Beyond BMI:

Removing Harmful Barriers to Joint Replacement Surgery

March 2026 - England briefing

Arthritis UK

Introduction

Over 7 million people in England have osteoarthritis (OA) of the hip or knee.[1,2] Joint replacement surgery is regarded as a clinically and cost-effective treatment for managing advanced OA, and most patients experience a good outcome from surgery.[3] However, we now have evidence that almost a fifth (19%) of Integrated Care Boards (ICBs) in England are rationing joint replacement surgery by disadvantaging patients with a higher Body Mass Index (BMI). A further 54.7% have policies that restrict or alter access to surgery in some other way for those with overweight or obesity. Not only are these policies unfair, but they also contradict National Institute for Care and Excellence (NICE) Guidelines and Government policy.[4,5]

Arthritis UK is calling for all ICBs to stop using these policies and stop rationing surgery based on a person's BMI alone.

Research led by academic Dr Joanna McLaughlin found that many ICBs have implemented policies that delay or deny joint replacement surgery based on a patient's BMI score.[6] In some of these policies, access to surgery is determined by a patient's BMI alone, meaning that people who are living with overweight or obesity may be delayed or denied surgery regardless of their clinical need. These policies fail to recognise the need for individual assessments of the relevance of overweight or obesity ahead of surgery. While BMI may be considered, among other factors, as part of an individualised surgical risk assessment, it should not be the primary consideration for fitness for surgery. Any decision to have or not to have surgery should be reached through shared decision making.

Furthermore, some policies require patients to engage with weight management services before they can be considered eligible for surgery. Arthritis UK is concerned that the impact of these policies is compounded by a lack of weight management services, long waiting lists, and unequal access to services - all of which further reinforces health inequalities.

The clustering[a] of ICBs, from April 2026, provides an important opportunity for ICBs to bring their policies in line with their statutory duties and to improve inequalities in outcomes, access and experience.[7] The use of BMI policies contradicts these duties[8], therefore, newly clustered ICB policies for joint replacement surgery should be based on clinical evidence, prioritise clinical need, and prohibit the use of BMI as a predetermined barrier to surgery.

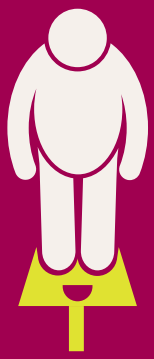
In this policy briefing, we set out the extent to which BMI is being used to ration surgery, the impact of these policies, and what needs to change. Importantly, we come to this from the perspective of those people living with arthritis who have been affected by rationing or weight-based barriers to referral for surgery.

a To achieve a 50% reduction in costs, ICBs have been 'clustered' or joined, although still legally separate Boards. From April 2026, the Government has approved that clustered ICBs in London, East of England and South East regions will be legally merged to create larger and fewer ICBs. Decisions on further ICB mergers will take place in summer 2026. See: ICB clusters and mergers: what you need to know | NHS Confederation

