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Editorial

Nurse Case Manager: Responding to Complex Chronic Care Contexts

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The sustained increase in life expectancy over recent decades represents one of the greatest successes of contemporary health policies.[1,2] However, this quantitative gain has not been accompanied by a proportional increase in years lived with quality, independence, and well-being.[2] In Portugal, despite a life expectancy above the average of the Organisation for Economic Co-operation and Development (OECD), healthy life years after the age of 65 remain below the European average, reflecting the high prevalence of chronic disease, multimorbidity, and functional limitations.[2–4] This reality poses new challenges to the sustainability of health systems by intensifying resource use and exposing the limitations of fragmented care models, thereby highlighting the need for more integrated, personalised, and continuity-based responses—within which case management, particularly when led by nurses, assumes a strategic and differentiating role.[2-5]

Data presented in the Access, Performance and Health Indicators Report (RADIS, 2025)[3] and in *Health at a Glance* (2025)[2] converge on an unequivocal finding: the main challenge currently faced by health systems no longer lies solely in responding to acute episodes associated with chronic disease, but rather in the capacity to design and operationalise continuous, integrated and genuinely person-centred models of care for people living with chronic and complex conditions.[2,3] Against this backdrop, reflection on the adequacy of current organisational models in addressing the complexity of chronicity becomes imperative—a reflection to which this editorial explicitly seeks to contribute, grounded in key international frameworks and the evidence available for the Portuguese context.

Understanding chronicity goes beyond a set of isolated diagnoses; it constitutes a complex condition expressed in the lived experience of the person, often marked by persistent suffering, ongoing processes of adaptation, a high treatment burden, functional limitation, and a significant impact on family, social, and professional roles.[4,5]

Recent empirical studies show that people with chronic multimorbidity face a cumulative burden associated with the simultaneous management of complex therapeutic regimens, multiple contacts with the health system, and administrative and informational demands, with direct repercussions for treatment adherence, safety, and quality of life.[6-8]

Scientific evidence indicates that care trajectories associated with complex chronicity are frequently characterised by identity and relational discontinuity, fragmentation of clinical information, and deficits in coordination across levels of care—factors associated with poorer clinical outcomes, greater avoidable service use and negative patient experiences.[9–11] In this context, patient experience—assessed through patient-reported outcomes and patient-reported experiences—emerges as a critical indicator of the adequacy, continuity, and quality of care provided in situations of complex chronicity.[2,12]

The OECD and the WHO emphasise that this complexity translates into care trajectories marked by multiple transitions between levels of care, a high therapeutic burden, and an increased risk of fragmentation, particularly when systems remain organised around episodic, disease-centred logics.[4,5] According to recent OECD estimates, more than 80% of people over the age of 45 who use health services live with at least one chronic condition, and more than half present with multimorbidity.[13] In Portugal, this reality is compounded by low levels of health literacy, persistent socioeconomic inequalities, and difficulties in navigating the system, as extensively documented in RADIS 2025.[3] One in three people report feeling lost along the care pathway, with communication in disease management identified as a structural weakness.[3]

Fragmentation between primary, hospital, continuing, and social care results in avoidable hospitalisations, social admissions, duplication of procedures, and preventable suffering for people (and family caregivers) who primarily require continuity, predictability, and close follow-up.[13] It is therefore unsurprising that unplanned hospital admissions have increased in recent years, with social and economic costs.[2,3]

Within this framework, international guidance converges on the defence of person-centred care models oriented towards coordination, integration, and longitudinal follow-up across disease trajectories.[4,13,14] It is in this domain that advanced nursing practice—and particularly the intervention of the nurse case manager—assumes outstanding relevance. Scientific evidence demonstrates that nurses with advanced competencies in holistic and systematic assessment, formulation of diagnoses centred on the person's needs, clinical coordination, organisational liaison and the development of sustained therapeutic relationships are particularly well positioned to recognise suffering, understand the impact of illness on daily life, identify available resources and respond in an integrated manner to the clinical, emotional and social needs of people living with complex chronic conditions.[15–17] Their role does not replace that of other professionals; rather, it articulates, coordinates, and brings coherence to the care pathway of people with complex chronic illness, ensuring continuity across health transitions and care settings.[17]

Nurse-led case management models have been associated with significant improvements in continuity of care, reductions in treatment burden, greater patient satisfaction, and more appropriate service use, translating into sustained clinical and organisational gains.[16,18–20]

In Portugal, the nurse-to-population ratio per 1,000 inhabitants remains below the OECD average, and investment in prevention and primary care continues to be limited.[2] In this context, organisational strategies oriented towards care coordination and integration, such as case management, have been associated in the scientific literature with gains in efficiency and value in health, particularly through care reorganisation.[16,20]

International reports underline that people's satisfaction with health services is strongly associated with perceived health status and the quality of communication.[2] In this domain, professionals with coordination and longitudinal follow-up roles, such as nurse case managers, play a particularly relevant role by empowering people with chronic illness to understand their condition, recognise warning signs, manage complex therapeutic regimens and participate in informed decision-making about their care, in line with the principles of person-centred care and shared decision-making.[4,14]

This continuous follow-up has been associated with reduced unplanned use of health services, enhanced clinical safety, and increased patient autonomy—particularly relevant in a context in which the burden of chronic disease translates into work absenteeism and increased pressure on social protection systems.[2,5]

Despite positive experiences already in place in Portugal, nurse case management often remains dependent on local projects, temporary funding, or the initiative of particularly motivated teams, as illustrated by some territorial experiences, including the Alentejo Coast.[3,20] However, RADIS data and OECD reports show that care fragmentation and the inadequacy of organisational models for chronicity constitute structural and persistent problems, requiring equally structural and sustained responses.[2,3]

Within this framework, the formal integration of the nurse case manager into care models for people living with chronic conditions—across primary, hospital and continuing care—aligns with the principles of person-centred care; with the transition from acute episode-oriented models to trajectory-based approaches; with a focus on prevention and chronic disease management; and with the promotion of greater territorial and social equity.[4,13] More than an organisational innovation, this represents an ethical and strategic choice.

Available evidence clearly demonstrates that traditional care models remain misaligned with the complexity of chronicity. Person-centred care, coordination, and the longitudinal organisation of care are recognised as essential pillars for responding to the needs of people living with chronic and complex conditions; however, their effective translation into policy, organisational, and educational decisions remains insufficient.

In this context, the nurse case manager emerges as a coherent response aligned with the principles of person-centred care and the demands of managing health complexity. Consolidating this role requires deliberate investment in specific education, the development of advanced competencies, and the strengthening of applied research capable of systematically evaluating intervention models, health outcomes, and organisational impact across different care settings.

In a health system under pressure from ageing, multimorbidity, and finite resources, persisting with acute episode-oriented responses perpetuates a widely recognised misalignment. By reorganising care pathways and strengthening longitudinal coordination, nurse-led case management constitutes a response with demonstrated impact on health system efficiency, contributing to reduced unplanned service use, more rational resource allocation and value creation in contexts of complex chronicity.

Keywords
Case Management; Nurse Case Manager; Chronic Disease; Multimorbidity; Continuity of Patient Care; Patient-Centered Care.

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