

14 July 2008

Submission No. 124
(Inq into Obesity)

ML 12/7/08

Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600
AUSTRALIA

Via Email

Dear Sir/Madam,

RE: INQUIRY INTO OBESITY

Johnson & Johnson welcomes this opportunity to place before the House of Representative Standing Committee on Health and Ageing a submission in relation to the inquiry into obesity.

We would welcome the opportunity to appear before the Committee at its schedule of public hearings should the Committee require additional information.

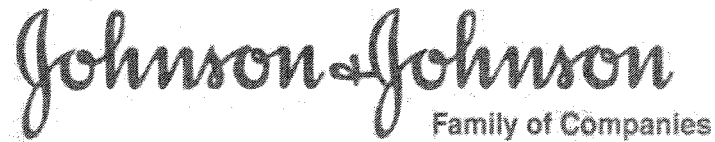
If you do require additional information then please do not hesitate to contact me:

Direct Line: 02 9815 3913

Email: pvicary@medau.jnj.com

Yours sincerely,

Peter Vicary
Director Government Affairs and Policy



***Johnson & Johnson
Family of Companies in Australia***

**Submission to the
House of Representatives Standing
Committee on Health and Ageing
Inquiry into Obesity**

July 2008

Telephone: (61 2) 8875 3333
Fax: (61 2) 8875 3300
Toll free: 1800 226 334

1-5 Khartoum Road
North Ryde NSW 2113
Australia



Our Credo

We believe our first responsibility is to the doctors, nurses and patients,
to mothers and fathers and all others who use our products and services.

In meeting their needs everything we do must be of high quality.

We must constantly strive to reduce our costs
in order to maintain reasonable prices.

Customers' orders must be serviced promptly and accurately.

Our suppliers and distributors must have an opportunity
to make a fair profit.

We are responsible to our employees,
the men and women who work with us throughout the world.

Everyone must be considered as an individual.

We must respect their dignity and recognize their merit.

They must have a sense of security in their jobs.

Compensation must be fair and adequate,
and working conditions clean, orderly and safe.

We must be mindful of ways to help our employees fulfill
their family responsibilities.

Employees must feel free to make suggestions and complaints.

There must be equal opportunity for employment, development
and advancement for those qualified.

We must provide competent management,
and their actions must be just and ethical.

We are responsible to the communities in which we live and work
and to the world community as well.

We must be good citizens – support good works and charities
and bear our fair share of taxes.

We must encourage civic improvements and better health and education.

We must maintain in good order
the property we are privileged to use,
protecting the environment and natural resources.

Our final responsibility is to our stockholders.

Business must make a sound profit.

We must experiment with new ideas.

Research must be carried on, innovative programs developed
and mistakes paid for.

New equipment must be purchased, new facilities provided
and new products launched.

Reserves must be created to provide for adverse times.

When we operate according to these principles,
the stockholders should realize a fair return.

Contents

The Johnson & Johnson Family of Companies	5
The Promise of Health Care – Our Belief and Our Role	7
Introduction	8
1. Managing Obesity	9
1.1 The role of Johnson & Johnson	9
1.2 Surgical solutions to treat Obesity	9
1.3 Laparoscopic Adjustable Gastric banding (LAGB).....	10
1.4 Roux-en-Y Gastric Bypass (RYGB).....	10
1.5 Sleeve Gastrectomy	11
2. Clinical Outcomes of Bariatric Surgery	11
3. Need for Surgeon Training	12
4. Clinical Evidence	13
5. Economic Evidence	15
6. Australian Evidence Reviews	16
7. Socioeconomic Profiles of Obesity	17
8. Equitable Access to Bariatric Surgery	17
9. Recommendations	19
10. Further Information.....	19
11. References.....	20



Worldwide

Caring for the world one person at a time inspires and unites the people of Johnson & Johnson.

We embrace research and science - bringing innovative ideas, products and services to advance the health and well-being of people.

Employees of the Johnson & Johnson Family of Companies work with partners in health care to touch the lives of over a billion people every day, throughout the world.

