Chapter 9

Health care interventions

9.1 Health interventions are essential for treating those already living with obesity. As described by Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services at The Children's Hospital at Westmead, 'you need prevention and you need clinical intervention for those that are affected'.[1]

9.2 Prevention programs and early clinical and allied health interventions to reduce the prevalence of childhood obesity are also important. Indeed, the World Health Organisation (WHO) pointed out that without intervention, obese infants and young children will likely continue to be obese during childhood, adolescence and adulthood.[2]

9.3 Health practitioners play a significant role in identifying, supporting and treating people who are overweight and obese. However, issues around access, availability, appropriateness and affordability of treatments are impeding the delivery of effective health interventions.

Interventions aimed at preventing childhood obesity

9.4 To mitigate the negative influences facing children, many submitters stressed the importance of prevention programs, early interventions and providing guidance to parents as obesity is completely preventable in early life.[3]

9.5 In terms of actions to prevent both childhood obesity itself, as well as interventions to prevent associated health issues, Dr Alexander cited clinical and allied health interventions known to be effective:

> Interventions using family-centred behavioural change in diet and activity have been shown to be effective…
>
> We recommend, amongst other things, that all states and territories provide dedicated training for health professionals as well as services to clinically manage childhood obesity. At a federal level, we would recommend a review of Medicare rebates associated with accredited allied health professional consultations for children with obesity to encourage and enable

1 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 3.

2 World Health Organisation, 'Commission on Ending Childhood Obesity', http://www.who.int/end-childhood-obesity/facts/en/, accessed 22 November 2018.

3 See for example: Dr Seema Mihrshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 1; The Boden Institute, University of Sydney, *Submission 130*, p. 3; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

> greater support in healthcare intervention, including an increased number of sessions for families of children and adolescents with obesity. [4]

9.6 Professor Anna Peeters from the Global Obesity Centre at Deakin University (GLOBE) discussed the integrated approach adopted in Amsterdam, and its success in reducing the prevalence of childhood obesity:

> In essence, what they've done in Amsterdam—and they've seen a three percentage point drop in childhood obesity over the last four years, so you do need a long time frame—is they've had quite a concentrated effort in schools around nutrition, activity and standards around the schools, but then also around the cities—things like removing unhealthy food and drink advertising from public transport, and sponsorship of sports. So they've done quite a wide range of things across the city, but they've made really intensive efforts in schools.[5]

9.7 Ms Alexandra Jones from The George Institute emphasised the need for a whole-of-government approach to addressing the problem, pointing to the experience in New South Wales:

> New South Wales have a Premier's priority on childhood obesity, and they've recognised that this can't just be the responsibility of the health ministry. A lot of these policies engage with transport, education and a whole range of things. So having a task force or a body at a national level that could coordinate action is absolutely necessary, and we can't just leave it up to the health department.[6]

9.8 Similarly, the ACT government suggested that, to be effective, a national framework would need to be coordinated across all levels of government and across diverse portfolios. It also stressed the importance of considering the social determinants of health:

> ln addition, it is important to consider social determinants of health as key factors, along with physical activity, active travel, consideration of the structure of workplaces in terms of work/life balance and the role urban design plays in creating and maintaining accessible public spaces and natural environments to support healthy connected communities.[7]

9.9 The Menzies School of Health Research highlighted the importance of a cohesive strategy to tackle obesity, starting in pregnancy and continuing throughout a person's life:

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4 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

5 Professor Anna Peeters, Associate Director, Global Obesity Centre, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

6 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24.

7 ACT Government, *Submission 87*, p. 3.

> First, effective policies are needed across the life span, from maternal health to infancy, childhood and youth and through to adulthood. Children are an integral part of families, and their diets are formed and influenced by family behaviours.[8]

9.10 Professor Steve Allender from GLOBE emphasised the need for comprehensive data and an evidence base to assess whether specific interventions are successful:

> What we also need to discuss with you is Australia's obesity evidence base or, in fact, the lack of an evidence base. There is a need for rigorous monitoring of childhood obesity, using a legislated opt-out consent approach, to give us meaningful and timely data.[9]

First 1000 days

9.11 There is strong evidence that the first 1000 days of life—from conception to age two—is a critical period influencing the likelihood of obesity in infancy, childhood and late in life.[10]

9.12 The focus on maternal and early childhood, running through a person's life course, was expanded on by Professor Susan Sawyer from the Royal Children's Hospital in Melbourne. Professor Sawyer discussed the concept of the first 1000 days of a person's life, and went further to look at it in terms of the first 1000 weeks:

> [T]hat life course perspective tells us that the most effective interventions are going to be those that take place during what we would refer to as the developmental years of zero to 24—that is the notion of the first 1,000 days from preconception—and that it continues through. Many of us are referring to the importance of the first 1,000 weeks and not just the first 1,000 days.[11]

9.13 Professor Peter Davies, Chairperson of The Early Life Nutrition Coalition, explained to the committee that there are five key elements in the 1000 days, which have a profound effect on the chances of a child becoming overweight and obese:

- high pregnancy body mass index in the mother;
- inappropriate maternal weight gain;
- an increased birth weight;

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8 Dr Frances Cunningham, Senior Research Fellow, Menzies School of Health Research, *Committee Hansard*, Sydney, 6 August 2018, p. 40.

9 Professor Steve Allender, Director, Global Obesity Centre, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

10 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Queensland Nurses and Midwives Union, *Submission 55*, p. 5; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 15.

11 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital, Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

- rapid growth during infancy; and
- prenatal tobacco exposure.[12]

9.14 A recent study found that infants experiencing rapid weight gain between birth and two years had nearly four times greater odds of being overweight or obese later in life.[13]

Preconception and pregnancy risk factors

9.15 The committee heard that maternal weight prior to and during pregnancy is important in terms of the future child health outcomes and weight.[14]

9.16 Professor Jacqueline Boyle from the Monash Centre for Health Research and Implementation explained that maternal obesity affects oocytes, early embryo development, and a baby's weight.[15]

9.17 Professor Sawyer pointed out that the issue of preconception weight is relevant for both parents as evidence would suggest that there are also male epigenetic factors in terms of sperm in relationship to obesity.[16]

9.18 The Boden Institute at the University of Sydney stressed the importance of monitoring and managing appropriate gestational weight gain as part of antenatal care.[17]

Early life nutrition

9.19 There is a growing body of evidence linking the nutritional environment in early life to an increased risk of obesity.[18]

9.20 The *Australian Dietary Guidelines* (ADG) recommend that children receive breast milk, and where that is not possible, suitable formula, until 12 months of age. The ADG also state that children do not require formula beyond 12 months of age.[19]

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12 Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

13 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3.

14 See for example: Professor Susan Sawyer, Director, Centre for Adolescent Health, Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 16; Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 27.

15 Professor Jacqueline Boyle, Deputy Director and Obstetrician, Monash Centre for Health Research and Implementation, *Committee Hansard*, Melbourne, 7 August 2018, p. 15.

16 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

17 The Boden Institute, University of Sydney, *Submission 130*, p. 3.

18 See for example: The Early Life Nutrition Coalition, *Submission 2*, p. 1; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Public Health Association of Australia, *Submission 73*, p. 7.

9.21 Professor Sawyer stressed the importance of breastfeeding:

> All the evidence is that, long-term, any breastfeeding is beneficial and protective against overweight and obesity in children.[20]

9.22 However, although 96 per cent of women start breastfeeding, there is a rapid decline in breastfeeding rates with each month after birth. The proportion of infants receiving any breastmilk in the age group seven to 12 months drops to 42 per cent.[21]

9.23 Professor Sawyer outlined other factors such as socioeconomic trends in breastfeeding, which can impact the weight and overall health of both mothers and children:

> [T]he importance of promoting breastfeeding, for example, as one of those elements that is healthiest for the infant and also healthiest for the mother in terms of reducing rates of overweight. Yet we know that we see socioeconomic trends in terms of rates of breastfeeding. [22]

Infant food products

9.24 Research undertaken by the Centre for Research Excellence in the Early Prevention of Obesity in Childhood (CREEPOC) shows compliance with the infant feeding guidelines from the ADG is low.[23]

9.25 Indeed, the early introduction of solids and inappropriate infant formula feeding practices are significantly increasing the likelihood of obesity in infancy and childhood.[24]

9.26 For example, Professor Elizabeth Denney-Wilson described to the committee how inappropriate use of formula can lead to overfeeding babies:

> Now what we see is people over concentrating infant formula, which gives babies more calories, in the belief that might help babies to sleep a bit better.[25]

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19 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 7.

20 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

21 Breastfeeding Coalition Tasmania, *Submission 102*, p. 3.

22 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital, Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

23 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 5.

24 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Breastfeeding Coalition Tasmania, *Submission 102*, p. 3; Institute for Physical Activity and Nutrition, Deakin University, *Submission 46*, p. 4.

25 Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.

