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Editorial

Chronicity: Attention and Management

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Editorial

The Statistical Office of the European Union points out that in Spain in 2007 15.7% of the population was over 65 and that the forecast for the year 2050 will be 34.1%, becoming one of the countries older Europeans [1]. According to data from the National Statistics Institute (INE), due to decreases in birth and mortality, in Spain on 1-1-2011 there were 8 million people over the age of 65, with 5.1% of the total corresponding to the elderly 80 years or older and in this age group 5% had two or more chronic diseases (CD). However, since longevity is a determining factor in chronicity, it is not correct to associate CD with an elderly person, since there are other age groups that also suffer them [2].

The concept of the chronically ill has changed in recent times from the definition of person affected from a single disease lasting more than three months to, at the moment, lasting more than six months, with various pathologies, limiting the quality of life and important repercussions in the personal, family, psychological, social and economic spheres.

CDs are superior to healthcare because they affect the quality of life and have a great socio-economic impact and are associated with dependency and disability that cause added psychophysical consequences. At the primary level we must modify lifestyles and at the secondary level detect and treat early, in addition to rehabilitating not only the patient but also the family and their environment [3].

Primary Care (PC) regulates the flows of chronic patients and coordinates health resources and guarantees their continuity, which means caring for patients before they become so. His family and community vision is ideal to maintain comprehensive care for the chronic patient. It is the continuity that allows the Family Doctor (MF) to carry out preventive activities and palliative care.

Thus, the response to chronic pathology should be the reorientation of the current traditional model of curative care based on episodic contact and focused on acute processes or decompensations of the disease to comprehensive and clinical care, but also functional and social, with prevention and involvement of the patient and his environment, participating in decision-making and self-care [4].

Scientific knowledge must be adequate for different patient groups, from healthy patients with risk factors that can make them chronic, as well as dependents and terminally ill. This combined health and social vision was launched in the UK following Kaiser's risk stratification model.

We must avoid the appearance of CD and/or the appearance of predictable complications through correct treatment and management. In this sense and as a key point we have prevention:

Primary: Avoid the appearance of diseases by acting before they appear. Medical advice on risk factors is more relevant for health promotion and prevention than screening for CD risk factors or early treatment of them.

Secondary: Those screened in healthy people that can be for the entire population or based on the active search for cases, the latter being where PA is the ideal framework.

Tertiary: It works with the disease already established, its objective being to reduce/avoid complications, delaying its evolution, avoiding disabilities and improving the quality of life.

Quaternary: Avoid adverse effects, focusing on avoiding health interventions or unnecessary treatments for patient safety [5].

Also important is the idea of the information that the patient must have to be more active in their health care. For this, paternalistic care must be abandoned in which the doctor has the knowledge and the patient does not. A well-informed patient cooperates better and is more responsible, ceasing to be a passive recipient and becoming an active decision-maker.

It is a model of shared decisions where the information on the part of the doctor must be truthful, based on scientific evidence, understandable, sufficient and personalized. Furthermore, responding to the complexity of chronic diseases is difficult for only a group of professionals, so teamwork (doctors, nurses, social workers...) improves functionality, reduces morbidity and mortality, decreases hospital admissions and eases the burden on caregivers-family caregivers.

The use of new technologies such as Electronic Medical Record (HEC) and the Internet allows information to be shared among professionals. With the first one, the patient's medical information is accessed, improving healthcare coordination and updating the therapeutic decision; while the second is an information tool for professionals and patients, allowing them

to access quality information and communication with professionals [6].

If we do a documented review on chronicity, it indicates the need to reorganize care and strengthen Primary Care teams (EAP), since this level of care is generally the user-patient gateway to the health system, where continuously and globally served [7].

The aging of our population is producing the progressive increase in CD that, together with dependent people, consumes 70-80% of health resources. Addressing chronicity implies changes in health policies with a model of care for chronic behaviors; For this, it is necessary to carry out a comprehensive management of chronicity in the population, coordinating patients, health professionals, caregivers and regional health systems.

Patients go to PC in the first instance, to hospitals for specific or urgent care and for specific treatments, therefore, since care for the chronic patient is the majority in this level of care, the PC should be in charge of managing and coordinating with others. Care levels care for these patients.

Health reforms in the path of different crises (financial, legitimacy, rationality and quality) together with technological innovation try to present strategies and models to curb health spending [8].

The macro and meso-health management (center management) together with the micro-management (clinical management) must act on the health professional without forgetting that it must also act on the community, with the person being the fundamental axis.

Chronicity is linked to the appearance of new models of care, reorienting the attitude of health systems towards the chronic patient:

• Chronic Care Model
• Permanent Kaiser Risk Pyramid
• Innovative Care (patients, care teams and the community).
• Priority health policies (CCAA health plans and the Plan on Strategy for Addressing Chronicity in the National Health System - SNS)

All of them must not only address the economic perspective, but must also pay attention to the fact that demographic changes (aging), the crisis and the increase in CDs need a multidisciplinary approach, in addition to acting on the ambulatory processes and communication between the different care levels [9-11].

This issue will talk about older people with CD, its impact on health spending and management from the PA. In fact, our health system does not work properly because it has been paying attention to acute processes and, for a few decades now, morbidity has varied quantitatively and qualitatively, not serving now, since most of the health resources are destined to chronic processes.

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