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BRINGING PATIENTS TO THE COMMUNITY CLINIC: AN INTEGRATIVE REVIEW OF TREATMENT RECOMMENDATIONS, PERCEIVED VALUE, AND WILLINGNESS TO USE PRIMARY CARE SERVICES

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Abstract:

Community health service centres sit at the bottom of nearly every health system pyramid, yet in many countries they remain under-used by the residents they were built to serve. One underexplored lever is how treatment options are recommended. Advice that discloses the full range of feasible options and adapts to individual patients may change not only what patients know, but what they believe a community clinic can do for them. This review asks what is known about such recommendation mechanisms in community settings, how they might translate into willingness to use community care, and where the evidence stops. It draws on thirty-three theoretical and empirical sources published between 1963 and 2025, purposively selected from PubMed, Web of Science and Google Scholar, and combines four literatures that developed apart: community service utilisation, shared decision making, value in health care and consumer behaviour, and behavioural models of care seeking. Three research gaps emerge. The communication and technology traditions of medical recommendation have never been joined, and both neglect primary care. Value is measured as a system-level scorecard, while its psychological counterpart, a patient's judgement that a service will deliver worthwhile benefit, is rarely used as a mediating variable. Willingness research catalogues factors but seldom tests how service practices pass through perception into behaviour. The proposed framework links the halves: perceived disclosure and perceived tailoring are expected to raise willingness through perceived efficacy value, the belief that the centre can deliver worthwhile benefit to someone in the resident's situation,

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with cost perception damping the step from belief to visit. Five propositions summarise the expected relations, running from main effects through mediation to cost and health-literacy boundary conditions, and each is matched to a feasible study design. The framework gives community health service managers an audit-and-training agenda for turning better recommendation into better utilisation.

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Keyword:

Health Information Systems; Health Service Utilisation; Perceived Value; Primary Care; Shared Decision Making; Treatment Recommendation

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Introduction

The Alma-Ata Declaration of 1978 put primary health care at the centre of global health strategy. Almost half a century later, the evidence base assembled in its wake is unusually clear: health systems with stronger primary care spend less and achieve better population health, with narrower inequalities (Starfield et al., 2005). China's reform experience illustrates both the promise and the frustration. Since 2009, the country has poured resources into community health service centres (CHSCs), built an extensive grassroots network, and widened insurance coverage, and access has improved substantially (Yip et al., 2012, 2019). What has not moved as quickly is where residents actually go. Many people still bypass the clinic down the street for a tertiary hospital ten kilometres away, even for conditions that community practice is designed to handle. The same pattern, in different institutional dress, appears across East Asia and beyond. Malaysia's public primary care clinics operate alongside a dense general practice sector that patients can enter without referral, and public facilities likewise compete for credibility rather than merely for capacity.

Why does a geographically close, cheap and formally adequate service lose patients? A well-established line of inquiry has answered this question in terms of structural factors: insurance design, reimbursement rates, distance, the standing of general practitioners, the distribution of specialist resources. These explanations matter, but they carry an implicit pessimism, since structural features change slowly and with great effort. They also leave a practical question unanswered for managers of community health services: what can the service itself do, in the ordinary conduct of a consultation, to become the option residents choose?

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One candidate answer has been discussed extensively but tested surprisingly little: the way treatment options are recommended. In a typical consultation at a CHSC, a patient with a manageable chronic condition faces several reasonable paths, and the physician's choice about which paths to mention, and how, is itself a decision. Two research traditions have grown up around this moment. The shared decision making (SDM) tradition treats recommendation as a communication achievement between clinician and patient (Charles et al., 1997; Elwyn et al., 2012). The technology tradition treats it as an information-processing achievement of algorithms and decision support systems (Garg et al., 2005; Topol, 2019). Each tradition has produced sophisticated work. Neither has asked, in a systematic way, what a receiving patient does with a recommendation: how it reshapes the patient's estimate that a community clinic can actually deliver health benefit, and whether that estimate is what moves willingness to use the service.

