# The Australian experience: Similarities and differences in surveillance

## How did you get the opportunity to travel overseas?

This opportunity came as part of the package of a Clinical lectureship with the National Institute for Health Research. The award is designed to increase research and clinical skills, and the awardee is encouraged to travel abroad to extend knowledge of practice in other parts of the world.

## What was the purpose of your visit?

An audit of arthroplasty follow up services in the UK had demonstrated that the everyday practice of arthroplasty surveillance is very different from national recommendations. This made me think that the same might be true in Australia where Australian Orthopaedic Association recommendations are for follow up at 1-2 years, 5 years and then 2 yearly thereafter. It prompted me to ask the following questions as I travelled around:

* What is happening in arthroplasty follow up in Australia?
* How does the provision of arthroplasty follow up relate to the organisation of health care in Australia?
* What research is currently taking place in relation to arthroplasty surveillance?

## Where did you go and who did you meet?

The trip started in Perth, then to Brisbane and finally to Cairns. I met researchers, orthopaedic physiotherapists, surgeons and administrators in private and public hospitals. The visit finished with four days at the combined Australian and New Zealand Orthopaedic Associations annual conference.

## Tell us about your research

All my current research is about arthroplasty surveillance, trying to find out if it is clinically effective and cost effective, and if so, who should it be offered to and who should be delivering the service. It includes surgeon and arthroplasty practitioner perspectives and, of course, service users.

## Have service users been involved in your research?

Yes they have, right from the beginning. As a clinician, my conversations with service users were one of the first prompts to begin research. In the post-doc period prior to the Clinical Lectureship, I was fortunate to be able to work with an established public and patient group to ask them about the subject of arthroplasty follow up. They kindly gave me written and verbal response to some specific questions, and I then attended a group meeting to discuss the issues further. I also have two patient collaborators for each of the grants with which I am working, and further meetings have been booked with the original group of service users.

In addition, one of my planned studies consists of interviews and focus groups with service users, one city based and one town based. These will give a wider picture of the patient perspective on this type of service.

## What were the similarities between the UK and Australia in arthroplasty health care?

The similarities were the common desire of physiotherapists and nurses to extend their skills in specialist areas to enhance patient care and their own job satisfaction. However, when specialist or advanced practice roles are created, there can be difficulty with recruitment to the posts, again true in Australia and the UK.

In terms of the delivery of health care, the role of GPs was similar in both countries, although the basis for reimbursement is different. The GP acts as the primary gateway to other services but the recent introduction of activity based funding rather than doctor-patient consultation based funding is producing some changes in the way that the elective orthopaedic services are delivered.

## What were the differences between the UK and Australia in health care?

The biggest difference that impressed itself on me was the lack of a national health service! Each of the five States manages the public health care services within its area, and its budget determines what will be offered. Much of the healthcare is provided through the private system which can be accessed through employer insurance or self-funded. This produces significant disparity across the country and across the lifetime of an individual, for geographic and socio-economic reasons.

For instance, the one public hospital that I visited is responsible for providing orthopaedic services to an area two or three times the size of Great Britain. They had a waiting list of 3700 patients last October and one of the physiotherapists explained that trying to provide treatment options for patients who lived hours and hours away was very difficult:

“…*And things take much longer, you know, people say, "Oh, you took so long to see that new patient." Yeah, 'cause I saw the patient - fine, came up with a plan, it's taken me two hours of firm work to find a psychologist before I start treatment, or it's taken me an hour to find a dietician. So my day could be...I see three patients and it's like seeing 15 or 20. 'Cause I'm trying to find options for them, so they don't come back.”*

The impression that I had about arthroplasty follow up was that it is very dependent on the arrangements for orthopaedic reimbursement within a hospital. Consequently, I visited one hospital which was owned by a charity but provided public services and they offered a thorough surveillance service for arthroplasty patients, delivered by physiotherapists alongside orthopaedic clinics. In another public hospital, all follow up had recently been stopped despite a 15 year history of providing excellent arthroplasty surveillance.

## What challenges have become apparent to you as a result of this trip?

The one challenge that comes immediately to mind is the difficulty of developing services that are provided by advanced practitioners in a system that is not currently supporting these roles. The interplay of the public and private health care systems and methods of reimbursement seem to impose a ‘glass ceiling’ on the development of non-medical health professionals. Where the drive for hospital efficiency leads to innovative initiatives, funding for advanced roles may be available but is not guaranteed for the longer term. This has a negative effect on recruitment and staff

## Are there any practice implications for arthroplasty practitioners as a result of your trip?

Yes! To appreciate the level of freedom and support that we have in the UK to practice at an advanced level in order to develop services that improve the quality of patient care. Alongside our appreciation, it is important to ensure that we use established frameworks of advanced practice to continue to define and develop our roles, and make the information available to our colleagues in other countries who may be trying to develop specific advanced practice roles.

## Did the experience change your approach when you returned to the UK?

Yes. My clinical work and my research are focussed on the need for, and the delivery of, arthroplasty surveillance in a UK setting. This experience has prompted me to think about an algorithm for arthroplasty surveillance that might be possible to use in the UK and elsewhere – one that would be flexible enough to be adapted into a local or national setting with a different type of health care system. It has definitely enlarged my view, which was the intention of the visit, and has extended my network of colleagues. It has also added to the list of questions that I am asking about arthroplasty surveillance, so I think I can keep myself busy with research for years to come!