Compression of morbidity is dead; long live compression of morbidity

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Most people don't grow up. Most people age. They find parking spaces, honor their credit cards, get married, have children, and call that maturity. What that is, is aging.

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The *compression of morbidity*, a hypothesis introduced by Dr James Fries in 1980,[1] remains an important concept in aging and population health research. It has also been called the *rectangularization* of morbidity and mortality curves. It reflects an ideal population health dynamic in which people live long, healthy lives with steep declines in physical and cognitive function occurring only in the final few months of life.[2]

As an aging family doctor with an aging practice—almost half of my patients are now 65 years or older—I live and breathe the fact that compression of morbidity has not unfolded as expected. Instead, I see the gradual accumulation of health problems that makes providing care to my older patients increasingly complex.[3] One of the biggest factors has been the impact of rising inequity related to social determinants of health. While affluent people may experience the compression of morbidity, older individuals with lower incomes and who have been racialized typically do not.[4] In my own practice this has forced me to slow down, reduce the number of people I see in each clinic, and spend increasing amounts of time helping my patients navigate specialist and hospital systems.

In my view, the impact of an aging population, the failure of compression of morbidity to materialize broadly, and the increasing demands of practising at the "edge of chaos"[3] are underrecognized contributors to the current crisis in Canadian health care and family medicine, and they are things for which we have failed to plan.

Content in the February issue reflects how *Canadian Family Physician* aims to support all family physicians who provide care to older people.

The issue features the second part of a practical clinical review on Parkinson disease (PD) by Dr Chris Frank and his colleagues (**page 91**).[5] Both the diagnosis and treatment of PD challenge us as family physicians.[5,6] Given that PD is the fastest-growing neurodegenerative condition and access to specialized care is limited in many parts of Canada—as with other complex, chronic health problems—we can expect that family doctors will be increasingly pivotal in providing care to people with this disease.

Cet article se trouve aussi en français à la **page 79.**

Many readers might already be familiar with Dr Frank—a family physician in Kingston, Ont, with a focused interest in care of the elderly—as he has contributed clinical reviews and ongoing series of articles, such as Geriatric Gems, to the journal over many years. In his recent essay, "A physician's grief observed," he touches on and offers consolation on another, often unacknowledged, aspect of caring for an aging practice population: the sense of loss as one's patients die.[7]

The February issue also includes an important case report by Kwame Agyei and Dr Donald F. Weaver that demonstrates the impact of social determinants of health and malnutrition on the diagnosis of a 92-year-old woman living in a *food desert* (**page 103**).[8] It is another reminder of how much family physicians can learn from the particularities of patients' lives.

Finally, we present a research study by Dr Andrea Gruneir and her colleagues from the University of Alberta in Edmonton that examines the impact of living with dementia and use of acute care services (**page 114**).[9] They discovered that older people living with dementia experienced frequent, and frequently compound, transitions in care that speak to the challenges that patients, their families, and their family physicians have in navigating a health care system under strain.

The compression of morbidity hypothesis remains highly influential and continues to shape approaches to thinking about healthy aging, but its limitations have been shown.[4] In many ways it remains aspirational. So, long live the compression of morbidity hypothesis. May it become a reality for us all.

References

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