The gap can be stated directly. The literatures that study how recommendations are composed, whether as conversation or as computation, and the literature that studies what residents believe a community clinic can achieve have never been joined at the level of the individual encounter. For CHSCs the missing link is practical rather than academic. Recommendation practice is the determinant of care-seeking that clinic managers control immediately, ahead of insurance design, facility budgets and referral rules, yet it is precisely this lever that the existing evidence leaves untheorised.

This review addresses that gap. It asks three questions: what do we actually know about the design and delivery of medical programme recommendations in community settings, and what remains unknown; through what psychological process might a recommendation influence a resident's willingness to use community health services; and under what conditions should that process weaken or strengthen? The review is motivated by a managerial concern as much as a theoretical one. If recommendation practice is a genuine determinant of utilisation, then it belongs on the agenda of every CHSC administrator, quality manager and health service educator, not only of clinical informaticians.

The paper makes three contributions. It joins the SDM literature, the clinical recommendation system literature, value-based healthcare research, and utilisation behaviour research into a single analytical conversation, something the four fields have rarely attempted. It reframes value from a system scorecard into a perceptual variable that service mechanisms can influence, drawing on consumer research where value has always been understood as a judgement, not a ledger entry (Zeithaml, 1988). And it converts the review's findings into an integrative framework with five testable propositions, so that the argument can be refuted rather than merely admired. The next section explains the review approach; the two that follow examine the four literatures and synthesise them; a discussion of implications and limitations closes the paper.

Review Approach

This is an integrative narrative review rather than a meta-analysis. Its aim is to reorganise a fragmented field and build a framework, tasks for which loose, theory-driven sampling outperforms exhaustive enumeration, and for which the integrative review format was designed.

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Sources came from PubMed, Web of Science and Google Scholar. Searches were run between 2024 and 2025, and the whole record was re-verified in 2026. The strategy combined three families of terms in various pairings: recommendation terms ("shared decision making", "treatment recommendation", "clinical decision support", "decision aid", "treatment preference"), setting terms ("primary care", "community health service", "general practice", "first contact"), and outcome terms ("health service utilisation", "care-seeking", "willingness", "perceived value", "trust"). A representative PubMed string was: (("shared decision making" OR "treatment recommendation" OR "clinical decision support" OR "decision aid") AND ("primary care" OR "community health" OR "general practice") AND ("utilisation" OR "care seeking" OR "willingness" OR "perceived value")). Reference lists of included papers and of two handbooks were snowballed backwards, and forward citation searches covered the streams flowing from Elwyn et al. (2012) and Porter (2010).

Sources span 1963 to 2025, and the span is deliberate. The opening date is not decorative: the framework still rests on classics that later work argues with rather than around, from Arrow's account of uncertainty in medical markets (1963) to Andersen's access model and Zeithaml's value hierarchy. For empirical studies the practical boundary sits near 2000, because utilisation surveys before then predate the digital, patient-centred context that defines the present problem. The 2026 re-verification looked specifically for post-2020 evidence on recommendation design in community settings. Beyond the general machine-learning literature, what surfaced was a fresh edition of the Cochrane decision-aids review (Stacey et al., 2024); community-level studies of user-facing recommendation remain scarce. The recency boundary therefore measures how little community work exists, not how far the search reached.

Inclusion required that a source address (a) how treatment advice is composed or presented, (b) how patients evaluate or act on health services, or (c) how health system value is defined and measured. Excluded were purely algorithmic papers without any user-facing dimension, editorials without data, and duplicate study families where a later review superseded earlier primary reports. Because the corpus is purposive rather than exhaustive, PRISMA-style flow counts are not reported; the limitations section states what that sampling choice rules out. The final corpus comprises thirty-three sources: classic theoretical works, systematic reviews, landmark empirical studies, and health system reform analyses.

The analysis proceeds in four steps. Each literature stream is examined for its research trajectory, its settled findings and its blind spots. Streams are then compared for overlap. A synthesis stage identifies the connecting variables that no single stream has fully theorised. Finally, propositions are generated and matched to feasible designs. Two tables organise the evidence, and one figure states the framework.

