What do we need to be in place?

IFSO, Melbourne, Sept 2024 – Session on The Young & The Old

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Chair of Child & Adolescent Health, University of Sydney

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[ ] I have the following potential conflict(s) of interest to report:

- Novo Nordisk
  - ACTION Teens Steering Committee – honoraria, travel support
  - Speaker fees
- Lilly
  - Advisory Committee – honoraria, travel support

The problem: Most health systems fail to address the needs of people living with obesity – in multiple ways

ORIGINAL RESEARCH ARTICLE

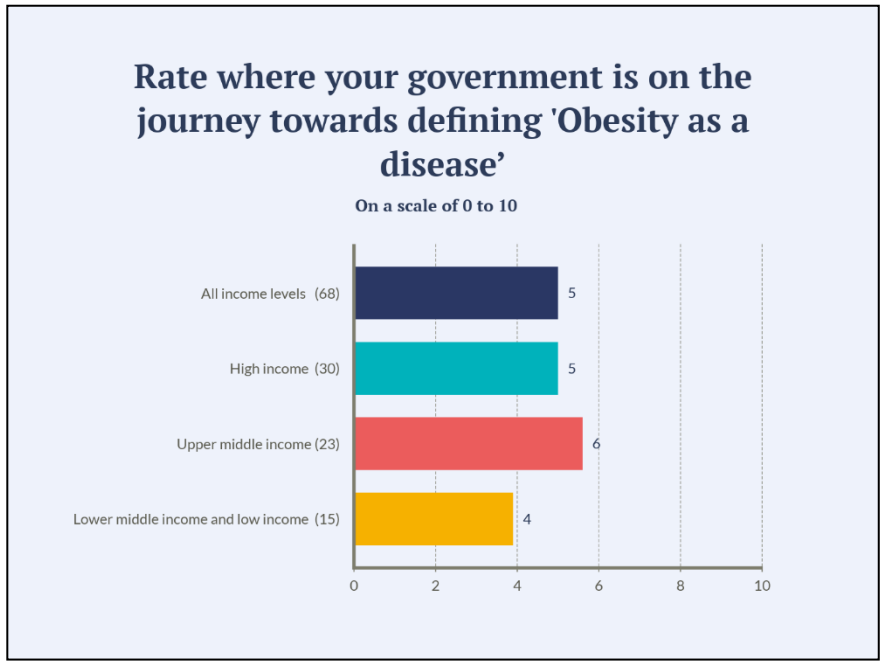
Clinical OBESITY WILEY

Clinical care for obesity: A preliminary survey of sixty-eight countries

Rachel Jackson Leach[1] | Jaynaide Powis[1] | Louise A. Baur[2] | Ian D. Caterson[3] | William Dietz[4] | Jennifer Logue[5] | Tim Lobstein[1,3]

- **Undertaken by the World Obesity Federation**
- **Aim: To assess the readiness of national health services to provide weight management and obesity treatment**
- **How?**
  - **Surveys & semi-structured interviews with >270 respondents from 68 countries**
    - **15 low & lower middle income, 23 upper middle income, 30 high income**
  - **May 2018 to August 2019**
  - **Rapid literature review of available documents**

