The primary care home: a new vehicle for the delivery of population health in England

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Abstract

Purpose – The purpose of this paper is to consider how the evolving concept of the "primary care home" (PCH) that is developing in England might be an effective vehicle for the delivery of the goals of "population health". The authors examine evidence from earlier initiatives to achieve similar objectives of primary care-led health system planning and care integration to understand relevant lessons for the PCH.

Design/methodology/approach – This paper is based on a descriptive review of the PCH using documentary sources and a non-systematic review of literature relating to primary care commissioning initiatives and recent initiatives to deliver general practice services on a larger scale.

Findings – The PCH is likely to bring forth relatively high engagement from general practitioners due to its neighbourhood scale, voluntary nature and its focus on professional partnership, personalisation of care and outcomes. It is important that participants have sufficient autonomy to act and that financial incentives are aligned with the goals of population health. It is also important that, unlike some earlier primary care initiatives, the PCH is given time to develop to maturity.

Originality/value – The PCH is a recent phenomenon that is developing in England and elsewhere. This paper locates the PCH within a historical context and draws conclusions from a relevant evidence base.

Keywords Population health, Primary care home

Paper type Viewpoint

Introduction

"Population health" is a concept that encompasses the proactive and multi-disciplinary management of the health and well-being of a defined population. It embodies notions of planning, population segmentation and disease prevention and management.

Population health has long been a goal of public health champions but has hitherto been less successful in becoming fully embedded in health care policies for the NHS in England, where the focus has been predominantly on the performance of health care organisations and improving access and experience for patients at the level of individual.

For nearly three decades, one strand of government policy has been to develop the role of the general practitioner and wider primary care team as leaders in the planning, design and budgeting of care, in part at least, to deliver the objectives that have now become understood as population health. Key national strategies have included enhancing the primary care team in terms of scale and clinical scope, establishing formal and informal integration with professionals in other care settings and taking collective responsibility for health and care resources so that primary health care plays a significant role in the shaping and commissioning of wider health care services for defined populations.

There has been a near-constant evolution of organisational models that might act as vehicles for this vision for primary health care. The primary care home (PCH) model developed by the National Association of Primary Care (NAPC) (2018) has emerged as a new staging post in the journey towards integrated care and the delivery of improved population

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health. The PCH seeks to provide a vision and structure for both the delivery of comprehensive, team-based care for a population of 30,000-50,000 people as well a focus for the planning of wider health care resources to achieve optimal health outcomes for that population.

The PCH has developed in England as part of a broader strategic initiative within the NHS, the *Five Year Forward View* (NHS England, 2014). This initiative, among other things, aims to improve health and the use of health and care resources through different models for organising and integrating primary, secondary and social care (known as "new care models"). While the PCH is not formally a "new care model" it has gained the support of NHS England (2018), as a means by which the principles of integrated care set out in the *Five Year Forward View* might be implemented at a more local level.

The various antecedents of the PCH can provide insights into how the PCH might be enabled (and what obstacles might be avoided). In this paper, we describe the concept of population health and briefly examine the evidence relating to earlier primary care models. We then describe the PCH and consider what insights might be drawn from the historical evidence to support the development of the PCH. Our perspective is drawn from our experience as a primary care practitioner and leader of a national primary care interest group (NC) and as someone who carries out research into primary care and supports ongoing development (RL).

Understanding population health

Population health has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig and Stoddart, 2003). In practice, a focus on maximising population health involves proactively segmenting the population into groups defined by a common symptom, condition or characteristic, assessing needs and then targeting interventions that are suitable for the people in that particular segment (Gray, 2016).

However, there may be some threats to this approach associated with a fragmentation of care delivery around specific subsets of population (Rosen, 2018). Notwithstanding this, health care leaders within the NHS are recognising the importance of developing a population health approach and the importance of a value dimension to health care. This is because of the increasing burden of patient and population need given the constraints of the resources available to meet those needs (Gray, 2016).

If population health is to succeed, a shift in activities, measurement and accountability is needed away from simply improving health care processes and towards overall improvement of health outcomes (Gray, 2016). It is also becoming increasingly clear that a focus on health service provision alone is unlikely to deliver the desired gains in population health. Several studies have estimated the impact on health outcomes because of the broader determinants of health. A King's Fund (2013) report summarises some of the key studies, one of which (McGinnis *et al.*, 2002) states that health interventions alone only contribute to 15 per cent of health outcomes, while a further 40 per cent are amenable to lifestyle behaviour patterns, and the remaining contribution comes from societal and environmental factors.

