

## TRENDS

### Inequities In Health Care: A Five-Country Survey

Access-to-care experiences across the five countries tend to vary along with the countries' insurance coverage policies.

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**ABSTRACT:** This paper reports the results of a comparative survey in five nations: Australia, Canada, New Zealand, the United Kingdom, and the United States. The survey finds a high level of citizen dissatisfaction with the health care systems in all five countries. Citizens with incomes below the national median were more likely than were those with higher incomes to be dissatisfied. In contrast, relatively few citizens reported problems getting needed health care. Low-income U.S. citizens reported more problems getting care than did their counterparts in the other four countries.

**T**HIS PAPER IS THE THIRD in a series of comparative studies of citizens' views of and experiences with health care systems in five countries (Australia, Canada, New Zealand, the United Kingdom, and the United States).<sup>1</sup> It examines a central tenet of universal health care systems: that universal coverage mitigates the inequities in getting access to and paying for health care. These inequities are of concern because of the higher burden of illness faced by persons with lower incomes.<sup>2</sup> The paper also looks at general trends across countries, some of which extend over eleven years.

Although four countries in this study have universal health care systems, these systems differ in the role of private insurance in each. In Britain's National Health Service (NHS), private insurance plays a minor role, accounting for only 4 percent of expenditures. New Zealand and Australia have a mixed private-public system with many cost-sharing requirements. Private insurance is used to pay these fees and provide access to private physicians, specialists, and hospitals. Approximately 30 percent of New Zealanders and 40 percent of Australians have such insurance. Canada has a universal public insurance plan, which prohibits

the use of private insurance to pay for services covered by the public plan. More than half of Canadians have private insurance.<sup>3</sup> The United States stands alone in this group as the only country with no universal system, with the exception of Medicare for the elderly. Among nonelderly Americans, in 2000 approximately 74 percent were covered by private insurance through an employer or a plan purchased in the individual market, 14 percent were covered by a public plan, and 16 percent were uninsured.<sup>4</sup>

■ **Study methods.** Surveys of nationally representative, noninstitutionalized adult populations in each of the five countries were conducted by telephone during April–May 2001 by Harris Interactive and its international affiliates. We interviewed 1,412 adults in Australia, 1,400 in Canada, 1,400 in New Zealand, 1,400 in the United Kingdom, and 1,401 in the United States. Identical instruments were used in all countries. The surveys were designed by researchers at the Harvard School of Public Health and the Commonwealth Fund and reviewed by experts in each country.<sup>5</sup>

One focus of the survey was income-based inequity in access to care. Survey respondents were given the national median household income in their country in 2001 and asked to

classify their own annual household income relative to the cited median income.<sup>6</sup> Those classifying their incomes as “much above” or “somewhat above” were grouped in the analysis as “above average,” and those classifying their income as “much below” or “somewhat below” were grouped as “below average.” The proportion of respondents in the below-average group ranged from 27 percent in New Zealand; 33 percent in Canada; 34 percent in Australia; 38 percent in the United Kingdom; and 39 percent in the United States. The proportion in the above-average group ranged from 36 percent in the United Kingdom; 40 percent in Canada; 41 percent in Australia; 43 percent in the United States; and 50 percent in New Zealand. Significant differences between countries and among above- and below-average income groups within countries are noted in the exhibits. Where multiple comparisons were made, significance levels were adjusted.

### Overall View Of The Systems

Beginning in 1988 and 1990 we asked the public in Australia, Canada, the United Kingdom, and the United States to rate their respective health care systems (Exhibit 1).<sup>7</sup> The question was repeated in

1998, with the addition of New Zealand, and again in 2001. Fourteen years ago Canada's health care system garnered the highest level of public satisfaction and the U.S. system, the lowest; the Australian and British systems ranked in the middle. In 1988 only in Canada was a majority of the public satisfied with the system. A decade later Canada has come to look like all of the other countries, with a majority calling for fundamental changes in the system.

