Dude, Where's My Primary Care? Lessons from Dutch Primary Care for American Reformers

Health Economics, Policy and Law Thesis

Samuel Chen

Student Number: 563255

Supervisor: Prof. dr. M Varkevisser

Reader: dr. E Birnie

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Erasmus School of Health Policy & Management

Erasmus University Rotterdam

Abstract

Background*:* The American primary care system is in need of reform. The suggestions for how to do so are numerous, raising the question of which policies to implement, and which to pass over. This study will attempt to narrow down the list of important reforms – as well as uncover new policies that might be useful for change makers to consider – by looking abroad and comparing the US to a nation that is broadly considered to have one of the best primary care systems in the world: the Netherlands.

Methods*:* A literature review and semi-structured interviews with American healthcare experts were performed to gather information on both nations' primary care systems. Drawing from various prominent authors in the field of comparative health policy research, a new method of comparison was developed, termed the *policy-characteristic-comparison-adaptation* framework. The results move through this framework stepwise, isolating noteworthy aspects of the Dutch primary care system, comparing them to the current state of American primary care, then looking for ways to adapt the strengths of the Dutch system to the American context.

Results*:* Four high-level "critical success characteristics" were isolated from descriptions of the Dutch primary care system. Comparison with the US revealed that three of these characteristics were semi-present or inchoate in the American primary care system, narrowing the unit of analysis down to an investigation of the fourth characteristic: strong institutional support for primary care. A historical analysis of the US uncovered various reasons for the lack of this support, mostly couched in the pro-specialist evolution of American healthcare.

Conclusion: American healthcare reformers should concern themselves more with cultivating stronger institutional support for primary care. In particular, future reforms should strengthen the standing of primary care in academia, create more direct channels for primary care experts to be involved in the policymaking process, and invest more in the training and payment of primary care practitioners, among other things.

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Section 1: Introduction

The American healthcare system is broken. Across the three public goals of healthcare that many nations strive for – accessibility, affordability and high quality care – America falls short of its international peers. In terms of affordability, the American healthcare system is infamously expensive, spending almost twice the OECD average (Tikkanen & Abrams, 2020). Despite the cost, accessibility is still quite lackluster. Though 92% of Americans had health insurance in 2019 (Keisler-Starkey & Bunch, 2020), a quarter of Americans in the same year reported delaying medical care for a serious condition due to financial barriers (Saad, 2019). Though measuring quality can be a difficult task in the world of healthcare, widely-accepted measures like avoidable mortality show the US at the bottom of the barrel relative to other advanced economies (Tikkanen & Abrams, 2020). The inferiority of these measures are magnified for certain demographics, a fact that was further exposed by COVID-19, which has disproportionately affected black and minority ethnic communities, among others (Mishra et al., 2021). Ultimately, when compared to other nations, the US demonstrates a clear need for healthcare reform.

Though the portrait of American healthcare is grim, the potential for sweeping change seems to be growing. Partly due to the pandemic, healthcare reform was at the fore of the political conversation in the 2020 election (“Role of Health,” 2020). The eventual winner, Joe Biden, has also helped pass the Affordable Care Act of 2010 as Vice President under Barack Obama, and has voiced his commitment to continuing the reforms that his Democratic predecessor began (Jost & Regan, 2021). Given his reputation as a coalition-building willing to reach across the aisle to forge bipartisan policies, Biden is one of the few figures in Washington who might be able to push a healthcare bill through a highly fractured Senate. The moment for healthcare reform may be on the horizon.

An often-proposed means of cutting the Gordian knot of healthcare challenges facing the US is through strengthening the nation’s primary care system. Primary care – defined broadly as the kind of “first-contact, continuous, comprehensive and coordinated care” delivered by

American family medicine physicians, among others – has been linked to a whole host of beneficial outcomes in healthcare (Starfield, 1994). Innumerable studies have shown the link between stronger primary care and lower rates of illness and death, more equitable distribution of health, and lower overall costs, among other outcomes (Starfield et al., 2005). Healthcare analysts note that the United States is unique among highly-developed countries in the weakness of its primary care system, suggesting that strengthening this system will help make American healthcare more accessible, affordable and high quality (Meyer et al., 2020).

Where opinions diverge is around how to strengthen primary care in America; one means of separating the wheat from the chaff and understanding what is necessary for a well-functioning primary care system is to look abroad. Comparative health policy research – as the field of study devoted to drawing lessons from side-by-side analyses of healthcare systems – holds great promise for teaching activists, policymakers, and other interested parties useful lessons about healthcare reform. This style of research can be useful both in inspiring the creation of new policies based on models plucked from abroad, and encouraging deeper reflection on the state of one's own healthcare arrangement (Marmor et al., 2009). With so many parties weighing in on how to "fix" American primary care, looking abroad can help one to better-understand which policy suggestions are worth exploring further, based both on what has worked abroad, and the particularities of one's own system, drawn out by the light of comparison.

An important first step is choosing the country of comparison. Strong comparative health policy studies require two things to be true: firstly, that the country of comparison has a health system that is similar enough to draw lessons from, and secondly, that that same health system is noteworthy enough for the lessons to be worthwhile (Marmor et al., 2009). Based on merit alone, several countries distinguish themselves as having exceptional primary care systems capable of delivering high quality, accessible care while constraining overall costs, top among them being the UK, Denmark and the Netherlands (Kringos et al., 2015). From this group, the Netherlands stands out as particularly comparable to the US in terms of industrial organization,

with both nations relying on private insurers in a system of “regulated competition” (Tikkanen et al., 2020a). This foundational similarity between the two nations’ healthcare systems has encouraged state visits by American politicians to the land of dikes and polders, as well as the crafting of a rich body of comparative health policy literature (“Lost in Translation,” 2008).

In pursuit of guidance on how to strengthen the American primary care system – and, through that, the healthcare system as a whole – this study will attempt to add to this literature by answering the question: “What, if anything, can American healthcare reformers learn from the Dutch primary care system?” Important sub-questions that must be answered in order to approach the above question in a more systematic way include:

- What are the critical success characteristics of the Dutch primary care system, and which policies and practices help to create these strengths?
- How does the US primary care system compare to its Dutch counterpart, especially in terms of the characteristics that help the Dutch stand out?
- How can some of the critical success characteristics of the Dutch system be adapted to better-fit the political and healthcare context of the United States?

Ultimately, the aim of answering the above questions is not only to study policies and practices from the Netherlands that might be worth adapting to the American context; it is also to turn the lens inward and learn more about America’s own system, about what works, what doesn’t, and what might. The final product will be policy suggestions based on both internal and external investigation that might be of use to lawmakers, activists, and general advocates for healthcare reform. Hopefully, the fruits of this research will prove useful in shaping the current debate around how best to harness the urgency of the COVID-19 pandemic and the opportunity of the Biden presidency to reform American healthcare.

Chapter 2: Conceptual Framework

This section will outline the foundation of this study based on three bodies of literature. Section 2.1 will assess the comparability of the Dutch and American healthcare systems, presenting broad facts about both and highlighting key differences that will become relevant later on in Section 4. Turning then to the theory on primary care, Section 2.2 will explore the questions, “what is good primary care, and how can it contribute to a health system?” Answering these questions will help establish what is at stake in this thesis, and what to look for in both primary care systems during the Results. The final section will explore the growing body of literature that is comparative health policy research. Learning across national boundaries is more complicated than simply juxtaposing two systems, and, in acknowledgement of this, Section 2.3 will spend time exploring best practices in comparative health policy research, which will form the basis of the methodology presented in Section 3.

Section 2.1: Overview of US and Dutch Health Systems

On a broad level, healthcare in the Netherlands and the United States share key similarities. Since its overhaul in 2006, the Dutch system has operated under the principles of “managed competition,” in which private insurers compete against each other and healthcare providers under the watchful eye of the government. The idea for such a system originally came from American academic Alain Enthoven, whose ideas likewise inspired many of the changes to the American healthcare system found in the Affordable Care Act of 2010 (Enthoven & van de Ven, 2007). This common theoretical underpinning makes American healthcare arguably more similar to the Netherlands than, say, single-payer systems like the U.K (Naderi & Meier, 2010). A number of comparative studies have used this rationale to justify juxtaposing the two nations’ healthcare systems, and this research will both draw from and expand upon this literature (e.g. van Weel et al., 2012; Faber et al., 2012).

Despite the seeming parallels between the two nations, meaningful differences still exist. In their categorization of different national health systems, Blank and Burau (2010) put the two nations in different camps. The Dutch system can be characterized as one of *social insurance* based on the Bismarck model, in which social solidarity is a guiding value, and universal coverage is a primary goal (Tikkanen et al., 2020a). Though health insurance for primary and curative care is provided entirely by private insurers, the government is heavily involved in the regulation of these insurers and other aspects of the healthcare system, in line with their commitment to "regulated" competition. The self-declared goal of the government is to protect three underlying values to Dutch healthcare: affordability, accessibility and quality. To do so, the government sets a base level of services that must be offered at a set price to all who are interested, have created a risk equalization fund to prevent risk selection among insurers, and mandate that all Dutch residents hold insurance. Though citizens pay for insurance through a combination of payroll taxes and premiums, many who make below a certain income threshold receive subsidies from the state, and children and adolescents are covered for free (Ministry, 2018). Related to their value of social solidarity, as well as factors beyond the scope of this paper, the Dutch have managed to make healthcare fairly affordable: the average yearly premium in 2019 was about $1,770 for an individual Dutch resident, while Americans paid about $5,376 (Scott, 2020; Porretta, 2020). As a result of both the insurance mandate and the greater affordability of plans, the Dutch uninsured rate is low, measured at less than 0.2% of inhabitants in 2016 (Tikkanen et al., 2020a).

This near-universal coverage and relatively strong level of government regulation contrast sharply with the United States. Blank and Burau (2010) categorize the US as a system of *private insurance*, in which "the basic assumption...is that the funding and provision of health care is best left to market forces." Though three forms of government insurance plans exist – Medicaid for low-income populations, Medicare for seniors, and Veterans Affairs insurance for veterans – more than two-thirds of Americans have private insurance, either through their employers or purchased individually (Berchick et al., 2019). As noted above, the average

premium is much more expensive in the US, and without a mandate for citizens to hold insurance, the adult uninsured rate was estimated to be about 8.9% nationally, though this varied by state from a high of 17.7% in Texas to a low of 2.8% in Massachusetts (Conway, 2018). At least part of this high uninsured rate has to do with political unwillingness on the part of some Americans for government involvement in healthcare (Gordon, 2014). Multiple attempts have been made by the federal government to expand the insurance system to ensure universal coverage, the most recent of which was the Affordable Care Act of 2010, which briefly established an insurance mandate similar to what the Dutch have, though this was quickly repealed (Fiedler, 2020). This reluctance to see state involvement in healthcare is a key difference between the Dutch and Americans, and the extent of private involvement in the American policy making process will figure into the discussion in Section 4.3.

Though many American healthcare reformers also aim towards the same public goals of accessibility, affordability and quality (Shi, 2012), a brief glance at comparative health system statistics indicates that the two nations differ widely in their ability to reach these goals. In a recent assessment of OECD data, Tikkanen (2019) found that, despite the fact that the U.S. far outspends the Netherlands on healthcare, they are grossly outperformed by the Dutch in areas like life expectancy, mortality amenable to health care and acute care average length of stay. A similar report from the Commonwealth Fund attempted to group measurements under different headings to more comprehensively rank health systems in terms of care process, access, administrative efficiency, equity and health care outcomes. The study found that the US measured last or nearly last across all categories except care process, while the Netherlands was among the top-ranked countries overall (Schneider et al., 2017).

In short, the US and Dutch share broad similarities in the pro-competitive bend of their healthcare systems, but differ significantly in other areas, like mandatory basic insurance coverage and attitude towards top-down control. One of the most prominent differences between the US and the Netherlands cited by the Commonwealth Fund report above is the gap in primary care strength between the two countries. Schneider et al. (2017) write that the current

arrangement of primary care in the US contributes to “inadequate prevention and management of chronic diseases, delayed diagnoses, incomplete adherence to treatments, wasteful overuse of drugs and technologies, and coordination and safety problems.” This contrasts sharply with primary care in the Netherlands, which has been widely lauded as exemplary, and which makes up the heart of the Dutch healthcare system (Kringos et al., 2015, Starfield, 1991). The following section will explore why a robust primary care system matters to overall health outcomes, thus justifying the importance of studying primary care in the first place.

Section 2.2: The Importance of “More and Better” Primary Care

To properly assess primary care, one must first define exactly what it is. One popular definition is that outlined in the Alma Ata Declaration of 1978, signed by all members of the World Health Organization, which affirms the importance of primary care as:

> [E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development and in the spirit of self-reliance and self-determination. It forms...the central function and main focus [of a nation’s health system]...[and] is the first level of contact of individuals, the family, and the community with the national health system (“Declaration of Alma-Ata,” 1978).

WHO member states seemingly affirm their belief that primary care must be the central part of a health system, accessible to all. As will be covered in Section 4.2, neither of these facts seem to be true in the United States, meaning that the WHO definition above may not be the best to compare the US and the Netherlands, since it doesn’t apply equally well in both places.

