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Understanding What Makes Americans Dissatisfied With Their Health Care System: An International Comparison

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ABSTRACT **For decades, public satisfaction with the health care system has been lower in the United States than in other high-income countries. To better understand the distinctive nature of US health system satisfaction, we compared the determinants of satisfaction with the health system in the United States to those in seventeen other high-income countries by applying regression decomposition methods to survey data collected in the period 2011–13. We found that concerns related to "accessing most-preferred care" (the extent to which people feel that they can access their top preferences at a time of need) were more important to satisfaction in the United States than in other high-income countries, while the reverse was true for satisfaction with recent interactions with the health system. Differences among US socioeconomic groups in survey responses regarding access to most-preferred care suggest that wide variation in insurance coverage and generosity may play a role in these differences. While reductions in the uninsured population and the movement toward minimum health plan standards could help address some concerns about access to preferred care, our results raise the possibility of public backlash as market forces push plans toward more restricted access and higher cost sharing.**

For at least the past twenty-five years, Americans have been consistently less satisfied than residents of other high-income countries with their own nation's health system.[1,2] Research and polls over time have identified several potential explanations, such as concerns about unaffordable care, poor access, and high system cost being more prevalent among Americans than among citizens of other high-income countries. However, the nature of the relationship between these concerns and health system satisfaction has not been closely studied.[2,3]

In some ways, Americans' low levels of satisfaction with their health system seem to defy expectations. For example, system satisfaction in European countries has been found to be strongly correlated with per capita expenditures.[4] However, this is not the case in the United States, where per capita expenditures are high compared to those in Europe. Perhaps even more curiously, low satisfaction with the US health system overall contrasts with the very high satisfaction Americans express with their own health care arrangements and with their perceptions of health care quality.[3,5]

To better understand the distinctive nature of health system satisfaction in the United States, we analyzed potential determinants of that satisfaction, benchmarking US results against those of other high-income nations and observing how these determinants varied within the United States. We compared the importance of satisfaction with one's own care and traditional

measures of access with the importance of an aspect of access that has previously been unexamined: confidence that when seriously ill, one will receive the best treatment available and be seen by the doctor of one's choice. We refer to this as access to most-preferred care, and it is a measure intended to capture a sense of security about being able to exercise health care preferences when needed. By better characterizing the distinctiveness of the US health care experience, this study sheds light on the drivers of health care system satisfaction in the United States and has implications for policy.

Understanding the determinants of public satisfaction with a country's health system has merit beyond its political and strategic value to reformers. Adequate responsiveness and accountability of health systems are widely considered to be core standards of health system performance, and public satisfaction is an important measure of the extent to which systems meet them.[6] More broadly, high public satisfaction with specific services such as health care is linked with higher trust in public institutions, which is an important element in the effective functioning of democratic governments.[7,8]

A number of distinguishing characteristics of the United States and its health system could make different factors more important to satisfaction in that country than in others. Distinctive cultural values, wide gaps in insurance coverage, and high out-of-pocket expenses may color the lens through which Americans evaluate their health system.[1,2,9] Additionally, fragmentation in insurance and delivery systems in the United States may lead to wider diversity of health care experiences and health system perceptions than is the case in other countries, whose systems are more centralized and uniform.[2]

Recent research by Irene Papanicolas and coauthors[3] shows that the determinants of overall evaluations of health systems are not consistent across countries. The authors observed variation in the extent to which public perceptions of health care affordability, effectiveness of treatment, and quality of one's own doctor act as predictors of desire for system change.

In our study we applied, across countries, a measure of relative importance that combined the strength of the relationship between each factor and system satisfaction with the amount that the factor varied. We focused on domains of opinion in which we most expected the United States to differ from other countries, given its unique culture and health care system. These include access barriers, satisfaction with the last health care experience, and the newly defined construct of access to most-preferred care.

Study Data And Methods

DATA Data used in this study came from the health module of the International Social Survey Programme, a cross-national collaboration that fields annual surveys on topics important to social science research.[10] Data were collected in separate surveys in each of the participating countries at varying points in the period 2011–13. To facilitate international comparisons, questions in the health module are identically ordered and phrased as consistently as translation permits. Participating countries also agree to a common set of standards for sampling, questionnaire design, and implementation.