Our Family of Companies comprises:

- The world's premier consumer health company
- The world's largest and most diverse medical devices and diagnostics company
- The world's third-largest biologics company
- And the world's sixth-largest pharmaceuticals company.

We have more than 250 operating companies in 57 countries employing 119,200 people.

In 2007 we invested US\$7.68 billion in research.

Our worldwide headquarters is in New Brunswick, New Jersey, USA.

In Australia

Johnson & Johnson Pty Ltd became an Australian corporate entity in 1931.

Today there are more than 1500 Johnson & Johnson employees in Australia and New Zealand and annual turnover of more than AUD\$1.1 billion.

There are six health and medical care focused operating companies in Australia: Johnson & Johnson Medical; Janssen-Cilag; Johnson & Johnson Pacific; Johnson & Johnson Research; Tasmanian Alkaloids; and Ortho-Clinical Diagnostics.

In 2005, Access Economics reported that during 2004, Johnson & Johnson in Australia accounted directly for gross value added of \$327 million, GDP of \$366 million and the employment of 1,313 full-time equivalents (FTE).

In addition, the flow on from inputs of domestically produced goods and services into Johnson & Johnson activities indirectly contributed additional gross value added of \$253 million, GDP of \$259 million and the employment of 2,772 FTE.

Combining the direct and indirect contributions, in 2004 Johnson & Johnson contributed gross value added of \$580 million, GDP of \$624 million and employment of 4,085 FTE to Australia.

We now outline the lines of business and companies within the Johnson & Johnson Family of Companies in Australia.



The Johnson & Johnson Family of Companies

Medical Devices & Diagnostics

Johnson & Johnson Medical

Johnson & Johnson Medical Pty Ltd (JJM) is a major provider to the Australian health care system through both the provision of products and the development and implementation of support services for the medical community. Each year, JJM reinvests more than ten per cent of its sales in Australia to provide training and other assistance to local doctors. It is focused on a broad range of medical products and through a number of separate groups: Ethicon wound closure and wound management; Ethicon Endo-Surgery minimally invasive technology (Keyhole Surgery), laparoscopic instruments and mechanical staplers; Ethicon women's health products and antiseptic products; Cordis cardiology, endovascular, electrophysiology and neuro-radiology; and DePuy Australia, a leading developer of state-of-the-art technologies for joint reconstruction which markets a range of orthopaedic products.

JJM also supports clinical research programs in Australia across all business franchises. From involvement in global programs, first-in-human studies of new innovative technologies, to support original research ideas from Australian clinicians and specialists. JJM is particularly proud to have a long track-record of partnering with Australian surgeons to bring new and innovative devices to the global marketplace.

Ortho-Clinical Diagnostics

Ortho-Clinical Diagnostics (OCD) and Veridex LLC supply professional in vitro diagnostic instrumentation and related supplies to hospital laboratories, private pathology laboratories, and blood donor centres. Products include reagents used for determining patient blood groups and the compatibility of blood units prior to blood transfusions, screening of blood for infectious agents (eg. Hepatitis C), and reagents and instrumentation used for clinical chemistry, endocrinology, serology and oncology blood testing.

Janssen-Cilag Australia

Janssen-Cilag Pty Ltd (JCA) is a research-based company that markets pharmaceuticals for a range of conditions in mental health, neurology, haematology, gastroenterology, virology, and pain management. One of its key focus areas is biotechnology, which represents the promise of entirely new and highly targeted therapies for a range of diseases. At the same time, innovative genomics tools are already beginning to revolutionise and advance the discovery of pharmaceutical medicines.

Johnson & Johnson Research

Johnson & Johnson Research Pty Ltd (JJR) was incorporated in 1987 to identify new medical discoveries in Australia and facilitate their commercial development into new products for Johnson & Johnson. The role of the company was expanded in 1992 with the establishment of the JJR laboratories with a focus on genetic approaches to diagnosis and treatment. JJR has purpose-built research facilities at the Australian Technology Park in Sydney and a workforce of 75, most of whom have tertiary credentials in science or medicine.



