Background. Despite increasing demand for joint replacement surgery and other health services for hip and knee osteoarthritis (OA), barriers and enablers to individual access to care are not well understood. A comprehensive understanding of drivers at all levels is needed to inform efforts for improving access.

Objective. The aim of this study was to explore perceived barriers and enablers to receiving conservative (nonsurgical) and surgical treatment for hip and knee OA.

Design. This was a qualitative study using directed content analysis.

Methods. Semistructured telephone interviews were conducted, with 33 participants randomly sampled from an Australian population-based survey of hip and knee OA. Each interview covered factors contributing to receiving treatment for OA and perceived barriers to accessing care. Interview transcripts were coded and organized into themes.

Results. Key barriers to accessing care for OA included medical opinions about saving surgery for later and the appropriate age for joint replacement. Other common barriers included difficulty obtaining referrals or appointments, long waiting times, work-related issues, and limited availability of primary and specialist care in some areas. Several participants perceived a lack of effective treatment for OA. Private health insurance was the most frequently cited enabler and was perceived to support the costs of surgical and conservative treatments, including physical therapy, while facilitating faster access to surgery. Close proximity to services and assistance from medical professionals in arranging care also were considered enablers.

Conclusions. People with hip or knee OA experience substantial challenges in accessing treatment, and these challenges relate predominantly to health professionals, health systems, and financial factors. Private health insurance was the strongest perceived enabler to accessing care for OA.
Over the past decade, a substantial increase in demand for joint replacement surgery for severe hip and knee osteoarthritis (OA) has occurred in many countries.\textsuperscript{1–3} Demand for other health services used to manage less severe OA is also likely to grow in the future. In line with current clinical guidelines for the management of hip and knee OA,\textsuperscript{4,5} nonsurgical care for OA is most commonly provided by general practitioners (GPs) and physical therapists,\textsuperscript{6} with referral to orthopedic surgeons made for assessment and consideration of surgery, as required.\textsuperscript{6,7} In Australia, the most recent national health survey showed that 53\% of people with arthritis had consulted a GP for their condition within the previous 12 months, with fewer people consulting a medical specialist (17\%) or a nonmedical health professional (17\%), such as a physical therapist, chiropractor, dietitian, or osteopath.\textsuperscript{8}

In countries such as Australia and the United Kingdom, access to health care is available through public and private health systems. In Australia, 59\% of hip replacements and 69\% of knee replacements are performed in the private system annually.\textsuperscript{3} The public system provides universal health care but commonly has long waiting lists for consultations and for surgical procedures, including joint replacement. The private health system is accessible to individuals with private health insurance and those who can afford the costs of treatment. In Australia, 57\% of adults currently have private health insurance,\textsuperscript{8} with incentives provided by the federal government to improve the uptake of private cover and reduce the burden on the public health system. Despite the availability of universal health care, ensuring timely access to care for OA is problematic, as evidenced by the introduction of major government reforms to prioritize and “fast track” patients for joint replacement surgery and optimize conservative management.\textsuperscript{5,10} Suboptimal access to physical therapy, rehabilitation, and surgery for OA also has been reported across a range of countries, including the United States,\textsuperscript{11–13} United Kingdom,\textsuperscript{14} New Zealand,\textsuperscript{15} Finland,\textsuperscript{16} and Canada.\textsuperscript{17}