Instead, this paper will follow in the footsteps of pediatrician and health system academic Barbara Starfield in adopting a broad, characteristic-based definition. In her comparative research on primary care systems, Starfield found that defining primary care by the services that it entails or the professionals who practice it can create room for comparative confusion (Starfield, 1994). A focus on general practitioners (GPs), for example, would work well for nations like the Netherlands where GPs dominate primary care, but not for the U.S., where

primary care services are also provided by general internists, family medicine doctors, and even gynecologists (White & Marmor, 2005). Instead, Starfield and her colleagues argued for a definition based on the characteristics that define the care provided. Referred to in the field as the “four pillars of primary care,” these are:

1) “First contact access for each new need;
2) Long-term person- (not disease) focused care;
3) Comprehensive care for most health needs [both mental and physical];
4) Coordinated care when it must be sought elsewhere” (Starfield et al., 2005).

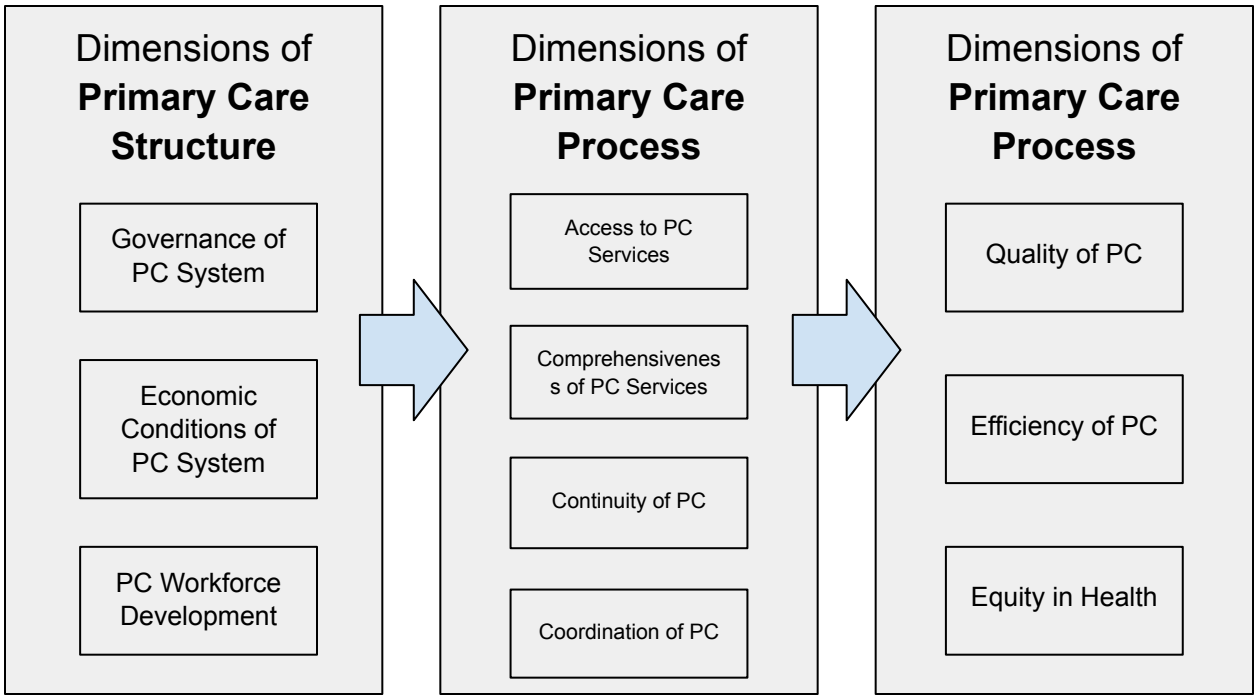
Under this definition, primary care is distinguished from secondary and tertiary care, both of which usually provide short-term (contra point two), focused (contra point three) care, which may be based on referral (contra point one and four) (Starfield, 1994). The breadth of this definition will allow for juxtaposing of more comparable services and professions between the Dutch and American primary care systems, rather than risking a comparison between apples and oranges.

Studies adopting this broad definition have found that primary care – when it is arranged well – is capable of improving healthcare systems in myriad ways. In a comprehensive review of the literature, Starfield et al. (2005) found that “more and better” primary care is linked to: improvements in a wide range of individual- and community-related health outcomes, lower disparities in these outcomes, as well as lower costs, both for individuals and the health system overall. The authors offer several explanations for these positive effects. As first-line providers, primary care professionals (PCPs) are well-situated to catch emerging health issues early, coordinate care to provide lowest-cost, most-appropriate services, and help patients manage chronic conditions and avoid unnecessary hospitalizations. Further, PCPs are also the primary source of preventive care in a health system, and are often the services most readily accessible among underserved demographics. Given its struggles with high costs and inequalities in care outlined in Section 1, the United States may well benefit from “more and better” primary care.

The question of what constitutes “better” primary health care – which sits as one of the major implicit questions in this research – is a difficult one to answer. Ultimately, the ideal primary care arrangement will depend on the overarching healthcare system within which it is embedded; what works for a national health system like the UK’s would arguably not work the same for America’s privatized landscape. That said, recent research from Kringos et al. (2010) has put forward a framework that attempts to answer this question of what “better” looks like. Building off of the research of Starfield and her colleagues, Kringos et al. conducted a thorough review of the empirical literature on what aspects of primary care structure yield beneficial outcomes. Grouping together effective policies allowed them to arrive at higher-level *characteristics* – like *c*ontinuity of care and workforce development – that have distinguished some primary care systems from their peers as far as various outcomes, from quality to cost, are concerned. These characteristics form the basis of their framework, termed the European Primary Care Monitor, which they later used as a tool to compare the effectiveness of various European primary care systems (Kringos et al., 2015).

The ten characteristics that Kringos et al. (2010) argue define most primary care systems are grouped into three clusters: the *structure* of primary care, its *process,* and the system’s *outcomes.* Primary care *structure* refers to “the basic conditions that enable a good functioning of primary care” (Kringos et al. 2010, p. 33). Characteristics that fall within this cluster include whether governments have a clear set of goals for primary care, how much of the healthcare budget is earmarked for primary care, and whether there are systems to ensure the proper number of PCPs, among other factors. Characteristics of primary care *process* relate to what services are provided and how they are delivered, and are captured by measures of accessibility, continuity, coordination and comprehensiveness of care. *Outcomes* are the results of both the structure and process of a nation’s primary care system, and are related not only to improved health, but also measures of equity and efficiency. Figure 2.1 offers an overview of each high-level cluster.

Figure 2.1: Overview of criteria that mark strong primary care systems, adapted from Kringos et al. (2010).



The European Primary Care Monitor is one example of a framework that helps to link specific aspects of a primary care system to outcomes of accessibility, affordability and quality. Though a full, point-by-point comparison of Dutch and American primary care systems based on this framework is beyond the scope of this thesis, their findings are important in highlighting which primary care policies and practices have been linked to real impact, and therefore which policies should be focused on in comparative health policy research. This is just one of the many best practices for comparative analysis that will be covered in the coming section.

Section 2.3: Best Practices in Comparative Health Policy

This study is, at its core, a study that falls squarely within the field of comparative health policy research. A fairly new and ever-growing field, comparative health policy has expanded

since the 1980s and 1990s, when supranational groups like the European Union and World Health Organization began taking a concerted interest in spreading policy learnings to help countries tackle what looked like very similar issues with rising costs and shrinking state budgets. Since then, the field has evolved into a useful tool for learning *about* how other nations arrange their healthcare system, understanding *why* these arrangements take place, and attempting to learn *from* experiences abroad (Marmor et al., 2009). In this sense, then, comparative health policy is useful as a tool for inspiration, sparking the imagination both in what one learns about other nations, and what one learns about one's own system (Klein, 2009). In this way, this style of research can be a powerful tool for policy makers, activists, or anyone interested in imagining a new and different policy future.

However, despite its many promises, incisive, well-considered comparative health policy research is difficult to carry out. As Marmor, Freeman and Okma (2005) point out, "[t]here is...a substantial gap between promise and performance in the field of comparative policy studies… [m]isdescription and superficiality are all too common" (p. 1). A number of comparative health policy experts have pointed to the inconsistent quality of comparative reports arising primarily from "ignoring methodological issues of comparison" (ibid). In the absence of the thoughtful deployment of methodologies from the field of comparative health policy, the validity of a report's suggestions remains in question. The following section will detail the most common pitfalls in comparative health policy research in order to outline the best practices upon which the research methodology – detailed in Section 3 – is built.

The first common pitfall in comparative health research is selection of "best practices" based on faulty assumptions of causality. Marmor (1994) illustrates this pitfall through a comparative study of the US and Japan. He argues that, based on outcomes alone, the American healthcare system seems to have much to learn from the Japanese, whose health outcomes are some of the highest globally. Upon closer investigation, however, Marmor points out that epidemiologists attribute most of Japan's good health to factors outside of the healthcare system, like measured diets and lower income inequality. Without establishing a

causal mechanism between healthcare and the higher-level outcomes being appraised, Marmor points out how easy it would be to draw unwarranted lessons from the Japanese system.

Avoiding this pitfall requires following the first best practice in comparative health policy: selecting policies to analyze based on their proven or theorized relationship to outcomes of accessibility, affordability and / or quality. In practice, this can be difficult to do. It is common knowledge that evaluating the impact of health policies can be difficult, and funding constraints often prevent the establishment of thorough causal chains (Frakt, 2019). However, thanks to the research performed by Kringos et al. (2010) above, it seems relatively plausible within the realm of primary care. By linking certain types of policies to outcomes through a thorough review of the literature, Kringos et al. enable a more discerning selection of policies to analyze, pointing researchers toward those that are more likely to be responsible for positive impacts on things like accessibility, affordability or quality, and helping to avoid the mistake outlined by Marmor above.

The second common stumbling block in comparative health policy research is that of naive transplantation. Prominent academics like Marmor et al. (2009) have warned against the dangers of this pitfall, whereby researchers suggest policy learnings with little regard to contextual differences between nations that might prevent such learnings from being effective. The vast institutional, political and cultural differences between nations means that, as Klein (2009) argues, “policy learning in practice is not about the *transfer* of ideas or techniques...but about their *adaptation* to local circumstances" (p. 307). Within this framework, the circumstances that must be adapted from and to are just as important as the ideas being adapted. Only by placing equal importance on both can more valid policy recommendations be made.

Two steps can be taken to avoid taking and applying policies out-of-context, the first of which involves transferring high-level characteristics rather than policies. Naive transplantation occurs when context-specific policies are ported across borders without consideration of the granular details of the policy that allow it to work in one nation but not in another. Working above

the level of such granular details can help to avoid such complications. For example, as will be explained in more detail in Section 4.2, a Dutch system of GP-run cooperatives provides comprehensive access to care outside of business hours. Though this policy works in the Dutch context, it would be unlikely to work in the American system; attempting to fit this policy into such a different system would be naive. However, if one abstracts this policy into a higher-level characteristic – like "grassroots efforts to expand coverage" – then it might be easier to imagine how such a characteristic could manifest differently in the US, but accomplish similar goals. This process of abstraction functions to gently remove the policy from its national context, which allows it to "travel" across national borders (Nielsen & Jensen, 2013).

After removing a policy from its home, transferring it to another requires the observation of the third best practice in comparative health policy: careful consideration of the national context within which one hopes new policies will take root. In his studies of the U.S., Canadian and Japanese health systems, Marmor (1994) attempts to adapt policies to new contexts by first examining whether they might be politically feasible in America, and then considering whether the non-American policy could be adapted to better-fit the American context. Both of these steps require the ability to understand what is and is not feasible in a nation, and why. One way to approach cultivating this knowledge is through applying the lens of historical institutionalism. This field of social science research concerns itself with understanding how institutions – defined as "formal or informal procedures, routines, norms and conventions embedded in the organization structure of the policy" – shape a nation's policy landscape (Hall & Taylor, 1996: pg. 6). To understand whether, for example, primary care practitioners in the US could serve a gatekeeping role, historical institutionalists would study the history and development of the American medical and political systems to understand whether such a policy seems feasible. They might argue that certain *path dependencies* – in other words, institutional momentum locking a country into one form of policy arrangements or another – either allows or disallows gatekeeping policies from being passed. Valid critiques have been raised against historical institutionalism in terms of how the theoretical framework conceptualizes changes as only due

to exogenous shocks to the system (Thelen, 1999). Despite this, its broad unit of analysis and strong focus on historical context makes historical institutionalism a powerful tool for conducting the steps outlined by Marmor, above. Ultimately, then, looking at the history and current state of a nation's political and healthcare systems can enable one to more thoughtfully transfer policy learnings from one nation to another while avoiding the naive transplantation fallacy.

Together, this collection of best practices form a series of guidelines for how to perform thoughtful comparative health policy research. Combined with knowledge of the relevant similarities and differences between the US and Dutch healthcare systems and some guidance on which parts of a primary care system are most important to study, these guidelines will help to inform the methodology outlined in the following section. Ultimately, it is these three literatures that ground this study.

Section 3: Methodology

The following section will detail the methodology deployed during the following study. As a reminder, this methodology was adopted to answer the following research questions:

Overall: What, if anything, can the US primary care system learn from its Dutch counterpart?