9.27 Food companies have developed a range of products aimed at young children, including toddler formula, junior milks and infant foods, which undermine optimal infant and young child feeding.[26]

9.28 These infant foods are heavily promoted by food companies and often contain a lot of sugar and unnecessary ingredients.[27]

9.29 CREEPOC pointed out that the use of concentrated juices and trans-fats in ready to eat foods for infants and young children greatly contribute to poor diets and obesity in young Australian children.[28]

Recommended initiatives and programs

9.30 Inquiry participants recommended the development of programs and campaigns to support, protect and promote breastfeeding for the first year of life and beyond.[29]

9.31 CREEPOC recommended the development and/or continuation of obesity prevention programs which provide:

- support to parents using home visiting or parents' groups;
- detailed advice related to nutrition, including the promotion and support of breastfeeding and appropriate infant feeding, guidance on when to introduce solids;
- advice on parenting that includes recognition of a child's hunger and satiety clues; and
- advice on promoting child sleep and active play.[30]

9.32 The Early Life Nutrition Coalition recommended expanding the Medicare rebate to include early life nutrition advice during stages of pregnancy and childhood to equip expectant and new parents with an understanding of the right type of nutrition needed to benefit the long-term health of their child.[31]

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26 See for example: Breastfeeding Coalition Tasmania, *Submission 102*, p. 3; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

27 Dr Seema Mihrshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5; Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.

28 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

29 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 9; Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 4.

30 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

31 The Early Life Nutrition Coalition, *Submission 2*, p. 3.

Committee view

9.33 The importance of preventing childhood obesity is paramount to preventing the onset of chronic disease as people move through their lives. The health, economic, and social impacts of an unhealthy start in life are endemic which is why there is so much focus on addressing the problem as early as possible.

9.34 All submitters and witnesses for the inquiry agreed that childhood obesity is a complex condition, with multiple factors influencing its prevalence. With children in particular, almost all of the factors regarding their diet and lifestyle are external. As Dr Seema Mihrshahi outlined in Chapter 1, they range from their mother's breastfeeding behaviours, to access to green space, to how much advertising they are exposed to.

9.35 The need for a comprehensive coordinated response is obvious. Because of the plethora of factors, many of the actions and interventions to arrest the trends are currently under the auspices of not only different government departments, but different governments and different levels of government. Even in a single state, such as New South Wales, they realised quite quickly that an intervention went far beyond just the Health Department.

9.36 The committee notes and welcomes the recent communique from the Council of Australian Governments Health Council on the creation of a national strategy on obesity, which includes a strong focus on early childhood. The committee therefore proposes that there should be a subset of the National Obesity Taskforce created which would be responsible for the development and management of a National Childhood Obesity Strategy.

Recommendation 15

9.37 The committee recommends that the National Obesity Taskforce, when established, form a sub-committee directly responsible for the development and management of a National Childhood Obesity Strategy.

9.38 The focus on a child's first 1000 days is a coherent, multi-pronged and evidence based intervention strategy. Research by many eminent academic and clinical research centres has found solid evidence around how low levels of breast feeding, poor pre-conception and pre-natal health, and the low nutritional value of some infant foods and formulas, can all contribute to childhood obesity.

9.39 The committee is therefore of the view that a focus on educating parents, rigid guidelines regulating infant foods and readily available advice on a child's activities should all be integral to deliberations of the body responsible for the development of the National Childhood Obesity Strategy.

Primary care interventions

Role of general practitioners (GPs)

9.40 Over 80 per cent of Australians visit their GP at least once a year and therefore GPs have a significant role in identifying and supporting patients who are overweight and obese.[32]

9.41 However, many GPs are not comfortable to raise weight related matters with their patients. As discussed in Chapter 2, talking about weight can be a very sensitive issue for medical practitioners.

9.42 Professor Lauren Williams, a Fellow Member of the Dietitians Association Australia, explained that some GPs may also be hesitant to raise the issue of weight with their patients because of their own personal circumstances:

> Some GPs are reluctant to start the conversation because not all GPs are in a healthy weight range themselves. I often get patients referred to me saying, 'I was really surprised when the GP told me, because I'm thinner than they are.' There's a lot of work that needs to be done.[33]

9.43 The committee also heard that many GPs and clinicians are not equipped to support their patients because they lack expertise and experience in treating people who are overweight and obese:

> It's a 21st century chronic disorder that many clinicians haven't had enough education and training and overt experience in.[34]

9.44 Many inquiry participants identified a need for training and recommended the development of education programs for medical practitioners.[35]

9.45 The Australian Medical Association (AMA) recommended the development of practical material for GPs so they can support their patients.[36]

Allied health services

9.46 At present, the current Chronic Disease Management (CDM) scheme is for patients who are referred by GPs and who have a chronic and complex illness. Under the CDM scheme, patients get five rebated visits per year to see allied health professionals.