Jackson Leach R et al. Clin Obesity 2020; e12357



There is lack of recognition of obesity as a disease

Countries have varying approaches to funding treatment …

Out-of-pocket payments were main funding source in 37 countries

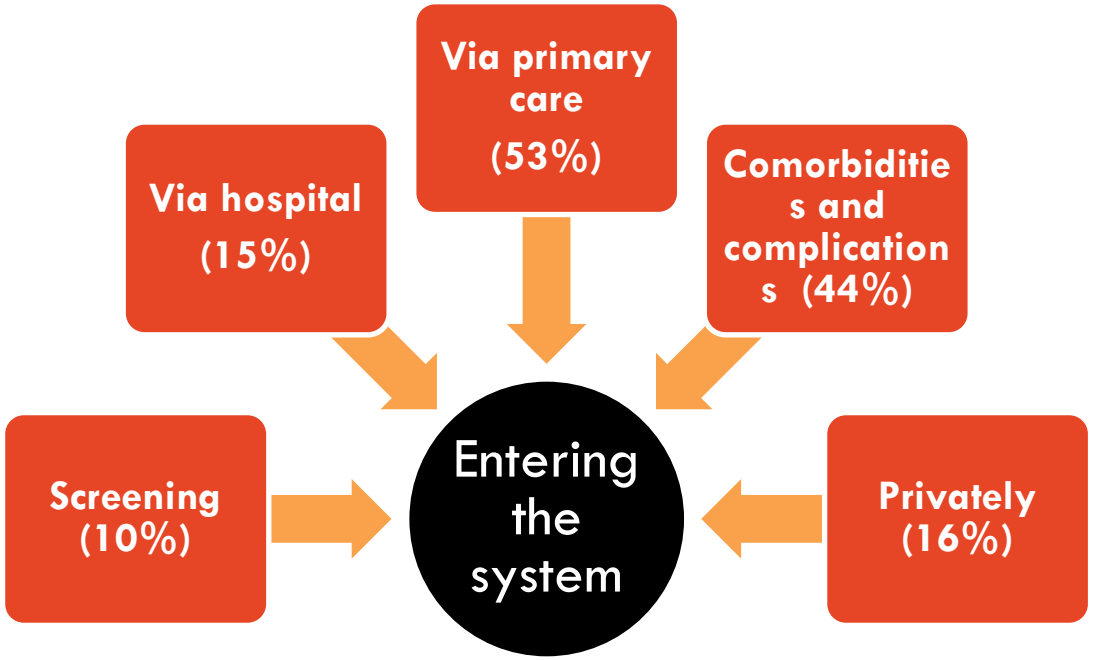
Only 4 countries had government funding / insurance coverage as main funding source

But several respondents said that when treatment is covered…. long waiting lists!

Jackson Leach R et al. Clin Obesity 2020; e12357

…. and different care pathways

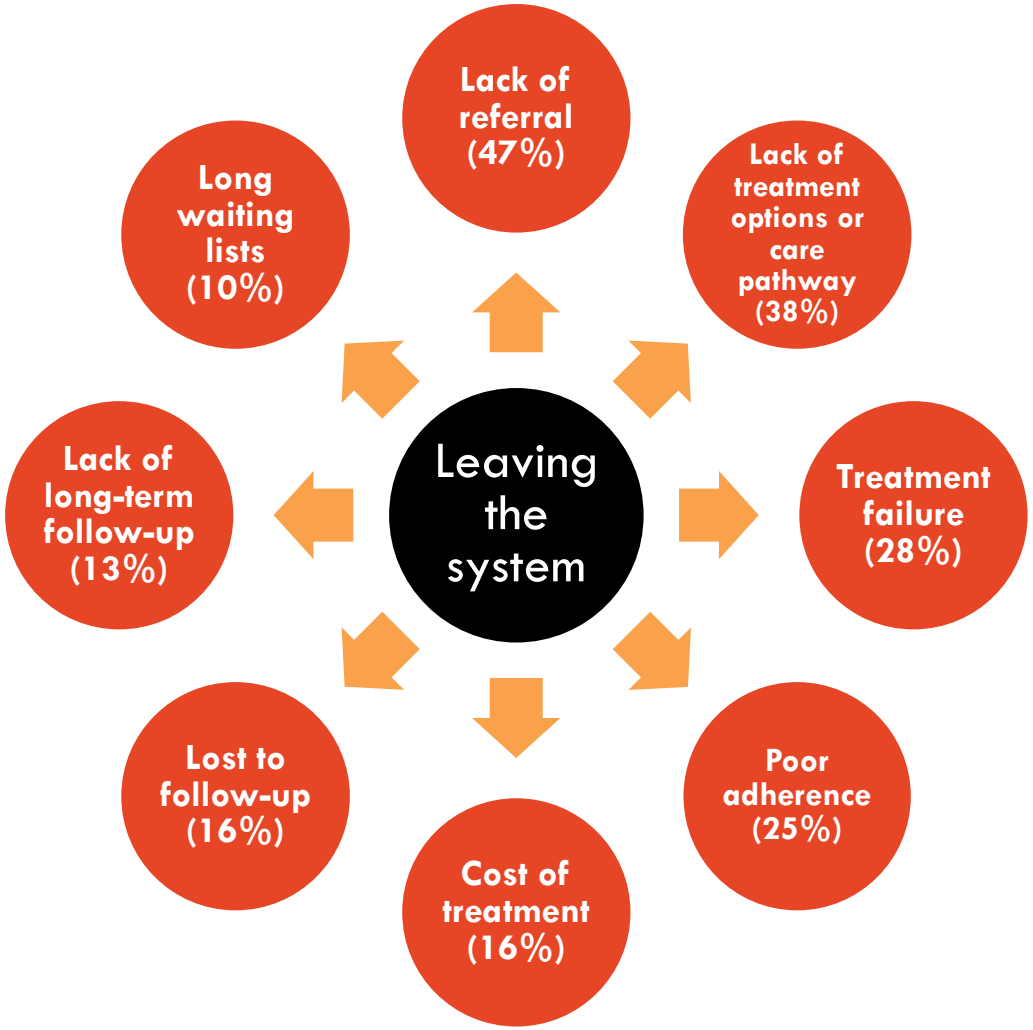
- **Primary care is the most common entry point into the system (mentioned in 53% of countries)**
- **… when they have comorbidities (mentioned in 44% of countries, but more of an issue in lower-middle and low-income countries)**
- **Those in rural areas have difficulty entering the system**