Therefore, it is important at a population level to think of broader systems of care and support which can address immediate health care needs, lifestyle-related behaviours and, through partnership with other agencies such as local government and the third sector, broader social needs. This multi-agency approach builds on the notion of viewing communities as "assets". Kretzmann and McKnight have proposed an approach to community development that emphasises building the capacity and capability of local communities to enhance their strengths and resources, tackling the issues that matter to them, and using existing resources and expertise to achieve improvements locally (Kretzmann and McKnight, 1993).

However, while improving health outcomes is a key aim of population health, it is necessary to take account also of patient experience (through personalisation of care) as well as of the overall value provided within the health care system. This approach has been popularised through the Triple Aim which seeks to optimise health system performance (Berwick *et al.*, 2008).

Gray (2016) considered three dimensions of value in relation to populations. The first relates to allocative value, that is the effectiveness of care at a programme level. The second relates to technical value such as the implementation of evidence-based interventions at a disease level. The third dimension relates to personal value, which are the outcomes that matter to an informed individual.

Primary care systems have the potential to improve all three dimensions of value. Starfield considered the characteristics and impact of primary care systems on population health and, in particular, dealing with health inequalities. She characterised primary care as providing accessibility for first contact care for health needs, long-term person-focused care (longitudinality), comprehensiveness of care, and coordination of care in instances in which patients have multiple care inputs. Systems built around primary care have been demonstrated to be associated with better health outcomes with lower inequalities, lower costs and higher satisfaction (Starfield, 2005).

The policy antecedents of the PCH

As described above, neither the notions of population health nor the importance of primary care development are new to the NHS. Indeed, since 1990, government policy has consistently identified as important the development of an enhanced model of primary care, increased general practitioner involvement in the delivery and design of health care services and a leadership role for primary care in the management and allocation of health care resources (Lewis, 2004).

The leadership of general practitioners and wider primary care in the overall management of population health care resources (more generally known as "primary care led commissioning") has proved an enduring and important feature of health care policy for more than two decades. Here, the intention is to use the unique position of the general practitioner (with their registered lists and "gatekeeper" role over onward referral to specialist services) to provide greater care management as patients transit through the NHS system, ensuring appropriate and higher quality specialist services and investing in services that would improve the health of their registered population (and, by extension, disinvesting in lower quality providers or services).

Since 1990 there have been numerous policies aimed at constructing the right architecture for this role. These include the GP fundholding initiative, "total purchasing pilots", Practice-based Commissioning, Primary Care Groups and, most recently, Clinical Commissioning Groups. All of these initiatives share some basic characteristics that are highly relevant to the PCH model. They involve leadership by general practitioners, some form of influence or control by general practitioners over population-based health care resources, a desire to enhance the proportion of services that are delivered in community settings and an objective to improve the integration of care across health settings (e.g. hospital, community and general practice care) and across the health and social care boundary. While some of these initiatives have focused at least initially on individual general practices as the organising feature and have therefore been relatively small scale, most have either evolved, or have been designed from the outset, to develop collaborative arrangements linking multiple general practices together to serve larger populations.

While primary care commissioning was concerned with the design and purchase of health care, in practice it bridged the gap between commissioning and provision of care. This related particularly to the development of extended primary and community care

services. By handing over commissioning responsibilities to primary care it was expected that this would ensure the transfer of resources and care from hospital to community settings and from "downstream" treatment to "upstream" prevention and care management.

Therefore, primary care commissioning can be seen as a development highly aligned with allied policies to develop primary and community care providers; in particular, efforts to create larger scale units of primary care delivery through organisational collaboration.

Primary care organisations and population health – what does the evidence tell us?

Attempts to develop and coordinate the delivery and commissioning functions of primary care have met with mixed success (Smith *et al.*, 2004; Miller *et al.*, 2012). The rapid succession of similar, although distinct, initiatives in this realm suggest that, while successive policies shared a basic agreement over the ingredients of success, there was far less consensus over the precise recipe.

