

The rising tide of multiple long-term conditions: Meaning and implications of multimorbidity

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Outline

1. Why should we be interested in long-term conditions?
2. How does multimorbidity affect experience of primary care and confidence in managing own health
3. Meaning and implications of multimorbidity
4. Unanswered questions
5. Possible ways forward
6. Implications for health policy

Rising tide of long-term conditions

Prevalence: 15 million people in the UK have long-term conditions

NHS: long-term condition “a condition that cannot be cured but can be managed through medication and/or therapy”

WHO: chronic condition requires “ongoing management over a period of years or decades”



Prevalence of long-term conditions in QOF

Type of long-term condition	Number affected		% change
	2006-07	2010-11	
Hypertension	6,706,000	7,460,000	11%
Depression	0	4,878,000	N/A
Asthma	3,100,000	3,273,000	6%
Diabetes	1,962,000	2,456,000	25%
Coronary Heart Disease	1,899,000	1,878,000	-1%
Chronic Kidney Disease	1,279,000	1,855,000	45%
Hypothyroidism	1,367,000	1,667,000	22%
Stroke or Transient Ischaemic Attacks (TI)	863,000	944,000	9%
Chronic Obstructive Pulmonary Disease	766,000	899,000	17%
Cancer	489,000	876,000	79%
Atrial Fibrillation	692,000	791,000	14%
Mental Health	380,000	438,000	15%
Heart Failure	420,000	393,000	-6%
Epilepsy	321,000	337,000	5%
Dementia	213,000	267,000	25%

