

MESSAGE FROM THE PRESIDENT

Value-based care: a South African perspective

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This communication is based on my experience with value-based care programmes for lower limb arthroplasty in South Africa's private healthcare sector since 2018. It gives a glimpse into many hours of meetings with several stakeholders.



Origins

The main impetus for value-based care in South Africa, without a doubt, started with the forced introduction of the programme in 2018 by Discovery Health. At the time, a limited number of hospitals (per hospital group) and a limited number of surgeons (based on volume) were to be included in the programme. The work by Michael Porter and Elizabeth Teisberg (Harvard Business School) and the adoption of the system in the United States fast-tracked the process.¹

It has long been known that higher volume centres achieve better results with primary hip and knee arthroplasty.² What exactly the cut-off in a South African context should be remains debatable. This change in direction of funding prompted several healthcare groups (Life Healthcare and Mediclinic) to start their own programmes. Third party funders like ICPS (Improved Clinical Pathway Services) and JointCare also gained momentum.

Growing pains

It was abundantly clear from the outset that this change in funding model would require a massive mind shift from everybody involved in the industry – none more so than orthopaedic surgeons.

Front and centre in these changes would be the introduction of time pressure on the whole team. No longer was an efficient surgical time enough; now you had to manage, control and take responsibility for everyone's efficiencies.

The establishment of intravenous access, the insertion of a spinal, and the placement of monitoring equipment, all had to take place under time scrutiny, as were positioning, cleaning and draping. Many surgeons moved away from double draping and cemented implants – citing literature – all in an attempt to save time. Skin closure changed, anaesthetists were exchanged for faster ones, and theatre staff selected and fought for.

The question that has yet to be answered is, what constitutes the surgical event? What can be performed outside of the physical operating room, and does it add to the procedure time? Some hospital groups have applied a strict, wheels in-wheels out regimen for this, with disciplinary measures for those who cut corners (i.e. theatre staff). In other operating complexes, the IV lines, spinal and cleaning are done before the clock starts and it is stopped when the skin is closed – hardly a uniform approach.

Next came the administrative burden. Every single item used now had to be scrutinised for cheaper alternatives and weighed on a risk/benefit ratio.³

Drapes, skin closure, cement and medication all fell under scrutiny. The time and cost-savings were all to be added to a surgical fee either on a case-by-case, quarterly or tier level. With this higher efficiency ratio, you could also be considered for inclusion into more beneficial programmes. The ethics of this approach has yet been tested in our legal system.

This ties in with the never-ending chase to get patients out of hospital and directly home. Initially some practices made extensive use of step-down facilities for up to 50% of their patients. This was soon identified and stopped.

It quickly became abundantly clear that the only way to save time and resources was to thoroughly prepare and offer guidance to patients about what was expected prior to their admission (i.e. short hospital stay, and to prepare to have help at home postoperatively). In a larger US study, an average of 141 minutes was spent by the surgeon and nurse practitioners in the pre-operative phase.⁴ This is never directly remunerated and can only be to the surgeons benefit if compensated by earlier discharge and fewer complications.⁵

The dreaded 30-day readmission and 12-month revision (any event) also contributed to the expansion of practice hours and staff to mitigate these risks.^{6,7}

The benefits and perilous future

There is no doubt that the introduction of these programmes has changed lower limb arthroplasty forever. Gone are the four-hour primary replacement and the incidental arthroplasty surgeons. Length of stay has been halved over the past ten years, and surgical time dramatically shortened. The introduction of same-day arthroplasty for selected patients has also shown promise.

I would like to end by asking some questions for the future – not only applicable to lower limb arthroplasty, but also to other evolving models. These are questions that we keep asking from the South African Orthopaedic Association (SAOA) point of view, in an attempt to keep arthroplasty sustainable for surgeons, patients and funders alike.

Should lower limb arthroplasty be the domain of a few? Fifty well-structured practices should be able to manage the current volume of arthroplasties performed in the South African private healthcare sector.

These will have to be high volume, high efficiency, high overhead practices. Can we accept or justify that 5% of surgeons earn 30–40% of orthopaedic payouts from medical aids?

Where will the next generation of arthroplasty surgeons come from? All established arthroplasty surgeons today, without exception, have had extensive exposure to national and international

training, education and surgical visits. Most of this has been paid for by the trade (implant companies). With increasing pressure on the trade due to no or below inflation annual increases, where is the skill and training to come from? The 13 local SAOA-endorsed fellowships (not exclusive to arthroplasty) all rely heavily on the trade for their survival. The biannual arthroplasty congress and annual SAOA congress depend to a great extent on sponsorship from the trade for their continued survival.

I have serious concerns as to the level of cost-cutting we can achieve. There is a physiological limit to the human body's ability to withstand and recover from surgery. There is a financial limit to the ability of implant companies to withstand and recover from continued financial pressure.

Will we also follow the trend of the United States where surgeon remuneration for these procedures has been eroded over the past ten years?^{8,9}

There is and will be a massive shortage of nursing staff in years to come (a topic for another editorial!).

I guess what I am pleading for is a reasonable approach to our unique healthcare setup. We must constantly improve for our patients' sake. We must educate for the sake of our future. We must always care for our humanity's sake.

References

1. Porter ME. Redefining health care: creating value-based competition on results. Boston: Harvard Business School Press. 2006.
2. Bockhorn LN. Increased orthopedic specialization lowers cost and improves outcomes in total joint arthroplasty. *J Arthroplasty*. 2019;34:S76-S79.
3. Krueger CA. The removal of total hip and total knee arthroplasty from the inpatient-only list increases the administrative burden of surgeons and continues to cause confusion. *J Arthroplasty*. 2020;35(10):2772-78.
4. Bernstein JA. The value-based total joint arthroplasty paradox: improved outcomes, decreasing cost, and decreased surgeon reimbursement, are access and quality at risk. *J Arthroplasty*. 2022;37:1216-22.
5. Krueger CA. Substantial preoperative work is unaccounted for in total hip and knee arthroplasty. *J Arthroplasty*. 2020;35:2318-22.
6. Shah RP. Rapid discharge and outpatient total joint arthroplasty introduce a burden of care to the surgeon. *J Arthroplasty*. 2019;34:1307-11.
7. Varacallo MA. Ten-year trends and independent risk factors for unplanned readmission following elective total joint arthroplasty at a large urban academic hospital. *J Arthroplasty*. 2017;32:1739-46.
8. Krueger CA. Projections of the impact to arthroplasty surgeons with changes to the 2021 medicare physician free schedule-a looming crisis of access to care? *J Arthroplasty*. 2021;36:2412-17.
9. Heckmann ND. Medicare cuts to hip and knee arthroplasty surgeon fees in 2021: will access to care be jeopardized? *J Arthroplasty*. 2021;36:791-94. ■