Sub Q1: What are the critical success characteristics of the Dutch primary care system, and which policies and practices help to create these strengths?

Sub Q2: How does the US primary care system compare to its Dutch counterpart, especially in terms of the characteristics that help the Dutch stand out?

Sub Q3: How can some of the critical success characteristics of the Dutch system be adapted to better-fit the political and healthcare context of the United States?

In order to answer these questions while following the best practices outlined in Section 2, a *policy-characteristic-comparison-adaptation* (PCCA) framework has been developed for the purpose of this study. The first step of this framework – *policy* – will follow the first best practice

described in Section 2 by selecting relevant Dutch primary care policies to study based on their theorized or tested connections to concrete outcomes. This will help to avoid issues of false causality, and ensure that the aspects of the Dutch primary care system being compared to the US are actually “truly exemplary and worth importing” (Marmor, 1994). To do so, aspects of the Dutch primary care system linked to improvements in accessibility, affordability and quality will be selected based on empirical studies of primary care like Kringos et al. (2010), plus critical studies of the Dutch primary care system. Next, these policies will be grouped into critical success *characteristics*, which represent the higher-level attributes of the Dutch system that make it exemplary. A more detailed description of how this process of abstraction is conducted will be provided in Section 4.1. Together, these two steps will answer Sub Question 1, regarding what makes the Dutch primary care system exemplary.

The final two steps, meant to help avoid the naive transplantation fallacy and answer Sub Questions 2 and 3, are those of *comparison* and *adaptation*. These encompass the final two steps of Marmor’s (1994) model, which involve i) gauging the political feasibility of foreign policies to the US, and ii) attempting to adapt said policies to the specifics of the American context. To apply both of these tests to the characteristics derived in step two, above, a few actions will be performed. Firstly, a *comparison* of how well the American system matches the critical success characteristics of the Dutch will be conducted in Section 4.2, in order to spot major differences between the US and Dutch systems and isolate areas where America seems to have the most to learn. After this gap-finding identifies certain policies or overarching characteristics that might be worth exploring in the US primary care system, a process of *adaptation* will take place. Following the suggestion of Wrede (2010), an historical institutional lens will be applied to explore whether, from a broader health policy perspective, certain Dutch policies would be (politically) feasible in the US. Beyond the historical analysis, and supplementing the document analysis, semi-structured interviews will be conducted with experts in American primary care to better-understand how to adapt critical success characteristics derived from the Netherlands for the American landscape. Together, this process will allow for a

more systematic process of comparison, one which attempts to contextualize policy learnings and avoid many of the pitfalls of comparative health policy detailed in Section 2.

In order to properly construct this study along the lines of the PCCA framework, two research streams were carried out, the dominant of which is a literature review, which will inform the answers to all three sub-questions. The overall literature review covered a number of broad domains, from comparative health policy research to overviews of both American and Dutch primary care, as well as American health policy reform suggestions. Given the huge breadth of literature that had to be consulted for this study, a complete review of all available sources on each topic was not feasible. Instead, each topic area was researched until a saturation point was reached, past which no significant new points were discovered. Databases were employed for this search, including Google Scholar and PubMed, as were websites from Dutch and American government agencies (e.g. the US Centers for Medicare and Medicaid Services) and interest groups (e.g. the Dutch College of General Practitioners). Journals were also searched, including Health Affairs and the European Journal of General Practice, among others, alongside think tanks like the Commonwealth Fund, and major news publications like the New York Times and Washington Post.

Given the importance of thoroughly studying the Dutch primary care system for Section 4.1, and the potential for missed research leads as a non-Dutch researcher, special steps were taken to ensure a thorough review process. Given limitations in Dutch language proficiency, only English language sources were consulted, though the inevitable narrowing of available literature was countered by focusing on review articles written by Dutch-language researchers (e.g. Kringos & Klazinga, 2014), which cite numerous Dutch-only publications. To draw useful lessons about what sets the Dutch apart, most of the literature cited in this section comes from the field of comparative health policy, which narrowed the field of study to sources from the Commonwealth Fund, supranational organizations like the European Observatory on Health Systems and Policies, and prominent Dutch / American comparative health policy researchers like Theodore Marmor, Dione Kringos, Wienke Boerma, and others. Search terms included:

Dutch primary care structure, comparative policy research of Dutch primary care, and others. Literature was reviewed until a saturation point was reached, in which articles were reviewed until findings became repetitive or the same articles were returned for new inquiries, indicating that a thorough base of knowledge had been developed (Saunders et al., 2018). The validity of the overall findings were confirmed with this study's research advisor, who is an expert in the organization of Dutch healthcare and could therefore point towards holes in the research.

The literature on American primary care reviewed for Sections 4.2 and 4.3 was much more vast that English reports on Dutch primary care, meaning that priority had to be given to certain sources over others. Again, comparative think tanks like the Commonwealth Fund were heavily consulted, and a focus on reviewing literature from major American journals like the New England Journal of Medicine and Health Affairs. When reviewing proposed primary care reforms for Section 4.3, most major primary care associations were canvassed, including the American Academy for Family Physicians (AAFP) and the American Medical Association (AMA), among others. Though reaching a saturation point for this portion of the literature would have been much more difficult, the thoroughness of the literature review was checked by performing interviews with experts in American primary care, a process detailed below.

Numerous articles were screened for relevance, with several exclusion criteria applied. First and foremost, due to language barriers, the articles reviewed were all English language. For sources on the Dutch primary care system, articles published before the 2006 healthcare reforms were excluded, due to the reforms' significant impact on the structure of primary care in the Netherlands. For articles on American primary care, most sources came from after the 2010 passage of the Affordable Care Act, though this act had limited impact on primary care, meaning that some sources from before this date were still considered relevant.

As a supplement to the document analysis outlined above, the second research stream involved a series of interviews with American primary care experts. Given scheduling difficulties, the two major interviews were conducted after most of the results were collected, and served two purposes: firstly, to uncover new sources for consultation which may have been missed in

the vast field of literature, and secondly, to check the validity of findings and policy proposals. These interviews were semi-structured in nature in order to allow the experts to drive the conversation towards topics that were not covered in the literature review, a key step in comparative health policy research noted by Wrede (2010). Mostly, the topics covered in these interviews were discussions of the institutional arrangement of American primary care, past attempts at reform, and the feasibility of future developments based on Dutch policies, though a list of jumping-off questions and topics is provided in Appendix A. Interviews were conducted with a convenience sample of experts from personal networks, mostly centered around the University of Chicago. Ultimately, two interviews were conducted with primary care practitioners based at the University who also have background in health system reform research. Interviews lasted between thirty minutes and an hour, and notes were taken as close to verbatim as possible, then later analyzed to pluck out key points and themes. After all interviews, a comprehensive review of the notes was conducted to pluck out any missing pieces of information or draw up cross-interview themes. Given the brevity and small number of these interviews, coupled with the vast amount to say about the literature review, space was not designated for a discussion of these interviews in the results. However, the findings gathered from them were used to guide research and prune aspects of the findings that interviewees felt were irrelevant, adding to the validity of the final results.

To enhance the validity of the findings, several steps were taken. The use of multiple research methods and varied sources for literature represents an attempt at data triangulation, whereby the convergence of information from varied sources can be used to test and enhance the validity of one's findings (Carter et al., 2014). Expert validation was also incorporated, with validity checks from both the research's Dutch academic advisor and several American primary care experts. A detailed research diary was kept to improve consistency and neutrality, noting changes in study design, emerging limitations and self-acknowledged biases, some of which will be discussed briefly in Section 5 (Noble & Smith, 2015).

The following research will chart a systematic course from the current state of Dutch primary care to the future of American primary care. Section 4.1 will introduce noteworthy aspects of the Dutch primary care system in order to complete the *policy* and *characteristic* stages of the PCCA framework. Section 4.2 will move on to the *comparison* step, applying the Dutch characteristics isolated in Section 4.1 to the American system to find major similarities and differences. Section 4.3 will cover the *adaptation* step, examining the history and context of specific American policy areas in order to better-understand the challenges facing American primary care and draw out well-informed solutions to said challenges. Section 5 will wrap up the research with a discussion of findings, limitations, and future research questions.

Section 4: Results

Section 4.1: The Strengths of Dutch Primary Care

In this first section of the results, the Dutch primary care system will be studied to set the stage for a comparative analysis in the following sections. In line with recommendations of Marmor (1994), this section will attempt to determine whether (part of) the Dutch primary care system is “truly exemplary and worth importing,” while also attempting to understand the critical success factors that distinguish the Dutch system. The section opens with a brief overview of the setup and performance of Dutch primary care system today, before diving into an explanation of how critical success factors were distilled. Next, each factor will be described, including an explanation of key policies that contribute to them, and the outcomes that these critical success factors contribute to. Ultimately, this will establish the comparative framework that will be used to judge the American system in Section 4.2.

An Introduction to Dutch Primary Care

Before diving into a policy-by-policy analysis of what makes the Dutch primary care system noteworthy, it's useful to begin with a general overview. Primary care is defined in the Netherlands as "directly accessible care, generalist care, provided in an ambulatory setting," and has long occupied a prominent position in the Dutch healthcare system (Kringos & Klazinga, 2014). Though primary care is delivered by a wide array of providers, from occupational therapists to home care nurses, the Dutch system has increasingly pushed one particular class of physicians – called general practitioners (GPs) – to become the central coordinators of the system (Kroneman et al., 2016). There were an estimated 13,364 GPs practicing in 2017, about 82% of whom worked in small, GP-owned practices between two and seven physicians (Tikkanen et al., 2020a). In 2013, GPs made up about 44% of the physician workforce, the sixth highest ratio among OECD countries ("Health Care Resources," 2013). All health insurance holders are required to register with a GP who lives within their postal code, and though provider networks can exist in the Netherlands, in practice, most policyholders have free choice among their local GPs (Kroneman et al., 2016). When visiting a GP, there are no out-of-pocket costs (Faber et al., 2012). These GPs play a gatekeeping role, which means that patients cannot visit a specialist without a referral. GPs themselves have a fairly broad scope of practice, including the ability to perform minor surgeries and procedures like gynecological exams (Willcox et al., 2011). Dutch GPs have been described as fairly non-interventionist, recording low rates of prescription and referral (Kroneman et al., 2016). After-hours, GPs are expected to offer care to their patients, and most deliver this care through local cooperatives that employ practice nurses to operate a triage phone line, a system that will be detailed more below (Smits et al., 2017).

In return for their gatekeeping efforts, Dutch GPs are compensated fairly well. In 2018, self-employed GPs reported a gross average annual income of €135,000 for in-hours care, just slightly less than the average income of €160,000 earned by salaried specialists in 2016, and higher than the national average of €37,230 (Tikkanen et al., 2020a; "Netherlands: Average,"

2021). Since 2015, this compensation has been delivered through a three-part payment schedule, which includes: 1) a base payment (~75-80% of GP earnings) that consists of a capitation payment per registered patient, plus a fee-for-service payment per patient visit; 2) bundled payments (~15% of GP earnings) delivered to groups of GPs for managing chronic conditions like diabetes; 3) payments (~5% of GP earnings) for good performance or participation in innovation initiatives (Schut & Varkevisser, 2017).

This particular primary care arrangement seems to be working quite well for the Dutch, when measured in terms of their own goals. The system is highly accessible: geographically, 99.9% of Dutch citizens live within a 10 minute drive of their GP, while the provision of free primary care means that just 9% of Dutch patients report that primary care is difficult to afford (Kringos et al., 2015). Availability of care was also high, with twice as many chronically ill Dutch patients reporting being able to get a same- or next-day appointment with their GP as compared to their American counterparts (Faber et al., 2012). Various mechanisms embedded within the Dutch healthcare system are associated with lower overall system costs, including use of GP gatekeeping and physician-ownership of practices (Garrido et al., 2011; Mostashari, 2016). In terms of quality, the Dutch primary care system ranks in the top five out of 31 countries assessed using the European Primary Care Monitor discussed in Section 2, placing particularly high in measures of coordination, continuity and comprehensiveness (Kringos et al., 2015). Though the system is not perfect (see: de Bakker & Groenewegen, 2009), it seems clear from the comparative rankings that Dutch primary care may have something to teach other nations.

