Autumn-Symposium 2014

The future of evidence based health care
– beyond medicine

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Challenges of demographic change

Modern medicine has witnessed a quite remarkable success story. Whether it is because of public health measures such as improved diet or living conditions, or the impact of new and effective therapies, our populations are living very much longer than in the past. The proportion of the world’s population aged 60 years or over increased from 8 per cent in 1950 to 12 per cent in 2013. Over the next four decades this will increase even more rapidly to reach 21 per cent in 2050. The trend towards an ageing population is similar wherever in the world one lives, even if the speed of progression varies.

Fig 1:
Proportion of the population aged 60 years or over: world and development regions 1950-2050

There are real challenges from this demographic change, including the inevitable pressures on pensions and public finances, the subsequent risks of poverty and ill-health, the need for safe and appropriate housing, and the importance of creating a society in which older people can participate fully and feel valued. Indeed, the challenges are so great that we frequently forget the enormous benefits to individuals and families of years of extra happy, and often healthy, life.

And every country on earth, even the most affluent, also has to face the fact that growing demand for health and social care is always likely to outstrip the public funding available to pay for these services.
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by David Haslam, NICE

Challenges of multimorbidity

The other major challenge is that of multimorbidity. In the past many people died of acute conditions like heart disease. Today they are more likely to survive and live with their conditions. Indeed, as the population ages, the issue of multimorbidity becomes ever more important. Patients with a constellation of symptoms and conditions are increasingly and exceedingly common. Every family physician will know of individual patients with – for instance – coronary artery disease, hypertension, hyperlipidaemia, chronic kidney disease, diabetes mellitus, osteoarthritis, macular degeneration, and depression.

In addition, as Stewart Mercer and colleagues have pointed out¹, multimorbidity is also increasingly common in younger people, especially those who eat too much, exercise too little, have a poor diet, drink too much and smoke. This is particularly true of younger people living in the most socioeconomically deprived areas, where multimorbidity develops 10-15 years earlier than in more affluent areas.

Nevertheless, in many countries the organisation of medical care ignores such patients. Hospitals have departments of cardiology, or renal medicine, or respiratory medicine. Does the patient with all of these conditions have to consult numerous different doctors? And if they do, does the quality of care they receive overall suffer as a result?

The question of what “good” care looks like becomes increasingly difficult when patients are treated for a number of different conditions in isolation, rather than treated as a whole person. This is when problematic prescribing, or polypharmacy, comes into play: patients find themselves taking multiple medications, with a risk of hazardous interactions between them – often with pills being prescribed to treat side effects of other pills. This overburden of medicines often leads to lower levels of medicines adherence, with poor health as a result.

Considering multimorbidity in guidelines for good care

This proliferation of multimorbidity creates obvious challenges for medical education and the delivery of services. It also has a particular impact on the development of healthcare guidance. National guidelines for good care, like those produced by NICE in the UK, are based on evidence. But much of the basic medical and therapeutic research – on which guidelines have traditionally been based – excludes many: patients over the age of 65; those with multimorbidities. Ironically, clinicians will spend most of their time with this exact group. We risk relying on idealised research from almost non-existent patients.

NICE is acutely aware of the challenges posed by an increasingly co-morbid population, and are developing new ways to tackle them. We are currently working on a new guideline on the clinical assessment and management of multimorbidity, which we are due to publish in September 2016. The guideline will help family

doctors translate existing, condition-specific guidelines into real-life clinical settings, and support them in determining priorities for decision making.

Of course, many of our existing guidelines already address common co-morbidities. For example, our guidelines on hypertension, chronic kidney disease and diabetes overlap in many ways, and we have modified our recommendations within these guidelines to make sure that treatment options are discussed with, and tailored to, patients with two or more of these conditions.

**Involvement of the patient**

This discussion of treatment options with patients is an important point: as in so many other aspects of medicine, the paradigm is shifting from the doctor doing medicine to the patient, to one where the doctor does medicine with the patient. The patient's choice of what they want from care quite rightly becomes much more central. Combining this entirely desirable focus on the individual patient with the world of evidence-based medicine and randomised double blind controlled trials (that frequently exclude patients with multimorbidity) is essential if we are to offer the very best care for our patients. It won't be easy. But it is a problem we can't afford to ignore.