Literature Review

Community Health Services and the Puzzle of Under-Use

Research on community-level services descends from the primary health care movement and its intellectual consolidation by Starfield and colleagues, who specified the properties that distinguish primary care from episodic specialist treatment: first contact, continuity, comprehensiveness and coordination (Starfield et al., 2005). The causal claim attached to this framework, that these properties improve outcomes and contain costs, has survived three

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decades of replication. The policy claim attached to it, that systems ought to be reorganised around primary care, runs into the behaviour of actual patients.

The Chinese case has been documented in detail by international observers of the 2009 reforms. Supply-side reforms achieved wide coverage and visible infrastructure, yet system re-orientation stalled precisely where patient flow was concerned: primary care volumes in some regions grew more slowly than expected while tertiary hospitals stayed crowded (Yip et al., 2012, 2019). Reform analyses point to weak perceived capability of general practitioners, patient habit, and payment rules that do not penalise skipping the grassroots tier. Note what this list is and is not. It includes capability and incentives. It does not include the content of the consultation, that is, what happens when a resident is sitting across from a community doctor and an actual treatment choice has to be made.

Trust research explains part of this omission. Trust is a functional requirement of any health system, because patients must act on advice they cannot verify (Gilson, 2003). A resident choosing between a community clinic and a large hospital is making a judgement about capability under uncertainty, and negative experience, hearsay or vague information can all depress that judgement. The service quality literature has long insisted that quality is not only what is provided but what is perceived, measured across structure, process and outcome (Donabedian, 1988), and gap-based models of service quality sharpened the point: perception forms in the comparison between expectations and experience (Parasuraman et al., 1988). Even so, empirical work on community health services has concentrated on structures (workforce, equipment, insurance) far more than on process variables at the level of the individual encounter. The mechanism through which a specific consultation practice changes a resident's behaviour has been treated as a black box.

Recommending Treatment: Two Traditions That Never Met

The first tradition frames recommendation as a moral and communicative achievement. Its classic definition is behavioural and minimal: shared decision making requires at least two participants, sharing of information, deliberation about preferences, and agreement on a course of action (Charles et al., 1997). Elwyn et al. (1999) showed that general practice consultations routinely fail at the second half of this sequence, because clinicians who have explained the problem and offered an option have not yet opened the space in which a patient's circumstances enter the choice. The later "three talk" model gave the sequence an operational shape, separating issue framing, option presentation and decision making (Elwyn et al., 2012). Evidence of effectiveness exists. Decision aids improve knowledge, produce more accurate risk perceptions and reduce decisional conflict, though effect sizes for behaviour change are modest (Stacey et al., 2024). Reviewing two decades of decision-intervention research, Frosch and Kaplan (1999) credited shared decisions with gains in knowledge and adherence, especially in chronic conditions where cooperation is itself part of the treatment, while pressing for stronger outcome designs. A useful consensus definition, with emphasis on exchange followed by deliberation, is offered by Stiggelbout et al. (2015).

The SDM tradition's own reviewers, however, are blunt about implementation. Légaré and Witteman (2013) catalogue barriers at three levels: clinicians (time, skill, scepticism about value), patients (low health literacy, deference habits) and systems (no incentives, no tools, consultation lengths set by old assumptions). Measurement lags practice: patient-reported instruments for shared decisions exist but their psychometric foundations are uneven across

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contexts (Scholl et al., 2011). Cultural portability is contested. The model emerged from Western autonomy norms, and in settings where families and clinicians expect paternalistic consultation, adoption requires adaptation rather than translation, an issue repeatedly raised in Asian primary care debates though rarely studied with the same rigour as the concept itself.