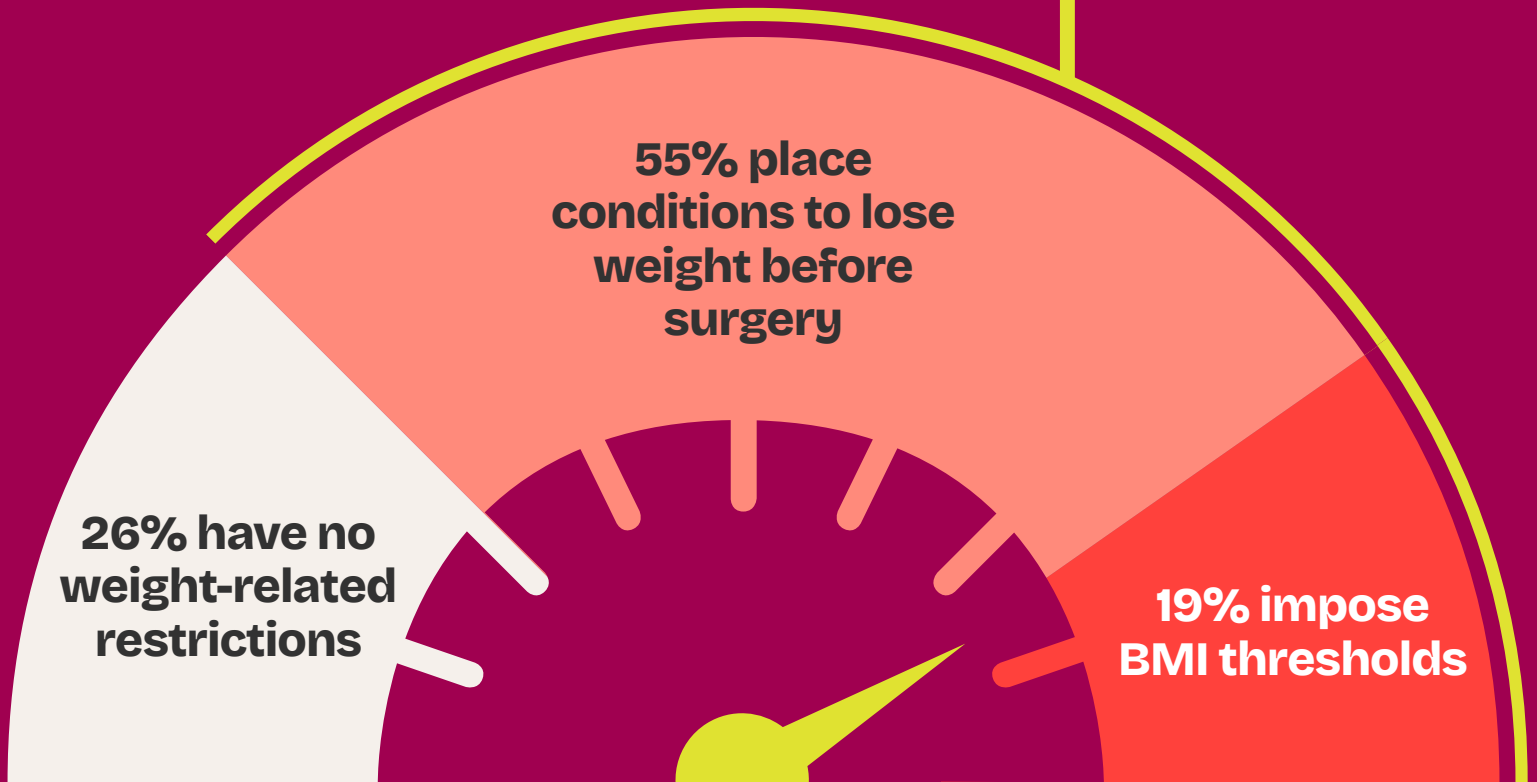
What are ICB policies on BMI?

Research found that 8 ICBs (19%) are rationing hip and knee joint replacement surgery based on BMI, by imposing defined BMI thresholds as criterion for referral to surgery. A further 23 ICBs have policies that encourage or mandate patients to lose weight to become eligible for referral for surgery.[9] These policies are often ambiguous in their requirements, leaving them open to interpretation by individual clinicians and leaving patients without a clear understanding of what is expected of them. This includes a lack of clarity on how weight loss attempts are deemed to be sufficient, and how they must be evidenced.

Only 11 ICBs do not restrict or alter access to joint replacement surgery based on BMI or obesity status.[9] Where ICBs are applying BMI thresholds, there is significant variation on the cut-off point. For example, Lincolnshire ICB will not offer surgery to a patient with a BMI above 35, whereas Leicester, Leicestershire and Rutland ICB will not offer surgery to patients with a BMI above 45 (a difference of about 13kg).[10,11] Access to joint replacement surgery across England is not equitable – access differs depending on whether your ICB has a BMI policy or not, but can also vary in the specific BMI threshold implemented by your ICB.