The discovery and early development projects in JJR arise from the company's unique capabilities in utilising DNA and RNA to regulate and measure gene function and expression.

As an R&D hub for Johnson & Johnson in the Asia Pacific with unique scientific expertise and a strong track-record in innovation, JJR contributes substantial strategic value to Johnson & Johnson and performs a central role in the region by sourcing high value new business opportunities for global operating companies. These include contract research and outsourcing, licensing of new molecular entities, and discovery & development of research collaborations.

Tasmanian Alkaloids

Tasmanian Alkaloids Pty Ltd is an advanced agricultural production and research & development company. It extracts alkaloids (morphine and thebaine extract) from poppies. Some of this product is converted to active pharmaceuticals (codeine phosphate and buprenorphine) with around 99% of the product exported.

In 1995, Tasmanian Alkaloids and JJR initiated a project to develop a high-thebaine poppy. In sampling the alkaloid content of thousands of plants, one plant was found to have a high content of thebaine and no morphine, and the first commercial crop of these unique poppies was harvested in 1998. The new plant revolutionised thebaine production and today it has up to 80% of the worldwide market for Oxycodone raw materials.

Tasmanian Alkaloids is presently the largest manufacturer of active pharmaceutical ingredients in Australia and the largest exporter of codeine and thebaine in the world.

Consumer Healthcare

Johnson & Johnson Pacific

Johnson & Johnson Pacific Pty Ltd (JJP) is the largest over-the-counter supplier to retail pharmacy in Australia serving all community pharmacies and being in the top thirty suppliers for manufactured goods to grocery supermarkets. JJP is committed to providing the best service, programs and advice to consumers, customers and the community, and is dedicated to bringing to market innovative healthcare solutions.

Our broad product range spans across baby, beauty, oral care, smoking cessation, upper respiratory, gastro intestinal, eye care and general medicine categories. Among our most famous brands are the Johnson's Baby® range, Band-Aids®, Listerine® and Reach®.



The Promise of Health Care – Our Belief and Our Role

At Johnson & Johnson, we believe that effective, compassionate health care systems are critical to achieving better health for people around the world. Such systems are centred on the needs of individuals, offer access to health care coverage for all, and provide people with information, encouragement, incentives and support to remain healthy, to obtain early diagnoses and to receive quality care and treatment when it is needed. We believe that people everywhere are served best when health care systems:

- Focus attention on prevention and public health measures in addition to acute and chronic care;
- Address the need for access to care across all economic and social circumstances;
- Allow patients and their health care practitioners to choose the best course of treatment;
- Support health choices with scientifically sound clinical and economic evidence;
- Protect the privacy of everyone's personal medical records;
- Provide for both public and private health care funding solutions;
- Provide incentives for medical progress;
- Promote market-based competition;
- Are characterized by strong and well-respected regulatory authorities;
- Promote transparent and ethical interactions among stakeholders;
- Are adequately funded to support the health care needs of individuals;
- Allow individuals, health care professionals, caregivers and payers to have access to up-to-date health information to help guide decisions; and
- Operate efficiently, providing affordable, quality, timely and continuous care, and maximum, equitable access.

We believe that, as a member of the global health care community, Johnson & Johnson has a responsibility to advance good health care through our actions as well as to work with others to help shape effective health care systems around the world that will serve the needs of people. We recognize that all members of the health care community must collaborate to achieve this goal. Using the vantage point of our broad base in health care, we will:

- Work to address unmet medical needs through science and innovation, using our talents and commitment to improve health care;
- Support efforts to enhance access to health care and health care products;
- Provide appropriate clinical and economic information about our products and treatments, as well as broad health, disease and prevention information, to individuals, health care practitioners, caregivers and payers in ways that facilitate health care decision-making;
- Protect the privacy of personal medical information;
- Lead by example in providing preventive, health-related and lifestyle modification tools and solutions to our employees and their families worldwide;
- Work with others to improve the quality, cost effectiveness and accessibility of health care for people in developed and developing countries;
- Promote strong regulatory bodies; and
- Enhance business models to ensure appropriate incentives and long-term sustainability.