The second tradition treats recommendation as computation. Computerised clinical decision support can measurably change practitioner behaviour, with weaker and less consistent effects on patient outcomes (Garg et al., 2005; Sutton et al., 2020). Machine learning has since expanded what such systems can attempt, from personalised therapy selection to risk stratification across millions of records (Topol, 2019), and the practical lessons of early deployments are instructive: benefits depend on workflow integration, interpretability and the trust of clinicians and patients alike (Rajkomar et al., 2019). The literature on intelligent treatment recommendation in the Chinese context mostly follows engineering agendas, optimising accuracy and response time while leaving acceptance and decision quality unexamined.

The division of labour between the two traditions is near-total. Technology papers rarely model what a patient does with a ranked list of options; SDM papers rarely imagine that presentation might be algorithmically supported. Both share a setting bias, with evidence generated in secondary and tertiary care. Primary care is the natural home of recommendation, since it is where undifferentiated problems meet an open option set, yet it is the least studied. And both share a vantage bias: the unit of analysis is the clinician, the system or the trial protocol. What the receiving patient actually processes, a recommendation that arrives as a claim about what a local clinic can achieve, is the missing object.

Value in Health Care: From Scorecard to Judgement

Value entered mainstream health policy through Porter's deceptively simple formula, health outcomes achieved per unit of cost spent, together with a measurement programme built around outcome tiers, cost accounting through the full cycle of care, and organisation around medical conditions rather than departments (Porter, 2010; Porter & Teisberg, 2006). The formula carried a diagnosis of the cost crisis as much as a prescription: systems fail to contain costs because they never measured the numerator, and cost control without outcome measurement can destroy value while appearing to save money (Kaplan & Porter, 2011). The Chronic Care Model, older than the value agenda but congruent with it, showed that structured, information-supported chronic disease management raises the benefit side of the equation (Wagner, 1998). Implementation has not matched the rhetoric. Outcome measurement in routine practice is difficult, contested and sometimes resisted precisely because it makes performance visible (Kaplan & Porter, 2011). More relevant here, the value framework is a framework for systems. Its currency is population outcome data, not individual belief. Yet a resident deciding whether to enrol with a CHSC does not have outcome statistics; they have a subjective estimate, formed from fragments, of whether this service will do them good.

Consumer research got there first. Value, in this line of work, is a personal trade-off: the consumer's overall assessment of utility based on perceptions of what is received and what is given (Zeithaml, 1988). It is hierarchical, running from concrete attributes through consequences to personal goals (Woodruff, 1997), and it is multidimensional, with functional, emotional, social and price components separably measurable (Sweeney & Soutar, 2001). Importing this into health care yields a precise distinction that the health services field often

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blurs: the difference between a service's value (an engineering property) and a patient's perceived efficacy value, the belief that this service will produce worthwhile health benefit for a person in my situation. The second is psychological and malleable, so how a service communicates may move it. Health literacy conditions all of this. Obtaining, processing and understanding the information needed for health decisions is itself unevenly distributed, and patients with weaker literacy face larger translation burdens when information arrives unprocessed (Baker, 2006).

Willingness to Use Community Services: Factors Without Mechanism

Andersen's behavioural model dominates this research area, and rightly so. Its three factor families, predisposing characteristics, enabling resources and need, give researchers a shared grammar, and later revisions embedded the model in policy and feedback loops (Aday & Andersen, 1974; Andersen, 1995). Enabling resources deserve attention here. In practice they have been operationalised almost exclusively as structural possessions: income, insurance, a usual source of care, distance. The model never forbade treating information as an enabling resource, but studies have barely tried. A resident whose condition admits several treatments and who receives none of them described is information-poor in a way the standard measures miss entirely.

Complementary theories supply the cognitive machinery the Andersen model leaves implicit. The health belief model reduces a care decision to perceived threat weighed against perceived benefits and barriers of action (Rosenstock et al., 1988). The theory of planned behaviour makes intention the hinge between belief and act, shaped by attitude, subjective norms and perceived control (Ajzen, 1991). Economic theory supplies the reason why these judgements carry so much weight: health care is a market in which uncertainty and information asymmetry make self-directed choice unreliable, and patients reasonably lean on whatever signals a provider emits (Arrow, 1963). A clinician's recommendation is exactly such a signal, and signalling theory explains why its credibility depends on the recommender's visible willingness to disclose rather than conceal (Spence, 1973).