Since 1998 there have been small, statistically significant improvements in the public's perception of the health systems in Australia and New Zealand. Only the British satisfaction rating shifted in a small but statistically significant negative direction from 1998 to 2001.

In Canada, New Zealand, and the United States adults with below-average incomes were significantly more likely than those with above-average incomes to say there was so much wrong with the health care system that it should be completely rebuilt (Exhibit 2). Low-income U.S. adults were much more likely to be dissatisfied.

### EXHIBIT 1 Citizens' Overall Views About Their Health Care System, Five Countries, Selected Years 1988–2001

	Australia	Canada	New Zealand	United Kingdom	United States
Only minor changes needed					
1988/90	34% <sup>a</sup>	56% <sup>a</sup>	– <sup>b</sup>	27 <sup>a</sup>	10 <sup>a</sup>
1998	19 <sup>a</sup>	20	9 <sup>a</sup>	25 <sup>a</sup>	17
2001	25	21	18	21	18
Fundamental changes needed					
1988/90	43 <sup>a</sup>	38 <sup>a</sup>	– <sup>b</sup>	52 <sup>a</sup>	60 <sup>a</sup>
1998	49	56	57	58	46 <sup>a</sup>
2001	53	59	60	60	51
Rebuild completely					
1988/90	17	5 <sup>a</sup>	– <sup>b</sup>	17	29
1998	30 <sup>a</sup>	23 <sup>a</sup>	32 <sup>a</sup>	14 <sup>a</sup>	33 <sup>a</sup>
2001	19	18	20	18	28

**SOURCES:** Canada, U.K., and U.S. data collected in 1988, Australia collected in 1990; Harvard/Harris/Baxter Foundation. For 1998, Commonwealth Fund/Harvard/Harris 1998 International Health Policy Survey. For 2001, Commonwealth Fund/Harvard/Harris 2001 International Health Policy Survey.

<sup>a</sup>Significantly different from U.S. in 2001 at  $p \leq .05$ .

<sup>b</sup>Not available.

## EXHIBIT 2 Citizens' Views On Their Health Care Systems And General Access Problems, By Income Group, Five Countries, 2001

	There is so much wrong with the system that it should be completely rebuilt	Access is worse than 2 years ago	Very or extremely difficult to see a specialist	Very or some- what difficult to get care in evening or on weekends	Often or sometimes unable to get care because it is not available where you live
Australia					
Below-average income (n = 483)	22% <sup>a</sup>	22% <sup>a,b</sup>	14% <sup>a</sup>	33% <sup>a</sup>	19% <sup>a</sup>
Above-average income (n = 587)	18	17	11	35	14
Canada					
Below-average income (n = 465)	23 <sup>a,b</sup>	28	20 <sup>a,b</sup>	46 <sup>b</sup>	23 <sup>b</sup>
Above-average income (n = 558)	13	24	14	36	17
New Zealand					
Below-average income (n = 374)	25 <sup>a,b</sup>	20 <sup>b</sup>	21 <sup>a,b</sup>	22 <sup>a</sup>	24 <sup>b</sup>
Above-average income (n = 693)	18	12	6	22	16
United Kingdom					
Below-average income (n = 526)	19 <sup>a</sup>	20 <sup>a</sup>	16 <sup>a,b</sup>	31 <sup>a</sup>	14 <sup>a</sup>
Above-average income (n = 500)	17	17	9	36	11
United States					
Below-average income (n = 545)	35 <sup>b</sup>	26 <sup>b</sup>	30 <sup>b</sup>	49 <sup>b</sup>	28 <sup>b</sup>
Above-average income (n = 609)	22	18	8	40	15

**SOURCE:** Commonwealth Fund/Harvard/Harris Interactive 2001 International Health Policy Survey.

<sup>a</sup>Significantly different from U.S. below-average income at  $p \leq .05$ .

<sup>b</sup>Significantly different from above-average income at  $p \leq .05$ .