31 of 42 ICBs[a] have policies that either ration surgery based on BMI or encourage or mandate weight loss to be eligible for surgery.



Why are ICBs using these policies?

ICBs seek to justify the use of BMI policies by citing the increased surgical risk associated with a higher BMI score. Where research evidences only a significant risk in those with a very high BMI for example over 45, it has been inappropriately used to justify policies that enforce a cut off at lower BMIs of for example over 35, affecting many thousands of adults who would have received the significant improvements in their joint pain and function.[12,13] Multiple large scale studies demonstrate that the benefits of surgery outweigh the risks, making surgery cost effective for the vast majority of patients.[14,15]

Moreover, research shows that patients with a higher BMI can still expect significant symptomatic improvement and satisfaction from joint replacement surgery, even though they may not attain the same level of post-operative pain and function scores as someone within a 'healthy' BMI range.[13,16] If a patient's BMI or any additional long-term conditions such as diabetes are likely to cause a significant increase in surgical risk, then the surgical team and patient should discuss the potential risks, benefits, and alternatives. This aids the patient in making an informed shared decision on whether to proceed with surgery, take steps to improve their health or seek alternative treatment. BMI can be used to form part of a wider risk assessment; however, there is no consistent evidence to justify the use of a specific BMI threshold that would reduce the risks associated with surgery.

Weight management is a core treatment for OA as a reduction in bodyweight can have a significant impact on symptoms and slow the deterioration of the joint.[4] Weight loss interventions may reduce or delay the likelihood of joint replacement surgery; however, this is not guaranteed, and many people will still require surgery. People with OA should be informed as early as possible in the elective care pathway about the benefits of maintaining or achieving a healthy weight, and be supported to do so. However, despite the positive impact weight loss can have on the symptoms of OA, this does not justify the use of BMI thresholds as a pre-determined barrier to accessing surgery.

Arthritis UK is concerned that ICBs are implementing BMI policies in a bid to cut waiting lists and costs. The NHS Trauma and Orthopaedic waiting list has consistently been the largest single group of people waiting for treatment and has the highest number of cases.[17]

In 2023, 92% of hip replacements and 98% of knee replacement carried out in England, Wales and Northern Ireland were conducted due to osteoarthritis (OA).[18]

National referral to treatment (RTT) targets have not been met since 2015.[19] The elective reform targets in England of 65% of patients being treated within 18 weeks, and waits longer than 52 weeks reduced below 1% of the total waiting list by March 2026, are expected to be missed.[20,21] Pressure is growing on governments to get a handle on waiting lists, and this is coupled with the 50% cuts in running costs that ICBs are being asked to make.[22]

Decisions must be based on clinical need and informed by a conversation between the surgical team and the patient.

What is the issue with using these policies?

The use of BMI policies is contrary to national clinical guidance. The National Institute of Health and Care Excellence (NICE) guidance for the diagnosis and management of OA states that people with OA should not be excluded from joint replacement surgery because of overweight or obesity based on body measures such as BMI.[4]