Put the pieces together and a pattern appears. Factor inventories are long. Mechanism tests are short. Most published studies regress utilisation or stated willingness on a battery of Andersen-style covariates, report which coefficients are significant, and stop. Three gaps summarise where the four literatures stop. Gap 1: no stream connects service-side recommendation practice with patient-side value judgement. The communication and technology literatures own the first half of the chain, the utilisation literature the last, and the middle belongs to nobody. Gap 2: value research measures value at system level while consumer research theorises it at the level of the purchase, and neither has operationalised a pre-use, provider-specific belief about achievable health benefit. Gap 3: the field lacks mechanism and boundary tests. Mediators beyond trust are understudied, moderation is almost untested, and single-theory papers talk past one another. The synthesis that follows is built to make each gap falsifiable.

Synthesis: An Integrative Framework

Table 1 summarises what each stream contributes and where it stops.

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Table 1: Four Literatures and Their Blind Spots

Literature stream	Core question	Settled findings	What it leaves open
Community health services and utilisation	Why are community services under-used?	Structural factors and trust explain much variance	What the encounter itself can do to change behaviour
Shared decision making and recommendation technology	How should options be communicated or computed?	Aids improve knowledge and reduce conflict; CDS changes practice	Patient-side perception in primary settings; the two traditions' separation
Value in health care and consumer research	What is value and how is it measured?	Outcome-based definitions; value as perceived trade-off	Perceived efficacy value as a mediating variable, not an outcome
Behavioural models of care seeking	What predicts willingness to use services?	Predisposing, enabling, need factors; attitudes and beliefs matter	Mechanisms linking service mechanisms to intention; boundary conditions

Source: Authors' own synthesis.

Defining Perceived Efficacy Value

The framework turns on one construct, so it is defined before it is used. Perceived efficacy value is a resident's belief that a specific community health service will produce worthwhile health benefit for a person in the resident's own situation. It is an estimate made before use, from indirect signals, of achievable benefit.

Three neighbours must be set aside. Perceived usefulness, in the technology acceptance tradition, is a belief that using a system will improve job performance (Davis, 1989); its home is task technology, not a clinic's capability to heal. Service quality perception grades the process of a service against expectations, often retrospectively (Parasuraman et al., 1988); efficacy value asks about the health result, not the manner of delivery. Satisfaction is retrospective by definition, a comparison of experience with expectation once the service has been consumed; efficacy value forms beforehand, which is exactly why it can predict first visits rather than merely rate repeat ones.

That the construct can mediate is not an assumption imported wholesale; three lines of evidence give it standing. Value judgements predict use intentions in consumer settings, one of the most replicated facts in that literature (Sweeney & Soutar, 2001; Zeithaml, 1988). Health belief research makes perceived benefit the pivot between information and action (Rosenstock et al., 1988). And the theory of planned behaviour places belief-based attitude upstream of intention (Ajzen, 1991). A belief about achievable benefit sits naturally at that pivot.

Framework and Propositions

Figure 1 states the model in one view. Two recommendation dimensions define the service mechanism. Full disclosure means the patient sees the complete set of feasible options for their condition, with plain-language information on benefits, risks and costs, rather than the subset

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a particular clinician happens to favour. Professional tailoring means the advice is explicitly adjusted to the patient's clinical and personal circumstances and justified in terms of them. In the framework, both dimensions work through perceived efficacy value. Full disclosure is expected to move this judgement by giving the resident grounds for an evidence-based estimate, and by the signalling logic that disclosure is credible only when the discloser has nothing adverse to hide (Spence, 1973). Tailoring is expected to work through a different route: advice marked as specific to "my" age, history and budget implies a better match, and match implies a higher probability of success for me personally. Willingness to use community services should then follow. Perceived cost enters as a boundary condition: since value in the consumer sense is a ratio of gains to sacrifices (Zeithaml, 1988), the step from "this will help me" to "I will go there" should stall for residents facing heavy out-of-pocket burdens, or heavy anxiety about spending without cure.