Our current knowledge of barriers to accessing surgical treatment for OA has been informed by the extensive body of literature reporting disparities in joint replacement provision according to sex, race, socioeconomic status, and geographic factors.\textsuperscript{18–21} Using large administrative data sets, these studies have elicited powerful information about access to arthritis care from the societal and health system perspectives. In contrast, there has been little research into access to joint replacement surgery from the individual’s perspective. In the United Kingdom, Sanders et al\textsuperscript{22} conducted in-depth interviews with 27 people with moderate-to-severe hip or knee arthritis or OA. They identified 3 key perceived barriers to receiving joint replacement: (1) personal reluctance to seek treatment, (2) difficulty in obtaining referrals for specialist care, and (3) joint replacement being considered unsuitable due to younger age or low level of disability. It is not known whether similar barriers exist in other health systems. Barriers to accessing nonsurgical or conservative care for OA were not explored in the study (beyond referrals to rheumatologists), and this remains an important area for research. A range of studies conducted predominantly in primary care settings have focused on patient or health professional perspectives on OA management or beliefs regarding OA and appropriateness for surgery\textsuperscript{25–28} rather than personal experiences of access to care. Although factors affecting health care-seeking behavior among people with hip or knee OA have been reported,\textsuperscript{29,30} individual views regarding factors that restrict or enable access to nonsurgical care are not well understood.

Qualitative research designs are needed to capture these individual experiences across the health care spectrum and to improve the understanding of factors that hinder access to OA care (barriers) and those that facilitate access to care (enablers) from the perspective of the person in need of care. Such research designs are particularly important when there has been little previous research to enable quantitative exploration.\textsuperscript{31} This study aimed to explore perceived factors affecting access to conservative and surgical treatment for hip and knee OA.

**Method**

**Study Design**

We conducted a qualitative study using directed content analysis\textsuperscript{32} to understand the barriers and enablers to receiving care from the perspective of people with hip or knee OA. A qualitative design was needed because current knowledge about access is limited.\textsuperscript{31}

**Participants and Procedure**

The study procedures are summarized in Figure 1. Participants for the qualitative study were recruited from a national cross-sectional survey that investigated the burden of hip and knee OA in Australia. We have reported the sampling methods and recruitment processes for the national cross-sectional survey previously.\textsuperscript{33,34} Of 130 individuals with hip or knee OA who took part in the cross-sectional survey, 107 (82\%) provided a contact telephone number. Allowing for refusals and difficulty in contacting potential participants, a sample of 40 individuals was selected using random sampling, an approach that is useful for selecting small qualitative samples from large populations.\textsuperscript{31} Individuals selected using a random number list were mailed an invitation letter regarding the qualitative study. Follow-up telephone calls were used to provide further information about the study and obtain informed consent to participate. Thirty-three individuals (83\%) agreed to participate in the qualitative study, 4 (10\%) declined due to illness, recent death of a spouse, or disinterest, and 3 (8\%) were unable to be contacted.

**Interviews**

We conducted semistructured telephone interviews with 33 participants. An organizing framework\textsuperscript{35} of elements potentially contributing to access to OA care had been developed by an experienced qualitative researcher (J.A.L.) and an experienced musculoskeletal physical therapist and researcher (I.N.A.) to inform the construction of the interview. These elements included the journey from development of OA to more severe joint disease, factors contributing to receiving care and perceived barriers,
and willingness to undergo joint replacement surgery. Qualitative findings regarding the journey from development of OA to more severe joint disease, willingness to undergo surgery, and factors influencing surgical decision making will be reported in a subsequent article. The framework was not emphasized in the interview; we used open-ended questions and prompts to ensure that the participants' own experiences and concerns were elicited. This approach meant the study combined both planned and emergent data, an increasingly well-accepted approach.\textsuperscript{36}

All interviews were undertaken by the first author (I.N.A.) using an interview schedule (Appendix); the sequence and questions were flexible, depending on individual responses and the need to confirm or explore responses in more detail. We obtained verbal consent for the electronic recording of interviews from all participants. Electronic recordings were transcribed verbatim by an independent research assistant, and each transcript was checked twice for accuracy. The interviews ranged from 9 to 30 minutes in duration, and the interviewer observed that no new themes were emerging over the final interviews.

Data Analysis
Demographic data collected as part of the cross-sectional survey were analyzed descriptively using IBM SPSS Statistics for Windows, version 21 (IBM Corp, Armonk, New York). Available data included age, country of birth, marital status, highest level of education, and employment status. Residential location was classified as metropolitan or provincial/rural based on Australian Electoral Commission ratings for each federal electoral division.\textsuperscript{37} We readministered patient-reported outcome measures, including the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), as described previously,\textsuperscript{33,34} prior to each interview. The WOMAC data were analyzed descriptively, with WOMAC pain, stiffness, and function subscale scores and the total WOMAC score reported on a scale of 0 ("best possible score") to 100 ("worst possible score").

