Editorial

Multimorbidity, nor a health condition nor complexity by another name

Multimorbidity, the circumstance in which individuals suffer from multiple health conditions, has clearly emerged as a priority for health care and research in the last decade (1). The rise in publications on this issue is exponential, and yet, the problem is far from new (2). At least five factors have converged to create the circumstances that may explain the relatively massive interest. Firstly, the progressive improvement in life expectancy has resulted in an increase in the prevalence of chronic conditions, which accumulate over the lifespan (3). Secondly, the widespread use of electronic health records has facilitated better keeping track of these conditions. Thirdly, there is a clear trend in both increased diagnosing of existing conditions and medicalization of what were once considered ailments (4). Fourthly, the development of performance metrics for Primary Care for incentive schemes has revealed the limitations of disease specific standards (5). Finally, and more generally, the movement for a more patient centred approach has found in multimorbidity a powerful argument founded in clinical needs to add to the ethical imperative and accountability principles that were at its basis(6).

The response to these challenges has taken multiple forms, both from researchers and health policy makers, but no substantive changes have occurred in the everyday experience of both patients and health professionals. One could argue this is not surprising given the paucity of evidence on interventions for people with multiple conditions (7) and the lack of primary evidence on how available interventions for specific conditions should be tailored in the presence of multiple conditions. However, two important conceptual issues may also be impeding progress.

A growing body of evidence is developing on the complex relationships between multimorbidity (multiplicity of health problems), co-morbidity (presence of additional problems in relation to an index problem), morbidity and treatment burden (severity and impact of the health problems and of treatments), patient complexity (including the previous ones as modified by relevant individual non-clinical characteristics, such as socio-economic position, language, etc.), polypharmacy (number of medications), frailty and a number of other relevant constructs (1). This is frequently overseen when the problem is simplified as one of patients with multimorbidity, considered as a distinct group within the general practice population. This simplification provides a rationale for the development and evaluation of potential treatment packages and even clinical practice guidelines specific for patients with multimorbidity. It is a sad irony that multimorbidity has been framed using the single disease approach. Multimorbidity is been conceptualized as a health condition on its own right, but one with a most bizarre diagnostic criterion: the multiplicity of other conditions.

Simultaneously, multimorbidity has come to replace the notion of complexity in clinical care and in policy documents. A number of yet unresolved complexity issues - which have captured for long the attention of health care managers and policy makers - are being reframed or rather simply relabelled as multimorbidity. However, the root of these problems actually lies elsewhere, most frequently in the severity of the conditions rather than in their mere presence. Therefore, efforts intended to help solve the problems posed by multimorbidity (how should best practice look like in the presence of multiple conditions) end up being addressed by solving the problems of the more severe cases in the population. Resource constraints would make it reasonable to prioritize this group with very high health care needs, but this approach has significant limitations. Firstly, by definition they are a very selected subgroup of patients with multimorbidity. Hence, any solutions successfully developed for these patients will not improve the lives of the many these interventions promise to improve. Secondly, by attempting to address a morbidity and care burden problem through a multiplicity lens, they are condemned not to deliver at a more fundamental level.

Therefore, it is worth restating the obvious. Multimorbidity is not a condition. The key question posed by multimorbidity is not how to improve care for a specific group of patients but rather how best to organize and provide care (including self-management) in a way that accounts for the fact that a significant proportion of the population has multiple conditions. This notion is relevant to almost every single aspect of clinical care. It is not as if we have never faced this issue before. Quite the opposite, this is something that GPs have learned and learn by doing, starting with their first patient. However, we lack the tools for taking a well-structured evidence-based approach. General Practice, almost more than any other medical discipline, requires a balance of science and art. Let us not hesitate to put more science in the delicate art of managing multimorbidity.

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REFERENCES

(1) Valderas JM, Starfield B, Sibbald B, Salisbury C, Roland M. Defining comorbidity: implications for understanding health and health services. Ann Fam Med 2009;7:357-63.

(2) Violan C, Foguet-Boreu Q, Flores-Mateo G, Salisbury C, Blom J, Freitag M. et al. Prevalence, Determinants and Patterns of Multimorbidity in Primary Care: A Systematic Review of Observational Studies. PLoS ONE 2014 9:e102149.

(3) Murray CJL, Lopez AD. Regional patterns of disability-free life expectancy and disability-adjusted life expectancy: Global Burden of Disease Study. Lancet 1997;349:1347-52.

(4) Welch, H. Gilbert, Lisa Schwartz, and Steve Woloshin. Overdiagnosed: making people sick in the pursuit of health. Beacon Press, 2011.

(5) Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA 2005;6:716-24.

(6) Valderas, JM. Getting impatient about person-centred health care. Eur J Gen Pract 2013;19:141-2.

(7) Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. Cochrane Database Syst Rev 2012;4:CD006560.