Data collection methods vary by country (in-person versus self-completed surveys). However, careful consideration of known biases associated with the data collection methods used in the International Social Survey Programme together with evidence from a split sample in one country mitigate concerns that this variation would affect our conclusions (for further discussion of our consideration of biases associated with collection methods, see section 1.c of the online Appendix).[11]

We limited comparisons in this study to the eighteen countries that were labeled advanced economies by the International Monetary Fund in 2014. In the United States, English and Spanish versions of the International Social Survey Programme health module were included at the end of the General Social Survey and fielded over six months in 2012.

The health module included questions on a wide variety of experiences, attitudes, and beliefs related to health care. We focused on the following three areas: barriers to access, access to most-preferred care, and satisfaction with recent health care experiences (there were two questions in each category). For additional information about the questions and the treatment of the data set, see sections 1 and 2 of the Appendix.[11]

ANALYSIS We compared the determinants of overall health system satisfaction in the United States with those in other high-income countries. To do this we used a metric of relative importance, which is one of several methods that have been used in a variety of research contexts to apportion model variance among variables.[12] We estimated the portion of explained variance in health system satisfaction that could be accounted for by each covariate.

Our relative importance metric, proposed by Richard Lindeman and coauthors and implemented in the R package relaimpo, averaged variable contributions to the R-squared value over all possible specifications of the model.[13,14] By including both independent and joint variations in its estimates of relative importance, the meth-

od proposed by Lindeman and coauthors[13] is better insulated than standard measures such as *t*-statistics from issues arising from the correlation of explanatory variables in the model (for a further discussion, see section 3 of the Appendix).[11]

We applied this measure to ordinary least squares linear models for each country included in the study, to assess the importance of several predictors of health system satisfaction in the United States and other high-income countries. We then plotted the cross-national distribution of relative importance values for each variable to compare the importance of variables in the United States and abroad.

We ran a separate series of ordinary least squares regression models to more closely examine how the studied variables related to system satisfaction within the United States and to explore how attitudes and experiences may mediate the role of insurance coverage and other sociodemographic variables in system satisfaction. The covariates included the attitudes and experiences described above as well as sex, age, income, education, self-reported health, and insurance status.

In sensitivity analyses, we applied similar metrics to ordered logistic models to account for the ordinal format of the outcomes. While some individual results were affected by model selection, our overall conclusions were unchanged (see sections 4.c and 4.e in the Appendix).[11] We report ordinary least squares results in this article for ease of interpretation of the "variance explained" metric.

Study Results

A little over half of US respondents expressed some degree of satisfaction with their country's health care system (Exhibit 1). Only Portugal, Japan, and the Slovak Republic had lower satisfaction levels.

However, the United States did well on several more specific items. Satisfaction with the most recent health care experiences was high in the United States relative to other countries, with 57 percent of US respondents either very or completely satisfied with their last visit to a doctor and 60 percent either very or completely satisfied with their last visit to a hospital (Exhibit 2). The United States ranked among the top three countries for both measures.

Sixty percent of Americans felt confident that they would get the best treatment available if they were seriously ill, which was about average among countries (Exhibit 3). Sixty-three percent of Americans felt confident that they would get the doctor of their choice if they were seriously ill, a higher percentage than in most countries.