Introduction

Johnson & Johnson welcomes this opportunity to make a submission to the House of Representatives Standing Committee on Health and Ageing inquiry into obesity.

The growing problem of obesity requires action across all levels of government, both in its prevention and treatment. This requires a wide range of programs based on considered analysis to be developed and implemented. It does however need to be recognised that this is not just an issue for government alone to address but one which requires action across the all sections of the community, along with individuals taking responsibility for their personal well being.

There is a substantial body of evidence setting out the wide ranging social, health and economic impacts of obesity. Therefore in addition to prevention programs, there is also a significant need for action to assist those in the Australian community who are already overweight.

As this submission sets out, there are a group of patients for whom attempting weight loss through diet, exercise and other programs has not been successful. For this group of patients, Bariatric surgery has been shown to provide significant long-term weight loss with its associated health, social and economic benefits.

In Australia, Bariatric surgery has been mostly confined to the private sector. The public health system has generally not made this type of surgery available despite the clear clinical need for it. Studies show that there is a greater incidence of obesity amongst lower socioeconomic groups. People in need of this type of treatment amongst lower socioeconomic groups are unlikely to be able to afford the costs of the surgery in the private sector.

This disparity of access between the public and private sectors raises significant equity and health issues. It is not acceptable that patients within the public sector have very limited access to necessary medical procedures on the basis of their inability to pay and decisions by state health authorities not to provide this type of medical procedure.

1. Managing Obesity

1.1 The role of Johnson & Johnson

Johnson & Johnson is committed to providing product and patient support solutions to treat morbid obesity on a global scale. Johnson & Johnson partner with healthcare professionals to develop innovative products and solutions. Furthermore, our goal is to show leadership in training healthcare professionals with the ultimate goal of achieving the best possible patient outcomes. Johnson & Johnson Medical Pty Ltd, a division of Johnson & Johnson, distributes surgical staplers, the Swedish Adjustable Gastric Band (SAGB) and other surgical equipment used in the Bariatric procedures outlined in Section 1.2.

1.2 Surgical solutions to treat Obesity

In Australia over 95% of all Bariatric procedures are Laparoscopic Adjustable Gastric Banding (LAGB). Based on data sourced from Medicare, over 8000 LAGB procedures will be performed this year and over 90% of these procedures will take place in the private sector, demonstrating a clear inequality in healthcare. The LAGB is the most commonly performed Bariatric procedure due to the LAGB having the lowest level of risk. The operation is minimally invasive to the stomach, totally reversible and adjustable to patient needs¹.

In many cases conventional management of obesity, including diet, exercise, lifestyle modification and pharmaceutical therapy are found to be ineffective at producing and maintaining long term weight loss. For morbidly obese patients who have been unsuccessful in achieving weight loss through non-surgical interventions, surgery presents a clinically effective treatment option that induces weight loss and reduces the presence of co-morbidities.

1.3 Laparoscopic Adjustable Gastric banding (LAGB)

The LAGB has been used worldwide for over 15 years and its efficacy has been validated with long-term clinical data. In this procedure, generally via keyhole surgery, a low-pressure soft band is placed around the uppermost part of the stomach dividing it into two sections and creating a small opening between the sections allowing food to pass through. The small stomach pouch created can hold approximately 30ml.

Patient restriction depends on how much fluid is injected into the balloon via a port that is placed subcutaneously and can be accessed by a needle through the skin. The band can be tightened or loosened over time to change the size of the passage by increasing or decreasing the amount of fluid. The procedure is a minimally invasive surgical technique where instruments allow access to the stomach through four or five small 1-2 cm incisions in the abdomen.

This procedure is designed for morbidly obese patients with a body mass index (BMI) of 40 or greater or a BMI over 35 with one or more co-morbidities such as sleep apnoea, diabetes and osteoarthritis. Patients can lose between 50-60% of excess body weight after 1-2 years when combined with diet and exercise. The LAGB has the lowest mortality rate compared to other Bariatric procedures.