Jackson Leach R et al. Clin Obesity 2020; e12357

…. with many people struggling to stay in the system

- **"a lack of initial referral" (mentioned in 47% of countries)**
- **… followed by lack of treatment options/ care pathways (especially in lower-middle and low-income countries)**



Jackson Leach R et al. Clin Obesity 2020; e12357

There are low levels of professional training in obesity care

- **Availability of training poorest in lower middle/ low income countries**
- **Nutritionists/ dietitians considered to be the most trained to deal with obesity (mentioned in 43% of countries)**

Jackson Leach R et al. Clin Obesity 2020; e12357

… and many perceived barriers to provision of adequate obesity treatment – *global* ranking across 68 countries

Barriers	*Overall rank*
Lack of political will, decision & action	1
Lack of training for health care professionals	2
High cost of treatment	3
Poor health literacy & behaviour	4
Obesity not recognised as a disease	5
Lack of financial investment in health system	6
Stigma	7
Food cost & availability	8
Cultural norms & traditions around obesity	9
Lack of evidence, monitoring & research	10

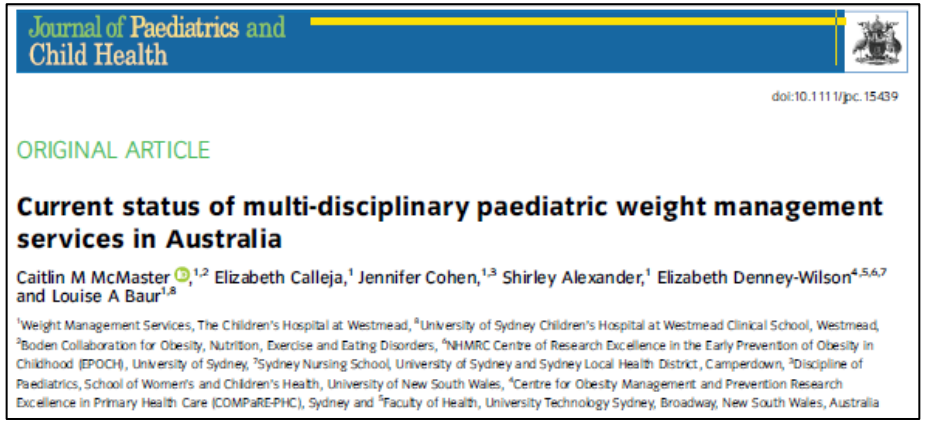
Jackson Leach R et al. Clin Obesity 2020; e12357

While the evidence-base for effective treatment is growing, much better access to obesity care is needed

There is inequitable & very limited access to obesity care in Australia for young people

- Very few paediatric **multidisciplinary obesity services** across Australia
- None in rural or regional Australia
- Long waitlists (2 to 12+ months)
- Similar situation in many other countries

We need improved access to multidisciplinary paediatric clinics



Journal of Paediatrics and Child Health

doi:10.1111/jpc.15439

ORIGINAL ARTICLE

Current status of multi-disciplinary paediatric weight management services in Australia

Caitlin M McMaster[1,2] Elizabeth Calleja,[1] Jennifer Cohen,[1,3] Shirley Alexander,[1] Elizabeth Denney-Wilson[4,5,6,7] and Louise A Baur[1,8]