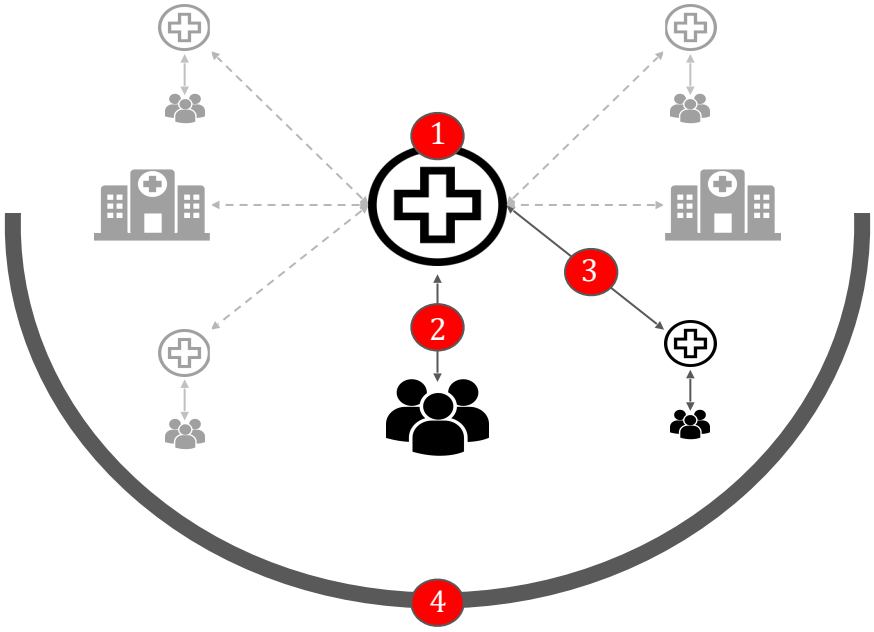
Defining Critical Success Characteristics of Dutch Primary Care

This research will follow in the footsteps of Marmor (1994) to adopt a characteristic-based approach to learning, as discussed in Sections 2 and 3. Isolating the following critical success characteristics involved several steps. First, a diversity of sources on Dutch primary care were consulted, with a special focus on papers devoted to comparison, as such sources

highlight noteworthy policies that mark the Dutch as different. From these sources, key policies were extracted, with an emphasis on those that have been linked to better outcomes in the wider Dutch healthcare system. From there, a process of policy grouping was undertaken. The aim of this was to find policies that were thematically similar and exemplary compared to other systems. Early drafts of these groupings were modeled after the work of Faber et al. (2012). After several iterations, in which the goal was creating a group of interlocking characteristics that were both mutually exclusive and collectively exhausting, a final group of four were isolated, and a model was created to ensure that these four critical success characteristics described as much of the Dutch primary care system as possible. This model is pictured in Figure 4.1.1 – developed for the sake of this research – in which a short description of each characteristic can also be found.

In the following paragraphs, each of these critical success characteristics will be described in detail. The policies that contribute to their construction will be enumerated, and any outcomes that can be associated with said policies will be described. Though the four characteristics cover only a sampling of policies that contribute to the functioning of the Dutch healthcare system, thorough review of the literature indicates that they represent the vast majority of policies singled out as significant to the exemplary performance of Dutch primary care.

Figure 4.1.1: Critical success characteristics that distinguish the Dutch healthcare system



1. **Empowered Primary Care Practices:** GP practices are given the incentives, support and autonomy to form a strong foundation for the overall primary care system.
2. **Relationship-Oriented Care:** Dutch primary care's emphasis on accessibility and continuity of relationships helps encourage deep GP-patient relationships, and thus better quality, more affordable care.
3. **Top-Down and Bottom-Up Attempts at Integration:** Both government-led and grassroots changes to policies and practices have helped integrate GP practices with each other and the rest of the healthcare system.
4. **Strong Institutional Support for Primary Care:** A foundation of support from parties like professional associations and academia allows primary care to hold a central role in the Dutch system, underlying all else.

Characteristic 1: Empowered Primary Care Practices

Primary care practices can be thought of as the bricks that build the foundation of a well-functioning healthcare system. This is especially true of the Netherlands, where several policies outlined as important by Kringos et al. (2010) – including universal health insurance, the obligation to register with a local GP, and their gatekeeping model – mean that primary care practices are a first and often final point of contact between patients and the healthcare system. Dutch GP practices are empowered to deliver comprehensive, high-quality care, and this can be linked to a number of beneficial outcomes, to be detailed below. First, however, this section will dive into the policies in question that allow individual GP practices to function independently and effectively.

The first set of policies that empower GP practices involves the notably wide scope of practice that Dutch GPs possess. According to Faber et al. (2012), most primary care practices in the Netherlands offer a broad range of services, from pediatrics and management of chronic diseases to more specialized procedures like spirometry. Across Europe, only Finnish GP practices provide a wider variety of services (Kroneman et al., 2016). Part of the payment structure for Dutch GPs is a fee paid specifically for administering treatment known to either improve quality of health (e.g. cognitive tests), or curb unnecessary secondary care (e.g. minor surgeries). Ultimately, this encourages Dutch GPs to play a larger role in the patient care system, which improves access by turning GPs into a one-stop shop for patients (Kringos & Klazinga, 2014). GPs' ability to handle cases in their practices without needing to refer out has also been linked to significant cost containment (Delnoij et al., 2000). In addition, shifting the responsibility to care from specialists to GPs has been linked to more favorable outcomes, shorter waiting times and higher patient satisfaction (van Hoof et al., 2019, Kringos et al., 2010).

This expansive role for GPs might risk overwhelming individual practitioners if it weren't for policies that encourage a team-based approach to primary care. Beginning in 2008, the use of practice nurses in primary care greatly expanded, with the government actively changing scope of practice laws and investing to expand the number of nurse training programs. GPs

receive additional payments to work with these nurses (Kringos & Klazinga, 2014), who lighten the GP's workload and provide focused care coordination for patients with specific conditions (Kroneman et al., 2016). As a whole, studies of the use of practice nurses have shown that quality of care is roughly comparable to that provided by GPs, and their integration into GP practices has been linked to improved health outcomes for patients with conditions like cardiovascular disease, as well as increased job satisfaction among both GPs and support staff (van der Biezen et al., 2016; Voogdt-Pruis et al., 2010; Lyon et al., 2018). In short, practice nurses have played a vital role in allowing Dutch GP practices to handle the responsibilities of occupying a central, empowered role in the overall system.

The independence and autonomy of GP practices also contributes to their position of power and centrality in the Dutch system. The vast majority of primary care practices in the Netherlands are small and independently owned, with one estimate stating that 85% of GPs are self-employed, while the other 15% are paid by another self-employed GP (Kringos et al., 2015). According to Faber et al. (2012), this largely independent ownership model "enables active participation in and commitment to quality improvement initiatives," and indeed, past research has found that GPs working in small, GP-owned practices are more entrepreneurial and innovative (Fleuren et al., 2004). Though there are likely several reasons why independent ownership is the norm, a major factor is pay: as outlined above, Dutch primary care physicians make a good salary relative to other professionals, and the mostly-capitated payment system means that Dutch GPs aren't beholden to volume requirements to fund their practice. This offers them a measure of financial independence, which can then be exercised by investing in their own practice. In other words, higher and more consistent pay for Dutch GPs empowers them to provide better care, as the overarching characteristic suggests.

Due in large part to the policies and practices outlined above, Dutch GP practices are individually powerful, which can be linked to a number of beneficial outcomes. Besides those mentioned already, accessibility is improved in a somewhat roundabout way by the same factors that make individual practices strong. Some have argued that the higher pay, expanded

scope of practice, and leadership roles given to Dutch GPs raises the specialty's status, which both attracts medical students to the field, and retains practitioners within the field for longer (Villanueva et al., 2019). A 2021 survey of GPs around the world found that the Dutch landed in the upper third for job satisfaction (Stobbe et al., 2021), and counts show that there is no major shortage of GPs, nor will there be given the rate of retirement and replacement (Willcox et al., 2011). The importance of adequate GP supply cannot be overstated: due in part to the number of GPs, Dutch patients report some of the greatest ease securing appointments with their primary care providers (Faber et al., 2012). Zooming out a level, the overall characteristic of empowered primary care practices creates a solid bedrock upon which a functional primary care system can be built, and the next layer upon that foundation is what will be explored in the coming paragraphs.

Characteristic 2: Relationship-Oriented Care

Moving the unit of analysis out from GP practices to their interactions with patients, the Dutch primary care system is noteworthy in the extent to which it helps to forge strong GP-patient relationships. Close relationships between doctors and patients have long been linked to beneficial health outcomes for patients (Chandra et al., 2018), and outside observers often note the unusual proximity between Dutch GPs and their patients (Jolly, 2012; Battin, 1991). The paragraphs below will detail some of the policies that enable this proximity, while also digging into the results it has on patients and the wider system.

Structurally, there are several aspects of the Dutch insurance system that encourage the creation of long-standing GP-patient relationships. Firstly, Dutch citizens need not pay anything to see their GP, creating low- to non-existent cost barriers. Further, because insurance policies are held by individuals rather than tied to employers, and insurers tend not to limit consumer choice, Dutch residents can keep the same GP even if they change jobs or insurance (Victoor et al., 2012). Given this fact, it's unsurprising that, in 2008, a Commonwealth Fund survey found

that 79% of Dutch patients had been with the same practice for over five years (Cohn, 2011). Beyond this, all Dutch insurance holders are strongly encouraged to register with a GP within their zip code. Though this focus on locality limits consumer choice, it also ensures that GPs are geographically accessible, and that the GPs themselves have a better sense of their patients' community, since they must practice within it (Battin, 1991). Combined with the high number of GPs, this means incredible geographic accessibility: in fact, it only takes an average of 1.3 minutes by car to reach a GP in the Netherlands (Kringos et al., 2015).

Two other common practices in the Netherlands have helped to increase access and create a tighter bond between GP and patient. The first is the common nature of physician house calls: in the Netherlands 100% of primary care providers report performing this service for patients (Doty et al., 2019). In 2009, the average GP delivered 8.75 home visits per week, and this frequency both increases accessibility of care to patients with difficulty traveling, and allows physicians to understand the home circumstances of their patients (Kringos et al., 2015). More recently, with the safety of house calls called into question by COVID-19, the Dutch system has also expanded access through a second avenue: its telehealth capabilities. Within the first acknowledged week of the epidemic, the Dutch government had created an incentive structure that drove Dutch GPs to create virtual access options for all patients (Huston et al., 2020). Early studies on the effect of telehealth utilization on quality of care during COVID are largely positive, but just beginning to reach publication (Leontjevas et al., 2021; Bos et al., 2021). More obviously, the effect of telehealth on accessibility is largely positive, shown in many cases to be an overall boon to the health system, both in terms of cutting down unnecessary visits, and giving GPs more time to see their patients (Hoffman, 2020).

Finally, the system of GP compensation encourages a more holistic approach to healthcare. As part of their payment package, GPs receive a capitated payment per patient in their panel, which may incentivize them to adjust their treatment plans based on patient needs rather than what is billable (Schut & Varkevisser, 2017). Research conducted after the Dutch switched to a blended capitation / FFS model after 2006 shows that time investment in follow-up

contacts increased, indicating a greater willingness to invest in patient care outside of the traditional visit (van Dijk, 2012). Moreover, studies have found that capitation payment models can improve quality through facilitating collaboration between providers and encouraging provision of more human- and community-centered care, like preventive services and population health (Wranik & Durier-Copp, 2011).

Ultimately, through a host of various policies, the Dutch seem to have crafted a system that encourages stronger relationships between GPs and patients, which can translate to numerous beneficial outcomes. Besides those listed above, the closeness of the doctor-patient relationship can improve patient satisfaction (de Waard et al., 2018), as well as encourage higher levels of trust, which may offer GPs more leeway to curb patients' use of specialists or experiment with new approaches to care (Chipidza et al., 2015). More than simply empowering individual GP practices, then, the Dutch are also worth emulating in the extent to which they build their primary care system on a foundation of strong GP-patient relationships.

Characteristic 3: Top-Down and Bottom-Up Attempts at Integration

Creating strong individual practices with close relationships to their patients isn't enough to create a strong overall *system* of primary care; this takes deliberate policymaking to ensure that these practices function well together and with specialists. Though the Dutch government is still seeking out new ways to ensure a more integrated and collaborative system (Willcox et al., 2011), several policies and practices are worth highlighting that have gone a ways towards achieving this goal.

One of the most noteworthy aspects of bottom-up integration in the Dutch primary care system, cited by many as an international example, is their system of after-hours care. Dutch GPs – who are expected to provide 24/7 access to care for their patients – once worked long hours answering late-night calls, until a few innovative practices came together to provide after-hours care cooperatively (Smits et al., 2017). Eventually, this arrangement spread and evolved

into a system of regional after-hours care centers owned by GPs, which employ practice nurses to operate a call center that triages out-of-hours care (Baier et al., 2019). The effect of these centers on accessibility is obvious, and they can also improve quality of care for chronically ill patients who may need sudden access to services (Cohn, 2011). Integration of these centers with emergency departments also allows GPs to lower costs by reducing contacts with emergency care. Finally, cooperation between GPs has also made the specialty a more attractive field: involvement in cooperatives dropped average overtime hours, while boosting both GP and patient satisfaction (Kringos & Klazinga, 2014). As a whole, the cooperatives – as an example of collaboration between the many individual GP practices in each region – have gone a long way towards improving the Dutch health system's performance.

A more top-down set of policies from the Dutch government have also helped bring primary care practitioners together to form a strong network of care. Starting in 2007, health insurers began providing financial incentives to primary care practitioners based on their level of collaboration. The result has been a gradual movement of independent GPs and other primary care professionals towards engaging in multidisciplinary collaboration through, e.g., regional collaborative care groups (Kringos & Klazinga, 2014). Group membership further expanded beginning in 2010, when bundled payment mechanisms were introduced to incentivize coordination between PCPs who treat patients with certain chronic diseases. Both moves have been linked to quality improvements (Hendriks et al., 2012; Cramm et al., 2012), demonstrating the benefits of incentive structures that help to achieve better coordination.

