Equitable Access to Care — How the United States Ranks Internationally

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The United States has been unusual among industrialized countries in lacking universal health coverage. Financial barriers to care — particularly for uninsured and low-income people — have also been notably higher in the United States than in other high-income countries. As more Americans become insured as a result of the Affordable Care Act (ACA), differences in access to care between the United States and other countries — as well as among income groups within the United States — may begin to narrow.

According to a 2013 Commonwealth Fund survey of adults in 11 high-income countries, the United States ranks last on measures of financial access to care as well as of availability of care on nights and weekends.[1] Uninsured people in the United States are particularly likely to report encountering barriers to care.

In general, the survey reveals that such barriers are particularly striking for adults with incomes below or well below their countries' median income.[2] But as Table 1 shows, lower-income Americans are more likely than their counterparts in other countries to indicate that, in the past year, they've had a medical problem but did not visit the doctor because of cost, did not fill prescriptions or skipped doses of medications because of cost, or did not get recommended tests, treatments, or follow-up care because of cost. Indeed, the United States ranks last among the 11 countries in terms of financial access to care for lower-income people. At least 30% of lower-income adults in the United States report encountering such financial barriers to care; the average proportion of lower-income adults in the other surveyed countries who reported encountering one of these three types of financial barriers was around 10%.

The United Kingdom, France, Germany, Norway, Sweden, and Switzerland stand out as leaders in ensuring equitable financial access to care. Switzerland, which provides coverage through nonprofit private insurance plans with deductibles, ensures that cost sharing is lower for lower-income individuals. The United Kingdom, Norway, and Sweden have public health care systems for the entire population with little or no patient cost sharing and allow a limited role for private insurance. France has a public insurance system, and Germany has a social insurance system with competing private "sickness funds."

Notwithstanding Americans' impression that other countries ration care, for lower-income adults, obtaining timely primary care is a bigger problem in the United States than in other industrialized countries. Lower-income adults in the United States are more likely to report that they had to wait 6 or more days for an appointment the last time they needed medical attention and that it was somewhat or very difficult to get care in the evenings, on weekends, or on holidays. They are also more likely to have to wait 2 or more hours before receiving care in the emergency department. Greater dissatisfaction with care is reflected in the fact that greater proportions of lower-income Americans than lower-income adults in the other surveyed countries rate their doctors and the quality of their care as fair or poor.

By contrast, higher-income adults in the United States are not more likely than higher-income adults in other countries to report having difficulty getting appointments, and they are not more likely to report that it is somewhat or very difficult to get care in the evenings, on weekends, or on holidays (see Table 2). In fact, higher-income Americans who seek emergency department care are less likely than higher-income adults in other countries to report waiting 2 or more hours. Six percent of higher-income adults in the United States — the same as the proportion of higher-income adults in other countries — rate their doctor as fair or poor, as compared with 10% of lower-income adults in other countries and 15% of lower-income adults in the United States. Furthermore, there are no significant differences between the proportions of higher-income adults in the United States and in other countries who rate the quality of their care as fair or poor.

But even Americans with above-average income report encountering some financial barriers to care at a higher rate than similar

Table 1. Percentages of Respondents with Below-Average Income Who Encountered Barriers to Care.*

Measure	Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	Non-U.S. Countries	United States	P Value (United States vs. non-U.S. countries)
Had medical problem but did not visit doctor because of cost in the past year	14	7	11	11	16	23	7	5	11	1	11	39	<0.01
Did not get recommended test, treatment, or follow-up because of cost in the past year	10	14	10	12	11	9	9	7	9	1	9	31	<0.01
Did not fill prescription or skipped doses because of cost in the past year	14	8	11	8	20	18	7	4	11	4	11	30	<0.01
Last time needed medical attention had to wait ≥6 days for an appointment	11	28	11	24	12	6	16	24	4	3	14	21	<0.05
If sought after-hours care, found it somewhat or very difficult to get care in the evenings, on weekends, or on holidays	58	67	64	44	53	64	48	67	56	40	56	70	<0.01
If went to emergency department, waited ≥2 hours in emergency department	28	48	34	20	22	15	33	37	20	24	28	36	<0.05
Rated doctor fair or poor	5	12	9	11	5	8	14	17	3	11	10	15	<0.01
Rated quality of care fair or poor	12	17	12	19	16	10	21	11	6	5	13	27	<0.01

* Data on waits for medical appointments and ratings of quality of care are from the 2011 Commonwealth Fund general-population survey; data on all other measures are from the 2013 Commonwealth Fund general-population survey.

people in other countries. Although they are less likely to encounter such barriers than their low-income compatriots, they are more likely than adults with above-average income elsewhere to report that during the past year, costs kept them from visiting the doctor for medical problems, from filling prescriptions or taking all recommended doses, or from getting recommended tests, treatment, or follow-up. For example, almost one fifth of Americans with above-average income report not visiting a doctor for a medical problem because of cost, as compared with 5% of their counterparts in other countries. This difference is undoubtedly related to the United States' greater reliance on patient cost sharing, including higher deductibles.