1.4 Roux-en-Y Gastric Bypass (RYGB)

In this procedure, stapling creates a small (15-20ml) stomach pouch. The remainder of the stomach is not removed, but is completely stapled shut and divided from the lower stomach pouch. The outlet from this newly formed pouch empties directly into the lower portion of the jejunum, thus bypassing calorie absorption in the duodenum. This is done by dividing the small intestine just beyond the duodenum and constructing a connection with the new, smaller stomach pouch. The length of either segment of the intestine can be increased to lower or higher levels of malabsorption.

RYGB patients can typically expect to lose 60-70% of their excess weight in the first 1-2 years following surgery. Although a commonly performed procedure in the USA, RYGB accounts for less than 5% of all Bariatric procedures performed in Australia. The RYGB carries increased risk of peri-operative death and complications compared to the LAGB. This procedure is typically reserved for patients with a BMI of over 40.

1.5 Sleeve Gastrectomy

Sleeve gastrectomy is a restrictive Bariatric procedure and can be performed via keyhole surgery. During this procedure, the surgeon creates a small, sleeve-shaped stomach. It is larger than the stomach pouch created during Roux-en-Y gastric bypass and is about the size of a banana with a capacity of about 200mls. The sleeve gastrectomy is not reversible and is typically considered as a treatment option for Bariatric surgery patients with a BMI of 60 or higher. It can be performed as a stand alone (primary) operation or as the first step in a two-stage procedure for RYGB. Sleeve gastrectomy patients can typically expect to lose 40-60% of their excess weight in the first 1-2 years following surgery.

2. Clinical Outcomes of Bariatric Surgery

Morbid obesity is associated with a range of serious co-morbidities including diabetes, hypertension, cardiovascular disease, osteoarthritis, sleep apnoea, depression, infertility and certain types of cancer. Extensive clinical research has shown Bariatric surgery to be effective not only at reducing excess weight but also resolving obesity related co-morbidities and improving patients' quality of life. This growing evidence base had led to Bariatric surgery (with lifestyle modification) being viewed as a highly effective treatment option for morbidly obese patients.

A meta analysis performed by Buchwald *et al*ⁱⁱ reported the effectiveness of specific Bariatric procedures. The table below outlines the findings for two types of surgery currently performed in Australia.

Procedure	Operative mortality	Mean weight loss kg	% Excess weight loss	Mean reduction in BMI
Gastric Banding	0.1% [#]	28.64	47.5%	10.43
Gastric Bypass	0.5%	43.48	61.6%	16.7

Both gastric banding and gastric bypass are shown to be effective at producing substantial weight loss.

Sleeve gastrectomy is also performed in Australia but was not reported in this review. A recent evidence summaryⁱⁱⁱ reported the effectiveness of this procedure. The review reported operative mortality of 0.9% and mean excess weight loss ranging from 52.8% at 6 months to 83.3% at 12 months.

Due to the different risk and outcome profiles of the various procedures it is important to take into account patient characteristics, risk profile and preferences when determining the most suitable treatment path.

An overview of key clinical and economic evidence is outlined in sections 4 to 6.

3. Need for Surgeon Training

Bariatric surgeons are typically Upper Gastro-Intestinal (Upper GI) surgeons or General surgeons who have a particular interest in performing weight loss surgery and undergo further training in the field of Bariatric surgery. Currently, training in Bariatric surgery is not provided by the Royal Australian College of Surgeons surgical training programs, but Bariatric fellowships can be undertaken as a sub-specialty of an Upper GI surgical fellowship. To further assist surgical fellows during their training and those established Upper GI or General surgeons who wish to specialise in Bariatric surgery later in their careers, training programs are provided in the private sector by the manufacturers of the devices used in this type of surgery.

[#] includes 2297 patients undergoing gastric banding and 749 undergoing gastroplasty

Any increase in the demand for Bariatric surgical procedures will put increased pressure on the surgeons that currently perform Bariatric surgery in the private system and are already operating at full capacity. Therefore, there will be a need to increase the number of surgeons who are competent at performing Bariatric surgery if public funding becomes available.