Electronic health records (EHRs) have played an integral role in facilitating integration. The Dutch were one of the early adopters of EHRs, which were widely adopted as a result of grassroots innovation among GPs (Faber et al., 2012). Since that early adoption, EHRs have become invaluable in coordinating cross-practice care. For example, after-hours care cooperatives regularly exchange EHR to keep daytime GPs up-to-date (Willcox et al., 2011), while more recent demands placed on hospitals by COVID-19 have driven tighter EHR integration between primary care practices and the hospitals to which these practices referred

patients improved substantially (Rawaf et al., 2020). Thanks in part to these tech-driven solutions, the Dutch system performs favorably on many measures of care integration relative to other nations with private insurance arrangements (Table 4.1.1).

Table 4.1.1: Comparison of care coordination methods between the US, Germany and the Netherlands (adapted from Doty et al., 2019)

Measure	**US**	**Germany**	**Netherlands**
Specialist usually sends patient history and reason for consultation	75%	47%	97%
PCP usually notified when patient seen for after-hours care	36%	36%	97%
PCP usually notified when patient has been seen in an ED	48%	40%	84%
PCPs electronically exchange patient clinical summaries with any doctor outside their practice	53%	12%	81%

Noted above are just a handful of the policies and practices that have made the Netherlands relatively proficient at care coordination. Two themes can be seen across many of them. Firstly, the Dutch have shown a willingness to experiment with payment models, which has helped to improve collaboration. The use of bundled payments, add-on incentives from insurers to collaborate with other practices, and other mechanisms have created an attractive carrot pushing GPs and other PCPs towards care collaboration. Second, a number of Dutch initiatives come not from the top- or middle-down, but from the bottom-up. After-hours care cooperatives and early experiments with EHRs were innovations that came from individual primary care practices, something that may be argued is made possible by the fact that, as

Characteristic 1 notes, Dutch GP practices are strong enough to innovate and experiment. This is evidence not only of the interlocking importance of each characteristic, but also of how building strong practices can contribute to the creation of a strong system.

Characteristic 4: Strong Institutional Support for Primary Care

Having already covered the characteristics that allow primary care practices to support their patients both individually and as a collaborative care network, it's important to now briefly discuss what underlies this system: strong institutional support. Healthcare in nations like the Netherlands and the US is a complex interaction between the competing interests of many institutions: the government, industry players, patient advocacy groups, insurance companies, among others. The fact that primary care can occupy a position of primacy within a healthcare system is not a given – as shall be made clear in the next chapter – and Dutch primary care in particular is able to play a central role in the healthcare system thanks only to support from a number of these institutions.

One of the main drivers of Dutch primary care's centrality within the larger health system is the strong professional presence of Dutch GPs. According to Marmor et al. (2009), the Dutch system is distinct from some other nations in the strength of GPs as a collective group. On a national level, GPs are supported by both a professional association (the Dutch College of General Practitioners, or NHG) and a powerful union (the Dutch Association for General Practitioners, or LHV). Faber et al. (2012) cites the NHG as a defining reason why primary care continues to occupy such an important position in Dutch healthcare, and Kringos et al. (2010) likewise identify strong professional associations as important to well-functioning primary care. Together with the LHV, the NHG wields significant bargaining power in the healthcare policy making process, which allows it to negotiate GP salaries, advocate for better working conditions, and create practice guidelines to ensure that patients receive high quality primary care (Kringos & Klazinga, 2014). It can be argued that these actions contribute to the

Netherlands' accessibility and affordability goals, since they help make the GP role more attractive, thus helping to draw in new doctors and retain existing ones for longer.

Not only have GPs held significant collective power at the negotiating table; they have also been robustly supported by a strong, pro-primary care government. The commitment of the Dutch government to centering primary care is evident in both the amount of money spent each year on primary care – 14.7% in 2010, above average among OECD countries – and in the way that the entire system revolves around primary care gatekeepers (Kringos & Klazinga, 2014). This support is integral in helping Dutch GPs maintain a favorable balance of power in the face of insurers, specialists, and other parties trying to claim a larger piece of the healthcare pie (Groenewegen, 2012). Though the combination of a pro-primary care government and strong primary care interest groups creates the risk of GPs abusing their dominant position and requires more vigilance on the part of the Dutch competition authority (Schut & Varkevisser, 2017), it has also helped to enable the primacy of primary care in the Netherlands, which has delivered the many benefits enumerated above.

The final source of institutional support for Dutch GPs comes from academia. Medical schools form the pipeline that provides fresh talent for the primary care system, and due in part to this, Kringos et al. (2010) point towards the status of primary care in academia as a key part of a well-functioning system. In the Netherlands, students are required to complete a general practice internship, which offers exposure to the life of a GP and may increase their likelihood of choosing this as their profession (Alberti et al., 2017). Similarly, many courses are co-taught by generalists and specialists to provide more balanced exposure to the field of medicine (Villanueva et al., 2019). Given the level of respect and attention accorded to general practice in medical schools, it's not surprising that, in 2014, 1250 medical students fought for just 750 GP traineeships in the Netherlands (Arie, 2015). Ultimately, this has helped to avoid a gaping GP shortage in the Netherlands, and this support from academia – alongside strong professional organizations and a pro-primary care government – has helped to create a solid bedrock upon which the primary care system can be built.

Conclusion

This chapter has attempted to construct a framework of characteristics that capture the major distinguishing aspects of Dutch primary care. The purpose of doing so is twofold. Firstly, organizing policies into broad buckets is a useful means of drawing out that which distinguishes the Dutch primary care system. Constructing a series of higher-level characteristics can highlight the underlying logics of the system, distinguishing what makes the Dutch different. The second reason for distilling these characteristics relates to what comes in the next section. The overall research question of this thesis – what can the American primary care system learn from the Dutch – demands a process by which to draw comparisons. Moving policy-by-policy may not be useful; as is discussed in the theoretical framework, doing so would be too granular and risk missing the forest for the trees. Distilling these policies will allow for the coming discussion of US primary care to compare not only individual policies, but also the underlying logics of both the US and the Netherlands when it comes to primary care. In doing so, a broader comparison will be made, adhering to the idea of comparative health policy as an inspirational act, rather than something purely technical.

Section 4.2: American Primary Care in Comparison

Having already distilled the critical success characteristics that distinguish the Dutch primary care system, this section will shift attention to the nation in need of health policy learnings: America. Following the third step of the PCCA framework described in the methodology, the following paragraphs will focus on *comparison*. By examining how the US system measures up to its Dutch counterpart in terms of the characteristics isolated in Section 4.1, the following pages will attempt to answer Sub-Question 2:

> *How does the US primary care system compare to its Dutch counterpart, especially in terms of the policies that help the Dutch stand out?*

In doing so, this section will isolate gaps between the Dutch and American systems, drawing attention to individual policies or overall characteristics where reform efforts should be focused. Before diving into the more granular comparison, though, it is necessary to describe the American system in broad strokes.

American Primary Care Overview

Compared to the Dutch primary care system – where GPs deliver services dictated by a universal base package of care – the American primary care system is more of a patchwork of providers and plans. General practice does not exist as a specialty in the United States; instead, family practice physicians serve a similar purpose as Dutch GPs. However, Americans are not required to receive primary care services through a family physician, and often seek similar types of care from other specialists, like internists, pediatricians, geriatricians and gynaecologists (Lancet, 2019). Together, physicians practicing these specialties are called "primary care providers" (PCPs). Right away, this makes it difficult to characterize primary care as a single field managed by a single class of physicians. Depending on their specialty, PCPs receive different training, which can have effects on their practice style (Shackelton-Piccolo et al., 2011). Where these physicians practice varies widely as well: for example, in 2017 almost a third of PCPs reported practicing in hospitals, which some argue fundamentally constrains their ability to practice a more community-oriented style of care (Kane, 2017; Cassel and Wilkes, 2017). In terms of who delivers primary care and where it is delivered, then, American primary care is fairly heterogeneous relative to its Dutch counterpart.

Another example of heterogeneity can be seen in how patients must access primary care. Unlike in the Netherlands, where all insurance holders access care without copays through a local GP who serves as a gatekeeper, the way in which Americans access care is highly dependent upon their insurance plan. There are four dominant coverage models that determine factors like: level and type of consumer cost-sharing to access primary care, free

choice of provider, use of gatekeeping, requirement to register with a PCP, and other factors ("Types of Health," 2018). Table 4.2.1 provides a comparison of the dominant models.

Table 4.2.1: Categorizations of different health insurance models available to American consumers (based on "Types of Health," 2018)

Coverage Type	**Description**	**Mandate to Register with PCP**	**Access Restrictions**	**Consumer Cost-Sharing**
Health Maintenance Organization (HMO)	Typically the most affordable plan, but also the most restrictive, limiting care with both gatekeeping and a care network outside of which one must pay full cost for treatment	Yes	Gatekeeping; limited network of physicians from whom one can receive covered care	Copays and / or deductibles
Exclusive Provider Organizations (EPOs)	Similar to HMOs in their use of provider networks, but with more free choice of provider on the part of patients	Sometimes	No gatekeeping; limited network of physicians from whom one can receive covered care	Copays and / or deductibles
Point of Service (POS) plan	A mixture of the HMO and PPO plans, which offers greater choice of physician at variable costs	Yes	No gatekeeping; coverage to see all physicians, with cost reductions for those deemed "in-network"	Copays and / or deductibles
Preferred Provider Organizations (PPOs)	The most permissive of plans as far as consumer choice of provider is concerned, but often at a higher cost	No	No gatekeeping; networks of providers are large, if not all-encompassing	Copays and / or deductibles

Based on this figure, three major differences between American and Dutch primary care are clear. Firstly, most American insurance plans don't entail a PCP gatekeeping function, de-centering American PCPs. Secondly, most insurance plans charge fees to access primary care, introducing financial barriers to accessing care. Finally, the American system has many different means of accessing care, which creates more red tape and restrictions on who patients can see, whether physicians can accept patients, etc., all of which creates high barriers to care and significant administrative work for physicians (Enthoven, 2009). In terms of how patients are able to access care, then, the American system is once again more varied than the Dutch.

One uniform characteristic of primary care in the United States is its minimization next to the power of specialists. Not only does the United States have significantly fewer physicians per capita than the Netherlands – in 2017, there were 2.6 physicians per 1,000 people in the US compared to 3.6 in the Netherlands – but there are also significantly fewer PCPs compared to specialists ("Physicians," 2018). Only about one-third of active physicians in the US are PCPs, compared to 44% in the Netherlands (Tikkanen et al., 2020b; "Health Care Resources," 2013). Specialists also make significantly more than PCPs in the US, with average primary care compensation amounting to less than 62% of what the average specialist made in 2017 (Hsiang et al., 2020). Though a gap likewise exists in the Netherlands, it's much smaller, with the average GP making 84% of what their specialist colleagues make (Tikkanen et al, 2020b). At a higher level, US government spending on primary care is quite low compared to its overall healthcare budget: 10.2% in 2018, compared to 14.7% in the Netherlands (Lancet, 2019; Schäfer et al., 2010). This underinvestment, alongside the pay gap, may be behind the nation's so-called "PCP shortage" (Collins, 2012), a growing problem whose implications will be discussed below. In short, on both the level of individual payment and government funding, PCPs are far undervalued compared to their specialist counterparts.

The Dutch and American compensation mechanisms for PCPs differ significantly, though experiments with new payment models may change this. Unlike the Netherlands, where GPs are compensated through a blended payment model combining capitation with some FFS

elements and different value-based add-ons, American PCPs are primarily paid through a fee-for-service vehicle. The tying of compensation to visit volume has been widely criticized by reformers for its propensity to drive up costs and spur unnecessary care utilization (Jain & Gadhe, 2021). Beyond this, lack of a baseline capitated payment to PCPs meant that, when COVID-19 hit and patient volume to primary care offices dropped, many primary care practices were financially crippled (Filippi et al., 2021). Amid loud calls for payment reform, the Centers for Medicare and Medicaid Services (CMMI) – which was created by the ACA to experiment with new methods of payment and delivery – has launched trials of different forms of value-based payment (VBP), with varying levels of success. Some of these will be covered below. Overall, though most agree that FFS needs to go, it is unclear what system – or systems – will take its place.

Taken as a whole, the American primary care system under-delivers relative to its Dutch counterpart. Access to primary care and overall use seems to be dropping in the US: in 2002, 77% of Americans reported having a source of primary care, while this same measurement dropped to 75% in 2015 (Levine et al., 2020). Among this 75%, many are enrolled in high-deductible health plans, which can make care financially inaccessible (Lancet, 2019). Access is even worse among certain demographics, including rural residents and a number of ethnic minority groups (Kirby & Yabroff, 2020; Hayes et al., 2017). System-wide affordability is threatened by the FFS compensation system, which some have estimated contributes greatly to the approximately $210 billion in unnecessary services provided in 2009 (Erickson et al., 2020). Quality outcomes associated with primary care are grim: hospitalizations for hypertension and diabetes – which can be prevented with access to quality primary care – were 50% above the OECD average in the US (Tikkanen & Abrams, 2020). In summary, American primary care shows a number of fundamental differences from the Dutch system, and these differences manifest themselves in far poorer access, affordability and quality. In the following section, these differences will be explored in greater depth to work towards a better understanding of the most important areas for reform.