We used QSR NVivo 10 qualitative analysis software (QSR International, Melbourne, Victoria, Australia) to support thematic analysis. Analysis commenced with a close review of each transcript to gain an overall picture of the data. We developed data categories using an integrated approach following 2 lines of reasoning.\textsuperscript{38} The first examined the data according to the barriers and enablers framework used to structure the interview questions.\textsuperscript{35} The other was an inductive and grounded approach\textsuperscript{39,40} to code the interview data until no new themes emerged. This use of complementary inductive and deductive approaches is consistent with the paradigm classified as "directed content analysis."\textsuperscript{32,41} Within themes, constant comparison was used to establish the boundaries of each theme. To ensure that the findings were comprehensive, the second author (J.A.L.) (who was blinded to the initial review) examined a subset of interview transcripts to confirm the themes identified and detect any important omissions. These findings were discussed by the first 2 authors, and some themes were refined slightly to reflect differences in emphasis between the researchers.

Role of the Funding Source
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the collection, analysis, and interpretation of data; in the writing of the manuscript; or in the decision to submit the manuscript for publication.

Results

Participant Characteristics and Health Services Use

The Table summarizes the demographic characteristics of the participants. The median age (interquartile range) of the sample was 64 (58–71) years, and 64% (n=21) were female. Sixty-seven percent of the sample (n=22) had been diagnosed with knee OA, 24% (n=8) with hip OA, and 9% (n=3) had both hip and knee OA. Most participants were born in Australia (n=23, 70%) and were married or living with a partner (n=18, 64%). Fifty-four percent (n=15) were retired, 36% (n=10) were in paid employment, and 1 participant (4%) had stopped work due to their hip or knee condition. Fifty-eight percent (n=19) lived in a metropolitan area, and the remainder (n=14) lived in provincial or rural areas.

The majority of the sample (61%) had previously undergone hip or knee surgery, including hip or knee replacement or knee arthroscopy. The Table shows that 7 participants (25%) had consulted a GP for their OA within the previous month, 4 (14%) had visited a physical therapist, 1 (4%) had consulted an orthopedic surgeon, and 1 (4%) had consulted a rheumatologist. No participant reported having seen a chiropractor, osteopath, dietitian, acupuncturist, or massage therapist for their OA within the previous month.

Barriers to Accessing Treatment

A range of difficulties in accessing health care for hip or knee OA were identified from the interview data. With some overlap, the emergent themes were broadly categorized into: (1) health professional–related factors; (2) health system–related factors; (3) financial factors; and (4) personal beliefs, knowledge, and support (Fig. 2). These themes are described in detail in the following sections, and examples of relevant participant responses are provided.

Health professional–related factors.

Medical opinion about the appropriate timing of joint replacement surgery was the most common barrier linked to health professionals. A considerable number of participants reported being told by their GP or medical specialist that they were too young for joint replacement surgery (n=7) or that surgery should be saved for later (n=8):

- The bottom line I was given was the only thing that was going to fix it was the full knee replacement. And because at that stage I was 42 years of age they, the specialist, said that he wouldn’t, he really didn’t want to touch me ’til I was 55. (Male, aged 49 years)

- And, in the meantime, I also saw the rheumatologist, who said don’t let them talk you into a knee replacement until you really need it. (Female, aged 63 years)

For some participants, the views of their health care provider seemed to be at odds with their own expectations and with the experience of their friends:

- I don’t know why they would do that, I mean, in my mind... in my mind, I believe that I need to be active now and not wait until I’m old and inactive before I actually get the surgery done. (Female, aged 67 years)

Although the reasons for delaying joint replacement surgery were not always articulated, some participants recalled being advised by their doctor to defer having surgery because of concerns regarding prosthesis longevity and the potential need for revision:

- He said the longer I can put it off, the better, because they only last 10 years. (Female, aged 64 years)

Health system–related factors.