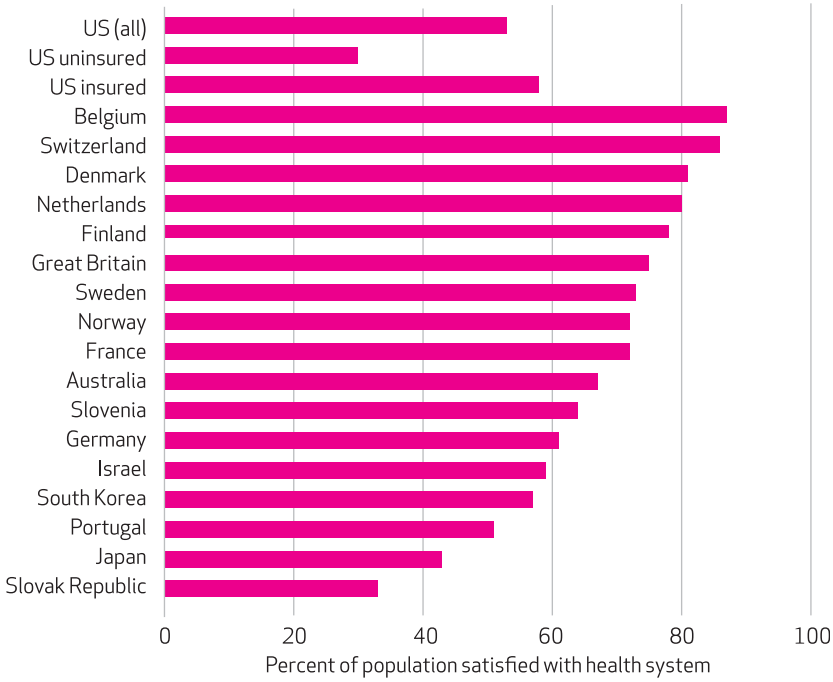
US respondents struggled with costs more than those in other countries, with 11 percent reporting not getting needed treatment in the past year because of cost (Appendix Exhibit A9).[11] However, when the uninsured were excluded, that rate dropped to 7 percent, which is more in line with the 5 percent average for the other countries. Conversely, only 2 percent of people in the United States said that they had not gotten treatment in the past year because waiting lists to receive treatment were too long, which was less than the average of 8 percent in other countries.

We next calculated for each country the relative importance of the individual studied variables to overall health system satisfaction. Then we compared the results for the United States with the averages and interquartile ranges for the other countries studied.

We found that security in accessing most-preferred care was more important in explaining overall satisfaction in the United States than in other countries, whereas satisfaction with recent health care experiences was less important (Exhibit 4). In particular, confidence in accessing the best care available explained more variance in ratings of system satisfaction in the United

EXHIBIT 1

Health system satisfaction, 2011–13



SOURCE Authors' analysis of data from ISSP Research Group (Note 10 in text). **NOTE** The percentages of populations "satisfied" consist of respondents who reported being "fairly satisfied," "very satisfied," or "completely satisfied" in response to the question, "In general, how satisfied are you with the health care system in [your country]?"

States than did satisfaction with a recent hospital or doctor visit—which in most countries was the most important predictor of overall satisfaction. (For a breakdown of the independent contributions to effect size and measure variance for each measure, see Appendix Exhibit A10.)[11]

As expected, having experienced a cost barrier also mattered more in the United States than in other countries (Exhibit 4). We conducted a separate relative importance analysis by insurance status and found that these patterns were even more pronounced among the uninsured in the United States than the insured (Appendix Exhibit A13).[11] Having experienced a cost barrier was a stronger driver of overall satisfaction among the uninsured than the insured, as was access to most-preferred care, whereas satisfaction with recent health care experiences remained less important. Conversely, the insured in the United States were more similar to citizens of the other seventeen countries. Nonetheless, the basic pattern was unchanged, and access to most-preferred care remained the top concern of insured Americans.

To better understand the distribution of these three categories of determinants within the United States and their relationship to insurance status and generosity, we compared responses among the insured and uninsured as well as responses among people in sociodemographic groups with better access to health care and responses of people in groups with worse access.