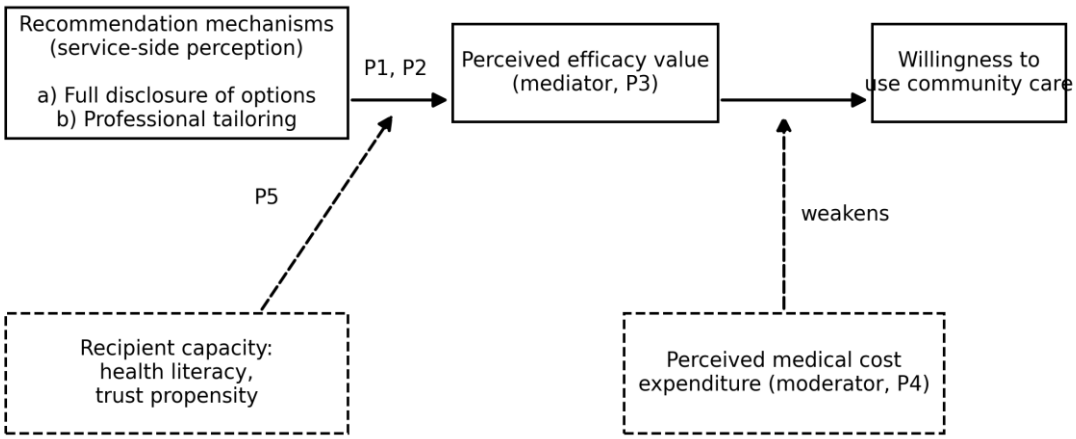


Figure 1: The Integrative Framework of Recommendation Perceptions, Efficacy Value, and Willingness

Source: Conceptual framework developed by the authors.

Five propositions state the argument precisely.

- **P1.** Perceived full disclosure of treatment options is positively associated with willingness to use community health services.
- **P2.** Perceived professionally tailored recommendation is positively associated with willingness to use community health services.
- **P3.** Perceived efficacy value is hypothesised to mediate the associations of both recommendation dimensions with willingness, the disclosure route being grounded in informed cognitive appraisal and the tailoring route in personalised relevance and trust.
- **P4.** Perceived medical cost expenditure is expected to weaken the association between perceived efficacy value and willingness; the indirect effects in P3 are correspondingly conditional, a pattern of moderated mediation.
- **P5.** The relative strength of the two routes is expected to vary with the recipient's capacity to process unstructured information: full disclosure should do more work for residents with adequate health literacy, tailoring for those with limited literacy or low trust propensity.

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- P5 deserves a defence, since it looks like a hedge. It is not. The two dimensions make different cognitive demands, and Baker's (2006) findings on health literacy give an expectation rather than a guess: unassisted comparison of multiple options is precisely what low-literacy patients cannot perform, so disclosure without assistance may inform the informed and confuse everyone else. If P5 holds, "better recommendation" is not one intervention but two, and services must staff and script them differently.

Table 2: From Gaps to a Research Agenda

Gap identified	Proposition	Design that would settle it
Encounter-level mechanisms ignored by structural research (Gap 1)	P1, P2	Field or vignette experiments varying disclosure and tailoring in real clinics
SDM and recommendation technology literatures disconnected (Gap 1)	P1-P3	Studies measuring both communication quality and algorithmic support of the same advice
Value measured at system level only (Gap 2)	P3	Panel designs tracking perceived efficacy value between visits
Mediation and moderation untested (Gap 3)	P3, P4	Structural equation models with interaction terms; cost salience experiments
Two recommendation routes not differentiated (Gap 3)	P5	Randomised presentation formats by health literacy strata

Source: Authors' own synthesis.

Discussion

Theoretical Implications

What the framework adds to utilisation research is an enabling resource hiding in plain sight. Information, in Andersen's grammar, need not remain a residual; treated as recommendation quality it becomes a measurable enabling resource with managerial consequences, and the review above showed how little of that potential has been used.