When recalling their experiences with accessing OA care, a number of participants reported being advised to put up with the condition, with few options offered for treatment:

- He said, “Yes, you have... um... you have arthritis in that left knee. I would advise you to put up with it.” (Female, aged 78 years)

- And he just said to me, “You’ve got to live with it.” and he’s not a young doctor, so he just sort of said to me... “Well, you know, you’re 81–82.” I’m 83 now... This is part of what the doctor told her, “You’ve got to expect these things.” (Female, aged 82 years)

A further concern expressed by some participants (n=3) was the difficulty in obtaining referrals from a GP to an orthopedic surgeon or rheumatologist:

- I think the GPs are always, my GP and from what I gather from other people I talk to, they’re usually a bit hesitant to refer you for surgery. (Female, aged 67 years)

- My husband has got quite severe OA, and his GP is not... doesn’t seem to be interested in referring him to a rheumatologist, which I would dearly like him to see. (Female, aged 72 years)

Two participants also reported encountering conflicting views among their treating medical specialists regarding the need for knee arthroscopy in the context of OA, as highlighted by this response:

- My rheumatologist was probably not all that happy that they did done surgery, because he said the [arthroscopic] surgery really was of no benefit to the OA and has probably resulted in making it worse... The orthopedic surgeon wanted to actually go in again... (Female, aged 56 years)

- He said, “The more time you can go without having that first operation done, it will be far better off for you.” (Male, aged 62 years)
Probably the fact that it’s difficult to get to see the doctor. . .there’s an overflow of patients, I guess. (Female, aged 44 years)

So he suggested to me to try and get on his public list, but his public list was about 18 months long. (Male, aged 46 years)

The following response captures the frustration experienced by one participant in relation to trying to obtain an appointment with her GP:

It’s just a chore getting there. To even see the doctor. (Female, aged 44 years)

Some participants (n = 3) also considered the limited availability of health services, including rheumatology and orthopedics, in smaller cities and rural areas and the distance to primary care and specialist services (for people living in non-metropolitan areas) to be barriers to accessing treatment. One participant commented that she would need to drive for a couple of hours to see another GP, and another participant reported that her community had no local access to orthopedic care:

Well, the orthopedic surgeon doesn’t come here. (Female, aged 78 years)

Financial factors. A number of participants reported financial barriers to accessing health care for their hip or knee OA. These barriers included difficulty taking time off from work for appointments with health professionals, surgery, and anticipated postoperative recovery (n = 4), particularly for participants who were the primary earner, self-employed, or engaged in shift work:

Yes, well, being self-employed as well, having 10 weeks off to recover would, would impact on our financial situation. (Male, aged 46 years)

It’s just finding the time, you know, because you’re only obviously allowed so much sick time, so. . .yeah. . .I guess that’s what it is, work and finding time. (Female, aged 54 years)