Characteristic-based Comparison of Primary Care Systems

This section will attempt to systematically compare the American and Dutch primary care systems by relying on the critical success characteristics derived in Section 4.1 to guide the comparison. The following paragraphs will step through each characteristic, comparing the two systems at both the level of individual policies and overall characteristics, to understand how similar the US primary care system is to its Dutch counterpart in terms of the factors that make the Dutch system effective. Both current and proposed US primary care policies will be used in this comparison, in order to reveal not only existing differences between the two systems, but also blindspots among healthcare reform advocates. Ultimately, doing so will help to draw attention to significant differences between the two nations – both current and proposed – worth exploring further in Section 4.3.

Arriving at the coming analysis involved a bottom-up process of comparison, which is outlined in Appendix B. Research began by comparing the US and the Netherlands policy-by-policy, across both current and proposed American primary care policies. Current policies were drawn from comprehensive overviews of the US primary care system from sources like the Commonwealth Fund, the Lancet, Health Affairs, and the American Journal of Medicine. Proposed policies were culled from a more select body of literature, with the reputation of those proposing the policies standing in as a proxy for feasibility: proposals consulted included those from leading political lobbying groups (e.g. the American Medical Association, American Academy of Family Physicians, etc.), prominent journals with wide readership (e.g. the New England Journal of Medicine, JAMA Network, etc.), and well-known think tanks (e.g. the Commonwealth Fund). Based on the policy-by-policy understanding of how the US and the Netherlands compare, an overall comparison at the characteristic level was formulated. For the sake of brevity, the following paragraphs will focus mostly on this characteristic-level overview, with a few policy-level examples selected based on their ability to illustrate the overall

comparison. After comparison across all characteristics, the final paragraphs of this section will be devoted to a high-level summary of the differences and what they imply for Section 4.3's analysis.

Characteristic 1: Empowered Primary Care Practices

As it stands, primary care practices in the US are relatively weak compared to their Dutch counterparts (i.e. GP practices), due in part to the lack of several of the policies that help center and empower Dutch GP practices. For one, financial pressures to consolidate have driven an increasing number of American PCPs to abandon ownership of their own practices, thereby relinquishing much autonomy and authority (Mazzolini, 2019; White & Twiddy, 2017). Beyond this, gatekeeping – perhaps one of the most important Dutch policies responsible for centering and empowering primary care – has had a sordid history in the United States. Though Medicaid in most states relies on a PCP gatekeeper model (Minemeyer, 2020), managed care plans are unlikely to gain widespread usage among private insurance holders – who still make up about 68.5% of insured Americans – after large-scale pushback against such arrangements in the late 1990s and early 2000s (Rosso, 2021). Termed the "managed care backlash," this pushback resulted in many American consumers abandoning insurance plans with PCP gatekeepers in favor of plans with greater consumer choice (Hall, 2005). In the long-term, this minimized the use of PCP gatekeepers in American healthcare, which likewise minimizes the role that primary care practices can play in coordinating care.

The care coordination and cost containment made possible by gatekeeping is currently being attempted in other forms, though, perhaps most prominently by the patient-centered medical home (PCMH) model. The PCMH model was developed by primary care experts from bodies like the American Academy of Family Physicians, in conjunction with employers and other parties invested in creating a more robust primary care system ("The Patient Centered," 2007). It describes criteria that primary care practices must meet in order to deliver high quality,

affordable and accessible primary care, and, since the federal government began offering enhanced reimbursement to practices that qualify as PCMHs in 2010, the number of PCMHs has exploded (Abrams et al., 2011; Peikes et al., 2020).. Table 4.2.3 details some of the requirements to be considered a PCMH, and demonstrates the resemblance between the PCMH model and the way that Dutch GP practices are structured. Early evidence has shown that, like the Dutch model, PCMHs can help cut costs and improve quality ("Benefits of NCQA," 2019), though the large-scale success of PCMHs on a wider scale remains to be seen, with some analysts predicting that a lack of PCPs will make it difficult for large-scale adoption (Kilo & Wasson, 2010). As a whole, however, the PCMH model demonstrates a willingness for the American system to pursue many of the policies and practices that distinguish Dutch primary care, just through alternate routes.

Table 4.2.3: Overview of similarities between the patient-centered medical home (PCMH) model and current Dutch primary care policies (based on Higgins et al., 2015)

Certification Category	**Category Description**	**Similar Dutch Policies, with related characteristics identified**
Comprehensive Care	Caring for the "whole person," providing physical, mental and preventative healthcare using a primary care team and coordinating with other care providers.	- Wide scope of practice for GPs (C1) - Team-based approach to primary care (C1) - Middle-out approaches to integration (C3)
Patient-Centered Approach	Providing "relationship based" care through a focus on patient engagement and the formation of strong doctor-patient relationships.	- Relationship-oriented care (complete C2)
Coordinated Care	Integrating with hospitals, specialists, etc., through improved communication models like EHRs.	- Top-down approaches to integration (C3)

Accessibility of Services	Offering enhanced hours and access to out-of-hours care arrangements, alongside expanded technological capacities like over-the-phone care.	- Expanded use of telemedicine (C2) - Access to out-of-hours care (C3)
Quality and Safety	Using data-driven quality improvement methods and advanced tools to track the health of their panel, among other things.	- N/A

Together, the examples of the failure of expanded gatekeeping and the early successes of the PCMH demonstrate the large contextual differences between the US and the Netherlands. Studies of the managed care backlash point to the role that cultural factors played in the failure of widespread managed care arrangements, arguing that Americans are far less likely than those in other nations to accept more constrained care options (Robinson, 2001; Victoor et al., 2012). This, among other policies studied in the creation of this section, indicate that not all pieces of a Dutch-style system would be politically or culturally feasible in the US. However, the example of the PCMH demonstrates how the US can use different policies to arrive at similar arrangements as the Dutch. As a whole, then, an examination of Characteristic 1 reveals broad similarities between what the Dutch system offers and what the American system is aiming to move towards, with the caveat that some aspects of the Dutch primary care arrangement are simply not possible in the US context.

Characteristic 2: Relationship-Oriented Care

The Dutch can create stronger doctor-patient relationships partly due to ease of accessibility, something that the American primary care system struggles with. At present, America lacks many of the policies that make the Dutch unique: both public and private insurers rely on consumer cost sharing mechanisms to curb unnecessary usage (Gabel et al., 2016), while home visits are rare and the use of telemedicine is only expanding due to emergency

reimbursement policies passed during COVID-19 (Oller, 2015; Volk et al., 2021). This lack of policies, coupled with geographic and coverage-based differences that make access to primary care much more difficult in the US, make the obstacles to strong PCP-patient relationships seem high (Jeong, 2015). However, recent changes are pushing the US in a new direction: emergency funding during COVID-19 allowed physicians to be reimbursed for most telemedicine consultations, spurring wider adoption (Koma et al., 2021), recent CMMI experiments measured significant cost savings when house calls were used more often to treat Medicare patients (Blumenthal & Abrams, 2020). So, though some policy differences between the two nations seem to be fixed, others are moving towards an arrangement that makes it possible for American PCPs to forge stronger bonds with their patients.

However, a number of major differences between Dutch and American primary care create doubt around whether the above policy advances will meaningfully change the doctor-patient relationship. For one, many American insurance plans optimize for patient choice and don't require a designated PCP, meaning that patients can see a different PCP anytime they seek care (Carroll, 2019). This, coupled with urgent care centers that allow patients to seek out immediate care with whichever physician is on staff that day, means that, even if access to care is expanded, many Americans won't see the same physician enough to form a relationship (Abelson & Creswell, 2018). Besides this, there simply aren't enough PCPs in the US to provide adequate care to all. Today, the average PCP would need to spend an estimated 21.7 hours each day to deliver the proper amount of acute, chronic and preventive care to their panel in a year (Altschuler et al., 2012). This amount could go up as the ACA expands access to primary care, more PCPs retire early and fewer medical graduates choose primary care specialties (Zhang et al., 2020).

Overall, a comparison of the US and the Netherlands across aspects of Characteristic 2 reveals foundational differences in how primary care is and can be delivered. With no mandate to see the same PCP, and fewer PCPs than would be needed to even accommodate such a policy, it seems doubtful that the US can create a similar proximity between doctor and patient,

even if home visits and telemedicine use do expand. As a note, the lack of PCPs was mentioned as a challenge to better-achieving the goals of Characteristic 1, as well, which suggests that the integrity of primary care's underlying foundation may be questionable. Characteristic 4 will explore this foundational weakness further, but first, this study will turn to understanding how American primary care integrates with itself and with other aspects of the healthcare system.

Characteristic 3: Bottom-Up and Top-Down Attempts at Integration

In terms of top-down efforts at care integration, experiments with new payment models in the US are showing early promise at better-coordinating care between primary and secondary care (Loria, 2019). One top competitor to a FFS arrangement is the accountable care organization (ACO) model. An ACO is an interlocking system of providers that is responsible for managing the total cost of care for an entire population of patients in a shared savings model, which incentivizes better coordination. As a result, ACOs share patient data and refer within the network, and are spearheaded by primary care professionals who coordinate patient care (Lowell & Bertko, 2010). However, despite spreading to cover over 33 million Americans, not all ACOs realize cost savings, leading some to believe that this model only works for certain types of providers / provider organizations (Sahni et al., 2020). Similar to the above paragraphs, then, the US seems to be in the early days of better-achieving top-down integration, though early indications suggest that there is no one-size-fits-all solution.

Bottom-up examples of integration, on the other hand, have been less promising, as detailed below. The often-cited example of bottom-up collaboration in Dutch primary care has been the system of GP cooperatives coordinating out-of-hours (OOH) care. No such singular model exists in the US, where nine different OOH care models exist, and only 34% of American PCPs report having OOH arrangements for their patients at all (Berchet & Nader, 2016; Huibers et al. 2009). Into this vacuum, national chains of urgent care clinics run by the likes of Walmart

and CVS Health have grown, threatening to erode the power of PCPs and interrupt continuity of care (Abelson & Creswell, 2018). The existence of this vacuum is partly due to something mentioned under Characteristic 1: the retreat of PCPs from private ownership. As factors like poor pay and long hours drive more PCPs into steady shift-based work for a hospital group or other large conglomerate (Alkon, 2018), incentive for bottom-up reform to the system is much diminished, thus also removing the likelihood of bottom-up integration efforts like the Dutch OOH care arrangement. This is just one example of how the weakness of primary care practices likewise weakens their ability to innovate, disallowing many of the noteworthy integration schemes introduced from the GP-level in the Netherlands.

Similar to past characteristics, then, analysis of Characteristic 3 in the American context reveals a mixed bag of reasons to be optimistic and pessimistic. Early success with new payment models gives reason to believe that America may finally shift away from FFS and towards a system that better-encourages the integration of primary and secondary care (Blumenthal & Squires, 2016). However, the same innovative grassroots approach that Dutch GPs have used to organize OOH care doesn't seem to be possible in the US, where innovation is likely to come from new players like Amazon Health or other major corporations. The power that these corporate entities seem to have relative to PCPs points to deeper, systemic issues in the balance of power between primary care and the rest of the system. The following paragraphs examining Characteristic 4 will shed more light on these issues.

Characteristic 4: Strong Institutional Support for Primary Care

Comparison between the US and the Netherlands reveals that support for primary care is, as a whole, weaker in the former than the latter. In terms of government support, though the federal government has shown greater willingness to center and support primary care since the passage of the ACA – passing two pay raises for PCPs and experimenting with funding for PCMHs (Abrams et al., 2011) – overall spending on primary care remains low, at just 10.2% of

the total healthcare budget, as compared to 14.7% in the Netherlands (Schäfer et al., 2010). Though only about 30% of healthcare spending comes from the federal government, their ability to dictate changes in market structure by, e.g., setting higher payment rates for primary care services, means they could drastically affect total investment, if they chose to (Straube, 2013). One reason they may not choose to is the weak position of primary care organizations. Though a number exist, including new pan-professional associations like the Patient-Centered Primary Care Collaborative, these associations play a very different role in policy making and budget setting than their Dutch counterparts: rather than offered a seat at the table in policy discussions, they must pay their way in. Lobbying is the primary means of political participation in the US, which pits underpaid PCPs against more heavily-resourced interest groups like the pharmaceutical lobby (Spithoven, 2016). Finally, in the academic sphere, the status of primary care is still marginal, with many schools lacking a strong primary care focus, the ramifications of which will be discussed later (Starfield & Oliver, 1996). Together, the low level of government support, limited political power of primary care organizations, and marginalized status of primary care in academia point to insufficient support from the institutions that shape the healthcare world.

