I am a GP Registrar in England in my final few months of training before becoming a GP. I decided to take part in the Erasmus scheme after attending a talk at the Royal College of General Practitioners (RCGP) Conference in Liverpool in 2014. I studied German at school and for one year at university so learning more about General Practice in Germany was of interest to me. I had previously done a one week placement in the private ward of a hospital in Cologne in 2009, so had a basic understanding of some of the differences between secondary care in Germany and England before I arrived.

In April 2017, I hosted a GP from Hannover in my practice for two weeks. This was a great experience, and gave me some insight into the differences in GP education and day-to-day work between the two countries. However, my two weeks in Oldenburg gave me a far deeper understanding of the German system. I had previously visited Germany approximately nine times including undertaking work experience in a fitness studio in 2005. However, this was my first time in Oldenburg, which is a university town situated in North West Germany near to Bremen.

I understand two weeks is not long enough to allow an in-depth comprehensive comparison between the systems, but I feel I have learnt a lot in these two weeks about a different way of working in primary care. I can also only comment and compare my experiences in one practice in Oldenburg to my experiences of working in practices in West Sussex in England, and am aware that different practices in Germany and England are likely to operate differently to those that I have knowledge of.

I have structured my report into the following sections:

- Education
- Role of the GP
- The working day
- The GP in the wider professional environment
- Patients
- Finance
- Learning points for General Practice in England
- Conclusion
Education

Medical school training is of similar length in both countries (5-6 years in England, 6 years in Germany), with a difference being that in England tuition fees are currently £9000 per year, whereas in Germany tuition is essentially free, with students only paying a small administration fee each term. In England, each medical school has their own final examinations with slightly different qualifications at different universities e.g. MBBS, MBBChir, whereas in Germany there is a nationwide final exam.

During my time in Oldenburg I was able to spend some time at the University of Oldenburg, which has a newly established medical school with an intake of 40 students per year. This was a great experience, as I sat in on a curriculum planning meeting which was being run by GP trainees who were working part of the week at the medical school providing teaching on General Practice related topics. To have the opportunity be this involved in undergraduate education as a postgraduate trainee is rare in England. It was good to see how generalist skills are being taught from the earliest stages of medical school in Oldenburg.

I was also able to attend a seminar on prescribing for medical students, some of whom were on exchange from Groningen in the Netherlands. During this seminar, we discussed differences in prescribing between the three countries i.e. in England and the Netherlands we predominantly prescribe generically, whereas in Germany brand names are used more commonly. There were also some small differences in national guidance for treatment of common conditions e.g. type 2 diabetes, coronary artery disease.

General Practice is a smaller specialty in Germany than in the UK, with approximately 10% of doctors in Germany becoming ‘Hausarzte’ versus approximately 50% in the UK.

General Practice training is much more structured in the UK. In both countries, training to become a GP takes at least five years from qualification from medical school. In England, we rotate through specialties every 4-6 months, with most trainees spending time working in general medicine, surgery, paediatrics, obstetrics and gynaecology, and psychiatry. In Germany, the only mandatory rotation is a minimum of 18 months working in General Medicine, and trainees can choose where they work for the remaining 18 months in secondary care. In England, we spend approximately 12-20 months working in General Practice before we become GPs, whereas in Germany this is longer (2 years).

In England, we apply through a national process to enter a structured GP training scheme, and are then allocated to a regional deanery and local hospital training scheme who oversee our rotations, and organizing our teaching. We often have little choice over our training practice. In Germany, trainees are free to approach and
choose their own practice, and there are no local organized formal training schemes in the Oldenburg area.

In England, the formal training requirements are more structured and in-depth, with two examinations (one theory and one practical), and three years of workplace based assessments and reflective essays which are recorded on an electronic portfolio which is maintained by the RCGP. In Germany, there is one final viva type examination, and a minimum number of certain competencies e.g. abdominal ultrasounds. In England, there is also a greater focus on the consultation itself, with use of video consulting and weekly tutorials in practice with a trainer to work on these skills. There is no formal tutorial or teaching system currently in Germany.

