Access to joint replacement: have we got it right?

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Much has been talked about the ageing population and its impact on current and future health delivery. Within New Zealand we can expect a similar pattern to other developed countries, with a rapidly increasing aged population who have improved health and functional requirements compared to previous generations. The 65+ age group is likely to make up over one quarter of our population in the late 2030s. Musculoskeletal problems comprise well over 50% of chronic conditions affecting those over 50 years of age and are the second leading cause for disability worldwide. Although governments have been alerted to this for some time with such initiatives as the New Zealand joint initiative (2006), few changes have occurred to create strategies to deal with this burden of disease. Osteoarthritis is one of the most common age-dependent diseases, which has resulted in the recent and predicted marked increase in requirement for joint replacement as a remedy for the debilitating pain associated with this condition. Harcombe et al in “Equity of publically-funded hip and knee replacement surgery in New Zealand: Results from a national observational study” criticise the current funding strategies, highlighting significant differences between District Health Boards (DHBs) in New Zealand and the fact that there has been no real increase in provision of these procedures between 2006 and 2013 within public hospitals. They conclude that females, patients over 75 years, Māori, poorer socioeconomic groups and smaller DHBs were all associated with higher rates of publically funded surgery, which may indicate that the most vulnerable groups are being targeted, however, as pointed out by the authors, this “fails to meet the Ministry’s key objective of equity across the country”.

The introduction of a four-month waiting list, although well intentioned, has created further problems with patients reaching the surgical threshold but being dismissed due to inability to perform the surgical procedure in the mandated time-frame. One of the advantages of having a longer waiting list has been the ability of patients to get a surgical assessment and confirmation of diagnosis as well as surety that surgery will help. Currently patients with clinical need are being denied access to Waiting lists. Singleton et al in “How effective is our current Orthopaedic Prioritisation Tool for scoring patients for arthroplasty surgery?” have confirmed that patients not accepted on to waiting lists have similar functional needs to those that have been accepted. This suggests that severely impaired patients are being denied this life changing surgery. This is a common theme in a number of recent studies and highlights that there is a significant unmet need within our community. The recent introduction of a national prioritisation tool (CPAC), which has been specially developed and validated to prioritise all patients accepted onto the waiting list, may enable direct comparison between subspecialties and different DHBs. This may result in better distribution of resources and improve equity of access. However, prioritising patients on a waiting list is irrelevant if they still fail to access surgery.

Not only is there a problem accessing waiting lists, there is also a significant problem in obtaining the first specialist assessment (FSA) required to even be considered for surgery, further compounding this unmet need. Triage of patients (rationing) is required to ensure that DHBs remain compliant with the Ministry’s mandate that all patient accepted for a FSA must be seen within
four months. Recent data from Canterbury show that 74% of spinal referrals requesting a FSA were declined due to lack of clinical resource\(^7\) and a similar pattern was observed for hip and knee referrals with approximately 50% declined. This is just the tip of the problem as targeted areas of need, such as hip and knee arthroplasty, have been relatively privileged compared to other musculoskeletal conditions.

Obviously there is a resource problem. Both of the above studies have documented the current failings in orthopaedic waiting times and shown that the current model of care is not working. Attracting increased health expenditure in this area has been difficult for a specialty which largely deals with healthy patients whose disability does not have the emotive overtones of specialties involved with “cancer, cardiac or kids”. Increasing health expenditure alone, without increasing the overall “surgical resource” is not the solution. This must be recognised by the Ministry and a co-ordinated approach, with DHBs, Orthopaedic departments and the New Zealand Orthopaedic Association in conjunction with community engagement to change the model of health delivery, is urgently required to avoid the unnecessary suffering of patients with musculoskeletal disorders.

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