Toward Better Clinical Management of Obesity in Australia

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Toward Better Clinical Management of Obesity

1. The prevalence of obesity in Australia
2. The case for Physician management of obesity
3. The growth in Surgical management of obesity
4. Take home messages and voting instructions
1. Prevalence of Obesity in Australia

- BMI is a very useful measure for population analysis.
- BMI is a somewhat useful measure, with others, for clinical analysis.
- More men are overweight than women (BMI>25).
- Men and women have the same rate of obesity (BMI>30).
- More men than women have Class I Obesity (BMI 30-35).
- But more women than men have Class II Obesity (BMI 35-40).
- *Twice* as many women than men have Class III Obesity (BMI>40).
Distribution of Australian Adult BMI by Gender

ABS NHS 2014-15

Distribution of Australian Adult BMI by Gender ABS NHS 2014-15
## Distribution of Adult BMI by Gender

Source: ABS National Health Survey 2014-15 Data Cube Table 8

<table>
<thead>
<tr>
<th>BMI</th>
<th>Male%</th>
<th>Female%</th>
<th>Total%</th>
<th>Male '000</th>
<th>Female '000</th>
<th>Total '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>2.9</td>
<td>7.6</td>
<td>5.2</td>
<td>246.9</td>
<td>687.9</td>
<td>931</td>
</tr>
<tr>
<td>20-24.9</td>
<td>26.5</td>
<td>36.1</td>
<td>31.4</td>
<td>2309.6</td>
<td>3255.3</td>
<td>5567.4</td>
</tr>
<tr>
<td>25-29.9</td>
<td>42.4</td>
<td>28.8</td>
<td>35.5</td>
<td>3694.9</td>
<td>2593.9</td>
<td>6297.1</td>
</tr>
<tr>
<td>30-34.9</td>
<td>20.1</td>
<td>16.6</td>
<td>18.3</td>
<td>1757.1</td>
<td>1492.6</td>
<td>3251</td>
</tr>
<tr>
<td>35-39.9</td>
<td>6.1</td>
<td>6.6</td>
<td>6.3</td>
<td>530.7</td>
<td>595.4</td>
<td>1119.9</td>
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<tr>
<td>&gt;40</td>
<td>2.1</td>
<td>4.2</td>
<td>3.2</td>
<td>185.6</td>
<td>382.6</td>
<td>571.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>8724.3</td>
<td>9006.6</td>
<td>17733.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BMI</th>
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<th>Female '000</th>
<th>Total '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean BMI</td>
<td>27.8kg/m2</td>
<td>27.2kg/m2</td>
<td>27.5kg/m2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median BMI</td>
<td>27.1kg/m2</td>
<td>26kg/m2</td>
<td>26.6kg/m2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese BMI&gt;30</td>
<td>28.40%</td>
<td>27.40%</td>
<td>27.90%</td>
<td>2474.3</td>
<td>2466.1</td>
<td>4943.9</td>
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</tbody>
</table>
2. The context for
Specialist medical management of Obesity

• Prevention of obesity should be a major priority for the Commonwealth and the states, through known effective methods and by researching additional control methods.

• Australian Algorithm for the management of obesity supports specialist medical management for Class III obesity with complications.

• Knowledge base, therapeutics and the approach to treatment are developing rapidly.

• Leadership is required, both of the therapeutic effort and in the wider health system.
Support for prevention measures is high

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>96%</td>
<td>Support ACT Government to ensure school canteens offer a wide range of healthy food and drinks</td>
</tr>
<tr>
<td>90%</td>
<td>Support limiting the sale of unhealthy food and drinks in school canteens</td>
</tr>
<tr>
<td>95%</td>
<td>Support the promotion of active transport for children, such as riding or walking to school</td>
</tr>
<tr>
<td>94%</td>
<td>Support the promotion of physical activity in workplaces</td>
</tr>
<tr>
<td>93%</td>
<td>Support increasing healthy food and drink options in workplaces</td>
</tr>
<tr>
<td>88%</td>
<td>Support restricting advertising of unhealthy food, especially around child-oriented places</td>
</tr>
<tr>
<td>87%</td>
<td>Support reducing the amount of unhealthy food advertised and displayed around supermarket checkouts</td>
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</tbody>
</table>
Australian Algorithm for the Management of Obesity (ADS, ANZOS, OSSANZ 2016)
Management of Class III Obesity must be about more than weight loss