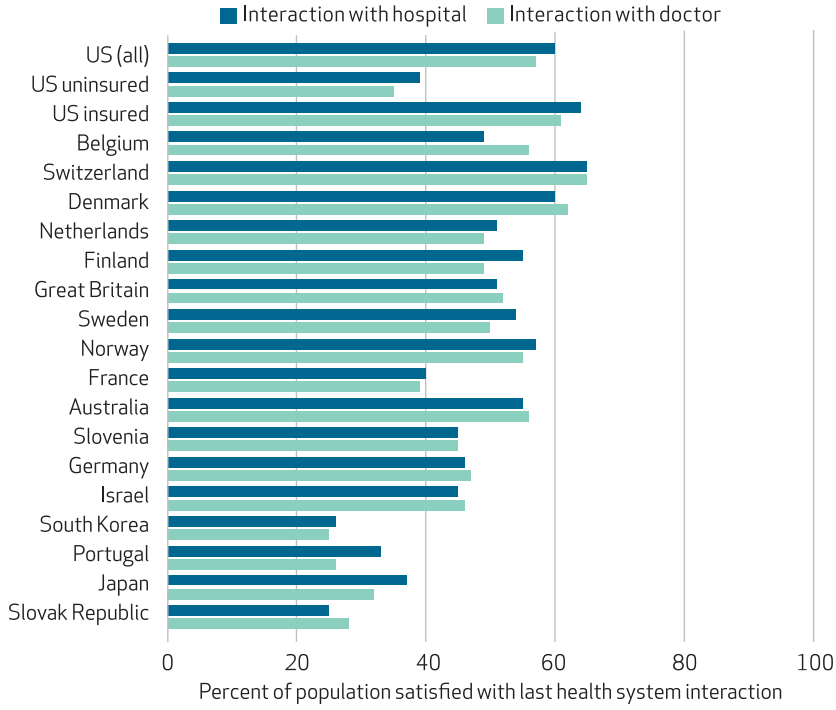
As expected, the uninsured in the United States were significantly less satisfied with the system than the insured were (30 percent versus 58 percent) (Exhibit 5). This gap coincided with dramatically more negative experiences and attitudes among the uninsured than the insured. Nearly a third of the uninsured reported having forgone necessary care because of cost, over four times the rate among the insured. The uninsured felt significantly less confident about accessing their most-preferred care, being far less confident that they would receive the best treatment if seriously ill or be able to see the doctor of their choice, and they tended to be much less satisfied with their most recent interaction with the health care system. The differences in feeling confident about getting the most-preferred care between the insured and uninsured (34 percent for best treatment and 41 percent for doctor of choice) were the largest for any variable studied.

System satisfaction in the United States was also significantly higher among older adults than people younger than sixty-five and among those with higher incomes than those with lower ones (Exhibit 5). These higher satisfaction rates were accompanied by better overall health care experiences and perceptions, particularly in the areas of insurance and perceived access to most-preferred care. In particular, compared to people younger than age sixty-five, older Americans reported very high rates of insurance (because of Medicare) and greater certainty of getting the best treatment available and their doctors of choice. Among the insured, Americans ages sixty-five and older continued to have higher certainty in these concerns and were more satisfied with the health system overall than those under sixty-five (data not shown).

In multivariate models, greater age and income were associated with greater satisfaction, and higher education was associated with lower satisfaction ($p < 0.01$) (Exhibit A11 in the Appendix).[11] It is notable that the results for age and income were independent of insurance status, although they were strengthened in models that excluded insurance status (data not shown). Having experienced a cost barrier was associated with lower satisfaction ($p < 0.01$). Greater confidence in getting the best care available and the doctor of choice were both associated with higher satisfaction ($p < 0.001$ and $p < 0.01$, respectively), as was greater satisfaction with one's

EXHIBIT 2

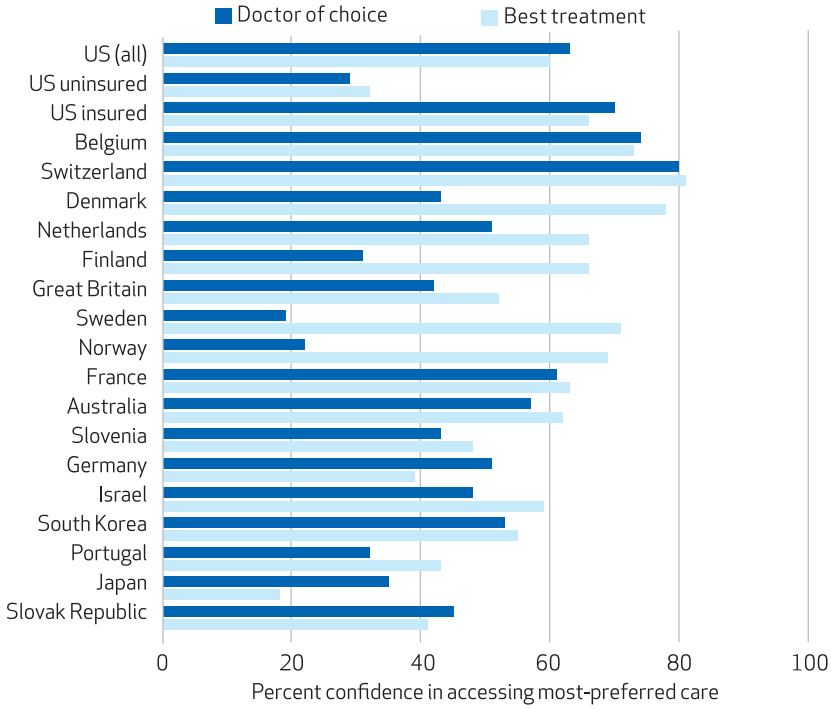
Respondents' satisfaction with last health system interaction, 2011–13