### Access To Care

■ **General access problems.** The survey included several general questions about access to care. Focusing first on the low-income population, the group with the highest burden of illness, we found that the majority of citizens across countries did not report access problems. However, more in this group reported problems on a number of measures than was true for adults with above-average incomes.

As shown in Exhibit 2, 20–28 percent of citizens with below-average incomes reported that their access to medical care had gotten worse in the past two years. In four of the five countries persons with below-average incomes

were significantly more likely than were those with above-average incomes to report worse access to care; Canada was the exception.

Difficulties with access to specialty care were reported by 14–30 percent of low-income citizens across the five countries. Americans with below-average incomes were much more likely than their counterparts in the other four countries were to report that it was extremely or very difficult to see a specialist. A statistically significant income disparity on this measure exists in all but Australia.

Exhibit 2 shows that 22–49 percent of those with below-average incomes reported that it was very or somewhat difficult to get

care on nights and weekends. Canadian and U.S. citizens with incomes below the national median were significantly more likely than those with higher incomes were to report this problem. Lastly, 14–28 percent of citizens with below-average incomes across the five countries reported that they were often or sometimes unable to get needed medical care because it was not available where they live. The survey finds a statistically significant income disparity on this measure in Canada, New Zealand, and the United States.

■ **Access problems due to cost.** The survey asked about four access problems attributable to cost: not filling a prescription; not getting a recommended test, treatment, or follow-up care; not getting dental care; and having a medical problem but not visiting a doctor. While the majority of citizens in the five countries did not report such problems, those with low incomes were more likely to report many of them. On all of these measures, low-income Americans were much more likely than their

counterparts in the other four countries were to report problems.

As shown in Exhibit 3, 7–39 percent of citizens with below-average incomes reported a time when they did not fill a prescription because of its cost. In Canada, New Zealand, and the United States citizens with below-average incomes were significantly more likely than those with above-average incomes were to report going without a needed prescription.

The proportion of low-income respondents who reported that they did not get a test, treatment, or follow-up care because of its cost ranged from 4 percent to 36 percent. New Zealand and the United States were the only countries in which citizens with below-average incomes were significantly more likely to report this problem than were those with above-average incomes.

Between 20 percent and 51 percent of citizens with incomes below the national median reported a time in the past year when they needed dental care but did not get it because of

### EXHIBIT 3

#### Access Problems Due To Cost And Medical-Bill Problems In The Past Year, By Income, Five Countries, 2001

	Did not fill a prescription due to cost	Did not get recommended test, treatment, or follow-up due to cost	Needed dental care but did not see a dentist due to cost	Had a medical problem but did not visit doctor due to cost	Problems paying medical bills
Australia					
Below-average income	21% <sup>a</sup>	17% <sup>a</sup>	38% <sup>a,b</sup>	14% <sup>a</sup>	17% <sup>a,b</sup>
Above-average income	18	14	31	10	8
Canada					
Below-average income	22 <sup>a,b</sup>	9 <sup>a</sup>	42 <sup>a,b</sup>	9 <sup>a,b</sup>	14 <sup>a,b</sup>
Above-average income	7	4	15	3	3
New Zealand					
Below-average income	20 <sup>a,b</sup>	18 <sup>a,b</sup>	40 <sup>a</sup>	24 <sup>a,b</sup>	20 <sup>a,b</sup>
Above-average income	11	11	36	18	7
United Kingdom					
Below-average income	7 <sup>a</sup>	4 <sup>a</sup>	20 <sup>a</sup>	4 <sup>a</sup>	4 <sup>a</sup>
Above-average income	7	1	19	2	2
United States					
Below-average income	39 <sup>b</sup>	36 <sup>b</sup>	51 <sup>b</sup>	36 <sup>b</sup>	35 <sup>b</sup>
Above-average income	18	14	24	15	11

**SOURCE:** Commonwealth Fund/Harvard/Harris Interactive 2001 International Health Policy Survey.

**NOTE:** For numbers of respondents, see Exhibit 2.

<sup>a</sup>Significantly different from U.S. below-average income at  $p \leq .05$ .