My current shift work arrangement. I work 3 days on and 3 days off. I start at 2:30 in the morning and finish at 1:00 in the afternoon. . . . So I’ve either got to do it on my day off or do it, like, after 1:00 in the afternoon and usually sitting there, you know, half asleep while someone’s trying to talk to me about stuff. (Male, aged 49 years)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y), median (IQR)</td>
<td>64 (58–71)</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>21 (64)</td>
</tr>
<tr>
<td>Diagnosis, n (%)</td>
<td></td>
</tr>
<tr>
<td>Knee OA</td>
<td>22 (67)</td>
</tr>
<tr>
<td>Hip OA</td>
<td>8 (24)</td>
</tr>
<tr>
<td>Hip and knee OA</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Body mass index (kg/m²), median (IQR)</td>
<td>29 (26–32)</td>
</tr>
<tr>
<td>Australian-born, n (%)</td>
<td>23 (70)</td>
</tr>
<tr>
<td>Marital status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>18 (64)</td>
</tr>
<tr>
<td>Single, widowed, or divorced</td>
<td>8 (29)</td>
</tr>
<tr>
<td>Highest level of education completed, n (%)</td>
<td></td>
</tr>
<tr>
<td>Primary school or less</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Years 7–10</td>
<td>6 (21)</td>
</tr>
<tr>
<td>Years 11–12</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Trade/technical education</td>
<td>8 (29)</td>
</tr>
<tr>
<td>University</td>
<td>8 (29)</td>
</tr>
<tr>
<td>Paid work, n (%)</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>15 (54)</td>
</tr>
<tr>
<td>Paid employment</td>
<td>10 (36)</td>
</tr>
<tr>
<td>Stopped work due to hip or knee</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Residential location, n (%)</td>
<td></td>
</tr>
<tr>
<td>Metropolitan area</td>
<td>19 (58)</td>
</tr>
<tr>
<td>Provincial or rural area</td>
<td>14 (42)</td>
</tr>
<tr>
<td>Previous hip or knee surgery, n (%)</td>
<td></td>
</tr>
<tr>
<td>Hip replacement (including bilateral surgery)</td>
<td>5 (18)</td>
</tr>
<tr>
<td>Knee replacement (including bilateral surgery)</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Knee arthroscopy</td>
<td>8 (29)</td>
</tr>
<tr>
<td>Osteotomy</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Consulted a health professional for OA in previous month, n (%)</td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>7 (25)</td>
</tr>
<tr>
<td>Physical therapist</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Orthopedic surgeon</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Rheumatologist</td>
<td>1 (4)</td>
</tr>
<tr>
<td>WOMAC score, X (SD)</td>
<td></td>
</tr>
<tr>
<td>Pain subscale</td>
<td>27.9 (21.1)</td>
</tr>
<tr>
<td>Stiffness subscale</td>
<td>31.3 (24.7)</td>
</tr>
<tr>
<td>Function subscale</td>
<td>29.6 (22.9)</td>
</tr>
<tr>
<td>Total score</td>
<td>29.4 (21.9)</td>
</tr>
</tbody>
</table>

aTotal numbers of participants may not equal 33 due to missing responses; some participants reported having had more than one type of surgery. IQR = interquartile range, OA = osteoarthritis, WOMAC = Western Ontario and McMaster Universities Osteoarthritis Index (range = 0–100, scored best to worst).
Enablers and Barriers to Hip and Knee Osteoarthritis Care

The costs associated with treatments, including physical therapy, were also considered to be a key barrier (n = 3), with some participants reporting that they attended a gym or performed their hydrotherapy exercises in a local pool to avoid physical therapy expenses:

"The only problem was with the physio [physiotherapist], it was becoming pretty ridiculously expensive to do it once a week because I was getting very little back from my [name of health insurance fund removed] insurance. So I gave that away for a while, went back to the gym, but I'm now doing Pilates, but just with a Pilates instructor, not a physio, and I'm finding it very beneficial." (Female, aged 65 years)

I went with the physiotherapist, and I did hydrotherapy swimming, but that was costing me $25 a lesson, and I thought, "Why can't I do it by myself?" And I just pay for 10 lessons, which cost me $59, and I can go anytime and as long as I like instead of just so many minutes. (Female, aged 64 years)

Not having private health coverage was perceived by 2 participants to restrict timely access to orthopedic surgeons and to limit access to high-quality joint prostheses, with friends' stories featuring as well:

"So her pain was quite severe, and to wait in the public system would have been, you know, probably agonizing. It would have been horrible. (Male, aged 68 years)

And also being on the public list, it would probably be an inferior prosthesis that I'd get. . . . Just because I was on the public list and I don't really get a choice of prosthesis. (Male, aged 46 years)

Personal beliefs, knowledge, and support. Several participants (n = 4) described a perceived lack of effective treatment for OA and their concern about the inability of health professionals to help with their OA. These concerns were commonly expressed as a personal experience of ineffectiveness:

"Well, I've never had any trouble accessing treatment, but I think probably, as I've said before, I think that the biggest problem with me is I've never found anything that works. (Female, aged 56 years)

When asked specifically about relationships with their GP, some participants had developed a view that GPs were unable to provide effective treatment for their OA:

"[They] haven't really been able to help me a great deal. Other than to tell me I've got it and it'll probably get worse and I might need a knee replacement, I suppose that's it. I've found them a bit powerless. . . . this is probably silly, I just feel a little bit... um... frustrated that doctors can't do more for you. (Male, aged 55 years)

He just wanted to help, and he felt like he couldn't. That's how I felt it went. But the treatment is not there, you know, other than lose weight was the only suggestion. (Female, aged 73 years)

Enablers to Accessing Treatment

Compared with the range of barriers reported, participants described a more limited set of factors that had made it easier for them to access treatment. The strongest perceived enabler to accessing treatment for OA was having private health insurance (n = 10). Health insurance was viewed as supporting some of the costs associated with conservative and surgical treatment:

"It's enabled me to claim significant amounts back for massage therapy, for physiotherapy... um... even for joining a gym and that sort of stuff. (Male, aged 49 years)

Because I'm in a health benefit scheme with [name of health insurance fund removed], on the full scale, on the full treatment. So it wasn't a big bill. . . . (Male, aged 64 years)

Private health insurance also was understood by participants to facilitate faster, more efficient access to procedures such as joint replacement surgery and arthroscopy, both from past experience and as a future option:

"Well, I think having private health cover was enabling me to get in and get it seen to very quickly. (Female, aged 68 years)

Well, my experience in the private health system is that I can organize with the doctor and my family when I need this done, when I need that done, and it's straight away. (Female, aged 78 years)

Luckily, I've got private health, so I was sort of in within a week of the surgeon saying, "Right, we'll get it done." (Female, aged 54 years)

The fact that I'm in private health insurance. . . . In terms of accessing specialists, or specialist surgeons I guess, that's made it quite easy. If I wanted to, I could probably have an arthroscopy next week. (Female, aged 56 years)

When asked to comment on anything that made it easier to get treatment for his hip OA, one participant replied:

"Being in the health fund—nothing else." (Male, aged 68 years)
Enablers and Barriers to Hip and Knee Osteoarthritis Care

Four participants also cited proximity to hospitals and other health services as another enabler. Living close to hospitals that provided care for OA was viewed positively by participants, who considered this close proximity made it easier for them to get treatment:

Well, I don't go anywhere for any more treatment. There's access to everything. We've got access in [name of town removed] to everything in that way. (Female, aged 69 years)

I'm handy to where the doctor is. (Female, aged 68 years)

The assistance of health professionals in organizing physical therapist services or arranging referrals for surgery also was valued by some participants (n = 3).

Local doctor, yes, he has suggested and organized my attending physio [physical therapy]... Mmm... and that's really helpful. (Female, aged 82 years)

Two participants also acknowledged the support provided by family and friends and arthritis consumer organizations in enabling them to obtain care for their OA:

I suppose the Arthritis Foundation was great. I mean that certainly, I think surgeons only looked at it as far as a new knee, but they looked at it from a broader prospective. (Female, aged 63 years)

One participant with a background in nursing considered her professional knowledge to be an enabler to OA treatment:

Yeah, having some knowledge of my own... I suppose being able to give accurate... symptoms. Um... and yeah, and researching what's available, I think. (Female, aged 67 years)

Discussion

Nestled within a national population-based study, this study explored the barriers to accessing surgical and nonsurgical care for hip and knee OA in Australia. This study also provides new information about factors that facilitate access to care, emphasizing the value of ongoing initiatives that support access to joint replacement and uptake of private health insurance. It also has corroborated several barriers that emerged from earlier qualitative studies in the United Kingdom22,24 and Canada,50 indicating that these barriers are not specific to individual health systems but rather are symptomatic of broader issues around the coordination and delivery of health services for OA.