Most prevalent conditions are hypertension, depression, and asthma

Conditions rising most quickly are cancers, diabetes, and chronic kidney disease

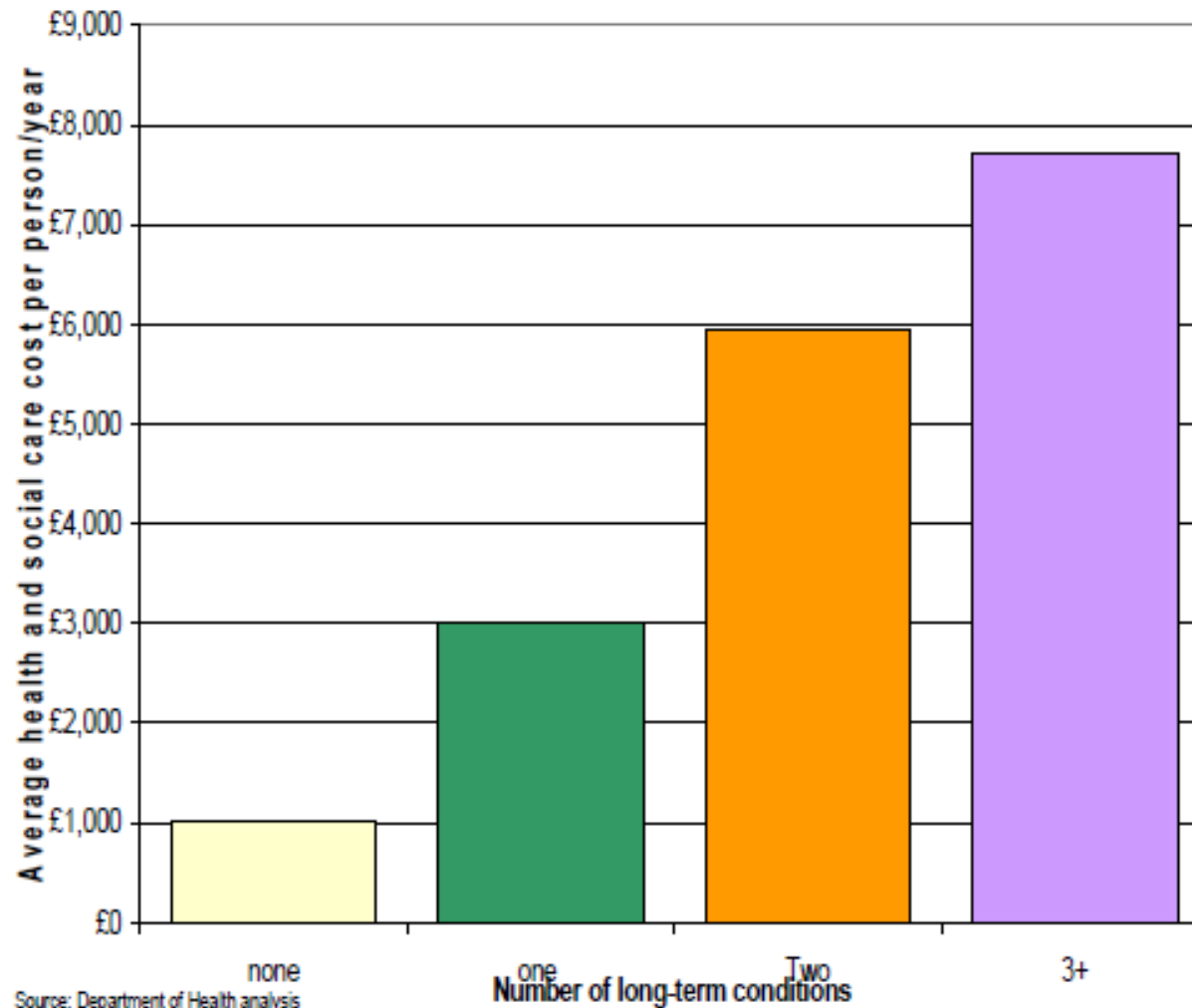
Use of health services

People with long-term conditions account for:

- 50% of GP appointments
- 70% of inpatient bed days
- 70% of the total health and care spend in England



The average cost of health care for someone with long-term conditions is higher than those without



An epidemiological transition towards multimorbidity

1. Research and policy talks about ‘people who have **a** long term condition’
2. 15 million adults with long-term conditions in the UK
6.75 million (45%) have **more than one long-term condition**
3. People with multimorbidity more likely to experience poor quality of life, die prematurely, be admitted to hospital, compared to those with single conditions

Multimorbidity: What do we know already?

1. Multimorbidity is common
2. Strong social gradient in onset and severity of multimorbidity
3. Combination of physical and mental health LTC is important
4. Health services and health policy do not often take multimorbidity into account: E.g., evidence-based medicine guidelines focus on single conditions; DOH policy framed as self-management of 'a condition'
5. Trends in delivery of care may be at odds with care needed for people with multimorbidity: E.g., increasing use of specialist care; decrease in continuity of care

Multimorbidity: Unanswered questions

1. How is multimorbidity related to patient experiences of health care, or confidence in managing your own health?



- Data from General Practice Patient Survey (2012) 1 million respondents, 85,760 with self-reported diabetes
- Confidence in self-management

THE GP PATIENT SURVEY



Q33

How confident are you that you can manage your own health?

- Very confident
- Fairly confident
- Not very confident
- Not at all confident

Diabetes Mellitus

Prevalence: 1996 1.4 million people with diabetes in UK
2013 - 2.9 million people

Cost: NHS cost of the direct treatment of diabetes in the UK £9.8 billion/year; further £7.7 billion diabetes complications

