Preventing inequalities in hip surgery

Naomi Gibbs, Antony JR Palmer, Mark G Bowditch and Matthew J Wilson

Naomi Gibbs is an Academic Clinical Lecturer in Trauma and Orthopaedics at the University of Oxford. Naomi is Culture and Diversity Chair for the British Hip Society.

Antony Palmer is an Academic Consultant Hip Surgeon at the Nuffield Orthopaedic Centre and University of Oxford. His areas of research include surgical pathways and peri-operative care.

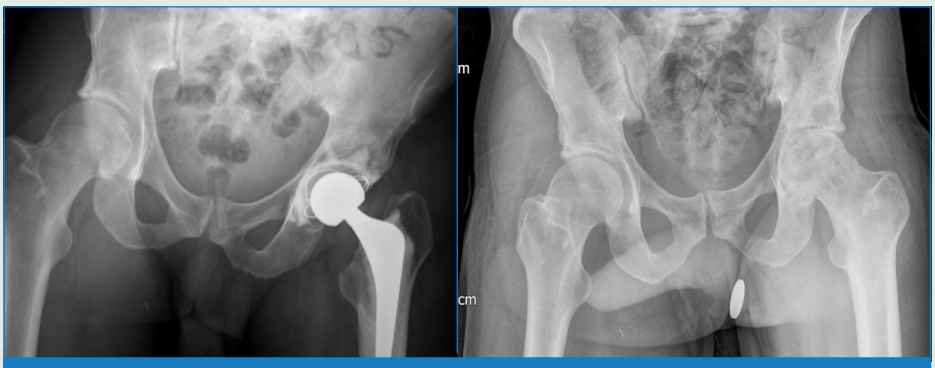
Currently, access to hip surgery in the UK is not equal, and we must address systemic barriers that deny patients timely and potentially life-changing care. Despite the profound improvements that a total hip replacement (THR) can bring to pain relief, mobility, and independence, there remains a growing cohort of patients unable to access care because of structural, clinical, and socioeconomic barriers. These barriers include universally applied thresholds without nuance, and clinical risk aversion which may increase inequalities rather than alleviating them. Left unchallenged, these obstacles deepen health and social disparities, counter to the NHS's founding principle of equitable access.

The government has just released the latest 10-year plan for the NHS – Fit for the Future – which places a strong emphasis on tackling health inequalities. The plan acknowledges that people living in deprived areas, from ethnic minority backgrounds, and in rural or coastal communities experience worse access to care, poorer outcomes, and shorter life expectancy. It outlines ambitious goals to halve the gap in healthy life expectancy between the richest and poorest regions and to ensure fairer distribution of NHS funding based on local health needs. By shifting focus from hospital-centric care to community-based, preventive approaches, and investing in local neighbourhood health services, the plan aims to make healthcare more accessible and equitable. Underpinning these reforms requires a commitment to social justice and the principle that high-quality care should be available to everyone, regardless of background or income.

Understanding the landscape of inequality

The roots of inequality in elective orthopaedic care lie deep within the social determinants of health – income, education, ethnicity, disability, housing stability and geographic location. Patients in affluent urban areas, with high consultant-to-patient ratios, may enjoy swift referrals, multiple local physiotherapy options, ready access to weight-management and smoking cessation services, and other social support structures. However, for residents in deprived or rural communities, recruitment of healthcare providers can be challenging. Additional barriers to healthcare access include the distance required to travel or poor transport links, with each step toward surgery carrying additional burdens.

Several studies and NHS reports have highlighted the 'postcode lottery' effect, where access to hip surgery varies dramatically between Integrated Care Boards (ICBs). Individuals residing in the lowest socioeconomic quintile are significantly less likely to be offered a THR than their counterparts in more affluent areas (22.5 per 10,000 in the most deprived quintile compared with 37.8 per 10,000 in the



Radiographs of a native septic hip in a substance misuse patient with post-operative single stage articulating spacer THR.

Mark Bowditch is a Consultant Orthopaedic Surgeon at the East Suffolk North Essex NHS Foundation Trust and is the current BOA President.

Matt Wilson is a Consultant Orthopaedic Hip Surgeon based in the Exeter Hip Unit at the Princess Elizabeth Orthopaedic Hospital, Devon. Matt is the current President of the British Hip Society.