In both countries, working within hospitals is deemed to be a high stress part of the training. In England, this is often due to rota gaps and excessive numbers of patients. However, from the trainees I spoke to in Germany, it was felt that working conditions were poor due to hospitals running as businesses, and thus not employing as many staff to maximize profit.

After training ends, both countries require 50 hours per year of continuing professional development. However, in England there is a more structured peer appraisal system each year, with a perceived greater emphasis on practicing evidence based cost-effective medicine, and being up-to-date with the latest national guidance.

Overall, I think medicine would be a more attractive subject to study at university in Germany due to the lack of tuition fees, and thus reduced student debt. Competition ratios for places at the local medical school in Oldenburg are much higher than in England.

Postgraduate education is much more structured and prescriptive in England. The benefits of the education system in England are that training is more standardized, and thus the standard and practice of GPs is perhaps less variable than in Germany. However, the added requirements and reduced flexibility of the system in England bring added pressure and stress, and perhaps a worse work-life balance than the trainees in Germany.

Role of the GP

From my first day in Oldenburg it was clear that there are noticeable differences between the work of a GP in Germany and England. One of the most obvious differences was that in most practices in Germany (aside from those in rural areas) paediatrics and gynaecology are not routinely seen, as patients are able to self-refer to specialists in the community. In the practice in Oldenburg, there was a gynecologist and a paediatrician working within the same building (but not part of the same practice) and so no children were seen whilst I was there, and only a few teenagers. This is very different to England, where paediatrics and gynaecology are part of the ‘bread and butter’ of General Practice.
In England, contraception, smear tests and menopause treatment are also mostly done in General Practice. In Germany, one patient I saw had been diagnosed with vasomotor symptoms secondary to the menopause, but as hormonal treatment is outside the normal role of a GP, she had been referred to gynaecology with a two month wait for an appointment. In my practice in England, we have some patients from other European countries who demand to see a gynaecologist or paediatrician, and we have to work hard with them to explain that this is not necessary and we as GPs are able to manage their problems without a referral. In Germany, most women see a gynaecologist once a year, so knowing this I now have a better insight into these ‘unreasonable’ demands from patients from overseas.

The role of the GP in towns in Germany is predominantly adult general medicine, and this role is similar to in the UK. However, in Germany as patients can self-refer to specialities, it is not necessary to see a GP in the way it is in the UK.

Additionally, GPs take on a much bigger role in preventative medicine in Germany, with a general check up every two years for patients aged 35 and over. Coming from the British system, the idea of a GP conducting a general check-up was completely alien to me! The check-ups (or GUs – Gesundheitsuntersuchung) last thirty minutes, and include a general history of the patient’s health including areas like physical activity, sleep and diet which we rarely enquire about in England unless clinically relevant to the problem they are presenting with. There is then an examination which looks for early signs on cancer e.g. lymphadenopathy, an inspection for skin cancer (with dermatoscopy if needed) and a brief neurological exam. For patients with private insurance, there is often also an abdominal and neck ultrasound.

At first I was quite skeptical about these check-ups, as in England we learn only to do what is clinically relevant, and we deal mainly with illness, rather than health and wellbeing. I was not sure how much check-ups would help clinically to improve outcomes. However, I realized that spending thirty minutes every two years with the patient allowed for a better rapport and understanding of the patient, their family, and lifestyle etc. than we are normally able to get in a ten minute problem based consultation. I am still unconvinced about asymptomatic ultrasounds, as I think the risk of finding an ‘incidentaloma’ or over-medicalising is high!

GPs in Germany are highly skilled at conducting ultrasounds, which few GPs in England can do. I think that this is a useful skill to have for making certain diagnoses e.g. symptomatic biliary tract disease, deep vein thrombosis. However, I think the time needed to do ultrasounds examinations would make it difficult to justify implementing this in England with the current workload pressures, but in an ideal world it is a skill I would like to have, as in certain clinical scenarios it would lead to quicker and potentially better outcomes for patients. In general, GPs in Germany are bigger adopters of technology e.g. dermatoscopy, electronic ECGs with easier comparison to
previous tracings, than in England, and I think as younger GPs in England we need to look to embrace technology more where it leads to better clinical care. Of note, there is also a much-increased use of ECGs, with a possible related increase in atrial fibrillation (AF) diagnoses and treatment.