The importance of building a strong basis of support for primary care cannot be overstated. Without more support from the government, academia, and primary care's professional associations, individual PCPs lack the countervailing power to push back against much stronger special interests like specialists or the insurance industry. Without a strong bargaining position, American PCPs have been unable to demand higher pay, contributing to the increasing primary / specialist care pay gap (Sandy et al., 2009). This pay gap, in addition to the low status of primary care in American academia, in turn contributes to the growing shortage of PCPs (Collins, 2012). As the number of PCPs drops, expectations of those who remain – to utilize the latest technologies, navigate the changing field of payment models, take on more patients, etc. – increase. Job satisfaction is low, and poorly-paid, overworked PCPs lack the time and resources to compete on their own with systems that have the resource backing of

companies like Amazon (Brown, 2015). Ultimately, many give up ownership of their practices, further diminishing the power and autonomy of primary care as a field. In this way, then, many of the obstacles to strong primary care cited above are interrelated, and pulling any individual string will lead one back to the central problem: weak support from institutions – like government, academia, and professional organizations – that shape the healthcare industry. Clearly, the need to strengthen such support is urgent.

Conclusions from the Comparative Process

The aim of this section so far has been to compare the American primary care system to its Dutch counterpart in order to discover meaningful similarities or differences worth exploring. Specifically, the above comparison sought to discover whether any particular policies or overarching characteristics were obviously lacking from the American system, in order to spend the following section exploring how such policies or characteristics could be adapted and implemented in the American context.

Ultimately, in terms of the first three characteristics, it seems that there is little new under the sun. Many of the policies that make the Netherlands a special place for primary care exist in the US, or are being experimented with, albeit with limited success. New payment models and integration of practice nurses and other support staff are a few examples. There are still a number of areas where America might learn lessons from the Dutch on a granular level: for example, studying how the Dutch have found success with VBP models might be of use to current American efforts to do the same. It is, however, beyond the scope of this thesis to investigate all such policies, and comparison across the first three characteristics indicates that America is, at the very least, slowly moving in the right direction with no glaring blindspots that the Dutch might help to illuminate.

Despite these innovative attempts to “fix” primary care, however, the American system is still deeply flawed, and one potential answer to why may be found in the comparison across

Characteristic 4. Section 4.1 outlined how support from various areas – namely the federal government, professional associations and academia – has helped Dutch GPs occupy a highly valued position within society. Comparatively, the United States lacks much of the systemic support for primary care that exists in the Netherlands, which can be traced through a kind of domino effect to many of the other issues that exist within the US system, from the PCP shortage to the anticipated success of policies like the PCMH. Attempts by the ACA to solve this general lack of support don't seem to have done enough (Peikes et al., 2020), raising the question of how American could approach the issue in a more impactful way.

This is a question that the coming section will attempt to address. As Klein (2009) points out, comparative health policy research "is as much a process of self-examination – of reflecting on the characteristics of one's own country and health care system – as of looking at the experience of others." Section 4.3 will turn the lens back inward, towards the history and context of American primary care, to isolate the problems and challenges that created the present situation, then provide better-informed policy suggestions that can strengthen the future foundation of primary care.

Section 4.3: Adapting Dutch Characteristics to the US Context

This section will build off of the previous two by continuing on to the final step of the PCCA framework: adaptation. Section 4.1 identified that one key element of Dutch primary care is the foundational support that it enjoys from the government, the academy, and its own professional associations. Section 4.2 found that, though many aspects of the Dutch and American system are similar or growing more similar, this foundational support aspect seems to be singularly different between the two nations. Carrying on the analysis, this short section will focus on the American context to analyze *why* primary care's foundation is so weak. Using a historical institutionalist lens, the development of primary care will be traced to understand what factors put the American system on a path to where it stands today. From this analysis, various

causes of this weakness will be identified, as will continued challenges that prevent a stronger support system from being constructed. Ultimately, this will set the stage for the final section, in which policy recommendations related to Characteristic 4 based on the context of the American healthcare landscape will be offered, thus rounding out the research methodology outlined in Section 2.

A look at the history of American healthcare is a history of slow and gradual dominance of specialty care over primary care. This began, arguably, in the 19th century due to a paradigm shift in how medicine was conceived of and delivered. It was around this point that doctors – who previously might all have been considered generalists – began utilizing expensive medical technologies that could only be found in hospitals (Howell, 2010). This transition to more specialist-heavy care was part of a larger paradigm shift towards what is called a "biomedical model" of care, wherein illness is considered a result of physical-chemical alterations within the body, and treatment of the body with cutting-edge technology is prioritized over whole-person, community-oriented care. The 1910 Flexner Report solidified the prominence of this model by advocating for the US to create "centers of excellence" where these kinds of cutting-edge treatments could be developed and taught (Sandy et al., 2009). Since the beginning of the 20th century, then, general institutional conceptions of health and healthcare have lent themselves more towards the organ- or procedure-centric approach to medicine that specialists adopt.

The Flexner Report helped create the academic medical center, which is still the dominant institution arrangement in medical education and one of the primary reasons why primary care is undervalued in academia. Following this report, medical schools merged with teaching hospitals, and slowly, specialists replaced generalists as clinical teachers. These centers became hubs for medical research, and following WWII, the lion's share of investment in medical research went towards specialists developing increasingly specific treatments (Howell, 2010). Then, as now, research publications were considered "the coin of the realm," and students, urged to join studies in order to advance their careers, followed the money into specialty careers (Sandy et al., 2009). Greater funding for specialist research, coupled with

greater student interest, meant that, when Congress offered teaching hospitals un-earmarked funding to create residency positions in any field they pleased, the vast majority put this money towards expanding their capacity to train students in the most attractive, prestigious specialties ("Why Is There," 2013).

With a few exceptions, the close association between medical education and specialists remains today. In 1996, Starfied and Oliver remarked that "the climate for primary care is decidedly 'chilly' in medical academia," and schools like Johns Hopkins, Stanford and Harvard still have no departments of family medicine. Funding for research is likewise heavily skewed towards specialists, with only 0.4% of funding from the National Institutes of Health (NIH) – which is largely determined by government appropriations – going towards primary care research ("High Quality Primary," 2021). Given that students' match preferences are determined by both strength of mentorship and availability of research opportunities (Mustafa et al., 2019), it should come as no surprise that 2019 saw a record low number of students match into primary care, relative to the number of spots available (Knight, 2019). In this way, a historical analysis of primary care reveals how the entrenched superiority of specialty care within academia contributes to the PCP shortage referenced throughout Section 4.2.

The PCP shortage has also been attributed to the large difference in pay between specialists and generalists, something that likewise has deep historical roots. The pay gap began with the first third-party payers, which developed to reimburse expensive specialist care, but would not pay for generalist services. Without reimbursement, generalists had to keep their prices low enough for patients to afford, while specialists were free to increase their prices at a greater rate (Sandy et al., 2009). In the 1960s, the federal government solidified this pay difference by creating a set of baseline prices based off of existing price differences, through a system called the "relative value unit" (RVU) system. To update these baseline prices, the Relative Value Scale Update Committee was created and populated with physicians so that they might determine their own reimbursement rates. Since 2012, however, the committee members have overwhelmingly come from non-primary care specializations, which means specialists

have more power than PCPs when determining relative reimbursement rates (Gao, 2018; Berenson & Goodson, 2016). This system of determining reimbursement rates makes it difficult for PCPs to push for higher pay relative to specialists, entrenching the PCP / specialist pay gap, and ultimately influencing the flow of medical graduates away from primary care, especially in light of the enormous cost of medical education (Verduin et al., 2014).

As was mentioned briefly in Section 4.2, this pay gap has led to further entrenchment of specialists' dominance due to the nature of political participation in the US. In the Netherlands, the Dutch *polder model* – a form of collaborative political decision making in which all relevant parties are invited to the negotiating table – means that primary care organizations play a role in creating health policy (Okma & de Roo, 2005). For example, when the healthcare reforms of 2006 were crafted, GP organizations negotiated with other parties and the government to gain more pro-GP concessions in the final policy arrangement (van Marwijk, 2017; Cohu et al., 2006). The US has no cultural or political mandate for inclusive policy building; instead, one of the few channels for political participation is through lobbying. The lobbying system is such that parties who spend the most often have a greater influence (McKay, 2012), and given the higher pay of specialists, it is unsurprising that lobbying groups representing specialists outspend their primary care counterparts: in 2020, interest groups associated with non-primary care specialties outspent those associated with primary care by 143%, contributing almost $15,000,000 to bend political campaigns towards pro-specialist interests ("Health Professionals," 2020). Given this arrangement, then, lower pay for PCPs snowballs into a lesser ability to push policy towards benefiting them.

Studying the context of America's primary care system reveals the origins of its many weaknesses, and also points towards potential solutions. Lopsided government investment in residency spots and research projects for specialists helped to offer them an early advantage in the growing medical academic-industrial complex, which suggests that shifts in such funding might help to have the opposite effect. Similarly, the federal government's use of a specialist-dominated council to determine reimbursement rates has favored specialists, but provides a

simple avenue for beginning to rectify this issue. Finally, comparison of the US and Dutch policymaking processes suggests that there are opportunities for more inclusive models through which to reimagine the healthcare system. Taken together, the top-down origins of many of primary care's challenges represent opportunities for top-down solutions, something that only becomes clear when time is devoted to digging into historical context. The following section will dive further into the solutions that this context leads one towards.

Section 5: Discussion & Conclusions

The purpose of this study was to draw lessons from the Dutch for American primary care reformers. The overall question of "what, if anything, can American healthcare reformers learn from the Dutch primary care system" was approached through systematically interrogating three sub-questions:

1. What are the critical success characteristics of the Dutch primary care system, and which policies and practices help to create these strengths?
2. How does the US primary care system compare to its Dutch counterpart, especially in terms of the characteristics that help the Dutch stand out?
3. How can some of the critical success characteristics of the Dutch system be adapted to better-fit the political and healthcare context of the United States?

Each of these sub-questions received its own portion of the results, and in this final section the answer to the higher-level question will be discussed. Based on this, several policy suggestions will be presented, and limitations and future research topics will also be covered.

5.1: Discussion of Main Findings

In short, this study revealed that there is much to be learned from the Dutch primary care system. After Section 4.1 isolated some of the major strengths of the Dutch system, Section 4.2 found broad similarities, at least on a surficial level, between successful Dutch policies and policies that America is testing, like value-based payment models and increasing access to telemedicine. Future research might pursue more granular, policy-centric comparisons to derive lessons from the Dutch experience.

This study chose to focus instead on one particular area where the US and Dutch diverge sharply: the amount of support that primary care receives from prominent institutions in healthcare. Following the policy-characteristic-comparison-adaptation (PCCA) framework developed in Section 2, this study began by identifying several noteworthy aspects of the Dutch primary care system – like the amount of government funding, academic prestige, and the strength of primary care organizations – that, together, create strong institutional support for primary care. Section 4.2 then found, in comparing the US and the Netherlands, that America lacks much of this support, and that this has a domino effect on undermining the strength of American primary care. Finally, Section 4.3 used a historical institutionalist lens to explore the context of American primary care, which revealed the roots of the weak institutional support, as well as potential solutions to this problem. Finally, the following paragraphs will use the historical context garnered above, as well as some inspiration from the Dutch healthcare system, to formulate policy recommendations that could help the US bolster its primary care system.

5.2: Policy Recommendations

The policy suggestions below are meant to serve as a final answer to the question of what America can learn from the Dutch primary care system. These policies were selected from existing calls for reform or crafted independently, based on both the factors that make the Dutch system exemplary isolated in Section 4.1, and the weaknesses and contextual particularities of

the American system found in Sections 4.2 and 4.3.The audience for these suggestions is predominantly the state and federal governments, though other players – including medical schools and advocacy groups – will also be addressed. Suggestions will cover three broad areas, related to some of the problems identified in Section 4.3, beginning with addressing how individual PCPs – and the system as a whole – are financially supported.

Policy Area 1: Change How PCPs are Paid and Supported

Some of the most fundamental issues with the primary care system have to do with how little is invested in primary care and its practitioners. The PCP / specialist pay gap drives the current lack of PCPs in the US, while low levels of government investment mean that the number and distribution of primary care centers is inadequate to meet the nation's needs. To take a first step towards correcting an imbalance system:

- *Making ACA pay increases permanent:* The temporary pay increases included when the ACA was passed in 2010 should be made permanent. Such a pay bump would increase the prestige of primary care, helping to attract more medical graduates, and to retain those still working in the field (Page, 2013).
- *Changing the way Medicare reimbursement rates are set:* A major cause of higher specialist reimbursement rates has been the fact that the Relative Value Scale Update Committee is heavily stacked in the favor of specialists. Better-balancing the committee with more primary care representatives could institutionalize a better balance in pay, creating a more sustainable solution.
- *Setting investment targets for primary care:* Though neither the US nor the Netherlands have lower limits for how much must be spent on primary care as a share of total healthcare spending, only one of these nations seems to require it. Individual states have begun experimenting with requiring that a certain share of the state healthcare budget be allocated to primary care (Block & Greenough, 2021), and the federal

government should follow suit and direct funds towards, e.g., constructing new primary care centers in high-need communities.