Johnson & Johnson Medical has a commitment to providing the highest standard of professional education for surgeons wishing to specialise in Bariatric surgery, with the goal of enabling both surgeons and allied health care practitioners to deliver optimal patient outcomes. Courses provide an overview of surgical approaches to the management of morbidly obese patients and include in depth training on patient assessment and follow up, surgical techniques, pre and post-operative patient care and the establishment of a multidisciplinary practice to deliver the best possible patient outcomes.

4. Clinical Evidence

Published clinical studies and Health Technology Assessments (HTA) have shown Bariatric surgery for morbidly obese patients to be a safe and clinically effective treatment that induces weight loss and reduces the presence of obesity related co-morbidities.

The effectiveness of Bariatric surgery was reported in a meta analysis by Buchwald^{iv} *et al.* 136 studies with a total of 22,094 patients were reviewed to determine the impact of Bariatric surgery on weight loss, mortality and co-morbidities. Findings included:

- In terms of safety, the authors conclude that Bariatric surgery compares favourably with operative mortality rates for other major surgical operations.
- The results for weight loss were a mean excess weight loss of 61.2%, an absolute weight decrease of 39.7kg and a decrease in BMI of 14.2.

- In terms of resolution of co-morbidities, the meta analysis identified that in studies reporting the resolution of diabetes, 76.8% of patients experienced complete resolution of diabetes following surgery, hyperlipidemia improved in 70% or more of patients, hypertension was either resolved or improved in 78.5% of patients and obstructive sleep apnoea was resolved in 85.7% patients.

The effectiveness of Bariatric surgery compared to non-surgical management of obesity has been reported in the Swedish Obese Subjects Study^v. This major longitudinal study has prospectively followed a cohort of 4,047 obese patients. Results have demonstrated:

- At 2 year follow up the surgical group had a mean weight loss of 23.4%, compared to an increase of 0.1% in the control group.
- In the subset of patients for whom 10 year follow up data was available, weight loss in the surgical group was higher (a weight decrease of 16.1%), than in the control group (a weight increase of 1.6%). Although lower than 2 year, reported weight loss surgery still showed superior results.
- For both the 2 and 10 year follow up the Bariatric surgery group reported superior results for recovery from all risk factors (including hypertension and diabetes) except hypercholesterolemia, where no significant difference was observed.

A systematic review by Clegg^{vi} *et al.* looked at the clinical and cost effectiveness of surgery for people with morbid obesity. When compared to non-surgical management the review found: Surgery led to significantly increased weight loss, between 23 and 37kg at 2 years. Weight loss was maintained at up to 8 years. Co-morbidities associated with morbid obesity, particularly hypertension and diabetes, improved significantly following surgery.

5. Economic Evidence

Given the substantial health and societal costs associated with obesity, there is increasing need to understand how treatments for obesity influence future costs. Whilst surgery can be considered an expensive treatment option it has been shown to positively impact the cost of managing obesity related co-morbidities and lost productivity costs.

A recent economic study^{vii} sought to quantify the cost impact of Bariatric surgery in patients with type 2 diabetes. The study compared the cost-effectiveness and budget impact of Bariatric surgery (adjustable gastric banding and gastric bypass) versus conventional treatment in obese patients with type-2 diabetes, in Germany, UK and France. Five years after surgery, Bariatric surgery was shown to be cost saving in Germany and France, and cost-effective in the UK with a moderate budget impact versus conventional treatment. Health care related savings in Germany and France were estimated to be up to €5 million for a cohort of 1,000 patients.

Similarly, a Canadian study^{viii} sought to quantify the impact of Bariatric surgery on health related costs. The health care costs of a cohort of morbidly obese patients treated with Bariatric surgery were compared to a morbidly obese control group who did not undergo surgery. The results showed:

- The initial cost of surgery and related hospital care was offset by a reduction in health care costs after 3.5 years.
- After 5 years the hospitalisation costs in the control group was 29% higher than the Bariatric surgery cohort.