Practices in Germany tend to be much smaller than in the UK. The practice I was at in Oldenburg had two GP partners, one salaried doctor, and one registrar. In comparison, my practice in England has four GP partners, one nurse partner, one manager partner, three salaried doctors, and currently has three registrars. As our practices are bigger in England, it allows us to ‘work at scale’ with purpose built buildings, and use of technology such as electronic check in, and calling the patient from the waiting room electronically. In the practice in Germany, this process was managed by the MFA (Medizinische Fachangestellte, see below) on the reception desk. In Germany, the practice was part of a larger office block with other specialty doctors with separate practices on different floors of the building. The practice had more of an office layout and was much more compact than a GP practice would be in England.

In Germany, practices do not usually have a practice manager, and instead the tasks of running the business e.g. managing staff, finances, fall solely onto the GP partners, meaning a considerable amount of extra non-clinical work is undertaken by the doctors.

As patients can choose whether to have a GP or not, and which practice to go to with much more flexibility in Germany, there was a feeling amongst some older doctors that it would be difficult to take time off or work less than full time, as patients choose to see them personally. In England, we work more as a team of clinicians, and this allows for more part-time working, and taking on other clinical roles outside of the practice e.g. having a subspecialty or leadership role in another work setting. Portfolio careers are much less common in Germany, and I think the smaller practice size would make this much harder to do.

One of the biggest differences between GP practices in the two countries is the non-GP staff. In England, our team within the practice consists of receptionists and admin staff who do not have clinical training, health care assistants who take blood, do ECGs etc. and have some basic training, and fully trained practice nurses, who can sometimes prescribe, and usually see their own patients and have a large role in managing patients with chronic diseases e.g. diabetes, asthma. In Germany, the practice staff who are not doctors are MFAs. They undertake two years of training, and have a similar role to receptionists and HCAs in the UK, with skills in phlebotomy, doing ECGs etc. Although the fact we use non-clinical staff in practices in the UK seemed strange to doctors in Germany, I think this does help with ensuring we have enough staff to work in the practices, and with close support from the doctors and other clinical staff the system works well.
The MFAs in Germany are not as well trained as practice nurses in England, and thus do not see their own patients. The job can be stressful with long hours, lots of computer work and limited patient contact. In some practices there is a shortage of MFAs, and as the training lasts two years, it is not as easy to recruit for the posts, as it is to find reception and admin staff in England who have much smaller training requirements.

One of the biggest differences I noticed on my first day in the practice was the dress code. In England, GPs tend to dress quite traditionally in smart dress e.g. suits with ties for men, dresses for women, with uniforms for the non-doctor staff. In Oldenburg, all the staff in the practice including the doctors wear the same uniform which consisted of a polo shirt with the practice logo on, white trousers and white trainers. This was a big cultural shock for me at first, as in England this would not be deemed to be smart enough, and doctors in practices never wear uniforms. However, it did lead to more of a unified team feel rather than the hierarchy that is more present in practices in England, and meant not having to overthink outfit choices each morning!!

I think both systems could be more efficient by ensuring GPs delegate tasks to non-doctor staff better. In Germany, most observations e.g. temperatures, BP, as well as urine dips are usually done by the MFAs when the patient arrives prior to seeing the GP. If we did this in England, it would certainly save time in most consultations, as some days I spend a lot of time testing and labelling urine samples, which could be better spent doing more important clinical work. In England, we do not need to code nearly as much as in Germany, and lots of our coding is done for us by our admin team. In Germany, the doctor’s time is used in every consultation to code and bill the insurance companies for additional services, and if added up this would be a significant amount of clinical time each month.

The clinical roles in each country also vary. In England, we tend to refer to specialists much later and as a result take on a larger clinical management role, and see more ‘sick’ patients. We tend to be more incremental in our investigations, and to use time and trials of treatment more over referring. Our consultation skills and approach are also slightly different in England, where we use the computer less during the consultation, and lay our rooms out differently, avoiding having the desk and computer between ourselves and the patient. We also always have tissues on our desk, as patients seem to cry more during consultations in England!

