	England	Germany
Strengths	There is universal coverage of the population. Healthcare is free at the point of access & is paid for out of general taxation. No need to apply year after year for care costs when it is clear that a patient needs ongoing nursing home care or home care). Everybody who has lived in the UK for 6 months is entitled – irrespective of nationality – so fair. Clinicians are not paid by what they do, so they don't order unnecessary tests. Any resident of the UK can register with the local GP and can access the service of the surgery without payment. The NHS doesn't expect patients to keep detailed records of their own health issues. Comprehensive records are held by GPs for all patients (and accessible via the NHS app obviously for the IT minded). The fact patients don't have to keep their own records is really helpful for the ill, elderly and disabled. The NHS handles appointments on behalf of patients, obviously this can be a hindrance, but again patients aren't expected to source and book their own secondary care appointments which could be difficult for some patients. In general the pathways for 2 week wait type appointments for suspected cancer are excellent. For example if a woman has a breast lump, they will be seen at a 'one stop' clinic appointment within 2 weeks. A clinical assessment,	Good range of medical methods, modern equipment in most hospitals and practices. When it matters, rapid action is possible both in emergencies and in cases of tumour diseases, for example. Preventive medical check-ups are available in several areas.

mammogram and ultrasound and biopsy if needed will all take place on the same day, without the patient having to co-ordinate anything.

UK primary care generally includes GPs and nurses obviously, but also access to district nurses, health visitors, midwives and pharmacists, and often other clinical staff and this means patients get coordinated care from the best person i.e. you don't get a GP guessing how to dress a wound! Provided staffing is adequate obviously.

The way primary care is organised and the standard IT systems used, mean lots of research can be done on the data they collectively hold on patients. This wouldn't be possible in a more fragmented health service.

The way the NHS is organised means there can be tertiary centres of excellence where unusual pathology can be escalated to and managed by specialist centres who are familiar with the unusual.

Direct taxation in theory means no taxpayer money diverted into managing an insurance/co-payment model. In theory this makes the NHS the most financially efficient type of healthcare provided.

Generally good quality care.

Corporate negotiation for medications has been very good to drive the cost of medications down for the NHS.

Free at the point of need for all, funded by all through taxation, from cradle to grave.

There is much less administration to be done by clinicians.

Much cheaper for the economy to not have to spend so much on overheads like health insurance.

Much clearer assessment of clinical need rather than wish and technical ability when diagnosing and treating patients.

This also allows very candid end-of-life care planning with agreed "ceilings of care".

As it is a national ([redacted]) system, the communication between GPs and all [redacted] hospitals is much easier. A lot of the computer systems are the same and can be viewed from lots of places. The unique patient number is nationwide and therefore transfers are easy. Cancer registries etc. are complete and easily accessible to all. Statistics are often much more reliable. As a clinician, I am much less tempted to fiddle the numbers.

Specialist services are delivered by hospitals only. All specialists working within a hospital setting providing out-patient and in-patient work. There is no fragmentation between in-hospital treatment and any follow-up. One can establish communication between all the different specialities straight forwardly. There are clear referral pathways to any tertiary care needed in larger hospitals. Transfers are therefore fairly easy forwards and backwards.

All specialists of each sub-specialisation are on equal terms and would usually each treat their own patients with cross-cover out-of-hours. The overall policies need to be agreed within and among the departments. This allows for a lot of discussions among clinicians and a lot of exploration of evidence and different approaches.

As hospital departments within hospitals work so very similarly, it is easy for trainees and young doctors (now called resident doctors) to move between departments and hospitals during their training. The training is usually nationally or regionally organised with a lot of rotating but run-through schedules which allows for planning and supporting trainees throughout their journey.

Named GP continuity of care.

Traditional GP partnership.

Flexibility, allied Health Professionals working/consulting with patients in the GP practice.

All GP practices computerised.

Electronic prescribing, paper-free from GP to pharmacy.

