after levothyroxine therapy initiation would have had to have been unrecognized by health professionals over several years and therefore is likely to represent only a small number of individuals.

Jolobe is also right to draw attention to the risk of overreplacement with levothyroxine in precipitating a transition from paroxysmal to persistent atrial fibrillation, which would certainly outweigh the benefits of replacement therapy, especially when the hypothyroidism is subclinical and the patient is elderly.

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HEALTH CARE REFORM

Access to Primary Care in England

To the Editor As in the United States, the availability of primary care appointments is prominent in current policy discourse in England. The United Kingdom government recently announced that approximately 14% of primary care practices in England, serving a population of 7.5 million, will begin to offer appointments from 8 AM to 8 PM, 7 days a week.[1] This intervention has arisen owing in part to the perception that appointment availability is insufficient and could result in greater utilization of emergency departments.

According to the GP Patient Survey 2012-2013, a national, validated survey of adults in England, 89% of patients were able to obtain a primary care appointment on their last attempt to do so.[2] Of these patients, 92% were offered a convenient appointment, and 85% saw a primary care physician or nurse within 1 week.[2] However, availability varies considerably between primary care practices; the minimum and maximum percentages of patients who received an appointment on their last attempt were 40% and 100%, respectively.[2]

In 2012-2013, the GP Patient Survey obtained 0.97 million responses, corresponding to approximately 2% of the English population.[3] Although the response rate was relatively low (35%), a weighting scheme was applied to the responses to account for the possibility of nonresponse bias and ensure representativeness of the eligible population.[3] A simulated patient study similar in design to that reported by Rhodes et al[4] has demonstrated the construct validity of measures of access derived from the GP Patient Survey.[5]

Compared with the results presented by Rhodes et al,[4] wait times for appointments in England are typically shorter than in the sampled US states, for both privately insured and Medicaid patients. Furthermore, appointment availability seems greater in England than for Medicaid and uninsured patients in the United States. Because all residents of England can receive primary care without charge at the point of use, patients in this country also benefit from protection against unaffordable appointment costs and, theoretically, greater equity in appointment availability across socioeconomic groups.

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In Reply The letter from Cowling and colleagues underscores that ensuring timely access to care is a challenge for health systems around the world. The United Kingdom (UK) has received high marks for access to primary care in cross-national comparisons of health systems.[1] This is confirmed by the GP Patient Survey, which found that patients in the UK are able to obtain primary care appointments in less than 1 week on average.[2] Higher levels of access in the UK have been explained by several structural and organizational factors. First, while the United States and UK have a similar ratio of physicians per population, a much higher fraction of these physicians provide primary care in the UK compared with the United States.[3] Second, the UK National Health Service assigns patients to a regular primary care clinicians—a practice that has historically been limited to managed care plans in the United States. Finally, the presence of a salaried clinician workforce operating within a universal insurance coverage scheme in the UK reduces financial barriers to care for patients and promotes higher supply of health care services in low-income communities.

Considering the UK experience will be valuable for US policymakers, as the Patient Protection and Affordable Care Act has intensified pressure to reorganize primary care. For example, insurance plans are increasingly steering patients toward preferred clinicians using autoassignment and narrow networks. These strategies can streamline the care-seeking experience for patients and lower costs but may also limit choice. The increasing use of chronic disease management programs led by mid-level clinicians in the UK may also increase the ca-