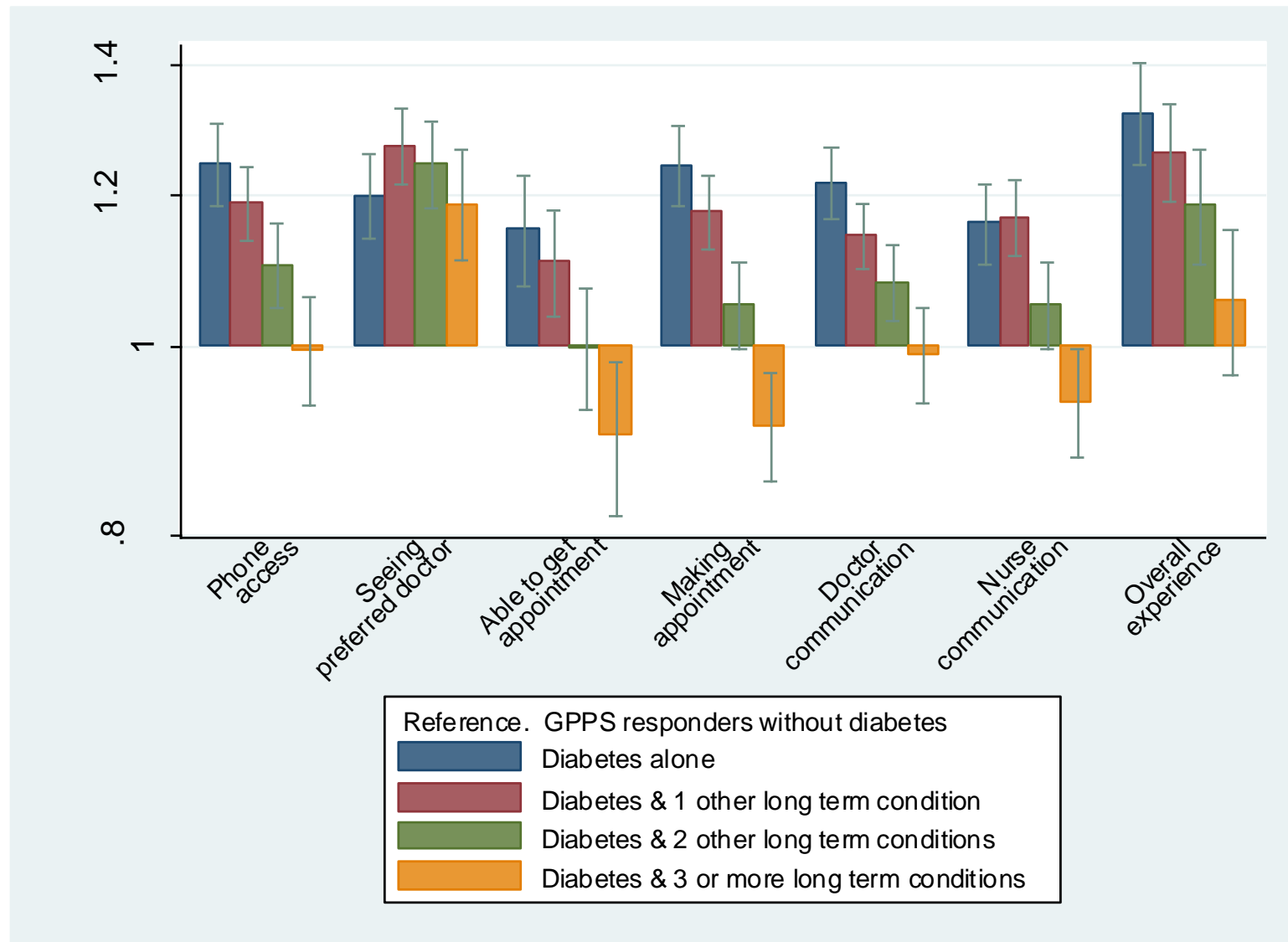


Research questions

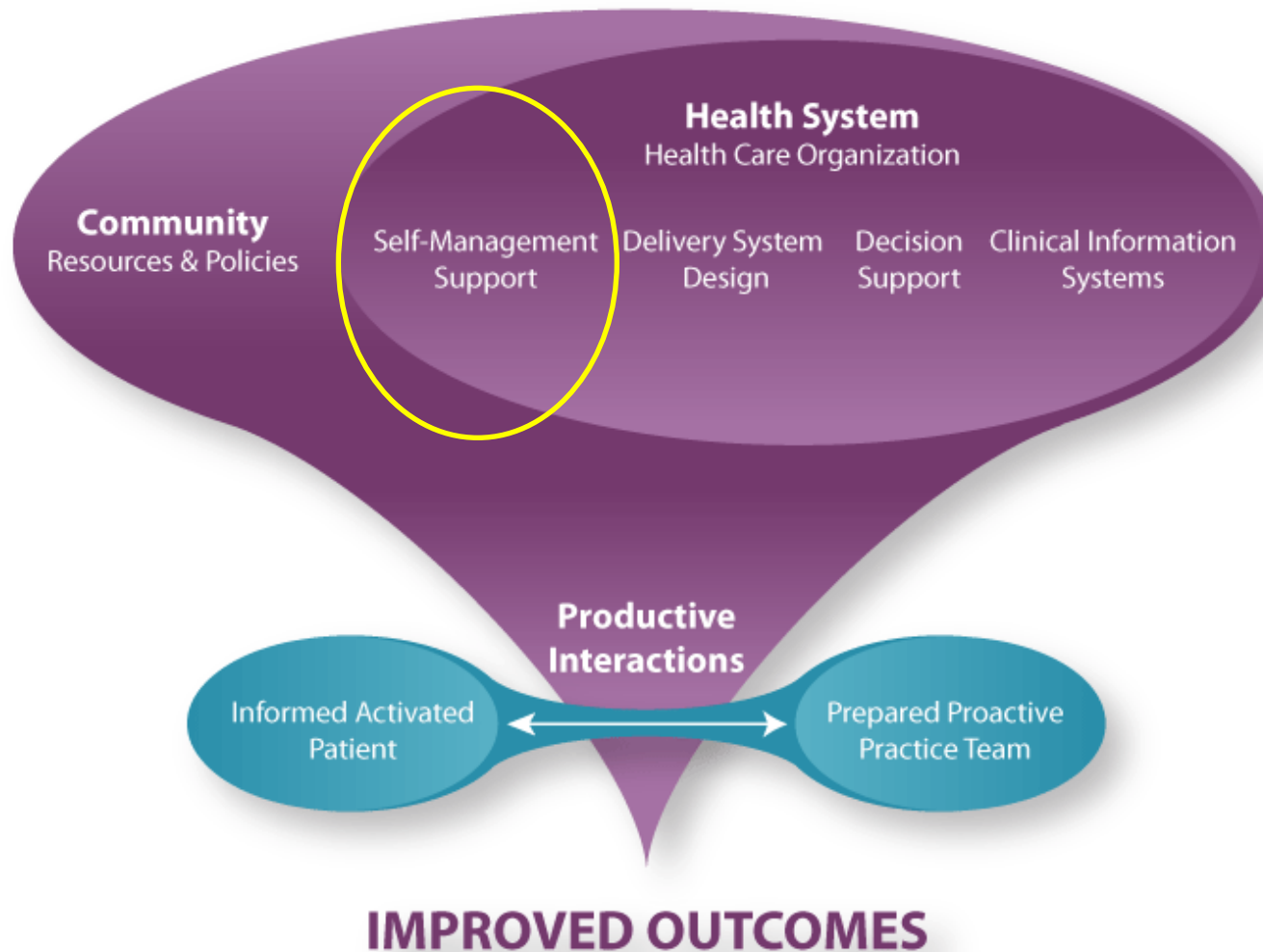
1. Among people with diabetes, does patient-reported primary care experience vary by number of additional long-term conditions?
2. Does confidence in managing your own health vary by number of additional long-term conditions?



