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National Osteoarthritis Draft Strategy

Main areas:

Prevention	Ranking
Implement multifaceted programs to prevent obesity and increase physical activity for the prevention of osteoarthritis	1
Adhere to joint injury prevention programs	7
Living well with osteoarthritis	
Support primary care practitioners to deliver best-practice, evidence-based, appropriate care to people with osteoarthritis, including increased prescription of lifestyle interventions	3
Improve the uptake of evidence-based and affordable, tailored, non-surgical care and support for ongoing self-management by all Australians with osteoarthritis	2
Advanced Care	
Optimise decision-making processes leading to total joint replacement surgery and maximise outcomes and satisfaction following total joint replacement surgery for people with severe osteoarthritis	6
Optimise non-surgical management as an alternative, where indicated, or as an adjunct to total joint replacement for people with severe osteoarthritis	4
Improve access to, the efficiency and cost effectiveness of services across healthcare systems for managing people with severe osteoarthritis	5

Painaustralia Limited
ABN 69 147 676 926
P: 02 6232 5588
E: admin@painaustralia.org.au
M: PO Box 9406, DEAKIN ACT 2600
A: Unit 6, 42 Geils Court, DEAKIN ACT 2600

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Are there any outstanding priorities not identified in the draft Strategy that you feel should be included?

As noted in the Draft strategy, osteoarthritis is a leading cause of early retirement: half of those with osteoarthritis aged between 45 and 64 years are currently not in the workforce, twice as many as those without the condition. To ensure that the focus on the whole of person journey is reflective of the lived experience of people with osteoarthritis, the strategy should consider prioritising better support so that People with osteoarthritis are supported to participate in work, education and the community. Pain is often a hallmark of musculoskeletal and osteoarthritis, and carries a is often the underlying symptom that causes early retirement. People living with chronic pain become socially isolated and endure higher levels of financial hardship.

More access to support and coordination of treatment and support has been shown to enable a return to function and/or work such and the strategy should prioritise this as well.

Are there any barriers to implementing the strategies recommended?

Chronic pain conditions such as osteoarthritis and mental health problems, particularly depression, commonly occur together. Major depression in patients with chronic pain is associated with decreased function, poorer treatment response and increased health care costs. High rates of generalised anxiety disorder, posttraumatic stress disorder and substance misuse are also reported in people with chronic pain. In Australia and New Zealand, 40.5% of pain patients captured in ePPOC data in 2016 reported also suffering depression and/or anxiety which correlates with global studies. This needs to be an important consideration when designing and developing implementation plans under the Draft strategy. In taking a biopsychosocial approach to addressing patient need, consideration should be given to using psychological interventions like Cognitive Behavioural Therapy in building pain coping skills for people with osteoarthritis.

Do you have any additional strategies you feel should be included, especially for the area(s) that you have ranked as the most important?

Consumer education and perception of a range of self-management strategies is important, and has been correctly highlighted in the Draft. Targeted communication strategies should also cover quality use of emerging treatments, such as medicinal cannabis for osteoarthritis, that focusses on disseminating TGA guidance and better meets consumer expectations.

Do you have any further comments about the draft National Osteoarthritis Strategy?

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