In addition to their systematic review, Clegg^{ix} *et al.* performed an economic evaluation to measure the cost effectiveness of Bariatric surgery compared to non-surgical management and the relative cost effectiveness of different forms of surgery. This type of evaluation looks at the costs of treatment relative to the health benefits achieved (measured in Quality Adjusted Life Years). The evaluation concluded that, when compared to non-surgical management, surgery was cost effective at £11,000 per Quality Adjusted Life Year gained. Comparisons of the different types of surgery were equivocal.

6. Australian Evidence Reviews

A 2002 review by the Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIPS)^x in Australia looked at the safety and effectiveness of LAGB compared to RYGB and VBG*. Whilst the review identified the impact of each type of surgery on both weight loss and co-morbidities, evidence of the relative efficacy of different surgical techniques was less clear. ASERNIPS concluded “Laparoscopic gastric banding is safer than VBG and RYGB, in terms of short-term mortality rates. LAGB is effective, at least up to 4 years, as are the comparator procedures. Up to 2 years, LAGB results in less weight loss than RYGB; from 2 to 4 years there is no significant difference between LAGB and RYGB, but the quality of data is only moderate.”

These findings emphasise the importance of ensuring the treatment choice takes into account individual patient characteristics, risk profile and preferences, history, surgeon expertise and available resources.

Australia’s Medical Services Advisory Committee (MSAC) also reviewed the safety, clinical and cost effectiveness of LAGB in 2003^{xi}. As a result of the review MSAC recommended that on the strength of evidence pertaining to safety, effectiveness and cost-effectiveness of LAGB public funding should be continued for this procedure.

The National Health and Medical Research Council (NHMRC) in Australia have also reviewed evidence on a range of treatments for obesity^{xii}. Bariatric surgery is included in their guidelines for the management of obesity. Their guidelines state^{xiii}: “Surgical intervention combined with permanent lifestyle change is the most effective therapy for weight reduction in terms of the extent and duration of weight loss. Although it is expensive, Bariatric surgery also appears to be cost-effective in the long term. As a result, for morbidly obese individuals with serious co-morbid conditions and in whom other therapeutic approaches have failed, surgical treatment is increasingly recognised as the treatment of choice.”

* Vertical Banded Gastroplasty – very few procedures are currently performed in Australia

7. Socioeconomic Profiles of Obesity

The Australia's Health 2008 publication identified that disadvantaged Australians will more likely have shorter lives and higher levels of disease risk factors compared with those who have social and economic advantages^{xiv}. These findings are reflected in the rates of obesity across different socioeconomic groups. The prevalence of overweight and obesity has been found to be higher in adults with lower socioeconomic demographics. Results from the 2004/05 National Health Survey found 22% of adults in the most socioeconomically disadvantaged population were obese^{xv}. This was almost double the rate found in the least disadvantaged population, where only 13% were obese.

The rates of overweight and obesity also vary by geographical areas^{xvi}. Rates are lower among people who live in major cities (52%), compared to inner regional areas (56%) and outer regional and other areas (60%). These rates are even higher in the male population. 69% of men were overweight or obese in outer regional areas, compared to 60% in major cities and 64% inner regional areas.

8. Equitable Access to Bariatric Surgery

Johnson & Johnson partners with health care professionals in both the public and private sectors. There is a need for access to health care across all economic and social circumstances. Unfortunately within the Australian health care sector at present there is not equitable access to Bariatric surgery across the public and private sectors. This is creating inequities in relation to the availability of this surgery to patients with a demonstrated clinical need.

As this submission has detailed, there is considerable evidence that obesity is disproportionately evident amongst lower socioeconomic groups which tend to be focussed in certain geographic areas. That is, amongst those with the least ability to afford Bariatric surgery in the private sector, there is the greatest clinical need. This raises both equity and health issues that the Australian community needs to address.



At present, this surgery has only limited availability in the public health sector, with the vast majority of operations performed on privately insured or self-funded patients in the private sector. Laparoscopic gastric banding surgery costs on average \$13,000 per procedure, plus the costs of ongoing follow up care to ensure the best patient outcomes.