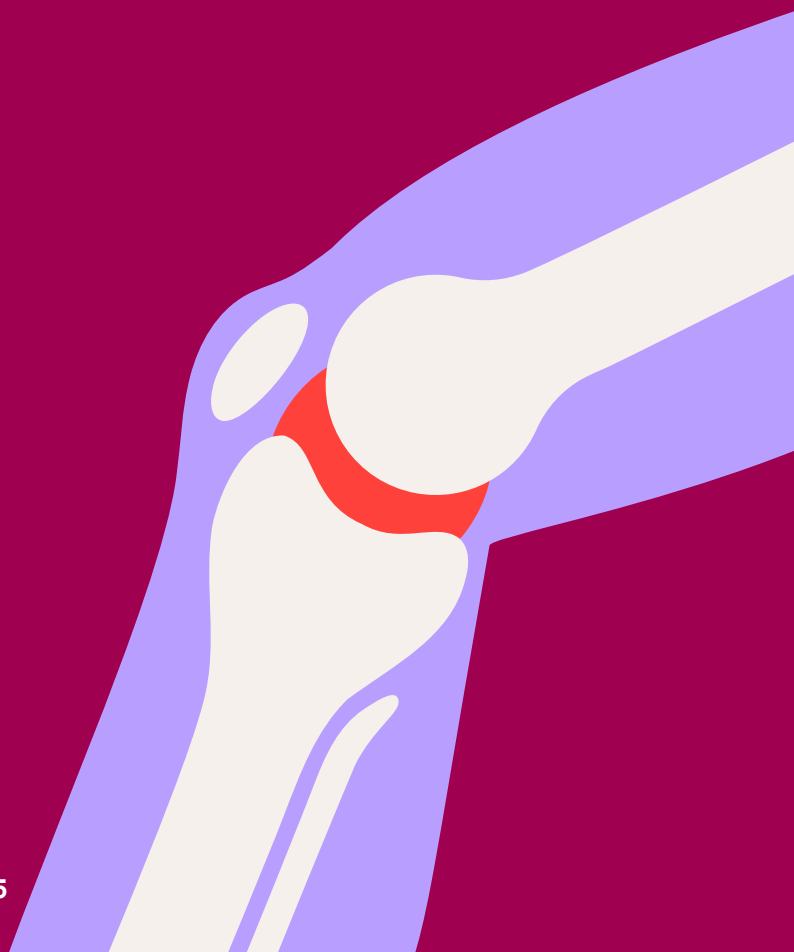
The UK Government has criticised the use of BMI as a barrier to surgery in response to a parliamentary question. Karin Smyth MP, the Minister of State for Health (Secondary Care), stated in October 2025 that:

> **As with all surgery, BMI would be considered as part of a holistic, personalised perioperative evaluation of the risks versus clinical need for joint replacement surgery of an individual patient. However, BMI should not be considered in isolation and in and of itself should not act as a barrier to surgery.[23]**
>
> Karin Smyth MP, Minister of State for Health (Secondary Care)

More widely, alongside Arthritis UK, BMI threshold policies have been publicly criticised by the British Orthopaedic Association (BOA), the Royal College of Surgeons of England (RCS Eng), and the Arthritis and Musculoskeletal Alliance (ARMA), of which Arthritis UK is a member.[24,25]

Most importantly, the use of these policies is negatively impacting people with arthritis.

They lead to people waiting longer than clinically necessary for potentially life-transforming treatment, prolonging pain and discomfort, and risk worsening symptoms for people living with arthritis and overweight or obesity.



Delays in surgery have a significant impact on the individual

These policies should be considered in the context of NHS England (NHSE) waiting times for elective care; there are currently over 840,000 cases waiting for Trauma and Orthopaedic surgery, which includes joint replacement surgery, just over two-fifths (41%) of those cases have been waiting longer than 18 weeks.[17] These waiting times are already unacceptable, and any further delays to treatment can have a significant impact on many aspects of people's lives.

Arthritis UK's *Left Waiting, Left Behind* survey of people with lived experience found that 6 in 10 people (60%) are living in pain most or all of the time due to their arthritis.[26] Delays to treatment can result in prolonged pain and further deterioration of the joint, which can reduce mobility and may result in irreversible damage that earlier surgery could have prevented. Waits of over 6 months for hip and knee replacement surgery have been shown to have a detrimental impact on health-related quality of life and frailty, with two-thirds of patients feeling their health had worsened.[27]

Specifically, BMI threshold policies, which delay surgery, have been associated with worsening symptoms (based on a pre-operative Oxford Hip Score) but we also see increasing obesity in the surgical patient population, as a result.[28] This illustrates that BMI policies not only have a detrimental effect on symptoms, but they are also counter-productive in supporting people to lose weight.

