Examples Abroad

Models of health care delivery in Great Britain and Switzerland

Pavitra Krishnamani and Jacqueline O'Neill

The United States became the newest resource-rich country to have a national health care system when the Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Drawing from the experiences of other nations with national health care delivery models, "Obamacare" continues to draw both gratitude and ire from its participants and commentators. Yet, every national model of health care delivery has its benefits and pitfalls. Great Britain and Switzerland have two very successful but very different models of health care delivery that preceded our foray into the ACA. Each country discovered its own approach to ensuring citizens are willing and able to seek health care while maintaining the fine balance between capitalism and the basic human right to health.

GREAT BRITAIN

Great Britain, which provides universal health care through its National Health Service (NHS), ranked first in the health care provided to its citizens among a cohort of 11 industrialized nations analyzed by the Commonwealth Fund, a health systems think tank. According to the 2014 report, the United Kingdom provided the best quality of care in the cohort while spending less per capita than any of the other 11 countries except for New Zealand. Based on the Beveridge Model of health care, the NHS is run and funded by the British government, which owns many of the nation's clinics and hospitals. "With services being overstretched in the NHS, the NHS also commissions private companies to look after their patients—although there are concerns over reduced quality and safety standards in these facilities," says Lisa Murphy, the National Training Director at Medsin-UK. In both settings, the government determines payment rates and patients never see a medical bill.

The system is fueled by tax revenue, with British citizens contributing around $6,923 annually to the NHS, and sees a high rate of satisfaction from its constituents. "Ninety percent of people who use the NHS think it's good or excellent, so people think very, very highly of it," said then-Whittington Hospital CEO David Sloman in *Sick Around the World*, a documentary on international models of health care delivery. "The majority of people will use it as the only provider of their medical care, and none of them will be presented a bill at any point during that time." According to the charity Kings Fund, only between 8.5 and 11 percent of the population has some level of private medical insurance, the majority of which is provided by employers.

This system works particularly well for primary

and emergency health care, but does result in longer waiting lists for elective and specialty care. "Patients should be seen within three months, with urgent referrals seen within two weeks," Murphy explains. "However, these can often extend far beyond these limits, with patients in certain services, particularly mental health, waiting nine to 12 months to see the specialist they require."

General practitioners (GPs) in the country hold down medical costs by serving as patients' health care guides. The amount of time it takes to see a GP varies across the country, but routine appointments are made within two weeks. After-hours appointments can take longer, Murphy says. "Emergency patients are often [seen] within 48 hours and GP practices have lunchtime phone appointments for doctors to speak with patients and ensure they are not in immediate need of seeing a professional. However, there are reports of around 10 percent of patients unable to get a GP appointment within one week, leading to increased attendance at [emergency] departments."

Patients can visit their GPs as frequently as they need to and GPs are paid a flat fee based on the number of patients they care for. The average GP makes about $130,895 a year, Murphy says. Specialists—known as consultants—can earn a base salary between $99,681 to $134,390. In addition, salary incentives are given out for exceptional service within a field, ranging from $2,623 to around $6,558. "There is some controversy surrounding these, as they can take into account a doctor

hitting predetermined target waiting times or outcomes rather than a patient's satisfaction with their care," Murphy says.

Physicians in Britain also benefit from the "improvements brought in by the European working time directive, which means that physicians will no longer work extensive and unsafe hours," says Murphy. She does, however, express concerns about losing this regulation because of political changes in the nation. She sees a hesitation to use emerging technology and to innovate in the field as the biggest drawback for physicians in the system. From a patient perspective, she cites the no-cost-at-point-of-care delivery and the ability of patients to provide their "opinions and perspectives on the system to improve service quality and safety" as the most salient benefits.

The amount of time it takes to see a GP varies across the country, but routine appointments are made within two weeks.

WHO health metrics routinely show that Great Britain is effective at keeping its citizens healthy, with an average English person living 82.7 years if she is a woman and 78.8 years if he is a man—both of these averages are higher than the average lifespan of an American of the same gender. However, England and Wales still have a higher infant mortality rate of 3.8 per 1,000 live births than many other resource-rich nations, although it performs considerably better than the U.S. in this metric. The nation's preventative medicine initiatives have received mixed reviews, according to Murphy, who cited the country's high rate of cancer screenings as one of its successes in this area. "However, I feel that we are failing to sufficiently address the obesity crisis, with our new sugar tax barely scratching the surface," says Murphy. She also cited the lack of provision of affordable healthy food and adequate recreation facilities in certain parts of the country as areas for improvement in this effort.