The lack of availability of Bariatric surgery within the public health system is a result of decisions by individual states and respective health authorities. These decisions have been made despite the documented long-term health benefits that this surgery can provide. The health benefits of Bariatric surgery for the morbidly obese would have a positive economic impact by reducing the costs of ongoing management of co-morbid diseases, which are currently funded by State and Federal governments.

In order to address the significant social inequity in relation to the availability of Bariatric surgery, the State and Federal governments need to consider making Bariatric surgery available to all appropriate candidates within the Australian community.

In summary, there is clear need from both a clinical, equity and economic perspective to make Bariatric surgery available to appropriate patients in Australia's public health system. Without action by state health authorities, a clinical need will continue to go unaddressed as will its associated social, economic and health impacts.

9. Recommendations

The following recommendations seek to address the current inequality of access to Bariatric surgery in the Australian health system:

1. Treatment is made available in the public health system for those patients with a demonstrated clinical need for Bariatric surgery
2. To ensure the best patient outcomes are achieved for public Bariatric patients, a comprehensive follow up care program would need to be implemented.
3. The establishment of a national register of Bariatric patients would allow for the monitoring of the clinical, social and economic impacts resulting from a public program. This register would enable the government to track progress of this patient group and furthermore, determine the ongoing benefits of funding Bariatric surgery in the public system.
4. An all of government approach to required to address obesity in the community, especially given the involvement of different levels of government in its treatment, management and prevention.

10. Further Information

Johnson & Johnson would welcome the opportunity to appear before the Committee at its schedule of public hearings should the Committee require additional information.

If you do require additional information then please do not hesitate to contact:

Peter Vicary
Director Government Affairs and Policy
Direct Line: 02 9815 3913
Mobile: 0414 951 409
Email: pvicary@medau.jnj.com

11. References

- ⁱ Mittermair RP, Weiss H, Nehoda H, et al. Laparoscopic Swedish adjustable gastric banding: 6-year follow up and comparison to other laparoscopic bariatric procedures. *Obesity Surgery* 2003; 13: 412-417
- ⁱⁱ Buchwald H, Avidor Y, Braunwald E, et al. Bariatric Surgery: A systematic review and meta-analysis. *JAMA* 2004; 292: 1724-1737
- ⁱⁱⁱ Iannelli A, Dianese R, Piche T, et al. Laparoscopic sleeve gastrectomy for morbid obesity. *World Journal of Gastroenterology* 2008;14(6): 821-827
- ^{iv} Buchwald H. *et al.* 2004
- ^v Sjostrom, M.D *et al.* Lifestyle, diabetes and cardiovascular risk factors 10 years after bariatric surgery. *NEJM.* 2004; 351,26: 2683-2693
- ^{vi} Clegg AJ, Colquitt J, Sidhu MK, Royle P, Walker A. Clinical and cost-effectiveness of surgery for morbid obesity: a systematic review and economic evaluation. *International Journal of Obesity.*2003; 27,1167-1177.
- ^{vii} Ackroyd MB *et al.* Cost Effectiveness and budget impact of obesity surgery in patients with type 2 diabetes in three European countries. *Obesity Surgery.* 2006; 16:1488-1503
- ^{viii} Sampalis J., Liberman M. Auger S., Christou N. The impact of weight reduction surgery on health-care costs in morbidly obese patients, *Obesity surgery.* 2004; 14:939-47
- ^{ix} Clegg et al 2003
- ^x Chapman A *et al.* Laparoscopic adjustable gastric banding in the treatment of obesity: A systematic literature review. *Surgery.* 2004;135,3: 326-351
- ^{xi} MSAC. Laparoscopic adjustable gastric banding for morbid obesity. MSAC Reference 14. 2003
- ^{xii} National Health and Medical Research Council. *Clinical practice guidelines for the management of overweight and obesity in adults.* 2003 www.nhmrc.gov.au
- ^{xiii} National Health and Medical Research Council. 2003 p170
- ^{xiv} Australian Institute of Health and Welfare 2008. Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW. p62

^{xv} Australian Bureau of Statistics. 4719.0 Overweight and Obesity in Adults, Australia, 2004-05. 2008. p11

^{xvi} Australian Bureau of Statistics p11