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- In Australia – 2% (72,000) of the 3.6M 5-17 year olds have *severe* obesity
- Current clinics have the capacity to see <5% of them

** McMaster C et al. J Paediatr Ch Health 2021*

There is inequitable & very limited access to obesity care in Australia

In 2022, of ~16,000 **primary bariatric surgery procedures - only 3.2% were in the public sector* …**

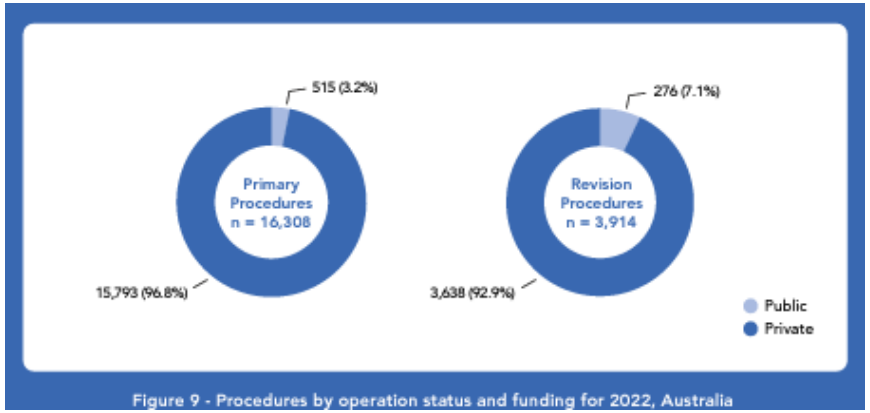

Figure 9 - Procedures by operation status and funding for 2022, Australia

… and only 18 procedures were reported for participants <18 years

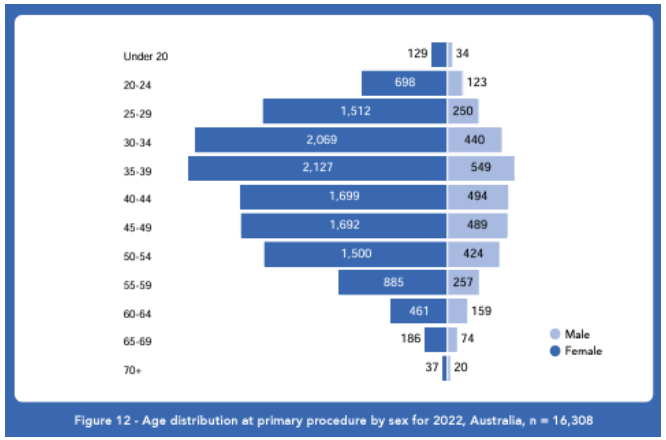

Figure 12 - Age distribution at primary procedure by sex for 2022, Australia, n = 16,308

We need many more bariatric surgery services in the public sector – including for adolescents

**The Bariatric Surgery Registry Annual Report - 2022. Central Clinical School, Monash University, June 2023, Report No. 10*

There is inequitable & very limited access to obesity care in Australia

- **In Australia – and most countries – obesity management medications are not covered by health insurance**
- **In those that do, there can be age limitations or other restrictions**

More equitable access to obesity pharmacotherapy is needed

Viewpoint

International coverage of GLP-1 receptor agonists: a review and ethical analysis of discordant approaches

Johan L Dellgren, Govind Persad, Ezekiel J Emanuel

Lancet 2024; 404: 902–906
Published Online August 16, 2024
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Introduction

Obesity can substantially diminish people's lifespan and quality of life. Severe obesity can shorten younger adults' lifespan by around 10 years compared with those with healthy weight.[1] Even moderate obesity is associated with truncated life expectancy. Moreover, health-related quality of life decreases as BMI increases.[2] Beyond these health effects, by 2035, the global financial burden associated with obesity is expected to exceed US$4·3 trillion annually.[3]

Glucagon-like peptide-1 (GLP-1) receptor agonists such as semaglutide and dual GLP-1 and glucose-dependent insulinotropic polypeptide receptor agonists such as tirzepatide could curb both the health and economic effects of obesity. In clinical trials, these receptor agonists reduce average bodyweight by approximately 15%—two to three times more than alternative medications.[4] GLP-1 receptor agonists have also been shown to be cardioprotective, reducing the risk of major adverse cardiovascular events by 20% compared with placebo for