SOURCE Authors' analysis of data from ISSP Research Group (Note 10 in text). **NOTES** The percentages of populations "very satisfied" consist of respondents who reported being "very satisfied" or "completely satisfied" in response to the questions, "How satisfied or dissatisfied were you with the treatment you received when you ["last visited a doctor" and "were last in hospital"]?" The proportions shown for each question exclude respondents who indicated that they had not received treatment from a doctor or in a hospital.

EXHIBIT 3

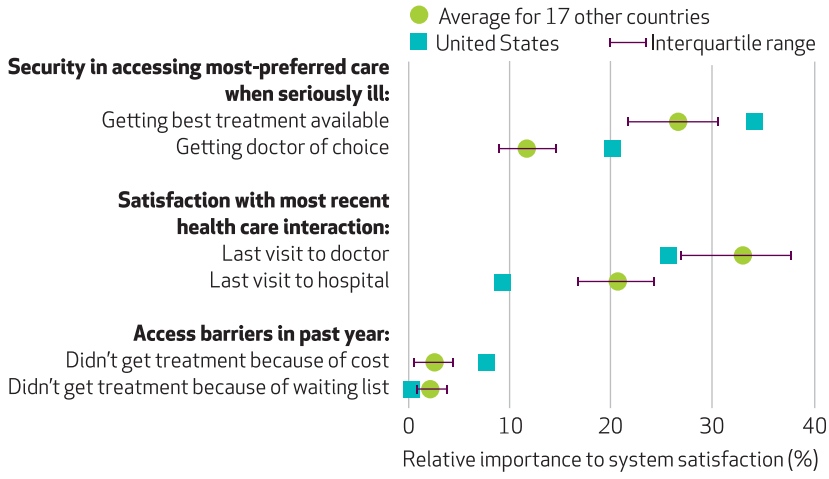
Respondents' confidence in accessing most-preferred care, 2011–13



SOURCE Authors' analysis of data from ISSP Research Group (Note 10 in text). **NOTE** The percentages of populations "confident" consist of respondents who reported that it was "likely" or "certain" when asked, "How likely is it that if you become seriously ill, you would get ["the best treatment available in (your country)" or "treatment from the doctor of your choice"]?"

EXHIBIT 4

Relative importance of individual variables to overall health system satisfaction, 2011–13



SOURCE Authors' analysis of data from ISSP Research Group (Note 10 in text). **NOTES** Relative importance refers to the percentage of a country's system satisfaction model that is accounted for by a variable. It relates to how important that variable is in explaining system satisfaction in that country relative to all other variables included in the model. The full analysis included two other access barriers: did not get treatment because of work and did not get treatment because it was unavailable. The results for these two barriers were near zero and are not shown.

last visit to a doctor ($p < 0.01$). The full model (including all covariates) explained roughly 30 percent of total variation in system satisfaction.