The NHS app gives patients access to their medical records, medication, test results, allows them to order repeat prescriptions and allows some limited communication to and from the surgery and access to online NHS 111 urgent triage algorithms.

Routine screening for a variety of conditions is well developed and coordinated regionally e.g. 2 yearly FIT testing for bowel cancer screening in the over 50s.

Weaknesses

Free access does not mean freely available.

Access to outpatient consultations with a hospital consultant can involve a ridiculously long wait and an even more ridiculous wait for a procedure to be carried out. For example the waiting time to see a surgeon about gall bladder symptoms was 44 weeks.

For a lot of hospital procedures the service has in effect been privatised unless you want to wait a very long time although of course not everyone can afford to go privately.

Access to GPs can be time-consuming and slow.

There is a tendency towards micro management and over regulation in the NHS which reduces the amount of useful work done.

There has been a constant refrain for many years in the NHS for improved IT systems and for systems that are more linked up. A lot of money has been spent but the results so far have not been great.

When doctors (and patients) talk about the German healthcare system, they can only conclude that we in Germany are heading for disaster: we have too few contributors and too many beneficiaries.

What costs nothing is worth nothing: here, an insured person pays nothing at all if, for example, they receive an MRI scan (in [redacted], you first pay a 'franchise' and then 10% of each treatment/examination, and in certain cases even more).

Patients take advantage of the emergency service (which costs nothing and has little waiting time) to have their ears irrigated...

Doctors respond to the system by, for example, closing their practices for the last 2-3 weeks of the quarter because the budget is full and they would have to work for free.

Doctors are increasingly subject to budgetary constraints: CAVE prescriptions for remedies, CAVE certain medications, etc. A bureaucratic monster ensures that processes are carried out and recourse is taken, from which doctors have to laboriously extricate

UK GPs are primarily funded by capitation payments from the government, which can mean a lower income in international comparison, more administrative burden, and a greater role for other team members like pharmacists in delivering care.

The rationing of access in the UK is something unimaginable to [redacted].

There is no benefit for the practice in the UK when a dissatisfied patient registers with them. In the UK, "doctor shopping" is discouraged.

Modern healthcare is a victim of its own success. Every time we prevent a death, we open the flood gates to that patient requiring further expensive treatment – death at 40 prevents a lot of expenditure.

Waiting times longer. Systems that people can't navigate, everybody trying to reduce their own workload, resulting in increasing work and slower patient journeys.

[redacted] had a [redacted] in 2019, referred, seen in 2021. The first time the surgeon didn't turn up to the appointment. The second time he said it had to be done in a different (i.e. general not community) hospital. The third time he was sent to a primary care hernia centre – who said he needed a district hospital, then he was sent to a private hospital, who said… then they did it – in Dec 2023.

A patient who went to the local Emergency Department (ED), was told he had a urinary tract infection (UTI) and was sent to the out-of-hours care (OOH) next door. They sent a urine sample and told him to contact his own General Practitioner (GP) for the result. The surgery said you need to call OOH – they did it. So he called out of hours – but his surgery is on the border of 2 – physically near to one and within the actually boundaries of the other. So he was out through to another service who couldn't help. Thus a 5 minute job for 1 GP turned into a 2 day failure for the patient to get results themselves instead of being able to continue treating patients during this time.

Appointments with specialists are becoming increasingly restrictive, with waiting times of four months or more for acute complaints in some cases… simply because too many patients are overwhelming the system (migration…).

Germany is no longer a good place for doctors.

But it is for patients who have never paid in and have no money.

Services are budgeted to keep the system financially viable. This is done on a flat-rate basis, and both hospitals and practices are used to implement these cutbacks. Politicians vaguely mention that many things are not financially viable, but always claim that there should be no cuts in services.

