When looking at health systems across the world the Netherlands is a regular top-table contender, finishing highly in rankings and featured in many case studies. Given the perpetual question and Great British pastime of ‘what is the future of the NHS’, I thought it would be a good idea to see if our Dutch colleagues have any answers.

My Hippokrates Erasmus+ placement was at the Pannenhoef Health Centre in Kaatsheuvel - a small town of about 20,000 residents which hosts one of the oldest theme parks in the world, Efteling. My Dutch was pretty poor (i.e. non-existent) but it mattered not, as 90% of the country speaks English and most patients were even kind enough to humour me with English consultations… with the occasional option of French/Spanish/German if I felt more comfortable in another European language!

Now notwithstanding the obvious limitations of a 2 week snapshot in a nation of 17 million people, I was really impressed and left with much to ruminate on. The bread and butter of primary care is broadly similar between our countries - appointments, patient mix, the GPs’ roles, salaries and hours mirror those in the UK. Where the Dutch take a different turn from us is primarily in two areas: how they pay for their health and social care, their GP workforce and their interface with secondary care.

General practitioners, *huisarts* in Dutch (lit. house-doctor), are the integral part of the Dutch healthcare delivery. And, at least to me, this seemed to genuinely extend beyond nebulous political platitudes: GPs have real ownership of their patient care and are the main drivers of the system. Love it or loathe it, the contractor model is alive and healthy here, with patients regularly seeing only their named doctor and each doctor’s list can be closed to new patients if it becomes full (about 2,700 patients each). GPs also have to partake in mandatory out of hours (OOH) day and night shifts on weekends and from 5pm-8am on weekdays. This too is a badge of honour, though many GPs are resentful of working long shifts - which are rationed between the GPs in the area depending on their patient list size - working out to about 1:11 in this region. OOH work takes place in a *huisartenpost* which functioned similarly to our community OOH centers in the UK, but is an entity owned and managed in partnership with local GPs similar to a federation. And what’s more, is that GPs have developed their own guidelines at NHG (the Dutch College of GPs) which are designed and tailored to primary care. As one local GP put it, “knowledge is power” and GPs seem to have a lot more professional respect and prestige than in the UK.
Even with the language barrier, I could feel and hear the pride in how GPs introduced themselves as *huisarts* and I wonder if our more nebulous term of general practitioner has detached some from our purpose and prestige? Moreover, the fact that GPs genuinely care for their patients outside of secondary care and had a strong connection with their communities did mean that the GPs were in a stronger negotiation position with the healthcare system.

Changes are of course always on the horizon and the GPs that I spoke to were unsure about the benefits of working together in groups of practices, which was something that was forced upon them by their insurance company paymasters. Indeed it seems that resentment against the insurers is a common theme amongst healthcare professionals here, with a perception that they can get away with huge profits and system redesign with little or no accountability, and also mistrust towards the government for letting huge corporate insurance groups lobby for changes that favour finances, not patient care.

Speaking of which, what took me a while to get my head around was the money. Again the distrust and dissatisfaction with the insurers was clear: they penalize doctors who perform outside their targets with less money – a complaint that we hear all too often from CCGs and NHS England here at home. Whilst we seem to be moving to outcome based commissioning, Dutch GP still seems to retain a large incentive on activity, with GPs being reimbursed on the number of patients/visits/procedures/ECGs etc that are done. I still found it strange to have conversations with patients about if they wanted to use their mandatory deductible (own risk) to pay for a blood tests, which could be quite expensive at around $100 – and patients who are just about managing financially would reject further investigation or referral simply due to this.

The skill mix in primary care was also very different, and somewhat simplified compared to the UK NHS. There are 3 main actors in the practice: the GP, the assistant and the *praktijkondersteuner* (POH). Assistants are school leavers who have taken a 3 year vocational course and are the receptionist/clerk/secretary/HCA role mixed in one. They do all the telephone triage, jabs, ECGs, BP checks etc. and there is dedicated time in the day where every session's calls or problems are presented to the GP for action. This seemed to work very well in this practice and took a lot of pressure off the GP who was always on ‘duty’ for any genuine emergency calls. The POH role was similar to our practice nurses who have specialized in chronic disease management and had to do a lot of the box ticking for extra payment from the insurers (DBC, similar to our QoF).
The Netherlands is also one of a handful of countries where euthanasia is legal, and often the patient’s GP is the one who administers the drugs to end their life. I saw a patient who was suffering from a rapidly progressing degenerative neurological condition and was very proactive in requesting euthanasia with support from his wife. He was rapidly assessed by the clinic and was given a date for his euthanasia all during the two weeks that I was at the practice. I had a long conversation with my host, who was supportive of euthanasia having done about 15 during his career. Dutch society seems to have accepted it but there were concerns about patients feeling pressured or signposted to consider it as a means to be less burdensome on their families and the health system – especially when they have no degenerative disease or are end of life, and simply feel they have lived long enough and want to die. My host said he had one such patient and refused to carry out this euthanasia, even though the specialist clinic had agreed that he could have it done.

Finally I also spent some time with the local GP trainees at the UMC Utrecht. GP is a very popular career choice here and is difficult to get a number in. Many trainees come to GP from other specialties as entry is possible directly after medical school. Their VTS-equivalent is led by the same 2-3 trainers throughout their 3 year studies and they are afforded a 1 day a week release every week (even when doing hospital placements). In return for such a protected educational experience their exam burden is significantly higher than ours, with MCQ exams twice a year; multiple portfolio entries including video consultations; clinical exams as well as 3-monthly reviews.

In summary I had an excellent time with my gracious host who really looked after me during my stay. It’s fascinating to see how a society that is so similar has set up a system that on the surface appears to have few differences but actually has quite fundamentally different approaches to health and care. It has broadened my horizons and with the unfortunate tide of Brexit about to hit our shores, I feel it has provided me with some opportunities to allow the NHS to remain open to ideas and continue to cooperate with people and cultures.