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32 Australian Medical Association, *Submission 126*, p. 8.

33 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 11.

34 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 3.

35 See for example: Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Melbourne, 6 August 2018, p. 3; Ms Ingrid Ozols, *Submission 37*, p. 3; Australian Medical Association, *Submission 126*, p. 8; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 21.

36 Australian Medical Association, *Submission 126*, p. 8.

9.47 Obesity alone does not qualify them for that service. Overweight and obese patients can only access the CDM scheme to see allied health professionals such as dietitians when there is already a co-morbidity.[37]

Expand access to Chronic Disease Management scheme

9.48 Nepean Blue Mountains Family Obesity Service argued that patients should have access to the CDM scheme for obesity alone. This would enable GPs to co-manage their patients with appropriate allied health specialists, including dietitians, clinical psychologists and physiotherapists.[38]

9.49 Similarly, Dr Alexander and Professor Williams are of the view that obesity needs to be treated as a chronic disease.[39]

9.50 The Council of Presidents of Medical Colleges also recommended recognising obesity as a chronic disease because this would facilitate access to early interventions:

> This will provide the framework for giving proper consideration to early and better access to health care services and effective treatments for people with obesity.[40]

Increase number of visits under CDM scheme

9.51 The committee heard that the current limit of five visits a year to see allied health professionals under the CDM scheme is inadequate to meet people's needs.[41]

9.52 Access to allied health services, especially Accredited Practicing Dietitians (APDs) to support dietary and physical activity interventions should be increased.[42]

9.53 Professor Williams stated that 'five visits in a year is not best practice' for managing an obese patient with a co-morbidity.[43]

9.54 She also pointed out that the five visits are shared across all allied health professionals, which means that a patient may end up with only one or two consultations with an APD:

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37 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 8.

38 Nepean Blue Mountains Family Obesity Service, *Submission 18*, p. 11.

39 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

40 Council of Presidents of Medical Colleges, *Submission 3*, p. 2.

41 Dietitians Association of Australia, *Submission 107*, p. 10.

42 See for example: Dietitians Association of Australia, *Submission 107*, p. 10; Early Life Nutrition Coalition, *Submission 2*, p. 2; Dr Alan Barclay, *Submission 37*, p. 10; Children's Hospital at Westmead, *Submission 44*, p. 13.

43 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 8.

> When you've got someone with type 2 diabetes, as dietitian you are sharing those five visits across a year with a podiatrist usually and maybe an exercise physiologist.[44]

Surgical interventions

9.55 Bariatric surgery is currently recommended for patients with a Body Mass Index (BMI) of 35 or more and with at least one obesity related medical condition, such as fatty liver disease or hypertension, or in patients with a BMI of 40 with no obesity related medical conditions. Bariatric surgery is also recommended in patients with a BMI over 30 with Type 2 Diabetes Mellitus which is poorly controlled with medication.[45]

9.56 All bariatric procedures are designed to reduce appetite and enhance satiety. Professor Michael Talbot, an Executive Member of the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS), explained how the surgery works:

> It basically alters the physiology of appetite, hunger and eating and changes patients' biological drive to eat so they become disinterested in food so you switch off the hunger that's been driving them to eat and then you train them to avoid food triggers that might create their metabolic or obesity problem again.[46]

Benefits of bariatric surgery

9.57 According to Mr Ahmad Aly, President of ANZMOSS, 'bariatric surgery is the single most effective treatment modality that exists for obesity, not only in terms of weight loss but in reversing or improving the obesity related diseases'.[47]

9.58 ANZMOSS submitted that bariatric surgery saves lives and is the best therapy for Australians with type-2 diabetes and class I and II obesity.[48]

9.59 The Swedish Obese Subjects study, the longest running longitudinal cohort study available, has demonstrated that obese patients treated with bariatric surgery gained a 38 per cent reduction in cancer mortality and a 48 per cent reduction in cardiovascular death compared to the non-surgically treated cohort.[49]

9.60 ANZMOSS reported that while most non-surgical treatment programs often result in weight loss, maintenance of weight is virtually never achieved. In contrast,

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44 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 9.

45 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 17.

46 Professor Michael Talbot, Executive Member, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 25.

47 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

48 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 9.