However, service cuts would make sense in several areas, e.g. when patients visit emergency rooms for absolute trifles or call the fire brigade for transport when this is not necessary (e.g. minor finger injuries in the home). Sanctions are then imposed not on the patients who caused them, but on the community of insured persons in general (see above), and doctors/nurses have to convey this.

involving several hours of patient effort/anxiety, and several other admin and healthcare professionals (HCPs).

You can imagine that if this is happening all over, it is not surprising that the waiting lists are getting longer despite people working harder. Each time he had to wait several weeks for a GP appointment and then get re-referred and join the waiting list again – work for the whole system, and unfair because he wasn't to blame for the wrong referral.

Similar – a patient phoned the GP for a prescription and the receptionist said he needs a medication review first – not until after the Easter weekend. Booked in, but would need to contact OOH for some doses for the weekend. He called Friday – not urgent and a busy weekend, so took until Sunday for a triaging doctor to call him. He called twice more in that time. How many more people and how much more time was involved there?

Or an outpatient clinic appointment. The patient was discharged in error. It wasn't possible to reinstate him by calling the booking office. I sent 4 emails and made 2 phone calls. In the end I had to write to the GP, explain what had gone wrong and ask her to re-refer the patient, and apologise because it was all so pointless.

And to doctors – we have to do job plans, to ensure we aren't saying we do more work than we actually do. Apparently this applies to a small percentage of the workforce.

They have to employ a number of people to manage this system. Mine (still ongoing) was started in Jul 2024, and an updated (better paying) contract depends on it. The consultant paid to confirm it took 7 months – then they sent me another one within a week of her signing it. Then they refused to pay me for what I was doing because they couldn't afford it. So why spend all the money on doing it?

... an idea of what our system does well - albeit it is creaking somewhat just now.

Unfortunately the NHS has big issues with underfunding and understaffing and major training bottle necks for Drs in training, despite the shortage of GPs and specialists. It seems the government simply doesn't want to fund Drs!

This means those currently in post are doing more than one person's job and considering cutting hours/emigrating/retiring.

Patients seen before such as just discharged are not allowed back into ward that they have been discharged from so forced back into acute admissions through Accident and Emergency.

GP's were allowed to stop doing on call so emergency care channelled through Accident and Emergency so the latter is completely overwhelmed.

Cancer patients are channelled through multidisciplinary teams (MDT's) which produces significant delay and is overly bureaucratic.

Unnecessary specialisation leading to shortages of super specialists e.g. how many specialists exist for ophthalmology? Answer 12!

Manpower shortages.

A lot of health care is looked at with protocols and guidelines. If your case does not fit into this, it can become difficult. It avoids duplication, but can sometimes lead to missing things.

The whole system is geared to a minimalistic approach, especially when it comes to funding equipment, logistics and hardware.

Getting new technology like MRI or other scanners etc. can be extremely frustrating and time and effort consuming and one has to be very patient ....

All this leads to very long waiting times for nearly everything you want to do for your patients.

One is a juggler of sparsity and often has to have careful discussions with colleagues to reach fair decisions for all patients.

The other bit is that there is not much incentive to work very efficiently and effective, The system can be exploited by people who want to go slow.

A big incentive especially in operative specialities is where people can work full-time in the NHS and then have a private practice out-of-hours. So, if people have to wait too long for their procedure on your NHS list, they may be tempted to see you privately...

Some of the statistics seem to show that the UK may have a worse out-come in cancer care or similar compared with the rest of Europe.

As the UK NHS is always keen to try to do things cheaper, it has looked into having “allied health professionals” to do things that usually would have been under the remit of doctors.

We were promised by Toni Blair that we would be paperless by 2000. That has not happened. The various computer systems that we use are not very practical for the users and do not always talk with each other. It can be very fragmented and time consuming to do even menial tasks.

Multiple reorganisation of local primary care management/oversight/administration over the years.

GP unemployment.

Overworked GP practices (also secondary care)/stretched funding.