<sup>b</sup>Significantly different from above-average income at  $p \leq .05$ .

cost. Significantly more low-income than high-income Australians, Canadians, and Americans reported this problem.

The proportion of low-income adults reporting that they did not get needed medical care because of cost ranged from 4 percent to 36 percent. In Canada, New Zealand, and the United States, citizens with below-average incomes were significantly more likely than were those with above-average incomes to report this problem.

Lastly, 4–35 percent of citizens with incomes below the national median reported that they had problems paying medical bills in the past year. Low-income citizens in all but the United Kingdom were significantly more likely than were those with higher incomes to report this problem.

### Inequities In The United States

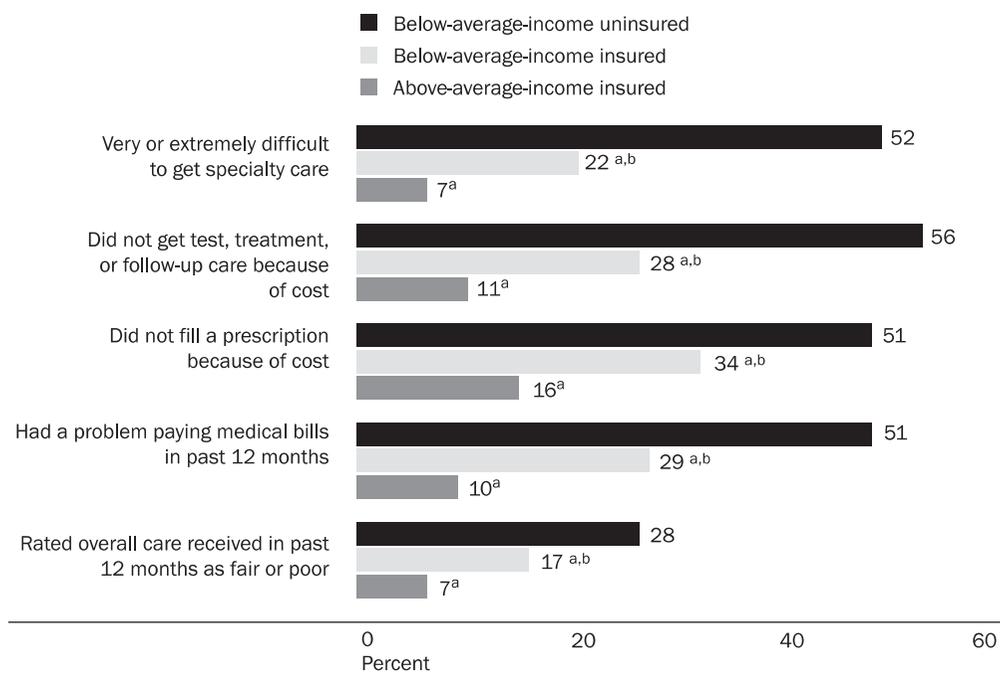
In the United States, having insurance eases

the access and cost problems faced by adults with below-average incomes. Uninsured adults with below-average incomes were significantly more likely than their insured counterparts were to report that it was extremely or very difficult to get specialty care; to report a time when they did not get a test, treatment, or follow-up care or fill a prescription because of cost; and to report problems paying medical bills in the past twelve months (Exhibit 4).

### Access Experiences And Quality Ratings

In addition to examining differences by income, the survey enables overall comparisons of access experiences and ratings of quality of care by country. Similar to adults with low incomes, most citizens across the five countries did not report access problems. A majority in each country reported that access for themselves and their families was about the same as

**EXHIBIT 4**  
**Impact Of Insurance Coverage On Low-Income Americans, 2001**



**SOURCE:** Commonwealth Fund/Harvard/Harris 2001 International Health Policy Survey.

<sup>a</sup> Significantly different from below-average-income uninsured at  $p \leq .05$ .