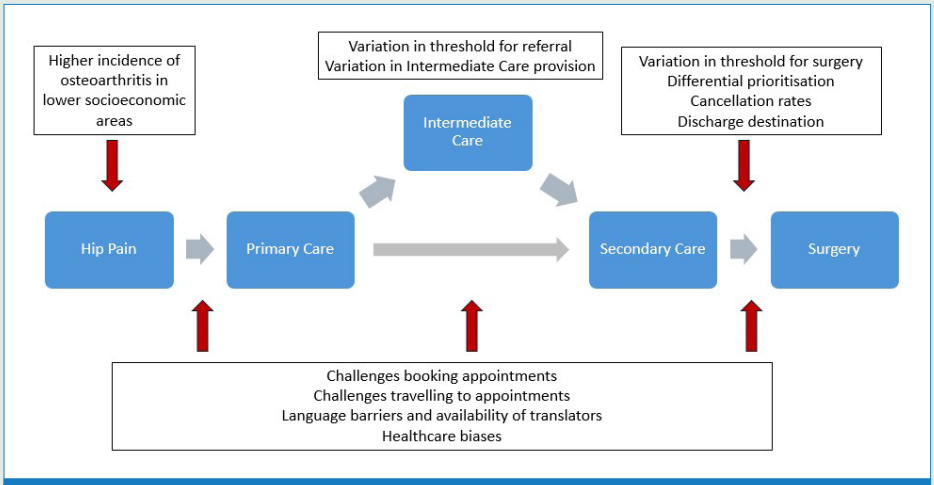


Figure 1: Potential barriers to access to healthcare.

most affluent quintile)[1]. They also face extended waiting times, often several months longer than the national average, and are more likely to drop out of the pathway entirely because of systemic obstacles[2].

In some regions, patients with moderate osteoarthritis may be referred quickly for total hip replacement while in others, even those with severe pain and mobility loss, may be held back due to rigid 'conservative management' pathways that act more as gatekeeping tools than therapeutic options. Delaying referral until joint disease is severe potentially increases the risk of adverse outcomes through muscle wasting, deconditioning and increased fall-risk, and escalates peri-operative complexity. In turn, frailty begets frailty, imposing an even greater resource burden on rehabilitation services and community nursing teams.

Thresholds: Risk management or exclusion by proxy?

A major source of potential inequality in hip-surgery access is the application of body mass index (BMI), smoking status, and glycated haemoglobin (HbA1c) thresholds. Patients with a BMI over 40, or HbA1c above a fixed level, may be excluded from surgery on the grounds of increased peri-operative risk. These thresholds are often used as rigid barriers to surgery by some surgeons, trusts, ICBs, and NICE, preventing individualised shared decision making over the potential benefits and complications of a hip replacement.

While these policies aim to reduce complications, their blunt application may act as a proxy for exclusion. Increased peri-operative risk should be balanced against the harm of continued disability. While acknowledging that prosthetic joint infection can be a catastrophic complication, and the risk may increase from 0.3% to 1% in higher BMI patients[3], the absolute risk remains low. This modest increase stands in stark contrast with the certain, progressive disability these individuals are likely to endure while striving to meet the BMI or HbA1c threshold. Neither of which for is there a true 'cliff face' risk increase cut off either side of the 'target'. For patients in socioeconomically deprived areas, who lack the means to access private nutritionists, gym memberships or psychological support, the requirement to lose significant weight or drive HbA1c into ideal ranges may prove insurmountable.

Some diabetologists have expressed concern that the drive to push HbA1c below arbitrary limits may lead to overtreatment without clinical benefit, especially in patients who have already made substantial lifestyle changes[4]. Consequently, these thresholds – intended to reduce risk – may instead increase the risk and penalise the most vulnerable, who have the least means to meet the thresholds. There are emerging therapies such as Glucagon like peptide-1 (GLP-1) receptor agonists (e.g., semaglutide) – which promise significant weight loss. However, not only are the side effects of these unclear, these also remain unevenly available and subject to restrictive prescribing criteria.

Acknowledging risk and shared decision-making

Risk is inherent to surgery. Every patient, whether frail and elderly or obese and metabolically challenged, carries a baseline risk profile that must be evaluated and discussed. However, recognising risk should not equate to denying care, rather it should form an ethical foundation to shared decision-making. By presenting both absolute and relative complication rates in clear, patient-friendly terms, clinicians empower individuals to consider their options against the certainties of ongoing pain, loss of independence and reliance on analgesia. >>

It should be acknowledged that accurately assessing risk for patients is challenging, since the very barriers that limit their surgical access also exclude them from many clinical studies. To address this evidence-gap and empower both clinicians and patients, it is essential to conduct inclusive research that evaluates outcomes across the full spectrum of risk profiles. In the short term this may involve shifting away from rigid exclusionary cut-offs toward a more adaptable framework, in which risk is managed rather than used as a barrier.