Both insurance status and self-reported health status were strongly associated with system satisfaction in more restrictive models, but they became statistically insignificant in the full model. This suggests that the negative impact of these variables was mostly mediated by the associated attitudes and experiences included in the model. In the case of insurance status, over 70 percent of its association with health system satisfaction was removed when the model included access to most-preferred care (Appendix Exhibit A11).[11]

Discussion

For years the Commonwealth Fund has fielded international surveys that use mostly objective measures of patient experience. The surveys have found that the United States underperforms its peers along many dimensions of cost, access, and quality and that Americans are more in favor of major system reform than are people in other countries.[2] In spite of these findings, researchers using the Commonwealth Fund data did not find the desire for system change in the United States to be very sensitive to performance on these measures, even measures of affordability—which leaves the determinants of desire for system change within the United States mostly unexplained.[3] Using a different data source and more subjective measures of personal care and satisfaction, we have taken a new look at potential drivers of satisfaction in the United States and have offered evidence on the ways in which that country differs from its peers.

Comparing results for the United States and international averages, we found that access-related concerns played an outsize role in determining system satisfaction in the United States and that confidence in accessing one's most-preferred care mattered in particular to Americans. Conversely, satisfaction with recent health care experiences, which tended to be the most consequential to system satisfaction abroad, mattered less in the United States.

One possible explanation for the dominance of access-related beliefs over experiences with care in the United States is the structure of the health insurance system. In other high-income countries, where access to health care is more uniform and minimum standards guarantee that most people receive health care of a certain quality, access to one's top choices may be perceived as less pressing, and recent individual experiences in the health system become more salient. The

EXHIBIT 5

Health system satisfaction and related experiences and perceptions in the United States, 2011–13

		Access barriers		Confident of getting:		Satisfaction with last health system interaction	
	Satisfied with the system	Insured	Did not experience a cost barrier	Best treatment	Doctor of choice	Doctor visit	Hospital visit
AGE (YEARS)							
Under 65	48%	79%	87%	56%	57%	84%	65%
65 and older	74	99	96	79	85	95	83
Difference[a]	26	20	9	23	28	11	18
INCOME PERCENTILE							
Under 70th	50	78	85	53	58	82	69
70th and higher	59	94	96	74	73	93	68
Difference[a]	9	16	11	21	15	11	-1
INSURANCE STATUS							
Uninsured	30	—[b]	68	32	29	68	53
Insured	58	—[b]	93	66	70	89	72
Difference[a]	28	—[b]	25	34	41	21	19

SOURCE Authors' analysis of data from ISSP Research Group (Note 10 in text). **NOTE** The proportions shown for satisfaction with last health system interaction exclude respondents who indicated that they had not received treatment from a doctor or in a hospital. [a]Percentage points. [b]Not applicable.

wide range of insurance coverage in the United States creates more significant gaps in the kinds of care that individuals can obtain, compared to those in other high-income countries.

This explanation is consistent with research that shows deep concerns in the United States over insurance-related economic security.[15] Wider variation in and less certainty about coverage in the United States compared to other countries may therefore explain the greater importance of access to most-preferred care and the diminished importance of recent health care experiences.

An analysis of subgroups within the United States offered further insight into the relationship between confidence in accessing most-preferred care and insurance status. More than any other sociodemographic variable, insurance status had the largest influence on whether people believed that they would get their most-preferred care. Americans without any coverage were also the group that was the least satisfied with the system. Model comparisons showed that the association between having insurance and system satisfaction largely disappeared when access to most-preferred care was accounted for, although this was not the case with the other variables studied. Therefore, among the variables analyzed, the higher system satisfaction associated with having insurance can be mostly explained by the greater confidence that the insured have in obtaining their preferred treatments from their preferred providers when needed.

These expectations are not a matter of simply having insurance; they are also related to the type of insurance held. The patchwork of public and private sources of insurance and the wide variation in insurance generosity in the private market create large differences in the comprehensiveness of coverage among the insured. It is perhaps because of this that access to most-preferred care remained the top predictor of system satisfaction, even among Americans with insurance.