Israel, Japan, the UK, and the USA) reimburse semaglutide (eg, Ozempic, Novo Nordisk) or another similar GLP-1 receptor agonist for at least some individuals with type 2 diabetes. Nine of the 13 countries fully deny reimbursement of GLP-1 receptor agonists for weight management, including Australia, Belgium, Denmark, Finland, Germany, Italy, and Israel. Canada and the USA do not have nationwide coverage of GLP-1 receptor agonists on public plans, although regional plans in these countries vary. For example, nine US state Medicaid plans cover GLP-1 receptor agonists for weight management in some capacity.[6]

Four of the 13 surveyed countries provide qualified national coverage for GLP-1 receptor agonists for weight management: France, Iceland, Japan, and the UK. Each of these countries has different conditions for coverage, restricting the eligible population (appendix p 2). The USA, the UK, and the European Medicines Agency have also allowed a new indication for Wegovy (Novo Nordisk) to treat patients with cardiovascular disease. This

Dellgen JL et al. Lancet 2024 404:902-906

Some groups of people have additional barriers to accessing care in real-like clinical settings

Barrier
Poverty
Culturally & linguistically diverse patients
Learning disabilities & developmental disorders
Low literacy
Family in crisis
Psychiatric disorders

PLUS, in many regions:

Services are often poorly resourced – or non-existent

Services may not be publicly funded

Health professionals may be inadequately trained

Minshall GA, Davies F, Baur LA. Behavioral Management of Pediatric Obesity. In: Ferry RJ Jr (Ed). Management of Pediatric Obesity and Diabetes. New York: Humana Press; 2011; Jackson-Leach R et al. Clinical Obesity 2020;10:e12357; McMaster C et al. J Paediatr Ch Health 2021

Healthcare professional training for obesity care in most regions/ countries is inadequate and must be improved

Health professional training in obesity care is very patchy

- **Globally there is often inadequate training:**
  - ***Future* workforce – medical, nursing, allied health students**
  - ***Existing* health workforce - in basic assessment and management of obesity**
- **Limited postgraduate training opportunities**
- **Need to reach those:**
  - **in primary care e.g. GPs, practice nurses, community nurses …**
  - **managing people with obesity complications e.g. endocrinology, sleep, orthopaedics, psychiatry, cardiac …**
  - **in low & middle income countries especially**

Dietz WH et al. Management of obesity: improvement of health-care training and systems for prevention and care. Lancet 2015; 385::2521-2533

Implications for training of health professionals in obesity care

We need to develop, evaluate & provide a range of health professional training:

- **Undergraduate & postgraduate level → a culture of continuous, integrated learning**
- **For many types of clinicians**
- **Ideally inter-professional training**
- **For most: short, modular, on-line/ accessible training**

Options?

- **Can you develop, or adapt existing, e-learning training packages?**
- **Needs to be culturally and locally relevant**
- **SCOPE training (World Obesity Federation)**
- **US: Formal credentialing of bariatric medicine physicians**
- **For most, *primary care* level skills are appropriate**
- **For some, *specialist* clinical training positions are needed: medical fellows, specialist nursing & allied health staff**

What training resources are available in your country? What training is suitable for different types of clinicians?