In Germany, the practice I was at provided several additional services which we do not routinely do as GPs in England. These included wound management (e.g. follow up of surgical wounds), infusions e.g. iron, and chiropractic treatments. These could help to improve patient care e.g. using manipulation to help with simple MSK problems, reducing the wait time for iron infusions in patients with symptomatic anaemia, but to offer these services in England they would need to be funded, evidence-based and not lead to reduced staff availability for other aspects of clinical care.
The sick certification system in Germany also means that many more young, healthy patients are seen for face to face appointments with self-limiting illnesses. Patients in Germany often require a doctor’s note for their employer from the first day of illness (versus the eighth day in the UK), so I saw many young well patients coming in with a short history of diarrhea or a cold. This meant these patients were also more likely to be investigated i.e. if there was a pattern of asking for a sick note for short episodes of abdominal pain, and I think were more likely to be given a prescription. There is also a cultural phenomenon where patients like to shake hands with the doctor both at the beginning and end of the consultation, which is not very pleasant for the doctor when they have come in with infectious gastroenteritis!

**The working day**

Routine General Practice is predominantly a Monday to Friday service in both countries, with both operating an out of hours service at other times.

In Oldenburg, the standard clinical working day is 8am until 5-6pm. The exception to this is Wednesdays and Fridays when most GP practices and many specialty practices close for the afternoon. I think this allows a better work-life balance and more time set aside to address the non-clinical side of GP. In England, although practices are open from 8am-6.30pm Monday to Friday, it is common for GPs to work eight sessions (a session is a clinical morning or afternoon) i.e. the same as in Germany. I think adopting the German working hours with the two closed afternoons would go some way to addressing the staff shortages in General Practice in England currently, but I think it would be impossible to implement this currently as it would be extremely unpopular with politicians and patients. The other issue with the German system is that it means the weekend is longer than in the UK, which whilst good for the staff, means that patients have an extra half day of being unable to access routine GP care e.g. for follow up in an acute illness.

The lunch break in Germany tends to be slightly shorter, but there tends to be less paperwork generated from consultations as referrals are shorter and done immediately so they can be handed to the patient to take with them. In England, by the end of a morning I will have accumulated several referral letters which I need to type, and which are much more in-depth than referral forms in Germany, and this can reduce my lunch break.

In both countries, there is a feeling amongst older clinicians that younger doctors are more interested in a work life-balance than in earning lots of money. I know this is true for me, and in both countries, there is a feeling that this is leading to an impending medical workforce crisis, with increasing numbers of younger doctors choosing to work part-time. In Germany, there is a current shortage of GPs in rural areas, whereas in England there is a nationwide shortage.
Appointment times in England are usually ten minutes, whereas in Germany appointment times are much more flexible, with 10 minutes for acute patients, 15 minutes for prebookables, and 20-30 minutes for ultrasounds or check-ups. I think the German appointment system is better in this respect, and consultations in general feel less rushed and time pressured than in England, although in both countries it is impossible to always run to time. However, the German approach does mean having to adapt to different paces throughout the day, which could be slightly challenging. In an ideal world, adapting the length of the appointment to the patient as they do in Germany would be much better and make the working day in England less stressful, but current workforce pressures in England would make this hard to implement. Overall, I think we see more patients in a day in England due to the shorter appointment times.

Due to referring later (so managing the patients for longer), and seeing children, gynaecology etc., I think the demand for appointments is much greater in England. As a result, we do many more telephone consultations than in Germany, and in most practices in England it is necessary for clinicians i.e. doctors and practice nurses to triage appointments to ensure appointments are given to those who really need them. In Germany as the demand is lower, there is more of a tolerance for ‘walk-in’ patients, which we try and completely forbid in my practice in England unless the patient is seriously unwell. However, there is a move to try and stop ‘walk-ins’ and instead for patients to ring in the morning for on the day appointments, with triage by the MFAs.

Another big difference is that most practices in England operate a ‘duty doctor’ system. At my practice in Crawley, this means one doctor per day (or two on a Monday!) have no scheduled appointments and instead do triage on the phone, home visits, and deal with urgent admin. As the practices and demand are smaller in Germany, this is not routinely done, but this does mean all clinicians are interrupted more frequently during their clinics to sign urgent scripts etc. The number of home visits was similar to the practice I work at in England, and in both countries, there has been a strong move to try and only do home visits where strictly necessary due to time constraints.

