	New Zealand	United Kingdom	United States: Total	United States: Insured all year	United States: Uninsured anytime
Unweighted N=	1176	1178	1061	2454	1121	842	279
Access							
No regular doctor or place of care	6%	6%	3%*	1%*	10%	6%	20%*
Saw doctor same day when sick	53*	27*	60*	40*	32	37	25*
Waited six days or more for appointment	6*	26*	2*	14	20	16	28*
ER visit in past two years	29	39*	26	30	34	27	46*
ER visit for condition regular doctor could have seen	10*	18*	7*	7*	16	14	21*
Somewhat or very difficult to get after-hours care	57*	61*	35*	46*	67	63	74*
At least one of three access problems because of costs†	33	17*	38*	10*	45	30	76*
Spent more than US$1,000 out-of-pocket	17*	12*	5*	4*	26	25	28
Coordination							
In the past two years a time when:							
Unnecessary duplication of medical tests	7*	6*	8	5*	14	10	23*
Received conflicting information	19*	15	15	15	20	14	32*
Test results or medical records not available at time of visit	13	14	14	14	18	15	26*
Any of three coordination problems	30	26	26	26	33	28	44*
Had lab, x-ray or other test in past two years:							
Did not receive test results or results not explained	17	29*	23*	23*	22	19	31*
Lab error or delay in receiving abnormal test results	9*	12	15	9*	16	13	27*
Those on medication, in past two years:							
Doctor did not review all medications taken	28	24	33	37*	27	25	31
Doctor did not explain side effects	24	28	29	39*	29	30	26
Doctor–Patient Relationship							
Doctor only sometimes, rarely or never:							
Listens carefully to you	9	13	7*	13	17	12	29*
Explains things fully	9*	9	7*	12	17	12	28*
Spends enough time with you	15*	19	14*	18	27	21	44*
Makes goals and treatment plans clear	15*	16	15*	21	22	20	29*
Gives you clear instructions	10	12	8*	14*	14	11	23*
Tells you about treatment choices and asks for your ideas/opinions	36*	37*	32*	52*	46	44	57*
Left doctor's office without getting questions answered	24	20	22	15*	27	23	35*
Rated doctor fair/poor overall	8	10	7*	13	16	11	27*

† Did not fill prescription or skipped doses; had a medical problem, did not visit doctor; skipped recommended test or follow-up because of costs during past year.

* Significantly different from U.S. insured all year at p<.05.

Source: Commonwealth Fund 2004 International Health Policy Survey.

Table 7. U.S. Nonelderly Adults' Care Experiences by Income and Insurance, 2004 (base: adults ages 18–64)

	Total	Insured all year: Above average income	Insured all year: Below average income	Uninsured anytime during the year
Unweighted N=	1121	510	169	279
Access				
No regular doctor or place of care	10%	4%	4%	20%*
Saw doctor same day when sick	32	37	40	25*
Waited six days or more for appointment when sick	20	12*	21	28
ER visit in past two years	34	24*	36	46*
ER visit for condition regular doctor could have seen	16	10*	22	21
Somewhat or very difficult to get care on nights, weekends, or holidays without going to ER	67	61	72	74
At least one of three access problems because of costs†	45	22*	44	76*
Spent more than US$1,000 out-of-pocket	26	32	26	28
Coordination				
In past two years a time when:				
Unnecessary duplication of medical tests	14	8	7	23*
Received conflicting information from different doctors	20	12	15	32*
Test results or medical records not available at time of scheduled appointment	18	14	13	26*
Any of three coordination problems	33	25	28	44*
Had lab, x-ray or other test in past two years:				
Did not receive test results or results not explained	22	17	22	31*
Lab error or delay in receiving abnormal test results	16	10	15	27*
Those on medication, in past two years:				
Doctor did not review all medications taken	27	26*	34	31
Doctor did not explain side effects	29	36	35	26
Doctor–Patient Relationship				
Doctor only sometimes, rarely or never:				
Listens carefully to you	17	8	13	28*
Explains things in a way you can understand	17	7	11	28*
Spends enough time with you	27	15*	22	43*
Makes clear the specific goals and plan for your treatment	22	16	19	29*
Gives you clear instructions	14	10	9	22*
Tells you about treatment choices and asks for your ideas/opinions	46	41	41	55*
Left doctor's office without getting questions answered	27	18*	26	35
Rated doctor fair/poor overall	16	6*	14	27*

† Did not fill prescription or skipped doses; had a medical problem, did not visit doctor; skipped recommended test or follow-up because of costs during past year.

* Significantly different from insured all year below average income group at $p<.05$.

Source: Commonwealth Fund 2004 International Health Policy Survey.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries (November 3, 2005). Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle M. Doty, Kinga Zapert, Jordon Peugh, and Karen Davis. *Health Affairs* Web Exclusive (*In the Literature* summary). This international survey found that one-third of U.S. patients with health problems reported experiencing medical mistakes, medication errors, or inaccurate or delayed lab results—the highest rate of any of the six nations surveyed.

Primary Care and Health System Performance: Adults' Experiences in Five Countries (October 28, 2004). Cathy Schoen et al. *Health Affairs* Web Exclusive (*In the Literature* summary). According to a 2004 Commonwealth Fund/Harris Interactive survey of patients in five industrialized nations, a serious shortfall in the delivery of safe, effective, timely, or patient-centered primary care is an international problem.

First Report and Recommendations of The Commonwealth Fund's International Working Group on Quality Indicators (June 2004). The Commonwealth Fund. This report to the health ministers of Australia, Canada, New Zealand, the United Kingdom, and the United States provides detailed data on 40 key health care quality indicators, which the Fund's International Working Group on Quality Indicators developed to help benchmark and compare health care system performance across the five countries.

How Does the Quality of Care Compare in Five Countries? (May/June 2004). Peter S. Hussey, Gerard F. Anderson, Robin Osborn et al. *Health Affairs,* vol. 23, no. 3. In this article from the Fund-supported international issue of *Health Affairs,* the authors report on efforts of the Commonwealth Fund International Working Group on Quality Indicators to compare the quality of care in Australia, Canada, New Zealand, the United Kingdom, and the United States.

Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens (January 2004). Karen Davis, Cathy Schoen, Stephen C. Schoenbaum, Anne-Marie J. Audet, Michelle M. Doty, and Katie Tenney. This report examines how well the health system works from the perspective of patients and confirms what several other recent studies have shown—that the U.S. performs worse than its peer nations on several dimensions of quality.

#534 *Room for Improvement: Patients Report on the Quality of Their Health Care* (April 2002). Karen Davis, Stephen C. Schoenbaum, Karen Scott Collins, Katie Tenney, Dora L. Hughes, and Anne-Marie J. Audet. Based on the Commonwealth Fund 2001 Health Care Quality Survey, this report finds that many Americans fail to get preventive health services at recommended intervals or receive substandard care for chronic conditions, which can translate into needless suffering, reduced quality of life, and higher long-term health care costs.