Policy Area 2: Change How PCPs are Educated

Solving the PCP shortage and encouraging a more holistic, person- and community-focused approach to medicine begins with how medical students are educated. The history of American medical education is a history dominated by specialists, and a first step towards realigning the American healthcare system will be realigning priorities within academia, like:

- *Expanding research funding for primary care projects:* Federal research funding through the National Institutes of Health predominantly goes to specialists; earmarking a greater amount for primary care-focused research like community health projects will help improve the prestige of the field within academia, attract more students, and ultimately bolster the supply of young PCPs.
- *Redirecting graduate medical education (GME) funds:* To begin correcting the imbalance between residency spots offered to specialists versus PCPs, some of the $12.5 billion in Congressional funding for residency training should be earmarked for primary care (Heisler et al., 2018). Doing so may also push medical schools to adapt to the new residency landscape by, e.g., hiring more primary care faculty, directing students into these positions, etc.
- *Centering primary care in how medicine is taught:* Cassel and Wilkes (2017) point out the significant role that mentorship plays in directing students towards primary care specialties, indicating that schools should endeavor to establish stronger mentorship systems that involve more primary care faculty members. The Dutch medical system offers an interesting model, in which medical courses are co-taught by one specialist and one generalist, and all students are required to do a rotation in primary care (Villanueva, 2019). Schools should consider adopting similar policies, and experimenting with new ways to present medicine in a way that centers primary care.

Policy Area 3: Change How PCPs are Involved in Policy Making

American PCPs must pay their way into influencing government legislation, which, given the existing pay gap, makes it difficult for them to fight back against the expanded interests of medical specialists. Beyond drastic, potentially infeasible moves like getting money out of politics or constraining how specialists and other interest groups can contribute, reformers may have more success with:

- *Establishing clearer governance overseeing American primary care:* Currently, no federal agency oversees primary care in the US. Some have recommended that the Department of Health and Human Services create a "Secretary's Council on Primary Care" to oversee the development of the field alongside the Office of Primary Care Research at the NIH ("Implementing High-Quality," 2021). Doing so would help to create the kind of clear, unified governance that Kringos et al. (2015) link to well-functioning primary care systems.
- *Creating government task forces on centering primary care:* The US government has a vested interest in expanding the role of primary care within the nation's healthcare system (Grundy, 2010). Though lobbying efforts may sway individual politicians, one way to signal a broader commitment to centering primary care is through the creation of task forces. Presidential and congressional task forces have long been used "to forge consensus, draft legislation...coordinate strategy and promote inter-party communication," making them a useful coalition-building tool, much like the Dutch polder model (Oleszek, 1999). Creating such task forces – which often recruit leaders from professional organizations like the AAFP – could create a more direct channel through which primary care advocates can suggest pro-primary care reforms.

The policies outlined above represent just a handful of possible approaches to strengthening the position of primary care within the US healthcare system. It should be noted

that these policy suggestions aren't advocating for primary care to dominate the American healthcare system, but rather for greater balance. The Dutch example shows that a well-functioning healthcare system requires such balance, between primary care and specialists, physicians and insurers, etc. Given contextual differences between the US and the Netherlands, how this balance is achieved will look different in the two nations. The benefit to instituting the above policies is that they will help to empower America's primary care establishment to advocate for itself, helping to craft a more bespoke arrangement that achieves similar goals to the Dutch system, but through their own, context-dependent path.

5.3: Limitations

It goes without saying that this research was constrained by several limitations. As is the case with much research, there was a tension between depth and breadth, and more lessons might have been learned by, e.g., including a third nation in the analysis. However, this would have come at the cost of greater space to contextualize each nation, which the literature argues to be of critical importance (Marmor et al., 2009). Even then, the literature consulted was vast, and it is inevitable that some perspectives were overlooked, especially given my lack of Dutch language ability. Future researchers might benefit from greater linguistic capacity, or a deeper background in the history of primary care in either nation.

Background in health policy implementation may have also been helpful in improving the feasibility of the policy recommendations in Section 4.3. Ultimately, the research methodology helped to arrive at policies that would benefit the US healthcare system, but not necessarily ones that are feasible to implement. The fact that many of the policy recommendations were drawn from bodies like the National Academies of Science, Engineering and Medicine served as a proxy for feasibility, but my own lack of background in the complexities of the American policy making process means that some of the policies detailed above may not be politically possible.

Though expert interviews were conducted in order to provide a feasibility filter, the limited number of interviews likewise limited perspectives on feasibility.

Methodologically, conducting a greater number of interviews earlier in the process may also have improved the quality and depth of the research. Though a number of experts were contacted, few responded, and those that did required multiple reschedulings until ultimately the timing of the interviews meant they could only serve as validity checks for results already gathered. In the future, a more intense, early-phase focus on interviewing should be adopted to help guide the research. It is worth noting, though, that the evolving nature of this research – in which the research questions themselves changed as I developed a better understanding of what areas of Dutch and American primary care to explore – would have meant that many early interviews may not have been useful in the final product. Ultimately, then, a longer research period, in which follow-up interviews could be conducted, would be the ideal conditions with which to gather insightful data.

Taken together, each of these limitations offers guidance for future research, which might benefit from focusing on a few areas that this study uncovered. Addition of a third country – perhaps Canada, which shares many cultural characteristics with the US (Marmor, 1994) – could help provide more inspiration for policy suggestions. A greater focus on singular policies, like new Dutch payment models, could offer suggestions on how to operationalize some of America's more recent experiments. The final example of potential future research avenues – of which there are many – would be to conduct a more in-depth study of why past attempts to strengthen American primary care have failed. This is an area of context that went unexplored in this study, and would offer greater perspective on what policies are and are not feasible by revealing what Immergut (2010) calls the "rules of the game" when it comes to forging new healthcare policies.

5.4: Overall Conclusions

Ultimately, this research has helped to accomplish one of the primary goals of comparative health policy: to offer enough perspective from the outside to push one to look inward. Lessons from the Netherlands helped to sort through the vast sea of American primary care policy recommendations to develop a more grounded understanding of what is and is not important to developing a strong system. In this case, the Dutch emphasis on creating sturdy support for the overall primary care system has helped Dutch GPs exercise greater power to push back against the interests of specialists, insurers and other parties. This has allowed Dutch GPs to construct a stronger system of primary care, something that the United States desperately needs. Looking at what has worked for the Dutch, then, helped to highlight what might be most important in the order of operations of American healthcare reform. In a moment when decisiveness will be key in taking advantage of the momentum favoring healthcare reform, this clarity in which policies to prioritize is useful.

This research has also helped to advance a new framework for comparative health policy research. Use of the policy-characteristic-comparison-adaptation (PCCA) framework – which was created in Section 3 by combining aspects of the comparative health policy literature cited in Section 2 – opens the doors for other researchers to adapt and advance this model. Of particular importance in this framework was its emphasis on contextualization in the comparative health policy research process. By designating an entire Section (4.3) to the process of contextualization, this research demonstrates the merits of taking one's time when studying. In a field characterized by studies "ignoring methodological issues of comparison," such examples of novel methods are important for advancing critical discussion of how to conduct comparative health policy (Marmor et al., 2005).

Perhaps most importantly for me, this project offered me an opportunity to explore and understand how things are done abroad in order to inform my future work at home. As I begin my educational path towards becoming a physician and hopefully a health policy expert in the US, I will benefit from the knowledge of both the Dutch and American primary care systems that

I gained from this study. Having never explored the complexities and nuances of healthcare policy and organization to the depth that I needed for this research, I can safely say that I have a much better understanding of just how complicated healthcare systems are, how difficult they can be to change, but how ultimately rewarding the work can be. In short, then, this thesis helped me to achieve the overall goal that I set for myself when I came to study in the Netherlands: learning a lot about others, and a bit more about myself and my own home.

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Appendix A: Guiding themes and questions for interviews

Background: The list below represents the jumping-off points for more unstructured conversations guided by the expertise of the interviewee. As a note, these interviews were only conducted with experts in the American primary care system, so questions only pertain to the Americans. As a note, the number and depth of topics covered varied from interviewee to interviewee.

Topic 1: Overview of American Primary Care

Purpose: To hear experts' opinions on the current arrangement of primary care in the US, and reveal blindspots in desk research.

- What has been your experience of working in primary care, both over the years, and during the COVID-19 pandemic?
- What are some common false assumptions about American primary care that those outside of the profession often make?
- What are the current strengths and weaknesses of the American primary care system?
- Which reforms do you feel are most pressing or most important to make first?

Topic 2: Current Reform Efforts

Purpose: To understand the reform landscape: what is being done, what are the current challenges, and what could be done better?

- What are, in your eyes, the most promising reform efforts currently underway?
- What groups have the most power / sway to change the primary care landscape?
- What are major obstacles to reform within the US, and do you feel they can be surmounted?
- In your opinion, what needs to be done better by reformers? Do you feel they have any major blindspots?

Topic 3: Focus on Institutional Support for Primary Care

Purpose: To learn more about the topic of Section 4.3.

- In your opinion, what is the attitude towards primary care within academia? How do you think it might be improved?
- How strong are professional bodies representing primary care practitioners? What have they helped to accomplish, and are there ways that they might actually hinder progress?
- Both professionally and academically, what is the balance of power between primary care and other aspects of the healthcare system? What causes / reinforces this arrangement?

Topic 4: Feasibility Analysis

Purpose: One interview was conducted after final policy recommendations were constructed, creating the opportunity to check each with an expert in the field.

- [Interview covered as many policy recommendations as time permitted to check for feasibility / validity]

Note: This final portion of the interview ultimately led to some pruning on recommendations, adding more detail to the importance of payment reform, and cutting some from other policy areas.

Appendix B: The process of comparing Dutch and American Primary Care

Background: Section 4.2 draws comparisons between Dutch and American primary care based on the characteristics isolated in Section 4.1. A full representation of the research that went into this comparison is not possible here, but, for the sake of illustrating how the comparative overviews in Section 4.2 were arrived at, this appendix uses the first characteristic as an example to illustrate the overall process.

Step 1: Compare Dutch policies to existing and future American policies

Policy / Practice	*Dutch Overview*	*Current American Overview*	*Future of American Policy*
Wide Scope of Practice	Dutch primary care physicians are granted a wide scope of practice, allowing them to handle more cases in their own practices, and potentially increasing job satisfaction given the clinical range offered to GPs (Zomahoun et al., 2021).	American PCPs, like their Dutch counterparts, can perform minor surgeries and other procedures often reserved for specialists, though surveys have shown that the actual skills used by PCPs are well below their full scope of practice (Coutinho et al., 2015).	Movement towards patient-centered medical homes (PCMHs) will mean an expanded role for PCPs to function as team leaders, coordinating a group capable of delivering the wide scope of services the Dutch GP practices do (Peikes et al., 2020).
Use of Gatekeeping	Dutch GPs constrain access to specialists, allowing them to cut down on unneeded treatment (Tikkanen et al., 2020a).	One model of American health insurance coverage – called the health maintenance organization (HMO) – includes gatekeeping arrangements. Most others don't, which reflects the overall rejection of Americans of patriarchal control over their access to care (Robinson, 2001).	Widespread use of such arrangements were tried and failed in the late 1990s, and few consider gatekeeping politically feasible at a wide level (Mechanic, 2004).

Expanded Roles for Support Staff	Dutch GPs are increasingly receiving support in their practices from practice nurses and other professionals, which can take some of the load off of their shoulders and allow for better-focused care (van der Biezen et al., 2016).	Nurses are increasingly being integrated into PC due to the PCP shortage, and the PCMH model advocates for building such teams (Park & Dowling, 2020).	Tensions between nurse organizations and physician interest groups have flared, with physicians putting up strong resistance to expanded scopes of practice for nurses ("AMA Successfully Fights," 2020).
Small, Independent Practices	The vast majority of Dutch GP practices are owned by GPs, creating greater autonomy at the level of individual practices (Tikkanen et al., 2020a). This ownership is linked to a unique entrepreneurial spirit, with Dutch GPs having created a string of bottom-up initiatives to improve primary care (Scott, 2020).	American PCPs have shown a movement away from owning their own practices, due mostly to increasing demands and an inflexible fee-for-service payment structure (Mostashari, 2016).	Payment reform could make independence more feasible, and some reformers are calling for greater physician ownership of, e.g., accountable care organizations to incentivize innovation (Sahni et al. 2020).

Step 2: Distill overall conclusions from the table, highlighting some boxes over others

The current status of **"Use of Gatekeeping"** and **"Small, Independent Practices**," as well as pushback against **"Expanded Roles for Support Staff"** suggest that primary care practices in the US are not as strong as those in the Netherlands, given their lack of key policies.

However, the future outlook of **"Wide Scope of Practice"** and the current status of **"Expanded Roles for Support Staff"** both indicate that the movement towards the patient-centered medical home (PCMH) model may make the US more Dutch-like. Ultimately, this indicates that, though primary care practices may not be as strong as the Dutch system now – in part due to cultural differences behind the future of **"Use of Gatekeeping"** – they are moving towards a model that may make up for some of the current deficiencies in, e.g., gatekeeping.

Note: the bolded titles above indicate boxes that will be integrated into the overall summary in Section 4.2, since they contribute to the overall understanding of the policy. Some, like the future of **“Small, Independent Practices**,” are excluded from the analysis for the sake of brevity because, though this information is important for a thorough, point-by-point comparison of the US and the Netherlands, its inclusion would be somewhat redundant, since the need for payment reform will be covered elsewhere.