<sup>b</sup> Significantly different from above-average-income insured at  $p \leq .05$ .

it was two years ago, but the survey also found that 15–26 percent reported that their access to care had gotten worse (Exhibit 5).

Across all five countries, a third or more of respondents reported that it was somewhat, very, or extremely difficult to see a medical specialist or consultant. In addition, approximately 20 percent of respondents in four of the five countries reported that they were often or sometimes unable to get care because it was not available where they live. Only in Britain

did a significantly smaller percentage (as compared with the U.S. percentage) of respondents (13 percent) report the same problem. Lastly, getting care on nights and weekends was the most frequently reported problem across all five countries.

■ **Access problems due to difficulties paying for care.** U.S. respondents were significantly more likely than respondents in the other four countries were to report access problems due to cost (Exhibit 5). At least one

### EXHIBIT 5 Citizens' Views Of Access To And Quality Of Care, Five Countries, 2001

Access	AUS	CAN	NZ	UK	US
Very or extremely difficult to see a specialist	12% <sup>a</sup>	16%	11% <sup>a</sup>	13%	17%
Somewhat difficult to see a specialist	23	28 <sup>a</sup>	23	22	22
Not too or not at all difficult to see a specialist	60	51 <sup>a</sup>	61	53	59
Access worse than two years ago	19	26 <sup>a</sup>	15 <sup>a</sup>	17	20
Access about the same as two years ago	69 <sup>a</sup>	65	71 <sup>a</sup>	69 <sup>a</sup>	62
Access better than two years ago	8 <sup>a</sup>	6 <sup>a</sup>	10 <sup>a</sup>	11 <sup>a</sup>	17
Somewhat or very difficult to get care on nights or weekends	34 <sup>a</sup>	41	23 <sup>a</sup>	33 <sup>a</sup>	41
Often or sometimes unable to get care because it is not available where you live	17	21	18	13 <sup>a</sup>	20
Did not fill a prescription due to cost	19 <sup>a</sup>	13 <sup>a</sup>	15 <sup>a</sup>	7 <sup>a</sup>	26
Did not get medical care due to cost	11 <sup>a</sup>	5 <sup>a</sup>	20 <sup>a</sup>	3 <sup>a</sup>	24
Did not get test, treatment, or follow-up care due to cost	15 <sup>a</sup>	6 <sup>a</sup>	14 <sup>a</sup>	2 <sup>a</sup>	22
Did not get dental care due to cost	33	26	37	19 <sup>a</sup>	35
Problems paying medical bills	11 <sup>a</sup>	7 <sup>a</sup>	12 <sup>a</sup>	3 <sup>a</sup>	21
<b>Quality ratings</b>					
Rated overall medical care as					
Excellent	26%	20%	27% <sup>a</sup>	21%	22%
Very good	37	34	40 <sup>a</sup>	32	35
Good	26	32 <sup>a</sup>	23 <sup>a</sup>	30	28
Fair	8	9	6	13	10
Poor	2	3	2	2	3
Rating of physician responsiveness as excellent or very good					
Treating you with dignity and respect	80 <sup>a</sup>	79 <sup>a</sup>	84 <sup>a</sup>	73	72
Listening carefully to your health concerns	73 <sup>a</sup>	74 <sup>a</sup>	75 <sup>a</sup>	67	65
Providing all the information you want	72 <sup>a</sup>	67	73 <sup>a</sup>	58 <sup>a</sup>	63
Spending enough time					
Knowing you and your family situation	69 <sup>a</sup>	62 <sup>a</sup>	71 <sup>a</sup>	54	58
Knowing you and your family situation	63 <sup>a</sup>	59	67 <sup>a</sup>	51	57
Being accessible by phone or in person	59 <sup>a</sup>	55 <sup>a</sup>	64 <sup>a</sup>	48	52

**SOURCE:** Commonwealth Fund/Harvard/Harris Interactive 2001 International Health Policy Survey.

**NOTES:** Some columns may not add up to 100 percent because each respondent was given the option to say that they were not sure or could decline to answer altogether. For Australia, N = 1,412; Canada, N = 1,400; New Zealand, N = 1,400; United Kingdom, N = 1,400; United States, N = 1,401.