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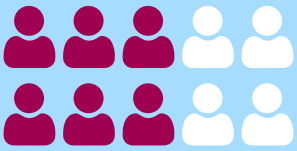


60%

are living in pain most or all of the time due to their arthritis

2 in 3

patients say their health worsened while waiting

It's not as simple as just 'losing weight'

> **Being denied [a] knee operation for being overweight only made things worse because of problems getting around so you end up putting on even more weight**
>
> YouGov survey respondent, man, over 55

We know that increased physical activity can support weight loss. However, from the perspective of someone living with chronic pain and limited mobility, the prospect of undertaking exercise can be daunting or unachievable. In *Left Waiting, Left Behind*, nearly 1 in 2 people reported that their ability to exercise was affected severely or very severely by their arthritis symptoms.[25] Reduced mobility can make it more difficult to maintain a healthy weight, leading to weight gain; this can become a cycle whereby people are denied surgery based on their weight, have difficulty losing weight due to the impact of arthritis on their mobility, resulting in them maintaining or gaining weight that may further delay their surgery.

BMI policies either infer or require that patients lose weight or engage with weight management support to be eligible for joint replacement surgery. Some policies outline patient referral to weight management services; however, the availability and accessibility of weight management services varies greatly across England. This means that patients are being denied access to surgery due to their BMI yet may face limited or no access to weight loss support.

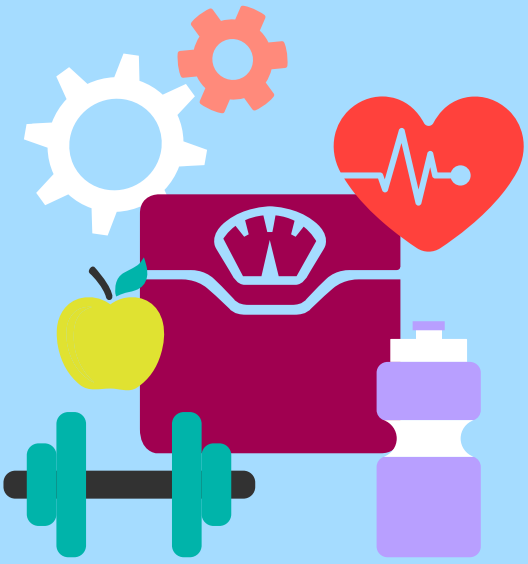
In 2018, the All-Party Parliamentary Group (APPG) on Obesity report found variation in access to obesity services.[29] At the time of the report, 52% of local authorities commissioned a Tier 1 service, 82% commissioned a Tier 2 service, 57% of clinical commissioning groups (CCGs) commissioned a Tier 3 service, and 73% of CCGs commissioned a Tier 4 service.[b] Since the restructure of NHS England from Clinical Commissioning Groups to Integrated Care Boards, no comprehensive review of weight management services has taken place, therefore it is unclear what level of provision is currently available.

b The classifications of weight management services are referred to as Tiers 1 to 4.
Tier 1: universal prevention services, these are typically public health or primary care activities such as health promotion or provision of information regarding overweight or obesity.
Tier 2: behavioural overweight and obesity management services; these include lifestyle or behavioural interventions to support people in changing dietary behaviours and increasing physical activity. These services are often time-limited (typically 12-weeks) community-based interventions funded by local authorities, sometimes delivered by commercial companies (e.g. Slimming World).
Tier 3: specialist clinician-led multidisciplinary interventions designed to support individuals who have not responded to conventional weight management interventions and who are at high risk of, or have already developed, obesity-related complications. These are NHS commissioned services that include dietitians, psychological support and weight-loss medications.
Tier 4: surgical interventions, such as bariatric surgery.

