

Multimorbidity: A new emerging epidemic

Multimorbidity is defined as the presence of two or more long-term diseases at the same time.^[1] Complex multimorbidity is sometimes defined as four or more long-term diseases. It differs from comorbidity, in which there is an index condition.^[2] The common multimorbid conditions include coronary heart diseases, hypertension, heart failure, stroke/transient ischaemic attack, atrial fibrillation, diabetes, chronic obstructive pulmonary diseases, painful conditions, depression and dementia.^[3] In addition, HIV-associated multimorbidities in sub-Saharan Africa have been emerging as a new health epidemic impacting nearly 20 million people,^[4,5] as cardiovascular and renal diseases are found to be more prevalent in people living with HIV than uninfected patients.^[6]

Risk factors for multimorbidity include smoking, alcohol use, lack of physical activity, low fruit and vegetable intake and increased body mass index.^[2,7] Patients with multimorbidity are found to be at higher risk of safety issues such as polypharmacy, poor adherence, adverse drug events, complex treatment regimens, increasing burden to healthcare services, complex patient needs, demanding self-management regimens and competing priorities, and increasing vulnerability to safety issues due to advanced age, cognitive impairment, limited health literacy and comorbidity of depression or anxiety.^[8]

Currently, these patients often find themselves having to visit a number of specialists, and may receive different and conflicting advice regarding their treatment. The multimorbidities affect different systems of the body, without one dominant condition. This requires management of all the coexisting conditions as interlinked, providing an integrated approach in the treatment of multimorbidity.^[1] For example, at primary healthcare level, people in need of extra support should be identified and provided with comprehensive medical advice, as well as a referral to a specialist when necessary. This would require making changes at a policy level, taking a systems approach, developing guidelines for prioritising care co-ordination and self-management support and simplifying treatment regimens.^[7]

In South Africa, a concerted approach should be in place to identify combinations of conditions that co-occur most commonly, and to develop a policy brief for implementation of a more standardised plan of treatment for multimorbidities, as well as more flexible guidelines for treatment and the drugs prescribed under this new model. This would enable health practitioners to strike a balance between the treatment guidelines for specific conditions and the needs of the patient as a whole. This would also raise awareness among the policy-makers and managers for creating an enabling environment for management of these patients, including prevention, and for the protection of their health.

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1. Thomas L. Multimorbidity treatment challenges. *News Medical Life Science*, 2018. <https://www.news-medical.net/health/Multimorbidity-Treatment-Challenges.aspx> (accessed 19 February 2020).
2. Sayer AA. What do we know about multimorbidity in the UK context and what are the gaps? [presentation]. *Advancing research to tackle multimorbidity: The UK and LMIC Perspectives Workshop*. London: 20 - 21 June 2018.
3. Farmer C, Fenu E, O'Flynn N, Guthrie B. Clinical assessment and management of multimorbidity: Summary of NICE guidance. *BMJ* 2016;354:i4843. <https://doi.org/10.1136/bmj/i4843>
4. Smit M, Brinkman K, Geerlings S, et al. Future challenges for clinical care of an ageing population infected with HIV: A modelling study. *Lancet Infect Dis* 2015;15(7):810-818. [https://doi.org/10.1016/s1473-3099\(15\)00056-0](https://doi.org/10.1016/s1473-3099(15)00056-0)
5. Dwyer-Lindgren L, Cork MA, Sligar A, et al. Mapping HIV prevalence in sub-Saharan Africa between 2000 and 2017. *Nature* 2019;570(7760):189-193. <https://doi.org/10.1038/s41586-019-1200-9>
6. Freiberg MS, Chang C-CH, Kuller LH, et al. HIV infection and the risk of acute myocardial infarction. *JAMA Intern Med* 2013;173(8):614-622. <https://doi.org/10.1001/jamainternmed.2013.3728>
7. World Health Organization. *Multimorbidity: Technical Series on Safer Primary Care*. Geneva: WHO, 2016.
8. Phillips RL, Bartholomew LA, Dovey SM, Fryer GE, Miyoshi TJ, Green LA. Learning from malpractice claims about negligent, adverse events in primary care in the United States. *Qual Saf Health Care* 2004;13(2):121-126. <https://doi.org/10.1136/qshc.2003.008029>