Weight stigma needs to be addressed

Recommendations for tackling weight stigma within paediatric practice

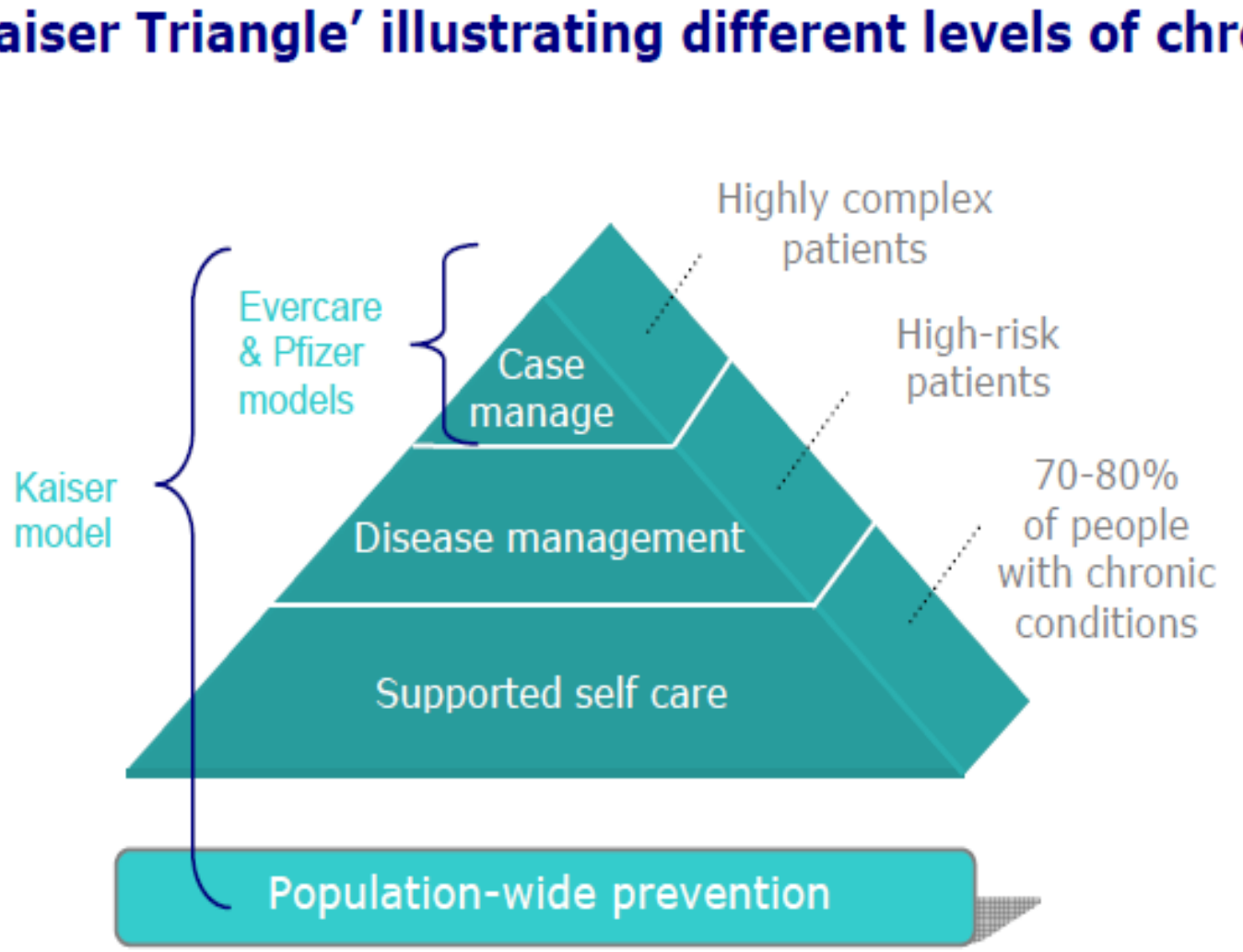
Can practitioners' role-model supportive and unbiased behaviours towards patients with obesity?

- **Use appropriate language and neutral word choices** e.g.
  - Use “unhealthy weight”, “BMI”, “above a healthy weight”, “weight”
  - Instead of “obese”, “extremely obese” or “fat”
  - What language would your patient prefer you to use?
- **Create a safe and welcoming practice environment**
  - Appropriately sized chairs, blood pressure cuffs, weight scales (location?), toilets, gowns, examination couches etc
  - All staff are welcoming
- **Have an empathetic approach to behaviour change counselling**

