



Editorial

Aging, Chronicity and Pulmonary Care[☆]

Envejecimiento, cronicidad y atención neumológica

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Over the last 60 years, we have witnessed a gradual change in the typical individual seeking healthcare. Our patient populations are now characterized by advancing age, increased incidence of chronic diseases, and a high prevalence of pluripathology. While it is true that chronic diseases can develop at any time during a patient's lifetime, these 3 features are closely interrelated, so it is equally true that their prevalence increases with advancing age. The same occurs with the development of comorbidities. In the specific case of the lung, aging is associated with genomic instability and epigenetic changes that are key factors in the development of chronic lung diseases.¹ According to the World Health Organization (WHO), chronic diseases account for over 60% of all deaths worldwide.² Add to this the impact of these diseases on patient and caregivers' quality of life, years of life lost,³ the economic burden and the costs of healthcare resources, and it is easy to understand how the care of chronic patients may be a major challenge for healthcare providers. The duty of these bodies is to achieve the best quality of care in chronicity, while continuing to offer the same level of care to acute cases. Improvements in social and healthcare standards mean that Spain is now among the countries with the longest life expectation worldwide, but the outcome of this is an increase in elderly subjects with chronic diseases. Chronic diseases currently account for 80% of consultations in primary care centers and 60% of hospital stays, particularly with respect to unscheduled admissions.⁴ It is estimated that by 2050, 35% of our population will be older than 75 years, so an exponential increase in the rate of chronic disease is only to be expected. The care of patients with chronic diseases, therefore, will be one of the most important challenges to be faced by the Spanish healthcare system in coming years.

The WHO has called on governments to introduce measures based on 3 key elements: mapping chronic diseases and social, economic, behavioral and political factors; reducing exposure to risk factors; and reinforcing healthcare provisions.⁵ The implementation of specifically designed models for caring for populations with chronic diseases has been shown to be an efficient approach in

various healthcare systems.^{6,7} These models, the most widely known of which is the Chronic Care Model (CCM),⁸ advocate a proactive approach, with a patient-centered, participative, multidisciplinary team with well-defined roles, in which shared decision-making is based on scientific evidence and on the preferences of the patient and their family members. An essential aspect of this approach is the availability of efficient information systems. The CCM, in particular, introduced the concepts of integrated care, disease management and case management. Another reference in the management of chronic care patients is the populational model known as "Kaiser Permanente".⁹ This system stratifies the population as a pyramid, so that the complexity of care can be adapted to the needs of each stratum or level. Both types of model can be taken as complementary, in line with the WHO's proposal for the development of an Innovative Care for Chronic Conditions Framework, in which 5 building blocks are specified: populational health approach, awareness and prevention of chronic disease, patient responsibility and autonomy, continuity of care, and interventions tailored to patient needs.⁵

Just 3 years ago, the Ministry of Health, Social Policy and Equality published a document entitled "A strategic approach to chronicity in the National Healthcare System".⁴ According to this document, chronicity must be approached from a multidisciplinary perspective, to ensure continuity of care and the full participation of the patient and their family/caregivers. In this model, primary care teams logically play a key role as the hub for coordinating care. Nevertheless, it is surprising that scientific societies and specialists involved in the care of the most common chronic diseases, such as pulmonologists (COPD and chronic respiratory failure), cardiologists (heart failure), or endocrinologists (diabetes mellitus) were not involved in the preparation of these recommendations. Before this strategy was published, autonomous communities, such as the Basque Country or Catalonia had already set down guidelines for the care of chronic conditions. Subsequently, strategic plans to develop community-specific programs were published by the remaining autonomous communities of Spain. However, the models are very far from uniform, and while in Madrid the involvement of different specialists is more notable,¹⁰ other communities follow the general, national model. Under the pretext of providing a more integrated approach to care in these patients, their aim is to focus on the internist as the central figure in patient management in hospitals, and on the family doctor in outpatient care. The role

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of the specialist is vague and relegated to the sidelines, a factor that can considerably undermine the quality of care. The significant progress in healthcare achieved by Spain in recent decades, it should be noted, is due to major advances in specialty care and therapeutic and diagnostic techniques, and in this time the “generalist” healthcare system has given way to a “specialized” system. However, the approach to chronic disease in the new care models amounts to a step backwards rather than forwards, motivated by the pursuit of theoretical savings, doubtless due to an incomplete analysis of the problem.

A patient is usually classified as “chronic” when he or she presents chronic disease in a single organ. Even in those cases in which other, more or less important comorbidities are present, the role of the specialist physician caring for the main chronic disease and their collaboration with other specialists, with the family doctor, nursing staff and the social services, is essential. In this model, the chronic patient is confused with the pluripathological patient, which is a serious mistake, since the same criteria are applied in both cases, when the approach should be different. There is no doubt that any chronicity strategy must ensure continuity of care, and instruments and algorithms for coordinating various healthcare levels and the social services must be designed for this purpose. This does not, however, mean ignoring the major role of the specialist who is most aware of all aspects of the disease, and who must, of necessity, direct the care strategy. Primary care and specialist inpatient and outpatient medicine must work hand in hand to achieve continuity of care for the patient. In this context, the nurse case manager and the provision of adequate social support are of particular importance. Integrated care is essential, but without sacrificing scientific and technical quality.

In this respect, the highly interesting article published in this issue of *Archivos de Bronconeumología* by Dr. Soler-Cataluña et al.¹¹ could not have come at a better time. The authors have clarified and evaluated what might be the role of respiratory medicine specialists in rising to the challenge of the chronic patient. They conclude that the only appropriate approach would be to adapt the guidelines and recommendations of the scientific societies to strategies designed for the care of the chronic patient. Taking COPD as a prime example of a chronic disease in which a very high proportion of patients present comorbidities, a patient stratification model based on the Spanish guidelines for the treatment of COPD is proposed. In this model, 4 levels of complexity are defined, from which the appropriate care requirements for each level can be established,

ranging from health awareness and disease prevention in the at-risk population to diagnostic and self-care programs. Management recommendations range from disease management in less complex cases to case management in the more complicated population.

In Soler-Cataluña’s proposal the role of integrated healthcare processes, in which the figure of the nurse case manager and the primary care team are essential, is preserved. Nevertheless, the authors make it clear that pulmonologists will have to play a central role, both in establishing population stratification criteria and in their direct involvement in the care of moderately to highly complex cases, for reasons of both quality and efficiency. This conclusion is applicable not only to COPD, but also to the management of other chronic diseases such as asthma, bronchiectasis and respiratory failure which generate high costs in terms of resources, and have a high impact on morbidity and health-related quality of life.

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