What it adds to shared decision making is the perceptual step between support and behaviour. Evidence that decision aids improve knowledge is stable (Stacey et al., 2024), but knowledge is not belief in a local service's capability. The framework names the missing inference: a patient converts presented options into a personal estimate of what will happen to them. Decision aid research can test that conversion directly rather than assuming it.

What it adds to value theory is an individual-level analogue of Porter's formula. A decade of value-based implementation showed why the analogue is needed: people act on their own accounting of benefit, not the system's (Porter, 2010; Zeithaml, 1988). Perceived efficacy value is offered as that analogue, a bridge between macro definitions of value and micro behaviour, and a candidate mediator for service features far beyond recommendations.

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A fourth contribution answers P5. Treating "good recommendation" as a single construct hides the fact that transparency and personalisation rest on different psychological foundations, informed appraisal versus felt relevance, and therefore respond to different populations. Splitting the construct is what makes the propositions testable rather than hortatory.

Implications for Practice and Management

For community health service managers, the review converts a vague exhortation to "communicate better" into three separable operations. Start with an audit of option coverage: when a patient asks how to treat their condition, are all feasible community-level options on the table, with plain-language benefit and cost descriptions, or only the incumbent favourite of the consulting clinician? Tailoring deserves the next line, treated as a skill in its own right. Explaining why an option fits this patient's work, budget and family situation is trainable and can be scheduled; it is not a by-product of clinical competence. Then manage the denominator. If cost perception blocks the path from value to visit, then publishing prices, explaining reimbursement on the spot, and sequencing advice toward affordable first steps are not accounting chores but demand management. None of the three operations requires new infrastructure. Each can be tracked with a short post-consultation questionnaire asking whether all feasible options were shown and why the chosen one fits, which doubles as the measurement the framework needs. Managers in systems where patients self-refer, such as Malaysia's, face the same three operations with the same logic, which is one reason the framework was written without reference to any single referral regime.

Quality education and purchasing bodies should notice a further implication: if recommendation quality moves utilisation through patient belief, it belongs in quality measurement instruments, not merely in consultation training. Existing SDM instruments measure process occurrence; the framework argues for measuring the perceptual outputs of process, perceived disclosure quality and perceived tailoring quality, from the patient side.

Limitations of This Review

The corpus is purposive, so selection bias in favour of famous literatures is possible; the framework could change under a stricter sampling rule, though the propositions' content is unlikely to move much given the breadth of corroboration. The search covered English-language sources; Chinese-language primary care research is substantial, and its exclusion may understate what is known about CHSC consultation practice specifically. The review synthesises conceptual arguments and study-level findings, not pooled effect sizes; no claim here is quantitative. Many propositions rest on evidence generated outside community settings, and transfer to resource-thin clinics is an empirical assumption, not a finding. The framing of "medical programme recommendation" derives from a Chinese policy context, and while the mechanisms travel, measurement instruments built there will require adaptation elsewhere. Finally, digital recommendation, the algorithmically generated variety, is under-represented because the community-level evidence barely exists yet; its absence here is a measurement of the field, not of the topic's importance.

Conclusion

Patients do not choose clinics; they choose their expectations of clinics. That observation dissolves none of the structural problems of community health services, but it redirects

attention to a lever the services already control: what they tell the patient standing in front of them, and how completely and personally they tell it. The four literatures reviewed here have each, in isolation, described a corner of the resulting mechanism: services compete under information asymmetry, recommendations are either communication or computation, value is a system scorecard or a personal trade-off, and willingness is predicted but rarely explained. Read together, they support an account in which two recommender actions, disclosure and tailoring, are expected to raise a resident's estimate of achievable benefit, and in which that estimate becomes a visit only when cost perception permits. Five propositions have been stated so that the account can fail empirically rather than rhetorically. The next step is not another review. It is a study, preferably an experimental one, in which patients receive different varieties of the same good advice and are followed long enough to see which of them shows up at the community clinic again.

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