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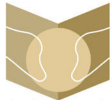

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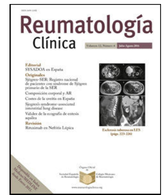

Letter to the Editor

Models of healthcare delivery for osteoarthritis

Modelos de prestación de asistencia sanitaria para la artrosis

Dear Editor:

Arriaza R et al.[1] recently concluded that Spain lacks an adequate Model Of Healthcare Delivery System (MoHds) for osteoarthritis (OA). In addition, 68% of the practitioners believe that a prevention program would be necessary to provide adequate care for this disease.

OA is a complex disease, and a leading cause of disability worldwide with a substantial societal burden attributed to growing health care costs and loss of productivity.[2] At the individual level, OA impacts health-related quality of life.[2] Even following joint replacement surgery (TJR), there remains a proportion of patients with persistent chronic pain ranging from about 7% to 23% for total hip replacement (THR) and 10% to 34% for total knee replacement (TKR).[3] In Spain, hip (HOA) and knee osteoarthritis (KOA) have a prevalence of 4% and 10.2% respectively, accounting for about 0.5% of the gross domestic product.[4]

Core treatments for OA (education, access to adequate information, exercise, and weight management) are universally recommended by OA guidelines, but are still not being delivered efficiently by healthcare systems around the world.[5] This could be due to the existence of a knowledge translation gap in the implementation of evidence in the field of OA, affecting our own understanding, attitudes and beliefs towards this evidence.[6]

With OA self-management programs demonstrating only small treatment effects for people with KOA,[7] and the forecast of a dramatic increase in rates of TKR surgeries towards 2030,[8] more effort should be given to the implementation of programs that deliver the right OA treatment to the right person, at the right time. This thinking is driving the redesign of the MoHds internationally, aiming to provide more effective continuous and patient-centered service models.[5] The healthcare system should anticipate patient needs and provide appropriate care.

Recently, new models of comprehensive OA-specific multidisciplinary chronic care programs such as: Better management of patients with osteoarthritis (BOA) in Sweden, Osteoarthritis Chronic Care Program (OACCP) in Australia, Joint Implementation of Osteoarthritis guidelines in the West Midlands (JIGSAW) and Enabling Self-management and Coping with Arthritic Pain using Exercise (ESCAPE) in the UK, Amsterdam osteoarthritis cohort (AMSOA) in Holland and Good life with arthritis in Denmark (GLA:D) have been adopted across the world with encouraging results.

The OACCP, a 52-week multicentre program based on the core interventions of OA guidelines, was implemented in New South Wales in 2012, aiming to reduce TJR surgical waitlists.[9] Its impact has been shown in the yearly removal rates from TKR (up to 15%) and THR (up to 10%) from joint replacement waitlists due to relevant improvements in pain, function and quality of life.[9] Another study, states that, 30.6% of the participants who were willing/unsure to have TJR at baseline, were unwilling for surgery by the end of the program.[10] A reduction in obesity and hypertension at the end of the program, points to the value of programs like the OACCP as part of the management strategy for patients with a number of chronic disease comorbidities.[9]

Moving forward, a multidisciplinary preventive healthcare approach, supported probably in a creative eHealth technology use, have the potential to enhance the delivery of cost-effective holistic interventions and help to compile large-scale data registries that could lead to improve the chronic healthcare management and optimize the research goals.

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