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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

# David Oliver: A manifesto for multimorbidity

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In 2012 a Scottish study of over three million people showed that living with three or more long term medical conditions was the norm for people over 65.[1] In 2016 a study that used data from more than 200 000 people in England aged over 75 showed that 7% had severe frailty and 21% moderate frailty.[2] This year, researchers predicted that the proportion of people in the UK with four or more long term conditions would nearly double between 2015 and 2035, from 9.8% to 17%.[3] Two thirds of these would also have dementia, depression, or cognitive impairment.

The need for a greater focus on prevention of ill health is something I have argued for recently, not much of it requiring a traditional medical model.[4] However, for those people who will continue to get sick and continue to require healthcare we need to transform the business of healthcare, and fast. But how? Here are my suggestions.

First, healthcare professionals' training needs to focus far more on coordinated, planned care of individuals. It should be based on patients' overall goals and priorities and on balancing the risks and benefits of treatments, rather than simply on managing single diseases or organ systems.[5 6] Though there are pockets of good practice, such approaches are still far from the norm, and practitioners are often not well trained in them.[7] This training must include an appropriate amount of exposure to primary and community care, geriatrics, mental health, dementia, and care at the end of life.

Second, research priorities, prestige, and funding need to rebalance to reflect this new reality. Research has tended to focus on single conditions of younger or mid life and on high tech, cutting edge interventions,[8] rather than on pragmatic models of service delivery for people with complex needs. We have often excluded people with multimorbidity, frailty, or dementia, meaning in turn that the evidence base isn't fit for purpose.[9 10]

Third, we need to embrace and promote skilled medical generalism of the kind found in general practice, geriatrics, and acute internal medicine.[11]

Fourth, we need to focus much more on tackling inappropriate polypharmacy and the benefits of rational "deprescribing."[12 13] Let's think about what we are trying to achieve by prescribing for marginal gains, often driven by incentives that focus on single diseases or overspecialisation, and with insufficient consideration of patients' own goals or the downsides of drug-drug or drug-disease interactions.

Finally, we should redesign healthcare delivery to fit the reality of patients' needs now, and over the next 20 years, not an earlier era when life expectancy was shorter and people often died from single conditions.

This surely includes breaking down arbitrary, artificial, and provider centred barriers between what has traditionally counted as primary, secondary, community, and mental health services. The historical distinction between health and social care is especially ripe for reform, as is our failure to provide adequate support for the millions of unpaid carers who support so many people.[14] Bowman and Meyer described "formative care" approaches—optimising individuals' quality of life reframed by health status and quality of care—which could bring medical and social models closer together.[15]

If we are serious about making any of this happen at scale, as opposed to pockets of excellence, we can't do it without additional resources (targeted to the right places), adequate staff, and enough time and stability to escape immediate service pressures.

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