<sup>a</sup>Significantly different from U.S. at  $p \leq .05$ .

in five Americans mentioned problems paying medical bills, filling prescriptions, getting medical care, or getting doctor-recommended tests and follow-up treatment. The most frequently reported cost problem (19–37 percent) in all five countries was getting dental care.

**Quality-of-care ratings.** We asked respondents to rate the care they and their family received in the past twelve months. As in our 1998 study, a majority in each country rated their care as excellent or very good.<sup>8</sup> In 2001 between 53 percent and 67 percent gave their care this rating.

*Physician responsiveness.* To determine physician responsiveness, one measure of quality, we asked respondents to rate their usual physician on six dimensions of care: providing all of the information you want, being accessible by phone or in person, spending enough time with you, knowing you and your concerns, listening to you, and treating you with dignity and respect. In general, responses to questions about time and access by phone or in person were the least likely to receive strong positive ratings. A majority of respondents in all five countries rated their physician as excellent or very good on each.

*Hospital experience.* We also asked respondents who were hospitalized or who had a family member hospitalized in the past two years to rate their overall hospital experience. Except in the United Kingdom, a majority of respondents rated the care they received as excellent or very good; however, another one in five in each country felt that their care was not good (Exhibit 6). About half of respondents in all five countries said that during their or a family member’s hospital stay, the availability of nurses was excellent or very good, but one in four said that it was fair or poor.

*Waiting times for elective surgery.* In 2001 the United Kingdom had the largest share of the population waiting four months or more for elective surgery. As shown in Exhibit 6, the same was true in 1998. In 2001 the proportion of the population needing elective surgery and waiting more than four months ranged from 5 percent in the United States to 38 percent in the United Kingdom. Comparing trends between 1998 and 2001, Canada had the only statistically significant increase in the number of persons waiting four months or more.

*Differences in quality ratings by income.* As shown in Exhibit 7, quality ratings vary by in-

**EXHIBIT 6**  
**Quality Ratings Among Persons Hospitalized Or Needing Elective Surgery, Five Countries, 1998 And 2001**

	AUS	CAN	NZ	UK	US
Self or family member hospitalized in past 2 years	(380)	(248)	(303)	(246)	(274)
Rated care as excellent or very good	55%	54%	58%	48%	50%
Rated care as fair or poor	18	19	20	22	20
Rated availability of nurses as excellent or very good	55	50	55	46	51
Rated availability of nurses as fair or poor	24	22	22	28	22
Of those needing elective surgery in past year, 2001	(382)	(332)	(406)	(323)	(368)
Waited less than 1 month	51%	37%	43%	38%	63%
Waited 1 to less than 4 months	26	36	31	24	32
Waited 4 months or more	23	27 <sup>a</sup>	26	38	5
Of those needing elective surgery in past year, 1998	(299)	(192)	(282)	(224)	(235)
Waited less than 1 month	51%	44%	51%	30%	70%
Waited 1 to less than 4 months	32	43	28	36	28
Waited 4 months or more	17	12	22	33	1

**SOURCE:** Commonwealth Fund/Harvard/Harris Interactive 1998 and 2001 International Health Policy Surveys.

**NOTE:** For numbers of respondents, see Exhibit 5. Numbers answering various questions are in parentheses.

<sup>a</sup> Increase in those waiting 4 months or more in Canada between 1998 and 2001 is statistically significant at  $p \leq .05$ .