Our findings highlight some key points for physical therapists and other health professionals, particularly in relation to a perceived lack of effective treatment for OA among participants and the advice received from some doctors that they should “put up” with their condition or “learn to live with it.” A recent narrative review has highlighted similar perceptions among GPs that little could be done to manage OA,22-42 and reported difficulty in obtaining specialist referrals22 is consistent with data from the present study. In Australia, recent research by Brand and colleagues7 also revealed low rates of referral to physical therapist and orthopedic surgeons following primary care consultations for OA. Taken together, these findings may reflect outdated views regarding best-practice care for OA and inadequate knowledge of current clinical guidelines. Although a number of evidence-based nonsurgical modalities are available to manage mild-to-moderate hip and knee OA,43,44 it is apparent that these modalities are not well known to patients or their primary care providers. Osteoarthritis also is seen by some patients as an inevitable part of aging that may not be amenable to treatment.25,28,30,45 As adherence to physical therapy has been linked to personal perceptions of effectiveness and beliefs regarding the cause of arthritis,46 health professionals, including GPs and physical therapists, have an important role to play in promoting appropriate education, exercise, weight loss, and other pain management techniques. Our data also showed that assistance with arranging treatments or services was valued by people with OA, and this finding is consistent with Canadian research that highlighted the perceived benefits of having a “health care advocate.”50 As first-contact practitioners, GPs and physical therapists are well placed to provide this type of support.

We observed that medical opinions regarding the ideal timing of joint replacement were a key barrier to accessing surgery for OA, with the frequently expressed view that some patients were “too young” for joint replacement. Our study provides valuable examples from the patient’s perspective that are consistent with studies reporting a lack of consensus among orthopedic surgeons and referring specialists about the optimal timing for joint replacement.47,48 Further evidence of inconsistencies in the indications for surgery comes from research demonstrating significant national and international variation in age and disease severity before hip and knee replacement.49,50 Similar to our findings, researchers from the United Kingdom also have described situations where patients were told that they were too young for joint replacement, with little or no further guidance given.22,24 Our data suggest that the reasons for deferring joint replacement are not well understood by many patients, and it is likely that only limited information is being provided about why surgery may not be appropriate for their circumstances. Some participants recalled being told about a limited life span for prostheses; however, long-term prosthesis survival and functional data are available for hip and knee replacements.51-54 Although some people with OA acknowledge their symptoms are not severe enough to warrant surgery,27 qualitative research from the United Kingdom has indicated that a mismatch between patients’ and surgeons’ perceptions of need for surgery is a source of anxiety for patients.29 There are potential opportunities for improving communication in this area, particularly for patients who are perplexed by anecdotal reports of successful surgical outcomes from their family and friends. Where surgery is not an option, health professionals should ensure that patients are provided with appropriate education and support for self-managing their OA in the interim and that mechanisms are in place for identifying functional deterioration.

One health system–related barrier that was reported by a number of participants was difficulty in obtaining appointments with medical professionals or long wait-
This study has also provided new information about the influence of financial and work-related factors in accessing care for OA. Although some participants reported difficulties in accessing treatment due to their employment arrangements, others described the means by which they had avoided or minimized the costs of nonsurgical services (e.g., by performing unsupervised hydrotherapy exercises or attending a gym rather than physical therapy). Our research also has highlighted the perceived importance of having private health insurance in Australia, which has a dual health system structure. Participants perceived the benefits of health insurance to be threefold: elimination of waiting times for surgery or ability to streamline the process of arranging surgery, potential for receiving higher-quality joint prostheses, and support for the costs of both conservative and surgical treatment. Having private health insurance also has been associated with higher utilization of physical therapist services for musculoskeletal conditions in the United States and shorter waiting times for orthopedic consultation and hip replacement surgery in the United Kingdom. This study had a number of strengths, including the use of robust qualitative methods to develop a comprehensive understanding of the individual experience. The composition of our national study sample was another strength, including participants who utilized the public and private health systems, younger and older participants (age range = 44–86 years), and participants residing in metropolitan and nonmetropolitan areas. Incorporating the views of nonmetropolitan residents (representing 42% of the study sample) is particularly valuable, as large studies from the United Kingdom and Australia have shown that living in remote or regional areas can be associated with reduced access to joint replacement surgery and greater access to outpatient physical therapist services was evident among people living in urban areas of the United States. For pragmatic reasons, we used individual interviews rather than focus groups, as our sample was geographically diverse, with participants residing in all 8 Australian states and territories. We also acknowledged the limitations of this research. Similar to other population-based studies, participant eligibility for the overall study was based on self-reported doctor-diagnosed OA, as access to radiographic imaging was not available. Additionally, our data were collected in the context of the Australian health system, and although the broad themes are likely to be applicable to similar health systems, we do not know if the findings are generalizable to other settings.