In both countries, GPs feel they are overworked, and with a shortage of doctors in rural regions in Germany and all regions in the UK this situation is likely to worsen.

The GP in the wider professional environment

In both countries, General Practice is still viewed as a ‘Cinderella’ specialty, but this is much worse in Germany, where patients can self-refer to specialists, and do not need to be registered with a GP, so the GP role is not nearly as indispensable as it is in the UK. As a result of the self-referral system, and power and choice that the patients have, GPs refer to specialists much earlier than in the UK, and may refer to more than one specialty at the same time for the same problem, which would be highly frowned upon in England. There is also a feeling that it is not possible to say no to a referral, as
patients can overrule the GP by self-referring, and this leads to a much higher referral rate, and weakens the role of the GP in diagnosing and managing illness.

In Germany, specialists are also able to set up their own practices in the community, and these specialists work independently of the hospitals. This means the system is much more fragmented than in the UK. For example, hospital clinicians do not offer outpatient appointments, so a patient operated on as an inpatient would be unable to see their surgeon as an outpatient, and would need to find a specialist in the community to do their follow up. This seemed very strange, coming from the English system of doctors in the community being GPs, and doctors in the hospital being specialists, and I feel the German system could lead to reduced responsibility being taken by hospital clinicians e.g. for post-operative complications.

The lack of follow up (along with increased influence from the pharmaceutical industries and reduced use of national guidelines) also means hospital clinicians in Germany are much more likely to prescribe new and expensive medications for patients. GPs then have to have difficult conversations with patients about whether to continue these medications, with a risk that if they are continued by the GP, the patient’s insurance company may refuse to cover the cost, meaning the GP is paying out of their own money for the cost of the drug! As our health system in England is more guideline driven with a strong evidence base and cost-effectiveness being needed for medications to be included, this is not an issue which we see commonly in the UK.

From what I observed during my two weeks in Germany, there is also reduced multi-professional team working within the community. For example, in the UK we have monthly meetings in our practice with other health care professionals from other teams helping to care for our patients e.g. health visitors, community nurses, mental health workers. I think this is possible as the system is less fragmented in the UK, with an overriding feeling that we all work for the National Health Service, and more joined up processes and pathways which make inter-professional working possible.

As we have a more joined up healthcare system in England, it is possible to implement region or nationwide schemes to improve population health more easily than I expect it would be in Germany. Although we do not do nearly as much individual preventative medicine i.e. no check-ups for asymptomatic patients, we do have more population based schemes to improve health and wellbeing e.g. smoking cessation clinics, diabetes education programmes, diabetes prevention programmes, weight management schemes. Whereas in England what is on offer varies by area, in Germany these programmes tend to be influenced by what the patient’s particular insurer is willing to pay for. I was very surprised to learn that there are no increased insurance premiums for preventable disease risk factors e.g. smoking, as I think this would be a good (but unpopular) way of improving the health of the population in Germany!
In my local area in England, there is one acute hospital serving several towns and a population of approximately 500,000. In Oldenburg, with a population of approximately 160,000 there are three acute hospitals, and patients can decide which they go to (although some specialities are covered by one hospital only). This was very surprising, and I was shocked by the amount of choice patients have (two of the hospitals were within 300m of each other!), whilst people I spoke to in Germany where shocked by how busy our hospitals are, and how little choice patients have.