SWITZERLAND

Until the mid-1990s, Switzerland's health care system resembled America's prior to Obamacare: Medical insurance was voluntary and citizens were at risk of losing their coverage if they lost their job, as health insurance was linked to employment. In 1994, however, a new law known as "LAMal" made health insurance compulsory in the country, with the government subsidizing the cost of health care for those who could not afford it. "Switzerland requires everyone entering the country for longer than a certain time to buy health insurance and, thus, it is a private system, but based on Swiss law," says Federico Mazzola, vice president for external affairs at the Swiss Medical Student Association. "If you are not able to buy health insurance, the government will help you fund it—and since it is in the law and the private companies work on a beneficiary system, it is difficult for someone to go bankrupt from medical bills."

Similar to the U.S.'s ACA, the law retained commercial insurance policies, while imposing risk-sharing by requiring health insurers to accept individuals without discrimination against pre-existing conditions. However, where LAMal demands insurers cannot make profit from necessary medical coverage, the ACA allows it. In addition, LAMal provides a generous national standard for what is medically necessary, while the ACA has a rather skimpy definition of what services must be covered. In Switzerland, insurers cannot restrict provider networks, and provider services must have the same price across the board.

Health insurance generally costs Swiss citizens around $304 per month, or $3,653 annually. Those in serious need of medical attention may have an initial out-of-pocket payment between roughly $500 and $2,600, Mazzola says. "Usually, the bill gets sent to the insurance [company], which then asks [patients] for the out-of-pocket payment. Or, if that is already used up, they will ask the patient to cover 10 percent of the cost. Usually the amount covered by insurance is enough for any sort of medical treatment." Several different types of plans exist, with the type of plan determining

how quickly patients can access specialist care.

A GP-model health insurance plan requires patients to first visit a GP, who can then refer them to a specialist if necessary. When asked how long it takes to see a GP, Mazzola says, "Depending on the urgency, anything from straightaway to maybe a week. The study nurses triage the patients on the phone and will give an appointment accordingly." In total, seeing a specialist with a GP-model plan can take around two to three weeks. "If one has private insurance or a direct-specialist plan, one can call immediately and will usually get an appointment [to see a specialist] within a week or two," says Mazzola.

Unlike in Great Britain's socialized model of health care, most hospitals in Switzerland are independent from the government and the country's health care system reflects its fiercely capitalistic nature.

Unlike in Great Britain's socialized model of health care, most hospitals in Switzerland are independent from the government and the country's health care system reflects its fiercely capitalistic nature. According to Mazzola, "The government or even different municipalities are shareholders of the [hospitals]." GPs generally are paid about $202,954 annually and specialists make around $253,693. "Depending on the level of training, you receive bonuses," Mazzola says. "One usually gets a 13th month salary, which is common in Switzerland: One receives about a month's-worth of salary extra, at the end of the year."

When asked what two aspects of Switzerland's health care system shine brightest, Mazzola cited the high quality infrastructure and work opportunities available to physicians, as well as the prospect of a stable workplace with a good salary. He did, however, mention that the payment system per service provided was "really bureaucratic, time consuming, and not fair." He also cited overwhelming workloads and work hours as negatives. "[Work hours] are actually defined by the law at 50 hours per week, but [this is] rarely enforced," says Mazzola. For patients, the ability for individuals to choose a personalized health care plan and access quick consultations in modern hospitals with a high standard of care is the best aspect of the Swiss health care delivery model, according to Mazzola. However, he does worry that "different levels of health insurance may lead to unfair treatment."

At the moment, Switzerland boasts an average life expectancy of 80.8 for men and 84.9 for women, with an infant mortality rate of 3.9 per 1,000 live births, similar to that of Great Britain. "Switzerland has a long tradition of emphasizing primary health care, though we are having problems finding successors for GPs throughout Switzerland," Mazzola explained. The government, tasked with supporting the Swiss primary health infrastructure, has now mandated that university hospitals increase the teaching and presence of primary health care throughout Swiss medical schools. "For example, at the University of Zurich, we have new GP courses, where we have to work with a GP for six afternoons each semester for a year. We also have GPs holding more lectures and promoting their [field]," Mazzola says.

He also explained that the Swiss government is trying to focus more on preventative medicine, calling on citizens to be more alert about specific medical conditions. "They want to enforce low-threshold access for the entire population, especially [when working with] HIV and STIs," Mazzola says. "Switzerland is a very healthy country, being the only country in Europe where obesity rates have not risen. In that sense, Switzerland is doing something right for sure."

Jacqueline O'Neill is a third-year at the University of Mexico School of Medicine. **Pavitra Krishnamani** is *TNP*'s student editor and a medical student at Thomas Jefferson University.