In conclusion, this study has elicited individual perspectives on factors that hinder and facilitate access to health care for OA. It is evident that people with hip or knee OA face a range of important barriers to accessing conservative and surgical care, including medical attitudes, financial obstacles, and health system-related challenges. The strongest enabler to accessing care was having private health insurance, which supported the costs of conservative and surgical treatment and facilitated faster and more streamlined access to surgery.

All authors contributed to the design of the study. Data collection was undertaken by Dr Ackerman, and the analyses were performed by Dr Ackerman and Ms Livingston. Dr Ackerman drafted the manuscript, with critical feedback and revisions provided by Ms Livingston and Professor Osborne. All authors have approved the final manuscript. The authors thank the study participants for their support of this research.

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Appendix.
Semistructured Interview Schedule

1. **Journey from development of osteoarthritis to more severe joint disease**
   **Suggested prompts**
   - Thinking about when you first found out about your hip or knee osteoarthritis, can you tell me about this, please?
   - Has your hip or knee osteoarthritis changed over time?
     - Can you tell me more about this?
     - Were there any memorable/significant events?
     - Can you tell me about these special events?
   - Was there anyone close by you that you specifically discussed the diagnosis of hip or knee osteoarthritis with?
   - Can you tell me about how your hip or knee osteoarthritis affects your life at the moment?
   - What help have you received over time for your hip or knee osteoarthritis? OR
     - Can you take me through the history of your treatment, please?
   - Can you tell me about any other treatments or therapies you have tried for your hip or knee osteoarthritis?

2. **Factors contributing to receiving treatment for osteoarthritis and perceived barriers to accessing health care services for osteoarthritis (including conservative therapy and joint replacement surgery)**
   **Suggested prompts**
   - When I say “treatment for hip or knee osteoarthritis,” can you tell me if you think of the following as treatment:
     - Medication?
     - Physiotherapy?
     - Surgery?
     - Is there anything else you would consider to be treatment?
   - Thinking about getting treatment for your hip or knee osteoarthritis, can you tell me about things that went well for you in relation to getting treatment?
   - Thinking about getting treatment for your hip or knee osteoarthritis, can you tell me about things that did not go so well for you in relation to getting treatment?
   - Thinking about getting treatment for your hip or knee osteoarthritis, how would you describe your relationship with your general practitioner or other people who help you with your osteoarthritis?
   - Thinking about getting treatment for your hip or knee osteoarthritis, can you tell me about anything that has made it easier for you to get treatment for your hip or knee osteoarthritis?
   - Thinking about getting treatment for your hip or knee osteoarthritis, can you tell me about anything that has made it difficult for you to get treatment for your hip or knee osteoarthritis?

3. **Willingness to undergo joint replacement surgery**
   **Suggested prompts**
   - Can you tell me what you know about surgery as a treatment for hip or knee osteoarthritis?
   - On a scale of 0 to 10, where 0 means you would never consider having joint replacement surgery and 10 means you would definitely consider having joint replacement surgery, can you tell me how likely you would be to consider having joint replacement surgery for your hip or knee osteoarthritis?
   - Can you tell me why you’ve chosen that score?
   - What sorts of things might influence your decision to have joint replacement surgery for your hip or knee osteoarthritis?