I have created a diagram to demonstrate my understanding of the roles of different professionals across the health-illness spectrum in both countries:

### Health care usage across the health-illness spectrum

<table>
<thead>
<tr>
<th>ENGLAND</th>
<th>GERMANY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care</td>
<td>Self-care</td>
</tr>
<tr>
<td>GP</td>
<td>GP</td>
</tr>
<tr>
<td>Hospital[SERIES NAME] - inpatient</td>
<td>Facharzt - speciality doctors in the community</td>
</tr>
<tr>
<td></td>
<td>Hospital inpatient</td>
</tr>
</tbody>
</table>

### Patients

Whilst the people in Germany are fairly similar demographically to the UK, one of the major differences and things I will take away from the exchange is the difference in patient expectations. Patients in Germany were much more demanding than in England, which much more power due to the self-referral system. The sick certification system also means they are more likely to consult with self-limiting illness, and want treatment when it is not necessary. As a result of the higher patient expectations and demands, there was much more medicine in Germany being practiced which in England we would deem ‘clinically unnecessary’ e.g. seeing a neurologist for a simple headache, asymptomatic ultrasounds, gastroenterology for early stages of gastritis in a young healthy patient. There is also a risk of patients self-referring themselves to the wrong specialist e.g. seeing orthopaedics for a ‘shoulder pain’ which later turns out to be a lung cancer.

Coming from the British system where we always (or should always) ask ourselves if what we are doing is clinically relevant, justifiable and will change clinical management, witnessing the German system did make me feel uncomfortable, as I felt there was a risk of the system causing patients to be over-medicalised. The life expectancies in both countries are almost identical, so I do not think that a lot of the excess
investigation and treatment done in Germany due to patient demands actually leads to improved health outcomes, and with every unnecessary investigation that is done, there is the real risk of finding an ‘incidentaloma’, and submitting the patient to even more clinically unnecessary investigations.

Perhaps I feel this way as in England our health system is perpetually underfunded, and as a result we are cautious about over-medicalising, and use our clinical judgement as GPs more than in Germany, with less use of investigations (but also having to manage the associated risk which comes with our less investigative approach).

I also feel the routine two yearly check-ups help to reinforce more of a ‘consumerist’ approach to health, and increase patient expectations. I also wonder if they could have a detrimental effect by giving false reassurance to a patient that their health is good, when in fact these check-ups are fairly basic and of course cannot detect many diseases. I also wonder how effective asymptomatic check-ups are in patients who are not addressing other modifiable risk factors such as smoking or obesity.

As well as being free to choose their GP, and hospital, patients are also free to choose from the number of doctors working in each specialty in the area. However, in some specialities there is a very long waiting time for an appointment e.g. eight months for a routine cardiology appointment (longer than in England!), as there is no filtering out of inappropriate referral requests (saying no is a very important part of the role of the GP in England, and protects the specialists from being overrun with referrals). There is also a lack of rationing of services which can further increase waiting times e.g. patients can wait over a year for access to psychological treatments as there is no limit to the length of treatment, versus six sessions at a time in the UK, meaning new patients can be seen more quickly. Of note, I find the use of a diagnosis of ‘burn out’ in Germany for patients with low mood secondary to life circumstances is useful, as often in the UK we would call this depression, with the added implications this diagnosis may have for the patient.

GPs in Germany are now working with insurance companies to try and address this problem by asking patients to sign a HZV (Hausarztzentrierte Versorgung; GP contract) which states that the patient will see their GP for referrals and will not consult with another GP practice for the next year i.e. to try to stop ‘doctor shopping’ and reduce unnecessary referrals. If the patient breaks the agreement, they could potentially be asked to cover the cost of their appointment. However, due to the large numbers of patients asking to see specialists on a daily basis, referral forms are often printed by the MFAs for the GPs to quickly sign without having to have a consultation with the patient. With current patient expectations, it is felt that trying to say no or question whether the referral is really needed would be a fruitless task, and it is easier to say yes. This does not happen in the English system, and I say no to inappropriate requests daily.
As there is no list system in General Practice in Germany, patients are free to see whichever GP practice they want and consult at more than one practice if they choose. Unlike in the UK, the notes do not show any previous consultations, letters etc. from before the patient came to the current practice, so the patient’s word needs to be relied on with regards to their medication and past medical history, and it would be much easier than in England for patients to abuse the system e.g. to get certain medications. This could be seen as doctors in England being less trusting of our patients, and the doctor-patient relationship being less ‘private’, as other health care professionals e.g. community nurses have access to our notes. However, I think a healthy degree of cynicism is needed, particularly to avoid easy access to drugs which could potentially be abused. It is much more common in Germany for patients to have their test results printed for them, and I think this fits with patients being more like ‘consumers’ and doctors being ‘providers’ within the Germany system.

