Multimorbidity could cause a healthcare crisis—here's what we can do about it

August 2 2017, by Chris Salisbury

Credit: AI-generated image (disclaimer)

Multimorbidity is one of the biggest challenges facing healthcare. In recent years, a succession of research studies have shown that people with multiple health problems are more likely to have a worse quality of life, worse mental health and reduced life expectancy. The more health problems someone has, the more drugs they are likely to be prescribed

and the more frequently they are likely to consult a GP or be admitted to hospital.

You might think this is all rather self-evident – it's hardly a surprise that sick people get ill, take medicines and go to doctors more often than healthy people.

So why has multimorbidity become so prominent in discussions about healthcare over the last decade?

There has been an explosion in the number of research papers published on the the topic, numerous editorials and discussion documents have been written, and NICE (the UK's National Institute for Health and Care Excellence) published guidelines on multimorbidity in 2016.

The first and most obvious reason the topic has become so critical recently is that the population is getting older. Since multimorbidity is much more common in older people, an increasing proportion of elderly people leads to far greater pressure on the healthcare system to help people with multiple, complex healthcare needs.

But second, and perhaps more importantly, is the "industrialisation" of healthcare. It is well recognised that the quality of care for chronic diseases such as diabetes is very variable. One effective way to improve this is to standardise care so that everyone gets the most effective treatment.

Lessons from the car industry

Healthcare systems around the world have learnt from other sectors, such as the motor industry. This has led to clear guidelines for optimal care, which have been implemented using standardised checklists, new protocols and IT support systems. These approaches are backed up by

"pay-for-performance" schemes to incentivise healthcare providers to follow the guidelines.

All of these quality control mechanisms are focused on improving the care of individual diseases, such as heart disease, asthma or depression. Similarly, almost every aspect of the UK's healthcare system is designed to improve care for specific diseases. So there are now specialists and specific clinics for each disease, whereas the "generalist" GP service was designed in an era when most people attended with relatively straightforward single problems that could be treated in no more than ten minutes.

So how does this focus on single diseases make sense for the patient who has heart disease and asthma and depression?

Thanks to the ageing population, these are the people who fill GPs' waiting rooms and hospital out-patient departments. As industrial processes have been used to try to standardise healthcare, it's become increasingly clear that focusing on each disease individually hasn't led to a system which effectively helps people with multiple diseases. To pursue the analogy with the motor industry, it's as if a series of excellent factories have been created for manufacturing car parts, but without a factory to assemble the car.

So how should we do it better?

As the NICE multimorbidity guidelines make clear, there simply isn't much evidence about how to improve management for patients with multimorbidity. The problems are clear, but the solutions are less so. Because of the specialisation of medicine, almost all of the evidence about what works comes from studies of patients who have single diseases. The few studies of services that have sought to improve care for people with multimorbidity haven't shown clear and consistent

results.

But there is quite a lot of consensus on what the key ingredients of a new and more effective approach might be. These include providing greater continuity of care with a generalist doctor or nurse who takes responsibility for all aspects of a patient's care, co-ordinating other specialist input for specific conditions when necessary. Patients with complex needs can't be managed in a ten minute consultation (the time allocated for a typical GP consulation) – they often have a list of problems and need more time to discuss them.

Care should be more tailored to the individual needs, priorities and lifestyle of each patient, with their unique combination of diseases and environment. This starts with finding out the problems that bother the patient most, and agreeing with them a series of goals that the patient and health professional can work on together.

We need to think broadly and holistically, especially since people with multiple physical problems often have mental health or social problems, too. Doctors need to negotiate treatment plans with patients rather than dictating them. Decisions need to be shared, especially since the best course of treatment may not be obvious and it may be necessary to make trade-offs between benefits and risks for patients with complex medical histories.

Goals for the future

It may be wise to try to reduce and simplify complicated drug regimes when patients have been prescribed numerous drugs. All of these goals and decisions should be laid out clearly in a written plan, held by the patient themselves, which facilitates communication between patients and professionals and also between the many agencies which are often involved in providing care for people with multimorbidity.

We are currently conducting the 3-D study, funded by the NIHR Health Service and Delivery Research programme, which is looking at a new approach to multimorbidity that incorporates all of the above ideas. This is a large trial in which 33 general practices in different parts of the UK are randomly assigned to provide either the new 3-D approach or to continue care as usual. Over 1,500 patients have agreed to take part in this trial, and more than 80% of them have been followed up for 15 months. We are just analysing the findings, which should be available in early 2018. There is also a hashtag on Twitter, #capcbristol, that allows you to follow our work.

We will explore whether the 3-D approach led to improvements in participants' quality of life and improved their experience of more holistic patient-centred care. We will assess whether the new approach was cost effective within the NHS, and we will study in detail what happened during the trial so that we understand what worked well (or not) and how our approach can be improved.

This article was originally published on The Conversation. Read the original article.

Provided by The Conversation