Accessing weight management services

Research conducted in 2024 into the commissioning of Tier 3 weight management services found five ICBs had no Tier 3 provision.[30] Of these five ICBs, four have BMI policies that require weight loss before referral to surgery. North Central London ICB's policy outlines that patients will be required to achieve 'weight reduction' and they will offer 'referral to appropriate services'[31], while Northeast and North Cumbria ICB's policy states that they will only fund surgery if the patient has engaged in at least three months of weight loss interventions[32]. Yet neither of these ICBs commission Tier 3 services, therefore patients are without specialist weight management support.

Where ICBs do commission Tier 3 services, there are often long waiting times for support. For example, Cambridge and Peterborough ICB's BMI policy requires that patients with a BMI above 35 be referred to a commissioned weight management service, such as Healthy You. Healthy You offer Tier 2 and Tier 3 weight management services, however, their Tier 2 service in Peterborough is not currently accepting referrals, and to be eligible for Tier 3 support patients need to have BMI above 40 or BMI 35 with a weight-related condition (OA is not a qualifying weight-related condition).[33,34] Additionally, there is currently a waiting list of six months for Tier 3 weight management services.[33] This means that a person with OA, living in the Cambridge and Peterborough area and who has a BMI above 35, may have their access to joint replacement surgery delayed, and the only NHS weight management support they can access is Tier 1, as Tier 2 services are not currently accepting referrals, and they would be ineligible for Tier 3 support. If their BMI is above 40 and therefore eligible for Tier 3 services, they would face a six-month wait for support. As evidenced above, waits of over six months for hip and knee replacement surgery have been shown to have detrimental impact on health-related quality of life and frailty.



Patients face long waiting times for Trauma and Orthopaedic surgery and weight management services. BMI policies often leave patients with no alternative but to try to lose weight without any support. Most policies do not outline what happens to a patient if they are unable to lose weight. It is unclear whether patients will eventually be referred for surgery, whether a referral depends on increased clinical need caused by further deterioration of the joint while waiting, or whether patients are left in limbo attempting to lose weight.

Delays in surgery affect all aspects of a person's life

> **I have felt a little isolated. Financial impact - not being eligible for financial support. Weight gain due to physical limitations.**
>
> YouGov survey respondent, woman, over 55

While waiting for joint replacement surgery, people are forced to put parts of their life on hold. One in five (18%) of 50- to 65-year-olds in Great Britain who have not returned to the workplace following the pandemic said they were currently on an NHS waiting list for medical treatment.[35] In *Left Waiting, Left Behind*[25]:

- **68%** of respondents said that waiting for treatment had impacted their ability to work.
- **61%** said it affected their ability to perform caring responsibilities.
- **66%** said it impacted their mental health.
- **73%** said waiting for treatment impacted their social activities.

Being out of work or on sick leave can cause significant emotional and financial distress due to reduced income and uncertainty of the future, while having to put aspects of your life on hold can take a significant toll on your mental health. The impact of waiting for treatment is already significant, without the additional barrier of surgery being delayed further due to overweight or obesity.

> **[I was] very concerned to be told that I was not bad enough to go on the waiting list: I already could no longer walk down the street. Discrimination on account of my BMI. The surgeon I eventually saw privately said he did not use BMI as he considered it to be old fashioned. When will the NHS catch up with this?**
>
> *Left Waiting, Left Behind* survey respondent, woman, aged 65 to 74

BMI thresholds for surgery compound health inequalities

Deprivation is linked to an increased prevalence of obesity. Engaging in physical activity and eating healthier diets can require time or money that those on lower incomes cannot afford. In the most deprived neighbourhoods in England, 37.4% of adults have obesity compared to 19.8% in the least deprived.[36] Obesity is also a modifiable risk factor in developing OA. In deprived areas there is an increased prevalence of OA; the increased prevalence of obesity in these areas accounts for 50% extra risk for knee OA.[37]

Areas with the highest levels of deprivation have the most limited access to Tier 3 weight management services.[30] For example, Black Country ICB is the second most deprived ICB in England.[38] The proportion of adults in the Black Country who have overweight or obesity is 5% higher than across England (69% and 64% respectively).[39] Black Country ICB operates a BMI policy that denies access to surgery if

a patient's BMI is above 40, and in April 2024 there was a 12-month wait for a Tier 3 weight management service commissioned by Black Country ICB.[40] This highlights that people living in deprived areas are statistically more likely to be living with overweight or obesity, are at greater risk of developing OA, and have the least access to weight management services. Adding BMI threshold policies on top of that compounds health inequalities.