## EXHIBIT 7 Citizens' Ratings Of Quality Of Care, By Income Group, Five Countries, 2001

	Rating of overall medical care received in past 12 months	
	Excellent or very good	Fair or poor
Australia		
Below-average income	64% <sup>a</sup>	9% <sup>a</sup>
Above-average income	59	10
Canada		
Below-average income	51 <sup>b</sup>	15 <sup>b</sup>
Above-average income	60	9
New Zealand		
Below-average income	66 <sup>a</sup>	8 <sup>a</sup>
Above-average income	70	9
United Kingdom		
Below-average income	56 <sup>b</sup>	15
Above-average income	45	16
United States		
Below-average income	45 <sup>b</sup>	20 <sup>b</sup>
Above-average income	65	9

**SOURCE:** Commonwealth Fund/Harvard/Harris Interactive 2001 International Health Policy Survey.

**NOTE:** For numbers of respondents, see Exhibit 2.

<sup>a</sup>Significantly different from U.S. below-average income at  $p \leq .05$ .

<sup>b</sup>Significantly different from above-average income at  $p \leq .05$ .

come. Between 45 percent and 66 percent of citizens with low incomes rated the overall medical care they received in the past year as excellent or very good. The survey finds a statistically significant income disparity on this measure in Canada, the United Kingdom, and the United States. Canadians and Americans with lower incomes were less likely than were those with higher incomes to rate their care as excellent or very good. For Britons the opposite was true.

### Points Of Convergence And Difference

We find that there has been a convergence over time in the public's view of health care systems in these five countries. In all five the majority of citizens in 2001 were not satisfied with their systems as they stand and wanted substantial changes in the future. Public dissatisfaction with the health care system grew markedly in Canada between 1990 and 1998, likely reflecting the sharp curtailment in real

national health spending and reduced hospital inpatient capacity during these years.<sup>9</sup> Canada's commitment of additional national budgetary resources since 1998 was a response to these concerns. As of the 2001 survey, however, we find only a slight easing of concerns. In the United Kingdom the moderate deterioration of public satisfaction may well reflect highly publicized cases of medical errors and patients in distress while waiting for care.<sup>10</sup> The priority placed by the NHS to reduce waiting times appears to have had some effect by 2001, based on the finding that the United Kingdom shows a small, statistically insignificant improvement since 1998 in the percentage of persons waiting less than one month for surgery. The positive shift in public perceptions in New Zealand may reflect the latest reforms under the New Zealand Public Health and Disability Act (2000), which brought a restructuring of the health care system and promised more local participation and public engagement in decision making.

■ **Overall ratings versus individual experiences.** The high rates of dissatisfaction with systems overall stand in contrast to citizens' experiences with their respective health care systems, as the majority in each country did not report problems on most measures. The explanation for this seemingly paradoxical finding may be that overall satisfaction with the health care system includes an assessment of what is going in the health care system more broadly, including shortages of nurses and specialists, highly publicized examples of medical errors and denials of care, and other system factors that may only directly affect a small number of people at any given time, given the skewed distribution of medical care use.

■ **Access and health insurance.** Varying access-to-care experiences across and within countries tend to track insurance coverage and benefits policies. Canadian and British adults—with comprehensive coverage for core benefits—were notably less likely to report going without physician care because of costs than were adults in Australia, New Zealand, or the United States. Australia and New Zealand fall in the middle of the five countries in the extent to which they rely on patient copayments and private insurance; on average, they fare reasonably well on many measures of access and quality. Yet while cost sharing in Australia and New Zealand is often modest by U.S. standards, our findings indicate that front-end fees may result in patients' forgoing needed care, especially low-income adults unable to pay for private coverage to supplement public plans. Services that are less well covered, such as prescription drugs or dental care (except in the United Kingdom), were generally the services for which patients reported the greatest problems obtaining and paying for care.

The finding of similar rates of difficulties seeing specialists across the five countries is notable, given the much larger supply of specialists in the United States. Based on reasons given for difficulties, this finding indicates that demand-side barriers in the United States—lack of insurance or insurance controls—are the causes. Based on reports by income, supply-side as well as demand-side con-

straints create greater barriers to care for lower-income residents than they do for higher-income residents.