Models of enhanced primary care and primary care commissioning, in theory at least, draw efficacy from their ability to both empower and align clinical professionals (in particular, from GPs who by the decisions they make, commit a resource). It would therefore seem axiomatic that the success of these models would in part rely on their ability to draw forth clinical leaders and for those leaders to engage with and influence the broader clinical group. There is ample evidence on which to draw.

Engagement with general practice

Historical evidence is, perhaps unsurprisingly, mixed in this regard. Under GP fundholding, participants enjoyed significant autonomy which appears to be a factor in the comparatively high levels of GP engagement with this initiative. It is likely, however, that this is also linked to the fact that fundholding practices were generally single practices or small scale groups (Miller *et al.*, 2012). Engagement within this context proving more feasible, less costly in terms of time and effort and therefore more successful.

In contrast, more collegiate approaches to primary care commissioning struggled with engagement beyond the leadership cadre. The era of Primary Care Trusts (relatively bureaucratic structures with a somewhat constrained role for clinical decision makers) prior to the introduction of "Practice-based Commissioning" in 2005 has been identified as a "historical low point" in terms of clinical engagement (Miller *et al.*, 2012, p. 13). Primary Care Trusts were arguably the most "bureaucratic" model of primary care commissioning in terms of the relative powers of clinical and non-clinical management (with clinical leaders confined to a "professional executive committee"). This in part was a consequence of the wider range of statutory duties that PCTs had to discharge and their status as formal public bodies.

Practice-based Commissioning reintroduced notions of local GP practice "ownership" and decision making, although over time many practices formed consortia and operated jointly. The level of GP and practice engagement under this initiative was very variable (Audit Commission, 2007). This is likely to reflect the very varied powers that were assigned to practices in different local contexts.

Clinical Commissioning Groups arguably fared better. The national "tracker survey" found engagement among GPs on the governing body relatively high, but falling over time (from 83 per cent feeling engaged in 2013 to 64 per cent in 2016). Those GPs not in leadership roles were significantly less engaged or optimistic about the role of the CCG. Only 38 per cent felt that the CCG made their working life more fulfilling and only 20 per cent felt that they could influence the work of the CCG. A majority of GPs felt that CCGs had not made changes to referral patterns or quality of care (Holder *et al.*, 2016).

While autonomy enjoyed by GPs within a supra-practice endeavour is likely to impact on engagement, so too is the size of enterprise. As has already been noted, early models of fundholding tended to focus on single practices and with a relatively constrained scope of authority. This made engagement relatively easy, but undermined the ability of fundholders to influence services outside of the direct scope of the scheme (broadly elective care services) or to address strategic issues of health service reconfiguration across larger populations.

There is little conclusive evidence about the "ideal" size for a primary care organisation, and certainly not that bigger is necessarily better for all functions (Bojke *et al.*, 2001; Wilkin *et al.*, 2003). However, the genesis of any shared enterprise between primary care professionals is probably important in its subsequent performance. Configurations that are mandated "top down" (e.g. to fit pre-existing geographical boundaries or some other template) are more likely to lead to clinician disengagement and lack of innovation than those that are allowed to develop organically (Pettigrew *et al.*, 2016).

Impact of incentives

All models of primary care commissioning introduced a range of incentives aimed not only at engaging general practitioners but also at influencing their clinical decision making. A great deal of attention has been given to the use of financial incentives in primary care. These have included reimbursement of GP time spend in planning/commissioning activities, quality payments for certain outcomes and the ability to redirect NHS resources to develop services (particularly shifting resources from secondary to primary care).

Certainly, financial incentives have been associated with improvements in the delivery of structured disease management programmes in primary care (although the effectiveness of these incentives may plateau over time (Campbell *et al.*, 2009)). There is evidence that financial incentives were to some extent effective in influencing behaviours under GP fundholding, where budget surpluses were available for reinvestment in general practice services and facilities (Dixon and Glennerster, 1995; Croxson *et al.*, 2001).

The strength of financial incentives varied across the different models of primary care commissioning. In particular, this was affected by the level of direct control over the wider health care resources that was devolved to GPs. The most control over resources was enjoyed by GP fundholders compared with subsequent models. GP fundholders held legal budgets with the autonomy to spend against them with prior authorisation. Other initiatives involved only indicative allocations with the actual purse strings held by formal NHS bodies. Under Practice-based Commissioning, for example, the devolution of budgets was often nominal with GPs enjoying little actual control over the spending of the budget (Miller *et al.*, 2012). Moreover, their ability to direct resources to new clinical settings was constrained with 62 per cent of leaders reporting that they had not been given access to any of the budgetary savings with the remainder only having access to 60 per cent of those savings (Department of Health, 2009).

