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Editorial

Multimorbidity, not a health condition or complexity by another name

Multimorbidity, the circumstance in which individuals suffer from multiple health conditions, has clearly emerged as a priority for healthcare 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. First, the progressive improvement in life expectancy has resulted in an increase in the prevalence of chronic conditions, which accumulate over the lifespan (3). Second, the widespread use of electronic health records has facilitated better tracking of these conditions. Third, there is a clear trend both in increased diagnosing of existing conditions and in medicalization of what were once considered ailments (4). Fourth, the development of performance metrics for primary care for incentive schemes has revealed the limitations of disease specific standards (5). Fifth, 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 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 in 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 long captured the attention of

healthcare 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 healthcare needs, but this approach has significant limitations. Firstly, by definition they are a highly 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 morbidity and care burden through a multimorbidity (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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