Within a properly performing health care system, patients receive both affordable and timely care. It is only with enactment of the ACA that the United States has begun to address the gap in health insurance coverage and set standards for essential benefits and adequate coverage. The ACA also contains provisions to expand the availability of primary care, including through expanded funding for community health centers, increased payment for primary care services, and a Comprehensive Primary Care Initiative.[3]

The impact of the ACA coverage provisions has yet to fully materialize, and at the time of the survey, the only access-related mandate in effect was the requirement that insurers cover children on their parents' plans until they turn 26. The ongoing enrollment through the exchanges and in states that have opted to expand Medicaid will certainly increase

Table 2. Percentages of All Respondents and Respondents with Above-Average Income Who Encountered Barriers to Care.*

Measure	All Respondents				Respondents with Above-Average Income			
	Mean among 10 Non-U.S. Countries	United States	Difference	P Value	Mean among 10 Non-U.S. Countries	United States	Difference	P Value
Had medical problem but did not visit the doctor because of cost in the past year	7.7	28	20.3	<0.01	5.0	17	12.0	<0.01
Did not get recommended test, treatment, or follow-up because of cost in the past year	6.4	21	14.6	<0.01	3.4	11	7.6	<0.01
Did not fill prescriptions or skipped doses because of cost in the past year	7.4	22	14.6	<0.01	5.7	12	6.3	<0.01
Last time needed medical attention had to wait ≥6 days for an appointment	12.3	16	3.7		10.9	11	0.1	
If sought after-hours care, found it somewhat or very difficult to get care in the evenings, on weekends, or on holidays	50.3	61	10.7	<0.05	48.5	53	4.5	
If went to emergency department, waited ≥2 hr in emergency department	26.3	28	1.7		27.1	16	−11.1	<0.05
Rated doctor fair or poor	7.0	9	2.0	<0.10	6.2	6	−0.2	
Rated quality of care fair or poor	11.3	16	4.7	<0.01	9.5	7	−2.5	

* Data on waits for medical appointments and ratings of quality of care are from the 2011 Commonwealth Fund general-population survey; data on all other measures are from the 2013 Commonwealth Fund general-population survey. P values reflect the comparison between the United States and non-U.S. countries.

the proportion of Americans who have insurance. However, the failure of 23 states to expand coverage under their Medicaid programs will leave millions of lower-income Americans without health insurance coverage. Furthermore, the high deductibles and copayments in the lower-tiered health insurance plans coupled with limited government help for Americans with modest incomes means that having insurance will not necessarily make care affordable for all.

Further steps may also be needed to ensure the availability of health care in low-income communities, such as continued funding of community health centers and increased efforts to use payment reform to expand the adoption of advanced primary care practice, which aims to strengthen primary care.[4] Primary care practices that provide patient-centered, coordinated care are considered the foundation of a high-performance system. This transformation should not only improve accessibility and timeliness of care but also enhance quality of care and patient satisfaction.

The inequity of the U.S. health care system is particularly troubling. The difference in health care experiences between people with below-average and above-average incomes will need to be monitored over time to determine whether further steps to improve coverage, especially for those at the lowest end of the income range, are needed. Although Americans at both ends of the income spectrum were more likely than their counterparts in other countries to report financial barriers to care, it is the substantially worse experience provided to people with below-average income that most seriously undermines the overall performance of the U.S. health care system.

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Public Trust in Physicians — U.S. Medicine in International Perspective

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The U.S. health care reform process is entering a new phase, its emphasis shifting from expanding health coverage to improving our systems for delivering patient care. One emerging question is what role the medical profession and its leaders will play in shaping future national health care policies that affect decision making about patient care.

Research suggests that for physicians to play a substantial role in such decision making, there has to be a relatively high level of public trust in the profession's views and leadership. But an examination of U.S. public-opinion data over time and of recent comparative data on public trust in physicians as a group in 29 industrialized countries raises a note of caution about physicians' potential role and influence with the U.S. public.

In a project supported by the Robert Wood Johnson Foundation and the National Institute of Mental Health, we reviewed historical polling data on public trust in U.S. physicians and medical leaders from 1966 through 2014, as well as a 29-country survey conducted from March 2011 through April 2013 as part of the International Social Survey Programme (ISSP), a cross-national collaboration among universities and independent research institutions (ISSP 2011–2013) (see box for poll information). We found that, as has been previously reported, public trust in the leaders of the U.S. medical profession has declined sharply over the past half century. In 1966, nearly three fourths (73%) of Americans said they had great confidence in the leaders of the medical profession. In 2012, only 34% expressed this view (Harris 1966–2012). But simultaneously, trust in physicians' integrity has remained high. More than two thirds of the public (69%) rate the honesty and ethical standards of physicians as a group as "very high" or "high" (Gallup 2013). Our review of numerous analyses of public-opinion data about public trust in institutions and professions suggests that the decline in trust is probably attributable to broad cultural changes in the United States, as well as rising concerns about medical leaders' responses to major national problems affecting the U.S. health care system.[1,2] Today, public confidence in the U.S. health care system is low, with only 23% expressing a great deal or quite a lot of confidence in the system (Gallup 2014). We believe that the medical profession and its leaders are seen as a contributing factor.

This phenomenon does not affect physicians in many other countries. Indeed, the level of public trust in physicians as a group in the United States ranks near the bottom of trust levels in the 29 industrialized countries surveyed by the ISSP. Yet closer examination of these comparisons reveals findings similar to those of previous U.S. surveys: individual patients' satisfaction with the medical care they received during their most recent physician visit does not reflect the decline in overall trust. Rather, the United States ranks high on this measure of satisfaction. Indeed, the United States is unique among the surveyed countries in that it ranks near the bottom in the public's trust in the country's physicians but near the top in patients' satisfaction with their own medical treatment.

The United States is tied for 24th place in terms of the proportion of adults who agree with the statement, "All things considered, doctors in [your country] can be trusted." About 6 in