• Weight loss is a worthy gain, but we must be realistic about the effectiveness of our current strategies.
• The idea of a set point for weight, and of the factors that do or don’t influence the set point, is a strong guiding idea. Can it be changed?
• The vicious cycles between co-morbidities and obesity drive weight gain.
• Virtuous cycles between self-managed dietary and physical activity changes drive weight stabilisation and improvement in risk profiles.
• Understanding and coordinating care for co-morbidities also drives the virtuous cycles and reduce the risks associated with obesity.
ACT OMS (BMI>40) Co-Morbidities

- The first 50 patients had **303** comorbidities between them
- Mean 6.1 per patient, Range 1 to 21

![Bar chart showing the distribution of comorbidities]
Specialist Medical Management of Obesity: More than ‘Lifestyle’

• Ensure medical coordination and optimised management of obesity related medical problems (hypertension, dyslipidaemia, BSL, CKD, OSA, musculoskeletal and respiratory problems, depression...).

• Collaboration with dietitians for healthy diets and low energy diets where appropriate.

• Collaboration with exercise physiologists/physical trainers.

• Prescription of appropriate pharmacologic therapy for weight loss or weight-loss maintenance.

• Medical leadership and coordination of multidisciplinary team (eg through MDT meetings, care planning) and therapeutic groups.
Toward ethical leadership in Obesity Management

• Many professionals think that obesity is due to lazyness and greed.
• While medical moralising was common in the 19th century, it is now quite rare, with some notable exceptions including STDs and addictions.
• It is counterintuitive to take a moralistic approach to disease.
• This is an important observation. How are we to understand it?
  • It may be an expression of stigma, of frustration with the lack of effective therapy, and of the doctor’s need for authority
  • But it is counter-therapeutic: reinforces stigma, undermines the therapeutic relationship, reduces medical authority
• Telling doctors not to be moralistic appears to be no more effective than the moral instruction to lose weight.
• Perhaps moralising can be displaced with different ways of thinking, and knowledge of rational effective practice
Shame is not a therapeutic modality
Will-power cannot be prescribed

• The power of the will is quite limited

• As Spinoza said in his critique of free will, the exercise of our will is rarely solely determined by our free thought.

• Dietary and physical activity patterns could have been excellent illustrations for his demonstration of that ‘free will’ is largely illusory.

• His point was that only where there was reasoned understanding could we exercise our imagination and freely decide what to do.

• In this view, freedom is something acquired by investigation of the constraints, by dispassionate reasoning, and thereby build our understanding of the degrees of freedom
3. Bariatric Surgery Services in Australia

• Growth in procedure numbers
• Public – Private distribution
• Differential growth in procedure types
Bariatric Surgery numbers in Australia 2014/15

• In 2014/15 the AIHW reports there were 17,945 bariatric procedures (excluding band adjustment and revisions) across all hospitals in Australia.
• This was an increase of 7% over the previous year.
• Laparoscopic sleeve gastrectomy, the most common procedure, accounted for 69% of the total, with growth of 19% from 2013/14.
• Laparoscopic Adjustable Gastric Banding was the next most common, accounted for 20% of the total, with a reduction of 26% from 2013/14.
• In 2014/15, Medicare Australia reports there were 15,359 bariatric procedures claimed on the MBS (ie private patients), 86% of the AIHW total, up from 78% in 2013/14.
• Cf 2/3 of all elective surgery in Australia is done in the private hospitals.
MBS Bariatric Surgery in Australia

MBS items 31569(Band), 31572(RenY), 31575(Sleeve)
4. Take Home Messages

• 2/3 of the 600,000 Australians with Class III Obesity are women

• The Australian algorithm for Obesity Management calls for specialist medical management of Class III Obesity with complications

• Ethical leadership of people centred obesity management involves care coordination, multidisciplinary teamwork and an understanding of stigma

• Weight is not a behavioural risk factor; invoking shame is not a therapeutic strategy.

• Bariatric surgery is becoming more popular, but access for public patients is poor
ACT Obesity Management Service Outcomes

Vote 1 for Dr Kojima’s poster