Preparing for the Tidal Wave

Publicly Funded Bariatric Surgery

DDHHS’ Response to the Obesity Epidemic

Dr. Peter Gillies
Acting Health Service Chief Executive
Rates of Obesity have skyrocketed

People with a BMI >35 have twice the risk of death at any age when compared to people who have a BMI within the normal range.


“Obesity is now overtaking tobacco as the largest preventable cause of disease in Australia”.

(Australian Chronic Disease Prevention Alliance, 2010)

Five out of 10 of Australia’s unhealthiest regions are in Queensland.
237 patients older than 50, on the waiting list for possible TJR of the hip or knee.

63% had a BMI greater than 30

16% had a BMI greater than 40
Patients with a BMI greater than 40 are generally not considered suitable for joint replacement surgery at Toowoomba Hospital.

At any one time there are up to 40 patients on the waiting list whose weight alone precludes them from joint replacement surgery.

It also does not include those patients who have already been seen in an Orthopaedic clinic & who have been advised they are not suitable for joint replacement surgery because of their weight.
Mrs S 56 Y.O. Female patient:

<table>
<thead>
<tr>
<th>Date</th>
<th>Intervention</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>18/04/2008</td>
<td>First Orthopaedic appointment. 48 y.o.</td>
<td>Warrants TKR but too young for surgery. Review in 12 months</td>
</tr>
<tr>
<td>20/03/09</td>
<td>Orthopaedic review. BMI recorded as 35 – weight would be 80.85 kg</td>
<td>Continue conservative treatment and review 6 months</td>
</tr>
<tr>
<td>25/09/09</td>
<td>Has gained 10 kg</td>
<td>Review 12 months</td>
</tr>
<tr>
<td>27/10/10</td>
<td>No change in symptoms</td>
<td>Review 12 months</td>
</tr>
<tr>
<td>26/08/2011</td>
<td>Orthopaedic review. Weight recorded as 107 kg</td>
<td>Continue conservative treatment, review 12 months</td>
</tr>
<tr>
<td>28/11/12</td>
<td>Orthopaedic review. No change noted</td>
<td>Continue conservative treatment, review 12 months</td>
</tr>
<tr>
<td>26/02/14</td>
<td>Further GP referral – severe knee osteoarthritis</td>
<td>Review appointment arranged</td>
</tr>
<tr>
<td>7/05/14</td>
<td>Morbid obesity noted</td>
<td>Advised needs to lose weight, review in 12 months</td>
</tr>
<tr>
<td>6/05/15</td>
<td>Orthopaedic review. Weight 137.4, BMI 59</td>
<td>Would require significant weight loss before TKR could be considered.</td>
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It has been identified that a number of obese patients are returning to Orthopaedic OPD for regular review with a diagnosis of hip or knee osteoarthritis where joint replacement would be appropriate.

Each visit, they are advised that surgery is not feasible because of their obesity and they are given advice to continue conservative management, try and lose weight and surgery may be offered when they achieve a certain weight.

Unfortunately most of these patients have actually gained more weight when they return for review so they are given the same advice and a further review appointment made.

The clinicians are frustrated at not being able to offer these patients a more useful service, and the patients are frustrated feeling the hospital is not addressing their needs.
Clinical Benefits of Bariatric Surgery

“For patients with BMI 30-35 who do not achieve substantial and durable weight and co-morbidity improvement with non-surgical methods, **bariatric surgery should be an available option for suitable individuals**”. (American Society for Metabolic and Bariatric Surgery (ASMBS) Clinical Issues Committee, 2013)

“**Bariatric surgery, when indicated, should be included as part of an overall clinical pathway for adult weight management that is delivered by a multidisciplinary team (including surgeons, dietitians, nurses, psychologists and physicians) and includes planning for continuing follow-up**”. (NHMRC (2013) Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children)


Australian guidelines quote **weight loss figures of between 16-43%** (varying between 22 and 63 kilograms) for morbidly obese adults following bariatric surgery, claiming that these are “reasonably well maintained over three to eight years” (Australian Government, 2003, p. 168).

One trial showed Type 2 diabetes **remission rates of 75-95%** within 2 years following surgery (Mingrone et al, 2012)

“The co-morbidities of severe obesity affect all the major organ systems of the body. Surgically induced weight loss will **substantially improve or reverse the vast majority of these adverse effects from severe obesity.”** American Association of Clinical Endocrinologists (AACE) July 2011: AACE Task Force on Obesity

There is evidence to suggest that no other currently available therapies are as effective as surgical management in achieving weight loss and improving obesity-related diseases in morbidly obese individuals...Surgical interventions for morbid obesity carry some risk, but these are significantly less than the health risks associated with morbid obesity” (State Government of Victoria, 2009)
A study comparing the Australian lifetime costs and quality-adjusted life-years found that the mean number of years in diabetes remission over a lifetime was **11.4 for surgical therapy** patients and **2.1 for conventional therapy** patients.

Relative to conventional therapy, surgically induced weight loss was associated with a mean health care saving of AUD$ 2,400 and 1.2 additional QALYs per patient (Keating et al, 2009).
But there is a marked inequality in access to Bariatric Surgery
In 2007–08, over 90% of separations for weight loss surgery in Australia were in private hospitals, with private health insurance funding 82% of separations (Royal Australasian College of Surgeons, 2015a).

Currently the only public bariatric surgery service in Queensland is at the Royal Brisbane and Women’s Hospital.
Inequality in Bariatric Surgery Recipients

Bariatric Surgery Rates in Relation to Household Income

Bariatric Surgery Rates in Relation to Education

“RACS recommends **equity of access** to weight loss surgery by **publicly funding** bariatric surgery, including support from a team of expert clinicians for patients that meet appropriate clinical guidelines”.

(Royal Australasian College of Surgeons Recommendations, 2015)

Perception appears to be that if patients don’t pay for Bariatric Surgery they will lack motivation leading to less successful outcomes.

And that offering this service publicly will “open the floodgates”
Sydney and South Western Sydney Local Health Districts Pilot Study (Oct 2009)

“Our findings parallel similar studies suggesting that **there is equal benefit in publicly funded and privately performed procedures.** This study highlights that obese patients reliant on public health care maintain sufficient intrinsic motivation in the absence of payment and supposed value-driven incentive. Improved access to bariatric surgery in the public sector can justifiably reduce the health inequities for those most in need”.

Publicly funded patients pilot: Patient weight change over time after bariatric surgery

SOURCE: Lukas et al (2014, p.221)
Toowoomba Hospital is planning to undertake a small prospective trial where obese osteoarthritic patients on the waiting list for a joint replacement are randomised into a conservative management group or a bariatric surgery group.
Pre and Post Surgery Support team through private Allied Health providers

- Psychologist
- Exercise Physiologist
- Dietitian
- DDHHS Endocrinologist
- Home monitoring support available
- Face-to-face, group and phone support available

“Overweight” is defined as a Body mass Index (BMI) equal to or more than 25, and a BMI of 30kg/m² or above denotes “obesity”. (WHO, 2000)
A bariatric surgery service could be offered in a limited number of Centres of Excellence.

It could be a limited access service. I.e. requiring referral by a specialist of a patient already on an existing waiting list.
“Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek”.

Barack Obama