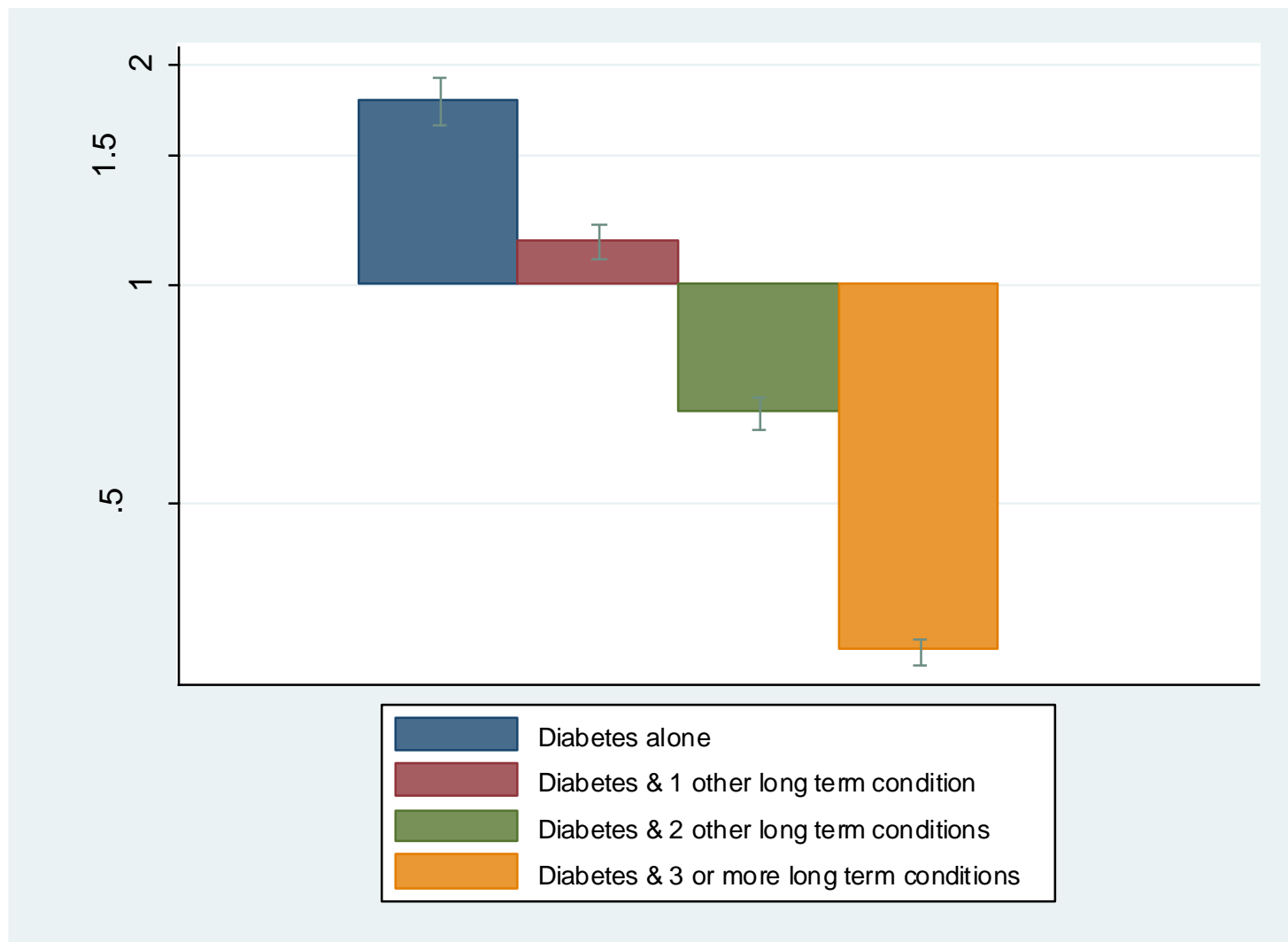
Results: Primary care experience among people with diabetes varies with multimorbidity



Confidence in managing own health



Results: Confidence in self-management among people with diabetes varies by number of comorbid conditions



Conclusions

- We know that multimorbidity is associated with mortality
- Our analyses show that multimorbidity, among people with diabetes, is associated with worse patient reported experiences in primary care, and lower confidence in managing your own health
- Prompt to think harder about importance of multimorbidity to experience of health, and health care

What do we mean by 'multimorbidity'?



'Multimorbidity' is not an illness, or an diagnostic label



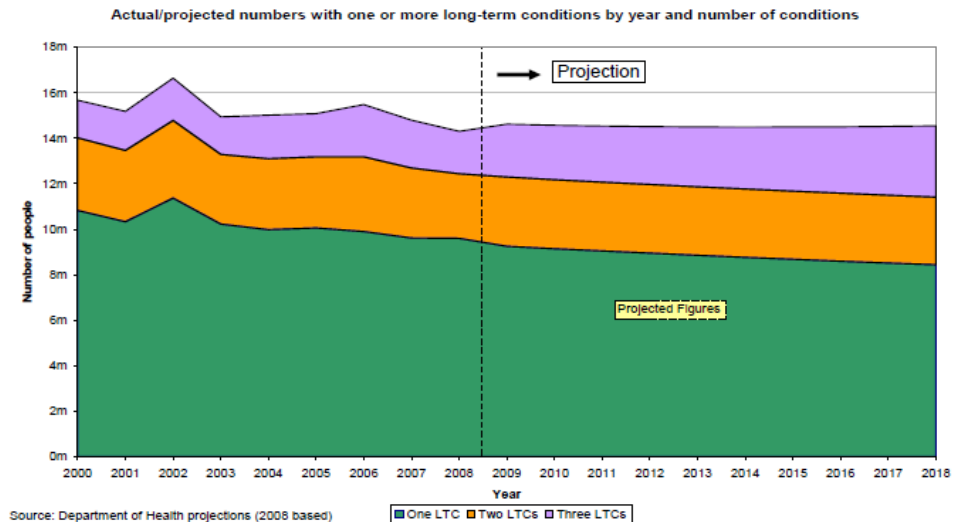
Meaning of multimorbidity for health of individual/use of health services varies, and depends on *specific* long-term conditions, and *specific interactions* between these

Epidemiological evidence-gap

International data showing prevalence of multimorbidity, and changes in prevalence over time



The number of people with one long term condition is projected to be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008.