Similarly, while very high satisfaction among people ages sixty-five and older may be partially due to universal access to Medicare, higher satisfaction in this age group does not appear to be simply a matter of having insurance. System satisfaction among the elderly was significantly higher than among the insured nonelderly, which suggests that the generosity and security of Medicare coverage may also play a role. Previous research has found that age is positively correlated with several domains of life satisfaction, although these effects are too modest to fully account for the differences we observed.[16]

Opinions in the United States about personal care and access appear to present a paradox. Despite relatively high confidence in getting their health care choices and satisfaction with recent visits to doctors and hospitals, Americans report low levels of system satisfaction overall. However, this is a paradox only if we assume that the way in which these feelings relate to system satisfaction is the same from country to country.

Expectations of individual dimensions of sys-

tem performance such as waiting times and access to the most advanced care have been found to be somewhat higher in the United States than in other countries.[1,17] Americans have also long been thought to have high expectations of choice and other features of health care consumerism, and health care satisfaction has been found to be linked to some degree of choice—particularly choice of physicians.[18,19] Furthermore, the importance of these dimensions can vary significantly both across and within countries, as the evidence presented in this article suggests.

It should be noted that the data used in our study were collected while health reform in the United States was being debated, which may have affected respondents' views of the health system. Nonetheless, the six-month data collection window of the General Social Survey insulates results from short-term fluctuations in opinion that may have occurred because of media coverage, and the gap in views of the system and personal care that we observed is consistent with survey results before passage of the Affordable Care Act (ACA).[15]

This study did not explore why overall system satisfaction is lower in the United States than in other high-income countries. Countrywide conditions or attitudes may affect overall satisfaction in ways that this study could not observe. Research has found, for example, that higher health expenditures and a larger primary care workforce per capita are associated with higher public satisfaction, possibly through their impact on system responsiveness.[4] However, understanding and comparing what accounts for variation in satisfaction within countries may provide clues about the kinds of reforms that stand to make the largest impact on public satisfaction within various country contexts.

It is also important to note that our research focused only on perceptions of personal access and care satisfaction, which represent a small subset of questions that are relevant to health system satisfaction. In particular, we lacked data on respondents' beliefs about health care quality, affordability, and equitability. We also did not observe variations in types of insurance, which would have enabled closer examination of fragmentation in insurance as a potential cause of our results. Regardless, we believe that access to one's most-preferred care and recent health care experiences are important areas of contrast and should be of interest to researchers and policy makers seeking to understand how system satisfaction and constituent attitudes are related.

Policy Implications

Our research found that the concept of access to most-preferred care is particularly salient to Americans' satisfaction with the US health care system. This research also underscores the important role that variation in insurance coverage and type in the United States may play in system satisfaction, in part through that variation's role in giving people security about being able to exercise health care preferences when needed. Therefore, reductions in the uninsured population resulting from the ACA may marginally improve system satisfaction.

The concept of access to most-preferred care is particularly salient to Americans' satisfaction with the US health care system.

Overall gains could be limited, however, since the reductions affect only a small segment of the population, and the types of insurance that people are acquiring tend to be less generous and more restrictive than what has been available through employers.[20] Broader improvements in satisfaction will likely require addressing the concerns of the insured as well as those of the uninsured, and the importance of Americans' access to their top preferences indicates that this may involve issues of network adequacy and treatment availability.

Requirements of the ACA meant to improve insurance quality, such as minimum standards for benefits and value, may improve satisfaction to the extent that they place a lower bound on the adequacy of coverage. However, whether these standards will have a meaningful impact on coverage variation remains to be seen. Policy makers should continue to monitor the adequacy of plans both in and out of state and federal exchanges in the face of these changes.

Conversely, existing trends in US health policy may be hitting a nerve that has particular relevance to system satisfaction. As medical technology advances, costs rise, and insurance plans become more restrictive with respect to provider networks and cost sharing, more and more Americans may perceive themselves to be locked out of high-quality care. In the 1980s and early

1990s, rapid changes in the health insurance market toward managed care caused a public backlash that led to a flurry of state consumer protection laws and shaped the national debate over health insurance reform. Researchers found that chief among the reasons for this backlash were concerns that managed care would not pay for or provide desired treatments in cases of severe illness.[21] Our findings regarding the drivers of system satisfaction in the United States suggest that insurance trends that threaten perceived access to preferred treatments or doctors at critical times could elicit a similar reaction.