However, the application of incentives to clinical professionals is complex and goes far beyond the simple use of financial incentives. Early GP fundholders, for example, were predominantly motivated by the desire to improve the quality of patient services (Glennerster *et al.*, 1992). Other GPs took part in alternative models as, among other things, a sign of hostility to GP fundholding and the perception that it was creating a "two-tier" system (Miller *et al.*, 2012).

While financial incentives appear to shape behaviours, they may also simply "crowd out" internal "moral" motivations. That is, by applying financial incentives to clinicians they may detract from, rather than add to, internal incentives such as professionalism, peer respect, concern for quality, etc. (Marshall and Harrison, 2005).

Changing patterns of care

Prior models of primary care commissioning demonstrated some impacts on clinical practice (and, by extension, on expenditure). Most types of primary care organisation were able to develop a wider range of primary care based services and quality assessment/improvement processes. Indeed, it was here that they were most successful (Smith *et al.*, 2004).

However, the impact of new types of primary care organisations on relationships outside of primary care is less clear, in particular with hospital specialists. Total purchasing pilots, for example, faced obstacles in influencing hospitals but had successes in delivering examples of integrated care between primary and community services (Miller *et al.*, 2012). In addition, a significant minority of GPs within CCGs reported better relationships with professionals outside of primary care (Holder *et al.*, 2016).

There was mixed evidence on the impact of primary care organisations on secondary care utilisation and expenditure. However, the rate of increase of elective admissions was lower for fundholders, particularly the early adopters (Dusheiko *et al.*, 2006). Total purchasing pilots managed to reduce the bed days and admissions for emergency hospital care (Wyke *et al.*, 2003).

The findings relating to primary care commissioning arrangements have also been mirrored in some reviews of collaborative arrangements between general practitioners as providers of primary care (such as "federations" of general practices or large scale "super practices"). Here, patient benefits such as improved access to primary care have been delivered through shared clinics for groups of practices (Rosen *et al.*, 2016).

In addition, there is also evidence relating to the development of integrated care provision in community settings regardless of the commissioning context. A systematic review by Powell Davies and colleagues demonstrates that a majority of provider integration strategies involving primary care as one of the parties improved health outcomes and a significant minority improved patient satisfaction. A much smaller minority had positive impacts on cost (Powell Davies *et al.*, 2006). Integrated care pilots focusing on proactive care management implemented in the English NHS had positive impacts in terms of staff views of care quality and their own job satisfaction as well as reductions in some forms of hospital care and overall hospital costs. However, perhaps surprisingly, some aspects of patient satisfaction diminished (Roland *et al.*, 2012).

Case studies carried out by the King's Fund suggest that the introduction of specialists into community settings lead to a better patient experience and have the potential to help patients manage better their long-term conditions. Rosen *et al.* (2005), however, also highlighted that the creation of extended clinical roles for GPs can lead to hostility from hospital specialists.

The PCH

The English NHS has developed the concept of "new care models" as part of a national strategy to address identified gaps in health and well-being, quality and resources (NHS England, 2014). At the heart of a number of these new care models is the concept of population health management, in that there is a commitment to an integrated care system focused on defined populations, with budgetary alignment across providers with responsibilities to deliver improved health outcomes. There is an expectation that the techniques of population health (such as population segmentation and proactive disease management) will be implemented within the new care models (NHS England, 2016a, b).

Different care models have been described based on integrated care systems for defined populations. Two examples are the Multispecialty Community Provider (MCP) (a horizontally integrated system of care incorporating primary, community and out-of-hospital services) and the Primary and Acute Care System (PACS) (horizontally and vertically integrated care systems providing all or the majority of services for a given population) (NHS England, 2014, 2016a, b).

Whilst some of these care models are being implemented at large population scale (e.g. there is an expectation that PACS models will encompass a population size of at least 250,000 (NHS England, 2016a)), there is also interest in models based on smaller population sizes at the level of a neighbourhood to understand better the optimal level for integration of care.

