



Polyclinics Must Integrate Health Care Vertically AND Horizontally

Kurt C. Stange, MD, PhD

Editor, *Annals of Family Medicine*
American Cancer Society
Clinical Research Professor

Gertrude Donnelly Hess, MD

Professor of Oncology
Research
Professor of Family Medicine,
Epidemiology & Biostatistics, So-
ciology and Oncology

In the interview with Professor Thomas, Lord Darzi acknowledged that health care is becoming increasingly fragmented, and that the solutions lie in broad coalitions cooperatively pursuing integration. He said:

I get clear feedback from patients – ‘the care we are receiving is fragmented; we want more integration’. That is the challenge. The solution is different – there is never one solution to a problem; I would be the first person to admit that. And the solution should only be decided at a local level, based on local circumstances. The principle is clear - the principle for me is to achieve integrated patient centred care, which I’ve described as personalised care, which is care tailored around the needs of the patients - that’s my definition of it. Now how do you achieve that? I think no one sitting in this department could make that happen.

Lord Darzi views primary health care as an important part of this integrative solution:

Primary care is a very holistic way. The best primary care provision I’ve seen, whether it’s in this country or elsewhere, is this holistic approach to care. It’s not just health care. It is health care, social care - all aspects of care that a community needs. So, primary care’s relationship with its community is very different than any other health care provider that you can think of, whether in this country or outside. That is the essence. That is the significant part of the purpose of primary care provision.

The question then, is how to support this integration? Lord Darzi rightly asserts that there is no magic bullet solution. Based on his personal experience, which is so nicely brought out at the beginning of the interview, he sees polyclinics as a mechanism for integrating health care. Personal experience as a surgeon has shown him the potential benefit of professional colleagues – GP and specialist physicians and nurses – talking and working together to assimilate different perspectives and expertise around specific problems, such as the eight Clinical Pathways (birth, children, staying healthy, long term conditions, acute episodes, planned care, mental health, and end of life). Lord Darzi has created much discussion by proposing the polyclinic as a way to integrate care.

But is the polyclinic the best solution to provide integration for these kinds of broad life and health problems? It is good at joining care vertically, through professional relationships. Is this the best way to foster the needed integration?

The international research by Geoff Meads is instructive. Professor Meads studied how primary care manifests in 33 countries with major health care reforms in the past decade. Studying 24 countries with

Correspondence to:

Kurt C. Stange, MD, PhD
Case Western Reserve
University
10900 Euclid Ave
Cleveland, OH 44106 USA
kcs@case.edu
001-216-368-6297 (direct)

in-depth comparative case histories, he and his colleagues identified a typology of 6 ways that primary care manifests in diverse circumstances. These are: extended general practice, managed care, reformed polyclinic, district health system, community development agency, and franchised outreach.¹

Meads defines the structure of the reformed polyclinic as a coalition, the process as divisional, the value base as commercial, the service focus as on medical conditions, the location as the multi-specialist clinic, and the endpoint as the client. This description is what is commonly understood as the polyclinic. In fact, Meads adds the word “reformed” to differentiate it from the old Russian polyclinic that has been much maligned.

But is this common understanding of the polyclinic, reformed or otherwise, what Lord Darzi means in his efforts to find a structure for health care reform in London? In the interview with Professor Thomas, he says:

Polyclinics are not buildings. Polyclinics are my way of describing integrated service provision. That is what polyclinics are.

I feel that I've done a lot of good by starting this debate, but at the end of the day, I think the solutions are local.

So I think what we've done is started a healthy debate, and we are also coming to the consensus of what our investment, our reform, should be in primary community setting.

I think the more grounded you are, the better it is.

Thus, the idea of a polyclinic that emerges from the Thomas interview with Darzi is quite consistent with more inclusive efforts toward health care integration than are usually associated with the term ‘polyclinic’. It is consistent with an important bottom line from Professor Meads’ research - that the best way to provide health care is highly dependent on the local political, social, cultural and economic conditions. As Professor Darzi notes: “Solutions to vertical and horizontal integration depend on the local circumstances.” There is no one magic bullet. Polyclinics, as traditionally understood, are one possible solution. Their strength is the vertical integration of care. But this strength also is a weakness. Establishing systems whose

primary purpose is to vertically integrate the care of specific diseases risks dis-integrating care of whole people. It risks devaluing problems that do not fit into the neat boxes of clinical pathways. It risks not heeding the opportunity of bringing non-professionals and community groups into the fold in improving health care and health. In short, polyclinics, as commonly understood, are one potential solution, but not the only solution. Lord Darzi’s vision and the needs of the people of London are broader.

In addition to the vertical integration of care that is the strength of the polyclinic, systems are needed that simultaneously foster the horizontal integration of care. This means providing mechanisms that enable ongoing creative interaction between different disciplines that together serve whole people, populations and communities, as well as working to improve the care of specific diseases and defined problems. Infrastructure that is good enough to support both vertical and horizontal integration will provide multiple opportunities for community and non-health care partners to work with diverse health care professionals to shape future developments – indeed Lord Darzi’s *Healthcare for London: Consulting the Capital*, is one example of this. Providing flexible structures and a place in the tent for everyone with an interest in improving health care and health may not lead to solutions that can be fed to the evening news in neatly packaged sound bites. It will, however, provide an opportunity for the messy but ultimately necessary process by which care is truly integrated – for people as well as their diseases, for communities as well as the NHS.

Several weeks ago, I had the privilege of witnessing just the sort of integrative, on the ground process that is needed. At the first workshop of the Ealing Primary Care Trust Development and Research Practices, diverse members of primary care practices met with public health and other groups to envision and begin to work on integrative solutions to the important problems they face in improving the health of the people of Ealing. The process created tension, but unleashed the front lines energy, creativity and inclusiveness that is needed to begin to tackle the challenging problems in health care.

Lord Darzi’s vision of polyclinics as a “way of describing integrated service provision,” can provide a space for such dialogue and action to vertically and

horizontally integrate care in ways that create locally effective processes. The challenge is to avoid an overly narrow interpretation of the polyclinic idea, and start processes from which continually evolving care improvements can emerge. The opportunity is to go beyond Lord Darzi's experience of integration of care in the hospital, beyond the GPs experience of integrating care in the office, beyond the district health nurse's experience of integrating care for people in the community, beyond public health workers' experience of population programs – to bring all these and other perspectives together to vertically AND horizontally integrate care.

The solution to fragmented care is too grand, too distant, for one person to see. The solution is less a vision that must be rolled out and implemented than it is a process for bringing diverse peoples together and supporting their work toward both vertical and horizontal integration of health care. This process can be started by broadening the focus to engage multiple perspectives and to allow multiple solutions to emerge as a process, rather than as an end.

As clarified in Professor Thomas' interview, Lord Darzi has called Londoners into an inclusive tent. Staying outside will thwart the process and result in a narrowly defined polyclinic that is focused on diseases and pathways. If diverse groups who care about health care and health come into the tent, integrated care has a chance to emerge. This integrated care will make sense for local needs and unleash the human potential that currently is pent up in “fragmented silos” of what could be an integrated whole.

As a family physician (GP) practicing in the world's most expensive, lowest value, and perhaps most fragmented health care system, I encourage you to listen to the call to build on the great strength of a system that creates space to work toward the common good.

REFERENCES

- ¹ Meads G. Primary care in the twenty-first century. Oxford: Radcliffe Press; 2006.