Clinical risk aversion and complex patients

Certain patient groups, including those with active or historical substance misuse, poorly controlled chronic medical conditions, or significant psychosocial instability, are frequently classified as 'inappropriate' surgical candidates. Even when their underlying joint-disease renders them immobile and dependent, the perceived burden of peri-operative management leads some teams to decline patients for surgery. This categorisation may result in exclusion early in their management, with clinicians wary of poor compliance and unpredictable postoperative outcomes, along with potential concern surrounding their performance metrics on national registries such as the National Joint Registry (NJR).

Institutional aversion to complexity may reflect the system's reluctance to allocate additional resources rather than considering a true clinical judgement. Often, these patients become concentrated in tertiary centres, creating bottlenecks where resources and capacity are already under strain, limiting timely access to necessary interventions. While surgical risk may indeed be higher in these populations, adopting a policy of early exclusion fails to recognise individual patient circumstances and potential for successful outcomes.

A more just system would regard complexity not as grounds for exclusion but as an indicator for enhanced, multidisciplinary pathways. Collaboration with multi-disciplinary physicians, addiction specialists, psychiatric teams and social workers may help to build robust peri-operative plans tailored to individual needs. By distributing responsibility across a dedicated network, orthopaedic teams may safely deliver THR to those previously left behind. It is also important that surgeons feel supported when operating on patients deemed to be at elevated risk of complications, both through resource allocation, and through transparent risk adjustment in performance metrics.

Ethnicity and unmeasured bias

Although relatively understudied in UK arthroplasty literature, emerging evidence indicates that patients from ethnic minority backgrounds experience delays in diagnosis, referral, and access to a total hip replacement[5]. Contributing factors may include language barriers, lower health literacy, structural racism within healthcare systems, and the geographic clustering of ethnic minority populations within economically disadvantaged and medically underserved areas. These intertwined factors may lead to fragmented care pathways, delayed clinical presentation, and poorer surgical outcomes. There is an urgent need for targeted research to quantify these disparities accurately, alongside widespread implementation of cultural competency training for clinicians. Such measures may empower patients, enhance clinician-patient communication, and mitigate implicit biases, improving healthcare delivery across diverse patient groups.

The burden of inequity

Delays or denials of a total hip replacement extend consequences beyond the individual patient. Carers may need to assume increased responsibilities, mental health sequelae may intensify, and reliance on social-care support frequently escalates. From a health-system perspective, postponed surgery is associated with higher rates of emergency admissions for falls and analgesia-related complications[6]. These outcomes cause greater expenditure in acute and community care settings, thereby offsetting any perceived savings from restrictive referral policies.

Towards integrated, equitable care

Overcoming these entrenched barriers remains a challenge and requires system-level reform:

- Nationally unified referral criteria, replacing local commission-driven thresholds with a flexible, evidence-based framework that empowers clinicians to tailor decisions, would be helpful.
- Peri-operative optimisation services should be embedded within every orthopaedic centre, offering multidisciplinary support for weight management, diabetes control, cardiac and pulmonary assessment, mental health interventions and addiction treatment.
- Cultural and inherent biases among healthcare providers need to be addressed to improve cultural competence and reduce implicit bias, ensuring patient evaluations are equitable and free from unexamined assumptions.
- Accountability through data transparency. Publishing referral, listing and outcome metrics stratified by socioeconomic status, ethnicity and clinical risk profile will illuminate hidden disparities, and promote equality; healthcare systems should aim to develop dedicated pathways for patients with complex needs, ensuring every individual receives a plan designed to minimise both surgical and social harm.

Conclusion

The barriers that impede equitable access to total hip replacement are multifaceted. Rigid treatment thresholds, institutional and surgeon aversion to 'high risk' cases, and the under-examined influence of ethnic and cultural bias collectively undermine the principle of universal healthcare entitlement. The resultant delays in surgical intervention exacerbate patient morbidity, precipitate secondary health complications, and impose increased demands on acute and community-based services. Committing to unified referral standards, integrated optimisation pathways, and transparent auditing may improve access to THR. The British Hip Society and the British Orthopaedic Association remain committed to guiding these endeavours in collaboration with commissioners, primary care, allied health professionals and patient advocacy groups. Professor Sir Michael Marmot's work[7] underscores that health inequalities are avoidable, unjust, and deeply entrenched. We look forward to welcoming him as the Keynote Speaker at the British Hip Society Congress in March 2026. ■

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