The concept of the PCH has gained traction as a means of organising care and teams around similar principles to those set out in the MCP new care model but focused on smaller neighbourhoods and communities in the belief that this is a more optimal scale for those activities. The PCH can be used as a local means of organising care within a larger entity such as an MCP or developed as a local enhancement to existing provider arrangements.

The PCH is a systemised approach to improve population health, utilising increased capacity within and leadership from primary care. A model of the PCH for England has been described by the NAPC (2018) with four key characteristics built around a population defined by the registered lists of general practice:

(1) an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;

(2) a combined focus on personalisation of care and improvements in population health outcomes through proactive and preventative services;

(3) aligned clinical and financial drivers through the collective management of resources with appropriate shared risks and rewards; and

(4) provision of care to a defined, registered population of between 30,000 and 50,000.

The PCH involves both horizontal integration (collaboration between general practice organisations and between general practice and other community-based services) and vertical integration (enhanced team working between primary and secondary clinicians, including the development of specialist services provided in community settings as well as generalist services in acute settings such ambulatory care).

Commencing in January 2016 there are now more than 200 sites across England, covering approximately 16 per cent of the population (NAPC, 2018). It is notable that the majority of GP practices joining the PCH programme to date are doing so voluntarily rather than being required to do so (though it is possible that this may change as a result of policy pressure to spread primary care networks more broadly (NHS England, 2017)).

The PCH model offers a greater breadth of provision of care within primary and community settings, supported by multi-agency working through a team-based approach. It requires some scaling of general practice provision in order to secure some of the benefits of collaboration (such as the provision of more specialist services within a community setting). However, the model seeks to retain a neighbourhood sense of belonging for patients and staff. Examples of early initiatives that are being adopted by the PCHs in England are set out in Table I.

Within the PCH approach, teams are formed to deliver services to specific population groups, but are then aggregated to a "whole" to ensure that the entire team responsible for the total PCH population functions in an integrated way. The approach being taken to population segmentation is shown in Table II.

The team may include colleagues representing physical and mental health, social care, local government and members of the community itself, working collaboratively with a focus on population health outcomes. The style of team-based approach desired has set the optimum population size threshold, which in the PCH case is defined as around 30,000-50,000.

An engaged clinical leadership takes responsibility for the collective management of (health care) resources at this level; key to this is the alignment of clinical and financial

Beacon Medical Group	*Larwood and Bawtry*
Pharmacist and GP supporting patients in care homes with medication review, ward rounds, discharge summaries	Pharmacist medication review to care home residents
Expanded Urgent Care team with additional Nurse Practitioners and new triage model	General Practice-based Community Advisory acting as patient advisor and navigator for community services
Reconfigured "virtual ward", with greater voluntary sector and community group involvement	Colocation of primary, community and voluntary services
Psychiatrist-led mental health clinics in general practice	Social care clinic in primary care setting
Influenza vaccination campaign	Integrated team working between community and practice nurses

Table I. Examples of PCH initiatives

Sources: Adapted from PA Consulting (2017) and NAPC (2017) case studies

Patient cohort targeted	Example interventions
Patients affected by general practice access issues	Single point of access
	Volunteer home-visiting
	Care navigation for non-health issues
	Overflow clinics for urgent needs
Complex patients at risk of hospital admission	Virtual ward
	Integrated practice and community care planning
	Prescriber undertaking home visits
Care home residents	Pharmacist-led ward round
	Volunteer visiting service
	Proactive frailty service delivered by MDT
Patients with polypharmacy risks	Regular pharmacist review
	Polypharmacy review as part of frailty clinic
Patients who may need specialist intervention	Practice-based dermatology clinic and diagnostic equipment
	Community Psychiatric Nurse practice-based clinics

Table II. Examples of patient cohorts targeted by PCHs and subsequent interventions

Source: Adapted from Kumpunen *et al.* (2017)

responsibility which enables the clinical team to be responsible for the stewardship of resources, as well as clinical effectiveness, quality and safety, these being essential elements of leadership of population health care (Gray *et al.*, 2017).

Will the PCH deliver improved population health?

The PCH is a model of integrated care provision. Yet, it very clearly builds on the experience of different models of primary care commissioning as well as the broader development of primary health care built around the registered list of general medical practice.

