

# General Practice, Multimorbidity and Evidence Based Policy Making: A Key Challenge

## Abstract:

Sir

Dr. Iona Heath, former President of the Royal College of General Practitioners, asked the medical profession to rise to the 'challenge of multimorbidity'. Heath argued for the 'necessary paradigm shift from a disease based model of care to one that focuses on care for patients' and to move away from single-disease focused guidelines, which silo patients inappropriately. Multimorbidity is defined as the co-existence of two or more chronic illnesses within the same patient. We know that multimorbidity is very common- half of all patients over 65 will have at least three coexisting diseases, with 20% having over five.

With a proposed radical overhaul of Irish general practice rapidly approaching, including free-at-the-point-of-delivery universal access, what is our knowledge about how such changes will affect care provision? Associate Professor Susan Smith recently concluded in a meta-analysis 'evidence on the care of patients with multimorbidity is limited, despite the prevalence of multimorbidity and its impact on patients and healthcare systems.' There is little current evidence on what effects universal access to Irish primary care will have on workload, health utilisation and outcomes for 'real-world' multimorbid patients.

We simply looked at health utilisation rates between GMS and non-GMS eligible patients in two chronic conditions, in a multimorbid population. We looked at 7,213 patients from the CLARITY database, all of whom had established heart disease. This was designed to research a multimorbid cardiovascular population, including patients aged over 50 years, who had two or more consultations over the previous two years, selected from 67,422 patients within 11 practices in the West of Ireland. We found that multimorbid asthma patients, with GMS eligibility, had significantly more primary care visits per annum than non-GMS patients, after modelling for confounding variables such as age, gender and smoking. GMS asthma patients had a mean of 10.7 consultations annually (95% CI 9.9 to 11.5) and non-GMS had a mean of 5.1 consultations (95% CI 4.2 to 6.1). Similarly, multimorbid COPD patients that were GMS eligible had significantly more primary care visits per annum than non-GMS patients. GMS COPD patients had a mean of 11.4 consultations annually (95% CI 10.4 to 12.4) compared to non-GMS having a mean of 6.6 consultations (95% CI 4.0 to 9.1).

We believe the provision of universal entitlement to primary care could result in three distinct outcomes, or a complex combination of all three. Firstly, utilisation rates for those who currently do not have GMS eligibility could increase to the levels of those currently with GMS eligibility. Alternatively, GMS-eligible patients could continue to have higher healthcare usage, albeit relatively lower than before. Finally, and least likely, no changes in utilisation may occur. What is clear is that further research needs to be performed regarding multimorbid patients in the community, so that evidence based policy is possible.

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## References

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