Access to joint replacement surgery is also a postcode lottery, as access differs according to where you live. For example, if you live in Sussex, the local ICB has a policy that states if your BMI is above 40 you would not be listed for hip replacement surgery. However, if you live in the bordering ICBs of Kent and Medway or Surrey Heartlands, your BMI would not be used as eligibility criteria for joint replacement surgery.

A further consequence of BMI policies is the fact they reinforce a two-tiered healthcare system, as some people may be able to afford alternative ways to access treatment. Weight loss injections are available through GP prescription to a limited group of people, or more widely through private providers.[41,c] Weight management medicines can result in rapid and significant weight loss, making them a potentially attractive solution to someone who has been denied access to surgery due to their BMI. Private provision of weight management medicines worsens health inequalities because only people with sufficient means can access them and benefit from weight loss that may make them eligible for joint replacement surgery.

Similarly, preventing people from accessing surgery based on their weight can result in some paying privately to have the operation. However, not everyone is able to do this, and we know that people living in more deprived areas are more likely to have OA and obesity, thus creating a risk of inequity.[42] As both routes are only available to people who can afford the cost of treatment, this creates further barriers to treatment for those who are unable to pay for treatment privately.

BMI policies have a significant detrimental impact on those they affect and risk causing further inequity in the healthcare system.

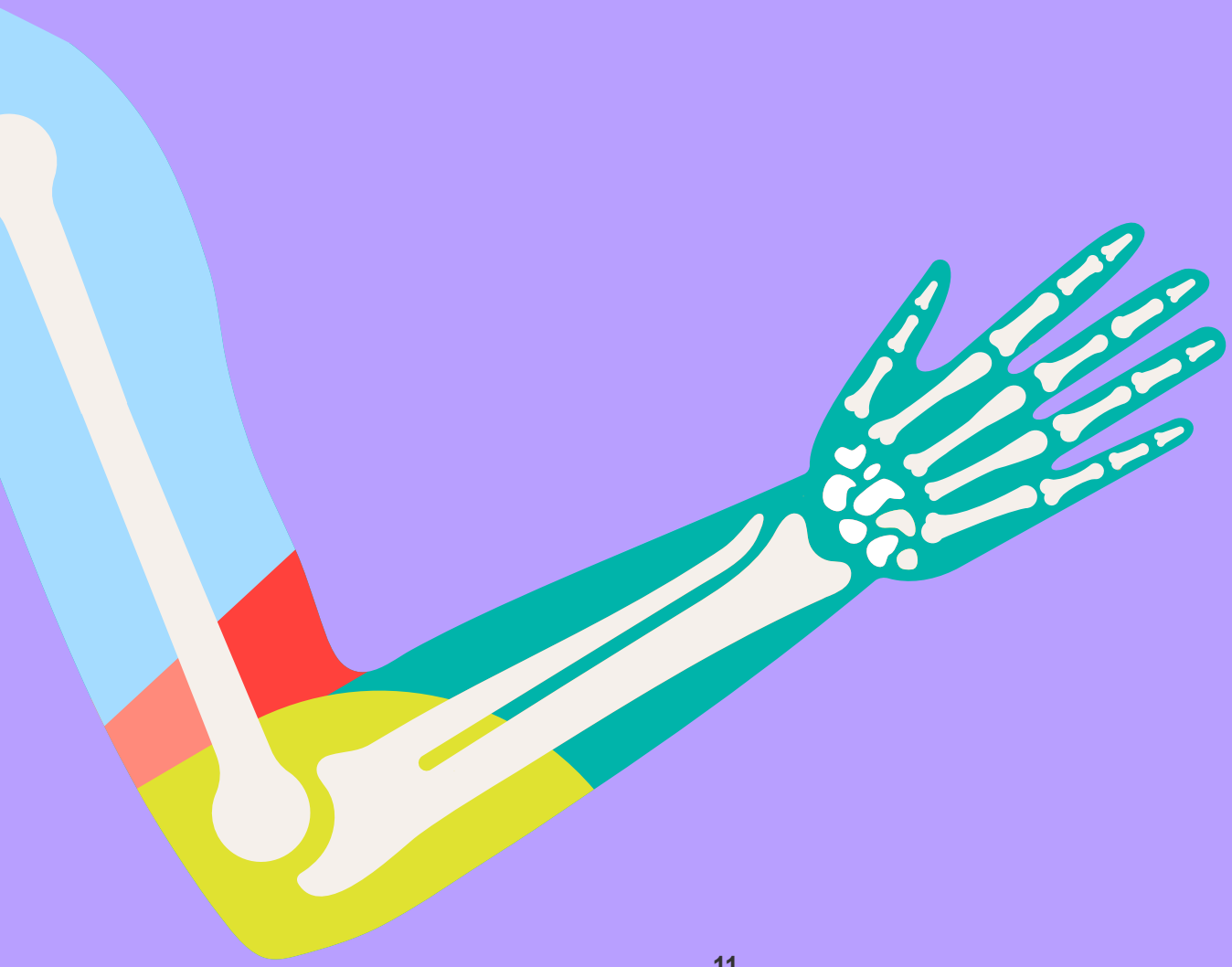
c There is not currently enough evidence to know the effects of weight loss injections on arthritis and MSK conditions, or how they interact with existing treatments for arthritis and MSK. Arthritis UK recommends that anyone using, or considering using, weight loss medications, does so with the knowledge and support of their medical practitioner. It is important not to take these medications without medical advice as they have side effects and risks. These medications should only be used under clinical supervision and form part of personalised care and support, which includes lifestyle changes such as a healthy diet and appropriate physical activity.