Two other concepts which I came across in Germany which we do not have in the UK are ‘Kor’ and ‘Reha’. These are intensive programmes which can be done as an inpatient or outpatient to help treat conditions such as disc prolapse, chronic pain, or psychosomatic complaints. These are funded by the insurance companies, and some view them as almost a free holiday, with access to lots of different treatments e.g. yoga, massage often in a nice location with time allowed off work to attend. These are completely alien to me as a doctor from the UK, where the only intensive rehabilitation programmes we have are for those things which are really necessary e.g. elderly patients post hip fracture, neuro rehab post brain injury.

Our treatment of a non-complicated disc prolapse, for example, is often a sheet of exercises, consideration of physio if symptoms last greater than 6 weeks, simple pain management and advice to keep moving. A full day three-week intensive rehab programme (as occurs in Germany) for a disc prolapse is unheard of, but may well be beneficial in improving recovery times for musculoskeletal issues, and potentially allowing psychosomatic complaints to be addressed in depth and intensively, which we do not have much time or resource for in England. However, this is all dependent on ‘buy in’ from the patient, and in our health system in England I really don’t think this expense could be justified currently.

I also noticed that third party consultations with a relative without the patient being present are much more common in Germany, without so much worry about confidentiality as we have in England. There are also no curtains around the examination couch, and patients are much happier to undress in front of their GP than they would be in the UK – I think this is cultural, but also shows the trust Germans have in their GP, and as one woman said, ‘What is the point in curtains, they are going to see me undressed to examine me!’ which is a fair point.
Finance

I think the major factor contributing to the differences between the two health care systems is the way in which they are financed. In England, our National Health Service (NHS) is free at the point of care for everyone. In Germany, health care is financed through insurance companies (and there are over 100 companies). Roughly 85% of the population has normal insurance, with 15% of the population having private insurance (both visit the same GPs, but on the notes it clearly flags who is a private patient).

In Germany, it is possible to be uninsured if a patient has not registered as unemployed etc. (unemployed patients are covered by the normal insurance). If uninsured, one could be faced with a large bill for treatment. The insurance companies are able to influence what can and can’t be prescribed, and also what health promotion schemes etc. they will finance.

There was a feeling expressed amongst some people that I spoke to in Germany that they pay money every month for their insurance (probably somewhere in the region of 350 euros/month), but do not really use the health service. I think it is this semi-privatisation which in turn fuels higher expectation and a sense of entitlement amongst some patients in Germany. There is also a sense that the current system is financially unsustainable due to rising costs, in a similar way that our health system in England faces financial problems. Germans pay more of their GDP on healthcare than we do currently (9.1% in the UK, versus 11.3% in Germany, source: The World Bank, 2014), but life expectancy is the same.

With regards to General Practice, for normal patients (i.e. those without private insurance), GPs are paid a sum for every quarter that the patient attends (the MFA on reception scans the patient’s insurance card when they check in). This is the same for specialists, and means many patients are followed up on a three-monthly basis to maximize payments i.e. for stable diabetes, when in the UK they would be followed up every 6-12 months. This also adds to the waiting times to see specialists, as three monthly follow up is common. There are some services which attract additional payments e.g. USS, considering a psychosomatic diagnosis, and at the end of each consultation the doctor has to code what has been done to ensure they are paid correctly. In contrast, in England the practice gets paid a certain amount per year per patient on the list, regardless of whether they attend numerous times or not at all. Chronic disease management and other services attract extra payments, but this tends to be done at a practice level, rather than being paid for individual patients.

For private patients, doctors can bill for everything they do i.e. all investigations, the length of the consultation. As a result, private patients are much more likely to be over-investigated and over-treated, with potentially worse outcomes. Some patients are aware of this, and ask the doctor to only do what is necessary. Amongst some patients,
there is a feeling that sometimes things being done may be due to money, rather than being clinically necessary.

In both countries, GPs are the doctors who are most aware of the overall health budget. However, money is more apparent in the clinical work of a GP in Germany, as although no money changes hands, the costs of various extra services are shown when producing a coded bill at the end of each consultation. Coming from the British system, this felt quite uncomfortable, as it made General Practice feel much more commercial than in the UK, and I think the constant awareness of payments probably influences consultations and management plans.