Debate about the appropriate mix of GP face-to-face consultations vs telephone/remote consultations vs email questions and answers.

Lack of fully compatible computer systems/data sharing across primary and secondary care.

Only England charges the patient directly for prescription medication.

Communication from hospitals to patients and ergo to GPs (they receive the same cc letters) can be poor.

Opportunities

There is a lot of potential in improved IT.

Efficiency improvements.

A review of regulatory and monitoring requirements

If there is a shortage of medical personnel then more need to be trained with sufficient opportunities for specialist training.

Coordination, common sense – not having competent administrative people that prevent clinicians doing.

The abolition of NHS England and reduction in management may help by reducing people who take up clinicians' time with non-clinical pointless things – forms to fill out etc.

Maybe we actually need to face the possibility of rationing – should we pay for £100,000 treatments which provide 6 months of cancer palliation? Should we pay for expensive fertility treatments when children are dying of asthma? Who decides?

Opening up more private healthcare would reverse the super specialisation as this would be an opportunity to make money preferably in the NHS. This is already beginning to happen but not in the NHS at present.

Overseas patients coming to purchase care is only really occurring in London presumably where the cost of living is high. Doctors around the country aren't getting involved in this presumably because they are too comfortable. NHS indemnity would probably be needed.

Large and reliable statistics. This is at the moment the big buzz for politicians as a lot of companies would like to have access to Big

Creation of a sensible control system to avoid unnecessary examinations, treatments and use of the system. Public discussion without regard to political sensitivities about the possibilities and measures that cannot be financed.

Introduction of a primary care system, preventing direct access to specialists. Sanctions for patients who want to demand unnecessary treatments and trips to emergency rooms.

	Data. This can be good for health research, but I think the future will be in Artificial Intelligence doing more and more diagnostics. NHS 10 Year Plan?? AI. Technology.	
Threats	Changing the funding model may mean that part of the population receives even less health care than at present. This has already happened with NHS dentistry. Increasing use of IT to access health care may disadvantage some sectors of the population if not carefully managed. The NHS may have to reduce what it does if funding and efficiency do not improve. The 10 year plan – came out this year – is increasing digitalisation – and thus health inequities for those who already struggle. E.g. people who struggle to get an appointment because a surgery only allows online appointments, or e-consults. Continual efficiency drives aging population – fewer workers, more ill-health. Corporate negotiation for medications may have gone too far so there is a withdrawal of drug development in the UK because the profit margins are too low. Trump's tariffs are not helping here. The younger doctors are much less tolerant of work than the older generation this will not help the NHS. Privatisation. Brexit: this has not really been a success for the NHS. It has cut off a lot of exchange between the EU and UK of health care workers and researchers and funding for research.	The greatest risk is the continuation of the current system without fundamental changes to eligibility.

We are experiencing a lot of random medication shortages.

Underinvestment: austerity is a big theme. Healthcare is classified by politicians as not affordable. Delays in investments for new technologies and new medications leads to very dissatisfied patients and workforce.

Pharmaceutical companies and other researchers moving away from Britain.

Change, change, change!

NHS 10 Year Plan/reorganisation (yet again) — Primary care and social care working to be combined into "Neighbourhoods", each one consisting of tens of thousands of patients and thus bigger than any one GP practice. GPs are not yet sure how they will fit into their supposed role of helping to run these super-sized services and suspect that it may involve salaried service as NHS employees and the end of GP partnerships as independent contractors to the NHS.

Staffing levels (risk of British brain drain going abroad).

Working hours — most GPs in England no longer provide their own out of hours care (18:30 to 08:00) directly, but hand over to out of hours services.

Taxation/NHS pensions: there has been a recurring risk of earnings reaching a critical mass where earning more crosses a cliff edge and actually results in such a big tax bill that the take-home is actually less!

“Morale! — after reading all the Weaknesses and Threats and my abject failure to identify more Opportunities, what more can I say?”