What needs to change?

This briefing demonstrates the injustices of using BMI thresholds as a criterion for joint replacement surgery.

There is a danger that ICBs, who are under pressure to cut costs, implement policies that leave patients in prolonged pain, exacerbate health inequalities, and stop people from living the life they choose. It is a means of inappropriately rationing surgery. Access to joint replacement surgery should be based on clinical need, as per the NICE guidelines and government policy.

This is why Arthritis UK calls on ICBs to scrap these policies and stop rationing surgery based on a person's BMI alone.



Arthritis UK makes the following recommendations:

- BMI policies where thresholds are applied as eligibility criterion should not be used to ration access to joint replacement surgery. **Access to surgery should be based on individual clinical need and ICBs' policies must be updated to reflect this.**
- ICBs should **ensure that surgical access policies are clearly worded** to alleviate any ambiguity for patients or clinicians over expectations of health optimisation.
- ICBs should **adhere to NICE osteoarthritis guidelines**.[4]
- **ICBs should ensure adherence to NHSE early screening, triaging, risk assessment and health optimisation in perioperative pathways guidance.**[43]
- **The Secretary of State for Health and Social Care must ensure that ICB commissioning policies adhere to their duty** of reducing inequality of access under the NHS Act 2006, and as amended by the Health and Care Act 2022.
- The Department of Health and Social Care should **ensure that any efforts to reduce waiting lists are not achieved through policies that contravene clinical evidence or to the detriment of patients' wellbeing**.
- ICBs and local authorities should ensure, through long-term ringfenced funding, that **appropriate weight management services and interventions for people with arthritis and MSK conditions are commissioned, available, accessible and integrated**.
- Healthcare professionals should offer weight management support from the onset of joint symptoms and continue after surgical intervention; **weight management support should not be offered solely for the purpose of surgery.**

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