Social science: building explanatory theory

Experience of health and illness, and health care among people with multiple long-term conditions

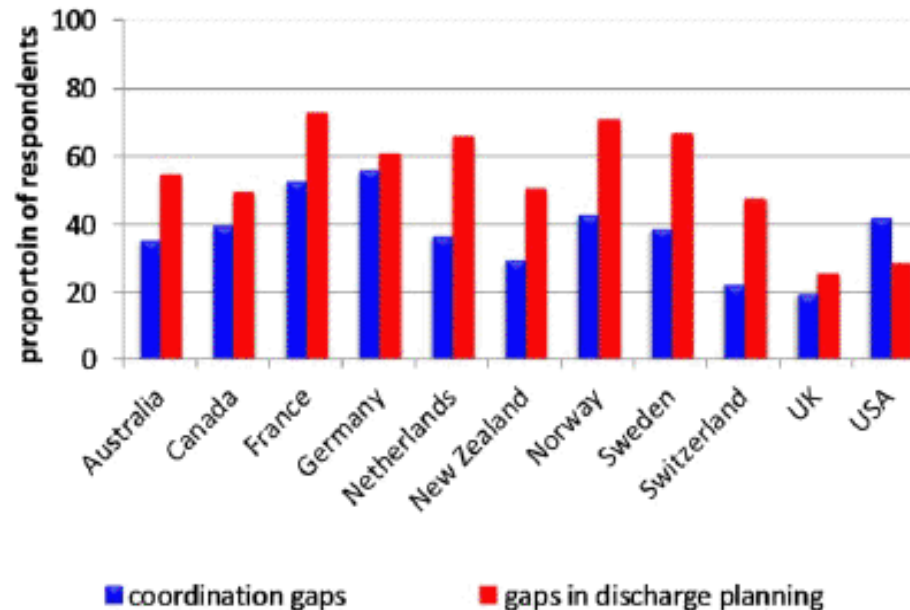
Role of patient priorities (for health, and beyond health) in treatment decision-making

Examining the potential 'burden of treatment'



Policy response – ‘what works’

Patients with chronic disease report problems with co-ordination of care



Interventions to improve co-ordination/integration of care – mixed evidence of success. What works and for whom?

Multimorbidity: Some possible ways forward

1. Improve conceptual understandings

- Explore how experience of multimorbidity may be similar/different to experience of single condition
- Examine variation in experience and impact of multimorbidity for different combinations of conditions
- Consider relationship between age and multimorbidity: careful not to pathologise 'normal aging'

Multimorbidity: Some possible ways forward

2. Build explanatory theory to help us understand variation in risk and impact of multimorbidity

- Consider importance of social and psychological context
(social isolation, mental health, resilience, dispositional affect)
- Qualitative research: focus on cognition > exploration of experiential expertise, emotional and bodily experiences of illness (e.g., see Pickard & Rogers, 2012)
- Potential burden of treatment
- Patient priorities in shared-decision making