Conclusion

Our findings raise particularly troubling questions about the implications of health care equity as it relates to variation in the types of health insurance that Americans can obtain. Changes in insurance that threaten to widen the gaps in access to and perceived quality of care between more and less privileged Americans may serve to increase the number of people who feel that their health care preferences are out of reach. Future research should focus on the role that variation in insurance types may play in system satisfaction and how inequality, both real and perceived, in health care access and quality in the United States may factor into the mechanisms of system satisfaction we have highlighted here. ■

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NOTES

1 Blendon RJ, Benson J, Donelan K, Leitman R, Taylor H, Koeck C, et al. Who has the best health care system? A second look. Health Aff (Millwood). 1995;14(4):220–30.
2 Schoen C, Osborn R, Squires D, Doty MM. Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries. Health Aff (Millwood). 2013;32(12):2205–15.
3 Papanicolas I, Cylus J, Smith PC. An analysis of survey data from eleven countries finds that "satisfaction" with health system performance means many things. Health Aff (Millwood). 2013;32(4):734–42.
4 Wendt C, Mischke M, Pfeifer M. Welfare states and public opinion: perceptions of healthcare systems, family policy and benefits for the unemployed and poor in Europe. Cheltenham (UK): Edward Elgar Publishing; 2011.
5 Blendon RJ, Altman DE. Voters and health care in the 2006 election. N Engl J Med. 2006;355(18):1928–33.
6 World Health Organization. Everybody's business: strengthening health systems to improve health outcomes. Geneva: WHO; 2007.
7 Christensen T, Lægreid P. Trust in government: the relative importance of service satisfaction, political factors, and demography. Public Performance and Management Review. 2005;28(4):487–511.
8 Ulbig SG. Policies, procedures, and people: sources of support for government? Soc Sci Q. 2002;83(3):789–809.
9 Jacobs LR. The health of nations: public opinion and the making of American and British health policy. Ithaca (NY): Cornell University Press; 1993.
10 ISSP Research Group. International Social Survey Programme: Health and Health Care—ISSP 2011. Cologne: GESIS [cited 2016 Jan 25]. (ZA5800 Data File Version 2.0.0). Available from: https://dbk.gesis.org/dbksearch/sdesc2.asp?no=5800
11 To access the Appendix, click on the Appendix link in the box to the right of the article online.
12 Johnson JW, Lebreton JM. History and use of relative importance indices in organizational research. Organ Res Methods. 2004;7(3):238–57.
13 Lindeman RH, Merenda PF, Gold RZ. Introduction to bivariate and multivariate analysis. Glenview (IL): Scott, Foresman; 1980.
14 Groemping U. Relative importance for linear regression in R: the package relaimpo. J Stat Softw. 2007;17(1):1–27.
15 Blendon RJ, Brodie M, Benson JM, Altman DE, Buhr T. Americans' views of health care costs, access, and quality. Milbank Q. 2006;84(4):623–57.
16 George LK, Okun MA, Landerman R. Age as a moderator of the determinants of life satisfaction. Res Aging. 1985;7(2):209–33.
17 Donelan K, Blendon RJ, Schoen C, Davis K, Binns K. The cost of health system change: public discontent in five nations. Health Aff (Millwood). 1999;18(3):206–16.
18 Lambrew JM. "Choice" in health care: what do people really want? [Internet] New York (NY): Commonwealth Fund; 2005 Sep [cited 2016 Jan 7]. (Issue Brief). Available from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2005/sep/choice–in-health-care–what-do-people-really-want/lambrew_853_choice_ib-pdf.pdf
19 Francis LP. Consumer expectations and access to health care. Univ Pa Law Rev. 1992;140(5):1881–917.
20 Gabel JR, Lore R, McDevitt RD, Pickreign JD, Whitmore H, Slover M, et al. More than half of individual health plans offer coverage that falls short of what can be sold through exchanges as of 2014. Health Aff (Millwood). 2012;31(6):1339–48.
21 Blendon RJ, Brodie M, Benson JM, Altman DE, Levitt L, Hoff T, et al. Understanding the managed care backlash. Health Aff (Millwood). 1998;17(4):80–94.