49 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 15.

bariatric surgery results in longer term maintenance of weight loss in the majority of patients.[50]

9.61 However, some inquiry participants believe that bariatric surgery has a very high rate of complication and failure.[51] For example, the Butterfly Foundation stated that 'bariatric surgery resulted in improvements in eating behaviour and body image that were not sustained over the long-term'.[52]

Access to bariatric surgery

9.62 Mr Aly explained to the committee that there are about 1.5 million Australians that, on broad criteria, would be eligible for bariatric surgery. However, only about 23 000 procedures are performed annually.[53]

9.63 The Australian Government Department of Health explained that bariatric surgery is available to public patients in some public hospitals; however waiting lists can be long.[54]

9.64 At a public hearing, Mr Aly stressed the lack of available public services in bariatric surgery:

> More alarmingly, of…about 23 000 procedures a year, only 10 percent are performed in public hospitals and only 4 percent are fully publicly funded.[55]

9.65 Similarly, Dr Tony Bartone, President of the AMA, told the committee that access to bariatric surgery in public hospitals is problematic:

> There are significant waiting lists and significant difficulties in obtaining and accessing this in a public hospital space.[56]

9.66 As a result, some people resort to access their superannuation early or go into debts in order to pay for surgery in the private sector.[57]

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50 Australian and New Zealand Metabolic and Obesity Surgery Society, answers to question on notice, 7 August 2018, p. 1.

51 See for example: Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 40; Dr Carolynne White, Lecturer, Health Promotion, Swinburne University of Technology, *Committee Hansard*, Melbourne, 7 August 2018, p. 41.

52 Butterfly Foundation, *Submission 99*, p. 10.

53 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

54 Australian Government Department of Health, *Submission 142*, Attachment 3, p. 28.

55 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

56 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 42.

57 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 23.

9.67 The AMA and ANZMOSS recommended that access to bariatric procedures be increased in public hospitals.[58]

9.68 Dr Stephen Duckett, Director, Health Program at the Grattan Institute, also pointed out that 'the evidence now is that obesity bariatric surgery is cost effective, and it is unfortunate that the public sector hasn't responded by making access more available'.[59]

Committee view

General Practitioners

9.69 The committee believes GPs have a key role in identifying and supporting patients who are overweight and obese. As discussed in Chapter 2, because of the stigma associated with obesity, GPs are not always equipped to discuss with their patients weight management and health issues related to obesity. The committee reiterates the recommendation made in Chapter 2 around the training of the medical profession and sees value in also developing practical materials for GPs aimed at supporting patients who undertake treatment for obesity and weight related conditions.

Chronic Disease Management scheme

9.70 The committee understands GPs are responsible for referring patients to allied health services under the CDM scheme. However, at present, they cannot refer patients for obesity alone as it is not recognised as a complex and chronic disease. The committee is of the view that overweight and obese patients should be able to access allied health services, especially APDs and exercise physiologists, without a co-morbidity. This would provide early and better access to health care services and effective treatments.

Recommendation 16

9.71 The committee recommends the Medical Services Advisory Committee (MSAC) consider adding obesity to the list of medical conditions eligible for the Chronic Disease Management scheme.

Bariatric surgery

9.72 The committee heard that bariatric surgery is a cost effective intervention, which saves lives and improve obesity related diseases. The committee noted that bariatric surgery items are on the Medicare Benefits Schedule and that bariatric surgery is available through the public hospital system. However, access to bariatric surgery services remains limited.

9.73 Firstly, too few hospitals offer bariatric surgery services. Indeed, the committee heard that only 15 public hospitals in Australia have a specialised obesity

58 Australian Medial Association, *Submission 126*, p. 9.

59 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, Melbourne, 7 August 2018, p. 35.

service that involves surgery.[60] Secondly, many health professionals continue to be reluctant to offer this treatment option.

9.74 The committee believes that the lack of access and availability of bariatric surgery services is partly due to the stigma attached to this type of surgery. As discussed in Chapter 2, the stigma and prejudice around surgical intervention to treat obesity cannot be underestimated. Attitudes and perceptions need to change within the medical profession. At present, it is resulting in some health professionals not offering this treatment option to patients. Furthermore, given the higher prevalence of obesity in lower socio-economic groups, it is imperative that affordable options are available to all those who could benefit from surgical intervention. Finally, it impedes the creation of new bariatric surgery services.

Recommendation 17

9.75 The committee recommends the Australian Medical Association, the Royal Australian College of General Practitioners and other colleges or professional bodies educate their members about the benefits of bariatric surgical interventions for some patients.

60 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 23.