Multimorbidity: Some possible ways forward

3. Epidemiological research

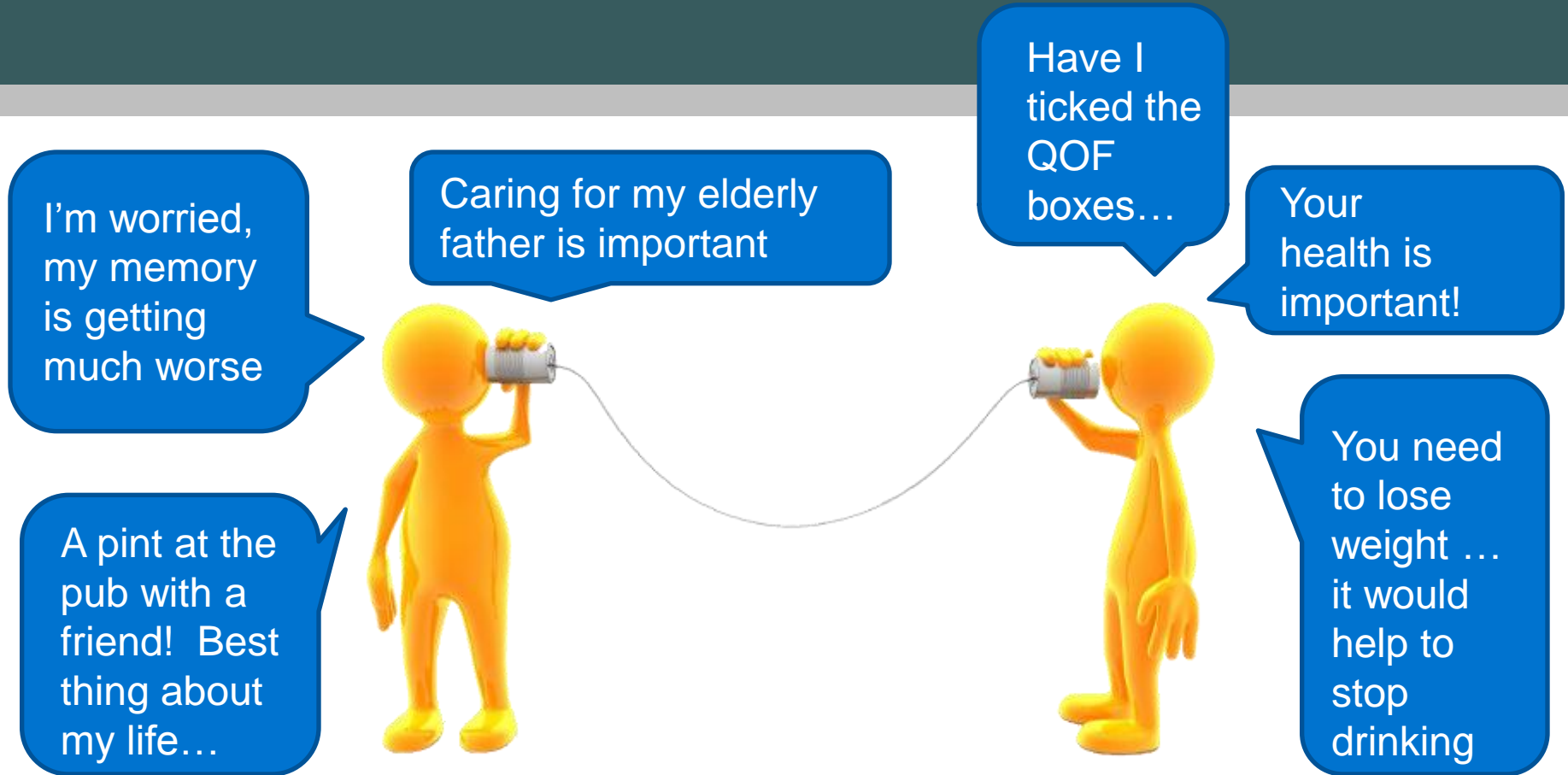
- Quantitative measurement: simple counts > sophisticated models
- Prospective cohort studies that examine change over time, using linked data sets
- International comparative data on prevalence of multimorbidity, and change over time
- International comparisons of policy responses to multimorbidity including data on 'what works' in providing care for people with more than one LTC

Multimorbidity: Implications for the design of health services

1. Impact of fragmented care on patient experience and health
2. How important is relational continuity? How can we support this?
3. Managing burden of treatment (in addition to burden of illness)
4. Managing known risks of poly-pharmacy



How can we improve shared decision-making?



What does 'shared decision-making' mean to patients, and to clinicians?

Multimorbidity: Implications for health policy

1. DOH resist framing health policy e.g., for increased self-management in terms of single long-term conditions
2. Promote and incentivise continuity rather than speed of access; and measures of QOL, not just markers of disease control
3. Workforce development: generalist physicians trained to have confidence in professional judgment and able to manage complex clinical care for multimorbid patients (often in absence of EB guidelines).

Multimorbidity: Redesigning health services for people who use them

- What does 'patient-centered care' really mean? What *could* it look like?
- Opportunities to co-design changes in health services with patients and their representatives



"When we want your opinion,
we'll give it to you"

Summary

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