When speaking to people in Oldenburg (both doctors and lay people), there were a few common myths about the NHS which kept coming up. One was the size of the wards (in Germany, inpatients are normally in rooms of one-two, so a bay of six is completely alien). The other was that we ration services according to age in the UK i.e. once someone reaches 65 they won’t be able to have a joint replacement. Whilst this is not true, we are much more judicious when deciding on medical interventions, and tend to only do what is necessary. I think we are also stricter about certain criteria prior to surgery e.g. weight loss prior to joint replacement.

One final point on finances, was that there was a piggy bank on the front desk at the practice I was at as a coffee fund for staff which patients could contribute to. This was extremely foreign to me, and I think this would not be accepted in England, where healthcare and money (currently) are not so closely linked.

Learning points for General Practice in England

<table>
<thead>
<tr>
<th>Things we do well</th>
<th>Things we could do better</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>- Structured postgraduate education</td>
<td>- Making medicine desirable subject to study</td>
</tr>
<tr>
<td>- Time set aside for training</td>
<td>- Involve trainees more in undergraduate education provision</td>
</tr>
<tr>
<td>- Yearly peer appraisals</td>
<td></td>
</tr>
<tr>
<td><strong>Role of GP</strong></td>
<td></td>
</tr>
<tr>
<td>- True generalism incl paediatrics and gynaecology</td>
<td>- Preventative medicine e.g. addressing health and wellbeing</td>
</tr>
<tr>
<td>- Self certification for sickness</td>
<td>- Use of technology e.g. ultrasound</td>
</tr>
<tr>
<td>- Use of specialist nurses e.g. chronic care</td>
<td>- Delegate more e.g. urine dip, obs</td>
</tr>
<tr>
<td>- Use of practice managers</td>
<td>- Clinical training for all staff</td>
</tr>
<tr>
<td>- Portfolio careers</td>
<td>- Extra services e.g. infusions</td>
</tr>
<tr>
<td><strong>Working day</strong></td>
<td></td>
</tr>
<tr>
<td>- Large volume of patients</td>
<td>- Flexible appointment times</td>
</tr>
<tr>
<td>- Triage and duty doctor system</td>
<td>- Reduced opening hours(!)</td>
</tr>
<tr>
<td>GP in wider professional environment</td>
<td>Patients</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>• GP role indispensable – referral system</td>
<td>• List system – avoid ‘doctor shopping’</td>
</tr>
<tr>
<td>• Multi-professional working</td>
<td>• Specialist follow up</td>
</tr>
<tr>
<td>• Use of evidence-based guidelines throughout health service</td>
<td>• Saying no</td>
</tr>
<tr>
<td>• Population health e.g. smoking cessation</td>
<td>• Avoiding over-medicalisation</td>
</tr>
<tr>
<td>• Patient choice e.g. of hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conclusions**

I have thoroughly enjoyed taking part in the Erasmus programme, and would highly recommend it to other GP registrars across England and Europe. Whilst working in General Practice in one country, one tends to only see one way of doing things, and thus think there is only one way. As we face increasing financial pressures in the NHS, it is important they we consider other ways of financing our healthcare system, and of working more efficiently. It is important as a young soon-to-be GP to have an awareness of how other systems work, as my generation of doctors will need to assist with changes to our current system to ensure it remains sustainable.

Going to Oldenburg has enabled me to reflect on the things we do well in England (structured postgraduate education, the indispensability of GPs, true generalism, and not allowing money to overly influence healthcare). It has also allowed me to see a bigger picture, and think about things we could improve i.e. delegation within the team, flexible appointment times, use of technology.

I think having some knowledge of the German language helped with the exchange, as I was able to understand consultations and have brief discussions with patients.

I think the main learning point I take away from this experience is that healthcare adapts to financial incentives, and that if we fund our system in the UK better in the future, we need to be careful about this causing increased patient expectations, over-medicalisation and paradoxically longer waiting times, as well as weakening the role of primary care, and fundamentally changing the doctor-patient relationship.