

Forces for Integration

Kurt C. Stange, MD, PhD, Editor

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Primary care is a force for integration¹⁻⁹ in a fragmented health care system and society.¹⁰⁻¹² But how can we understand integration? This editorial names two complementary forms—vertical and horizontal—and closes with two examples of horizontal integration: stories of the generalist healer and of the *Annals* on its fifteenth anniversary.

TWO KINDS OF INTEGRATION

There are two kinds of integration that bring people together in a world in which people seem to be moving farther apart.

Vertical integration is how we organize ourselves to manage tasks that range from simple to complicated. We stack things up so that A leads to B leads to C. We attempt to get well-specified tasks done through centralized authority.

Horizontal integration is how we organize ourselves to understand and deal with complex phenomena when more than one thing is important—such as helping communities to be healthier, or providing primary health care for whole people and families, or helping people live with multimorbidity. In these situations, we need contextual understanding to guide our actions among many possibilities. So we scan the horizon. Use appropriate available knowledge, experience, intuition, and pattern discernment. Make sense of things as best we can. Try something. Observe what happens. Adjust. Invest in needed connections. Try something else. Learn. Repeat, paying attention to the larger emerging patterns.

In health care, to achieve *vertical* integration, we develop service lines that bring together primary, secondary, and tertiary care for people with a particular disease or risk pattern. To achieve *horizontal* integration in health care, we try to develop cross-sector collaboration and information systems that make relevant data available at the point of greatest influence, and then we support investment in local relationships that allows that information be used for people whose disease labels or risks may be unclear, or whose needs are multiple.¹³ When developed in tune with each other, verti-

cal and horizontal integration create whole systems in which the benefits of both a narrow focus and a broad contextualization are achieved.^{13,14}

Vertical integration is better understood and more celebrated.¹⁵ Stories of vertical integration are about making things happen when the right course of action has become clear. The archetypal stories of vertical integration are about heroes and victims—people whom we reward or blame.

Horizontal integration is more subtle, but ties into a deeper human experience of wholeness. Stories of horizontal integration tend to get misconstrued. The quiet connectors inherent in horizontal integration lurk behind distorted narratives of how leaders use their platforms of authority to make extraordinary things happen.¹⁶⁻¹⁸ Occasionally, a true story of horizontal integration breaks through—a champion basketball team without individual stars, neighbors who self-organize to fight a fire or a hurricane. But more often, when horizontal integration allows abundance to emerge out of apparent shortage, a new vertically integrated order quickly reorganizes.¹⁹ Then the quiet, boundary-spanning catalysts of horizontal integration are either forgotten, or maligned and run out of town.²⁰

Primary care is fond of its four Cs: first Contact accessibility, Comprehensiveness, Continuity, and Coordination.²¹ Vertical and horizontal integration have their own four Cs. The four Cs of vertical integration are Command, Control, Celebrity, and Cash. The four Cs of horizontal integration are: Collective, Connect, Contribute, and Collaborate.

Here are two stories of horizontal integration:

THE GENERALIST IN HEALTH CARE

Once upon a time,* people felt the need for a healer. They identified those among them who seemed to have the ability to tie into an energy resonant within all, but largely hidden from view. They called these people shamans. Later they used terms like GP or family doctor, and even later CAM provider or Margaret.

* Actually, since the beginning of human time.

Healers often possessed special powers, techniques, and potions. Their extraordinary knowledge was known to be dangerous but often helpful when used in the context of ordinary local knowledge and with a goal of fostering connection, healing, or health. The care they provided often was humble. But that humility, and its inclusive focus on the wholeness of the person, family, and community, made it accessible, and made healing rituals relevant and connecting. Outsiders sometimes offered narrow healing knowledge that was made relevant by the local knowledge of the generalist healer. Healers invested in relationships and generated a bank of shared understanding and trust that could be called on during difficult life transitions.

As healers proliferated and generated more tools, their healing powers became conflated with the narrow capabilities of their tools. Their role as an integrator came to be understood as the sum of the parts of their tools and techniques, rather than as a higher force that included but transcended those trappings.²² A narrow focus became valued—in prestige, support, and money. Understanding of the value of an inclusive and integrative focus was nearly lost, as top-down bosses gained control and assumed they could *drive* quality by hammering the frontline healers to manage disease, as if everyone came for care with the appropriate label already slapped on their foreheads. Healers were paid for quickly delivering commodities of care, and those who tried to invest in relationship, to provide narrative unity for whole people and communities, to integrate and personalize care, were beaten down.²⁰

A vague sense of loss developed among both healers and those in need of healing and became the impetus for grounding but reimagining the role of the healer for a new era.²³⁻²⁷ That drive to recognize, reinvent, and support horizontal integration in health care is struggling to burst forth with force, even today.

THE ANNALS OF FAMILY MEDICINE

Once upon a time,[†] sensing that something important was about to be lost, a groundswell of those on the frontlines of family medicine called on their leaders to establish a forum for advancing knowledge essential to understanding and improving health and primary care, and for supporting a learning community of those who generate and use information about health and generalist health care.

Visionary leaders from three family medicine organizations,[‡] each of which already sponsored their own journals, came together to launch a new journal. They invited three other family medicine organizations,[§] and

later others,^{**} to join in. This was only the second time that these organizations had made a substantial financial commitment to a collective activity.^{††}

The new journal was supported by member dues, rather than commercial sources. Initially this was because commercial sources were deemed to be insufficient in quantity. But later this freedom from commercial pressures gained meaning as a source of independence, with freedom from bias and freedom to horizontally integrate.

The organizations came together to support a transdisciplinary, transnational forum that invited diverse voices to interact with what was published. This would be an academic family medicine journal, but one that gained insight and influence by being involved in broader conversations about diverse pathways to illness and to health, and of the role of family medicine as a part of broader solutions to seemingly intractable problems in healing and health.^{28,29}

Over time, the sponsoring organizations faced competing demands, budgetary challenges, and occasional calls to focus more narrowly on their mission or the immediate needs of their members. While heeding these calls, the sponsors remained steadfast in their role as horizontal as well as vertical integrators, and they continue to support a vehicle that includes but transcends their narrower interests. In so doing, they are creating a pathway for collective impact.

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† Actually, during the year 2000.

‡ The American Academy of Family Physicians, the American Board of Family Medicine, the Society of Teachers of Family Medicine.

§ The North American Primary Care Research Group, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors.

** The College of Family Physicians of Canada, and for two years, the Agency for Healthcare Research & Quality.

†† The first was investment in the Future of Family Medicine project, the blueprint of which was published as the first supplement to the new journal: Martin JC, Avant RF, Bowman MA, et al. The Future of Family Medicine: a collaborative project of the family medicine community. *Annals of Family Medicine*. 2004;2 Suppl 1:S3-32.

the new knowledge that is published in *Annals* and are grateful for the privilege of supporting the work.

To read or post commentaries in response to this article, see it online at <http://www.AnnFamMed.org/content/16/3/192>.

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