■ **Financial barriers to care.** In looking at equity across the five countries, the survey finds that inequities exist in all countries except the United Kingdom, although they are sharpest and most pervasive in the United States. While U.S. adults across all incomes reported much shorter waiting times for elective surgery, financial barriers to care and financial stress attributable to medical bills rather than to supply shortages have resulted in barriers to needed and recommended medical care for low-income adults.

The United States also stands out for having the highest proportion of the public reporting problems paying their medical bills. While this is especially true for lower-income adults and the uninsured, higher-income Americans are also much more exposed than are their counterparts in the other four countries.

■ **Quality of care.** In terms of quality of care, which has been a major focus of health policymakers, we find that the public is relatively satisfied with the quality of care they receive, with ratings not tracking national spending patterns. Patients' ratings of the quality of overall medical care and hospital care are quite similar across the five countries, with a shared concern about the shortage of nurses. Ratings of physician care were also generally positive, with less variation across the countries than found on access and other measures. Physician ratings tended to be highest in New Zealand and Australia. Interestingly, physicians in both of these countries were the least likely to complain about not having enough time for patients in a 2000 cross-national survey of physicians.<sup>11</sup> The finding that quality-of-care ratings are high across countries despite varying resource capacities could indicate either that expectations adjust to resource levels or that different systems have developed more efficient systems for delivering high-quality care, or they could be the result of the limits of simple household survey measures of quality-of-care ratings. This question of expectations versus experiences is an

area that needs further research.

■ **Top policy concerns.** Looking across all findings for areas in which each country stands out, the survey highlights areas for top policy concerns. In the United States the policy issue that stands out is the uninsured. Reflecting their high rate of uninsurance, U.S. adults with low incomes were the most dissatisfied of any group across the five nations and the most at risk of going without needed medical care on all access indicators. In the United Kingdom long queues for hospital care and elective procedures stand out as the most important policy issue. In Canada difficulty seeing a medical specialist is a serious concern requiring government attention. Copayments are an important policy issue for New Zealand, where a substantial minority report problems getting the care they need because of cost. Lastly, Australians report problems getting care on nights and weekends and affording prescription drugs, both important policy issues. The problem of paying for dental care is an access issue for all five nations.

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 An earlier version of this paper was presented at the Commonwealth Fund 2001 International Symposium on Health Care Policy: Health Care System Reforms and Strategies to Improve Access and Quality of Health Care for At-Risk Populations, 9–11 October 2001, in Washington, D.C.

#### NOTES

- For results of previous surveys, see K. Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs* (May/June 1999): 206–216; C. Schoen et al., "Health Insurance Markets and Income Inequality: Findings from an International Health Policy Survey," *Health Policy* 51 (2000): 67–85; and K. Donelan et al., "The Elderly in Five Nations: The Importance of Universal Coverage," *Health Affairs* (May/June 2000): 226–235.
- 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).
- G. Anderson, *Multinational Comparisons of Health Systems Data* (New York: Commonwealth Fund, 2000).
- P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey*, EBRI Issue Brief no. 240 (Washington: Employee Benefit Research Institute, December 2001). Numbers do not add to 100 percent because respondents may have been covered by more than one form of insurance.
- Surveys are subject to sampling error. Sources of nonsampling error include nonresponse bias, cultural differences in question interpretation, and interviewer error. To reduce error based on cultural differences in question wording, the instrument was reviewed by health policy experts in each country and pretested. Poststratification weights were applied to adjust for minor variations between the sample demographics and the known demographics in each country. To adjust for weighting in the analysis, STATA was used for all significance tests. Differences in survey practices among the nations make the calculation of a response rate infeasible.
- Prior survey work in the United Kingdom has indicated that Britons are more likely to respond to a question asking them to place their income above or below a national average than to a question asking for their actual income. For more discussion on this measure, see Schoen et al., "Health Insurance Markets and Income Inequality."
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