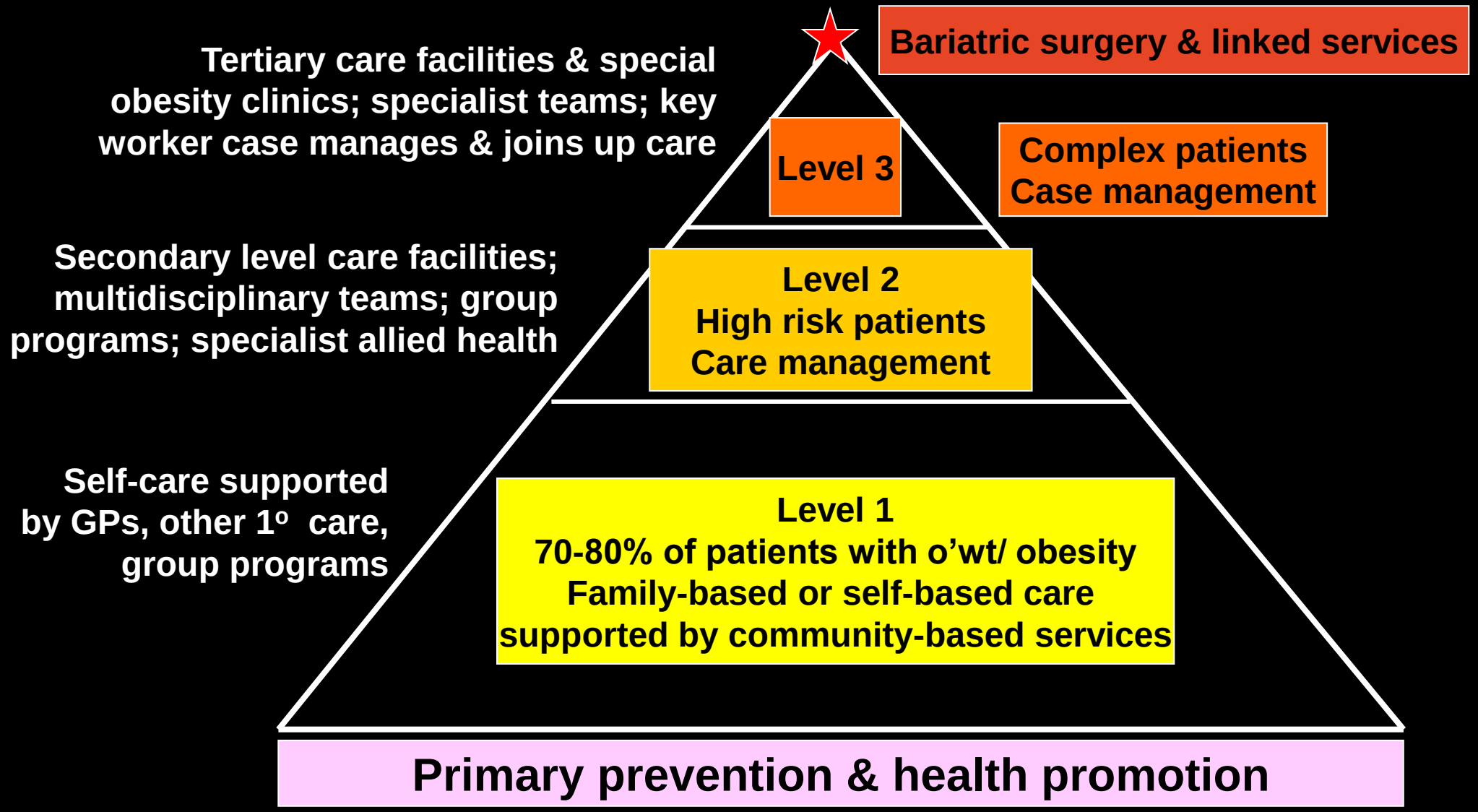
Pont SJ, Puhl R, Cook SR, Slusser W. Pediatrics 2017; 49: e20173034; Rubino F et al. Nat Med 2020; 26:485-497; Lister NB et al, Nature Rev Dis Primer 2023; 9:24; http://www.uconnruddcenter.org/weight-bias-stigma

Existing health services are generally disjointed and need to be better integrated

Example of a service delivery model for chronic disease care – the Chronic Disease Care Pyramid



Obesity and the chronic disease care pyramid



Baur LA et al, Nature Rev Gastroenterol Hepatol 2011; 8:635-45. Adapted from the Kaiser-Permanente and UK NHS chronic disease management pyramids of care

All parts of the pyramid are needed.
But their availability is extremely patchy.
What is available in your region?

What is the relative resourcing of each part of the pyramid?
Are they integrated with each other?
What is stopping such services being provided?

So, what needs to be in place?

Final comments

- **Access, access, access ….**
  - **To multidisciplinary care, pharmacotherapy, bariatric surgery …**
- **In almost all countries health systems have been very slow to respond to the need for provision of:**
  - **health professional training and**
  - **coordinated models of care**
- **How can we all show leadership in addressing weight stigma??**
- **What resources and training are most appropriate for health systems in different countries?**

Thank you!