

ADVOCACY IN ORTHOPAEDICS

Advocacy may be as old as the practice of medicine and is an important aspect of health care delivery (1). While many of us may be familiar with advocacy for patients, advocacy for the healthcare provider and the system may not be very common. The changing landscape of medicine worldwide is increasingly broadening the purview of the surgeon from a care giver to include advocacy (2). These changes have made it necessary for the surgeon to engage decision makers, third party payers and the pharmaceutical and implant industry (2). Various medical organizations including the American Medical Association and the American Academy of Orthopaedic Surgeons have recognized and embraced the pivotal role of advocacy (3, 4). Locally, though advocacy does occur, the main medical associations and societies are weak on this aspect. There exists a gap in the organized constructive engagement with various stakeholders. There are various aspects which if tackled through advocacy, will help the orthopaedic surgeon participate in making healthcare better.

Engaging with the national and county governments would be a first step in articulating the voice of the medical professional to key decision makers and may even help resolve the strained industrial relations. Lobbying for changes in policies and laws that make the delivery of quality healthcare a challenge is an important role for the surgeon. A case in point is the taxation of medical equipment and implants in Kenya. In 2013 a change in the Value Added Tax (VAT) act increased the tax on these items from 0 to 16%. This had a direct result in increasing the cost of healthcare by almost a third (5). On the other hand, South East Asia countries especially India were doing the opposite. They reduced taxes and introduced subsidies to make travel, accommodation and healthcare cheaper (6). Their governments also encouraged innovation that has helped to reduce costs and increase efficiency. This has resulted in an unsustainable situation where it is cheaper to perform surgical procedures abroad than in Kenya despite the existence of the skills locally. Advocacy with the national government could easily have prevented this and still offers an opportunity to remedy this.

While medicine and indeed orthopaedics is an expensive endeavor for any government, engagement with third party payers including the National Health Insurance Fund (NHIF), Medical Insurance companies and Non Governmental Organizations (NGOs) in the medical field would help lobby for the badly needed resources and also for better utilization of these to achieve a healthier nation. Orthopaedics is a highly specialized field in medicine and its inner goings on are complex and subject to many misconceptions. The practice of orthopaedics also requires the use of expensive equipment and implants adding to the already misunderstood practice. To educate the public and inform other stakeholders, advocacy is needed. In the papers by Doscche *et al* (7) and Kigera *et al* (8) the authors describe outcomes of Total Hip arthroplasty in the local African setting. This procedure though being useful in reducing morbidity in the patients that need it, it is relatively expensive to perform. This data is extremely useful to decision makers and the orthopaedic fraternity should use this in their advocacy efforts. This information will help determine the burden of disease as well as benefits and risks of the procedure. This will also help to determine the level of funding required to manage the conditions in the various countries.

Most developing countries have been dealing with communicable diseases for most of the last century. The tables are now turning and non communicable and lifestyle diseases are now the leading cause of morbidity in our population. The funding for healthcare has not changed to reflect this new reality. The role of advocacy is huge here. NHIF reimburses between KShs. 40,000 and KShs. 130,000 (US\$400 – 1300) for most surgical cases (9). While this may be adequate for general surgical cases, it is unlikely to be adequate for most orthopaedic surgeries that require implants. Data from the region has consistently informed us that injury of the lower limbs especially fractures of the femur and tibia are the commonest causes of morbidity after road traffic crashes (10). These cases will require implants which will cost about KShs. 40,000 (US\$400) rendering the rebate offered by NHIF inadequate.

The speed of approval of payment is also wanting by the national insurer with approvals taking up to two weeks. While this may not be an issue for elective cases like joint replacements, certain injuries like open fractures require operative management in less than 24 hours. The experts in the field should not assume that the other players in the sector should know these aspects of healthcare nor should they wait to be invited to present this information to stakeholders. We should be proactive and continuously provide this information at every opportunity so as to help make the system better. Lobbying and advocacy must be part of our everyday activities.

Rapid mechanization and urbanization has been implicated as a contributory factor in the large number of Road Traffic Crashes in Africa (11). While there has been some effort towards prevention of these events by increased road policing, the management of the people injured in these events is wanting. When the world hears of 'bodaboda' wards in various parts of Kenya, it is important to remember that the explosion in the use of two wheelers as a preferred mode of transport was partly triggered by a reduction in the tax on motorcycles (12). While this action by treasury was probably informed by certain economic and political realities, it was and still is the duty of the orthopaedic fraternity to inform the economists of the implication of that decision on the health care system. This would have allowed a more measured approach including improving the regulatory framework so as to ensure we do not have a situation where a single condition overwhelms the system and consumes most of the resources allocated to manage surgical conditions. The paper by Nganga *et al* (13) on paediatric long bone fractures highlights the burden of

disease in this vulnerable age group. It also provides an opportunity for advocacy as the common causes of fractures has been reported to be falls in the home and Road Traffic Crashes. This provides an opportunity to lobby the designers and regulators in the construction industry on the need of various changes needed to protect children from injury. It will also provide fodder for changes in regulations as relates to how children use the road transport including school buses. The orthopaedic fraternity should learn from the mistakes of the "bodaboda" roll out and engage the various stakeholders before we have an epidemic on our hands.

The paper by Seyni *et al* (14) reports on the use of allografts in the management of bone tumours. While highlighting the challenges of managing these potentially debilitating ailments, this paper also provides a platform for the advocacy on the need for a bone bank in Kenya. This comes at a time when the Kenya Orthopaedic Association bone bank is in the formative stages and requires a lot of legislative and regulatory support.

Advocacy is clearly an integral part of the healthcare system and orthopaedic surgeons must incorporate this into all aspects of their interaction with other stakeholders. This is an opportunity for the Kenya Orthopaedic Association to form a committee on advocacy in line with the trend in most international associations.

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