Early results from the PCH approach are encouraging, with reports of impacts in the test sites such as improved employee satisfaction, staff reported patient satisfaction and some areas of reduced secondary care utilisation rates (PA Consulting, 2017). Initial evaluation findings indicate benefits to inter-professional working but highlight the need for sufficient resources to enable primary care to implement changes and for good quality data to demonstrate any financial benefits of the model over time.

However, these findings are tentative and relate to the very early stages of PCH development. PCHs need to develop and the evidence from earlier models can be instructive in thinking about that development path.

Certainly, there are reasonable grounds to believe that levels of engagement of GPs with the PCH will be high. The current organic development of PCHs by volunteers

appears likely to facilitate relatively this engagement (or at the least avoid presenting a barrier to engagement). This "volunteerism" would change if membership of a PCH becomes mandatory.

In terms of their scale, PCHs are significantly smaller than current Clinical Commissioning Groups. At a scale of around 30,000-50,000 population, PCHs have located themselves well within the extremes of the population size that is characteristic of other primary care models. Indeed, in size they are most similar to total purchasing pilots which had a mean population size of 33,000 (Bojke *et al.*, 2001). However, while small scale may predispose to high levels of engagement, a key issue will be whether PCHs are able to collaborate effectively at larger population levels to implement more strategic developments. Or, put another way, will the drive to deliver major strategic goals by working at a larger scale serve to undermine clinical engagement at the level of the individual PCH?

It is also important to understand the incentives that may successfully influence the behaviour of general practitioners on the basis that the aims of the PCH are likely to rely on their leadership and involvement. PCHs need to be firmly rooted in purpose, quality improvement and clinical excellence if they are to marshal the potential powerful "internal" incentives discussed above and ensure that primary care clinicians are to consistently participate in and deliver the desired outcomes and behaviours. This view appears to be consistent with recent research in US accountable care organisations (which share similar aims as the PCH). Here, factors such as social purpose and the mastery of professional skill were more important motivators of physician behaviour than financial incentives (Phipps-Taylor and Shortell, 2016).

Therefore, a successful strategy for PCHs would be to ensure that incentives seek to align professionals with the goals of population health rather than personal or individual provider gains.

However, this does not preclude PCHs having meaningful control (or at the very least significant influence) over population resources. Indeed, this would be needed to ensure sufficient autonomy and engagement to allow innovation in service delivery. This control does not have to be in the shape of a formal budget (indeed, that may prove difficult in the current regulatory framework) but instead through relatively unconstrained involvement of clinicians in decision making.

It is also the case that the accountability for the management of resources will need new measures, which are applied over longer timescales, if the aims of population health are to be delivered by PCHs. Improvements to health outcomes, and shifts in the distribution of those outcomes within populations, are unlikely to be amendable to single year monitoring.

The development of greater integration between primary and secondary care services remains probably one of the most challenging areas given the degree of current physical and functional separation. The creation of a whole population budget may assist here as this may attenuate some of the potentially perverse outcomes of specialists collaborating with primary care. This includes the sometimes dramatic loss of hospital income as a result of shared care in community settings as can happen under simple case-based payment systems. It will also be important that PCH strategies to reshape hospital services take into account all aspects of any service and do not just cherry pick particular elements. It is also possible to address the barriers between primary and secondary care through the use of digital technology to improve and speed communication between these sectors.

Conclusions

The PCH is a new attempt to systemise population health through integrated care constructs that build on the role of registered list-based primary care in the NHS in England.

They can be seen as an evolution of previous models of enhanced primary care and population planning, albeit in a national policy context that is now more conducive to the aims of population health. The growth in PCHs nationally has been rapid.

Evidence from prior models provides a guide to enablers and pitfalls that should assist with the successful development of the PCH. It is clear that engagement of front line practitioners and the recruitment of suitable leaders are crucial. The evidence tells us that engagement is a function of autonomy and a driver of innovation. In this regard at least, the PCH, as a rapidly growing and voluntary activity, based on neighbourhood level populations, appears set fair.

However, one interpretation of the almost constant reinvention of primary care organisations over the last 20 years suggests that, in the minds of successive policy makers at least, hoped for levels of effectiveness have not yet been reached. An alternative hypothesis is that no one model has had sufficient time to establish itself and that the protagonists in primary care have been laid low by "change fatigue". In this case, perhaps the most important prescription for the PCH is sufficient time to develop to maturity.

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