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(Inq into Obesity)
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Parliamentary public hearing into obesity:

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Prevalence of obesity in Australia:

The rates of obesity amongst adults have doubled over the past two decades with Australia now being ranked as one of the fattest developed nations.

In 2004-05, 41% of males and 25% of females were classified as overweight (BMI 25.0-30.0) and **18%** of males and **17%** of females were classified as obese (BMI > 30.0). (Ref 1)

In 1995, 20-25% of Australian children were classified as overweight or obese. (Ref 2)

In recent years, the prevalence of obesity in Queensland has increased more than the national average and is now the highest of the States (Ref 3). I believe one reason for this is that Northern Queenslanders partake in less incidental exercise, in part due to living in a tropical climate.

Health consequences of overweight and obesity:

There are many studies showing a clear relationship between obesity and increased risk of many medical conditions, including ischaemic heart disease, type 2 diabetes, hypertension, dyslipidamia, osteoarthritis, gallstones, psychological disorders, sleep apnoea, asthma, musculoskeletal problems, some cancers (breast, endometrial and colon), polycystic ovary syndrome ,impaired fertility and kidney disease (Ref 4).

All these conditions are costing the health budget millions of dollars to treat. On best available evidence, obesity will result in an extra 700,000 cardiovascular-related admissions in the next 20 years – costing at least an extra $6 billion in health care (Ref 5).

Prevention is better than cure .... And will also help reduce the health budget!

Management of obesity within General Practice:

Current evidence is that management of obesity requires several approaches, including advice on diet, exercise and psychological therapy. In more severe cases, certain medications and gastric lap banding can also be helpful. I see one of the main roles of GPs is to **motivate** our everyday patients to change their way of life and to inspire them that change is possible and just losing even 5 to 10 kilos can make a major difference to their health (Ref 5). This brief intervention within the GP consultation **is possible**, but it takes at least an extra 5 to 10 minutes on top of the time taken for dealing with the patient's presenting complaint. It is very difficult for a GP to provide advice on preventative health in a 5 minute consultation.

The current medicare system provides GPs who conduct 5 minute consultations with the best financial reward. There is evidence to confirm that short GP consultations are associated with poorer quality medicine, more prescriptions and less time for preventative health (Ref 6)

Another problem with the current medicare system is that it is becoming increasingly complicated with a huge number of new GP medicare item numbers introduced for different conditions. The more complicated a system becomes, the less likely the item numbers will be used in the most appropriate way.

GP management plans (medicare item number 721):

GPs are permitted to develop a "GP management plan" for patients with a chronic condition lasting more than 6 months. For patients with a complex chronic medical condition, requiring referral to at least two other allied health professionals, GPs can also complete a "team care arrangements" plan (medicare item number 723) with their patient.

At present, "**obesity**," according to Medicare Australia, is **not** classed as a chronic condition and GPs are not permitted to do GP management plans for obese patients that have not yet developed a serious medical condition, such as ischaemic heart disease or diabetes.

My proposal: In my opinion, I would like to see the government make the following changes:

(1) **Allow the patient's usual GP to do GP management plans and team care arrangements for patients who are obese** (Adults: BMI greater than 30 & for children : BMI percentile > 95%).

This would encourage patients to see dietitians, exercise physiologists, psychologists and hopefully prevent the multitude of diseases which can be caused by obesity.

Alternative model:

I believe the one most successful GP medicare item numbers introduced in the last couple of years, has been the mental health plan (Item number 2710), which has allowed GPs to sit down with patients for a 30-60 minute bulk billed consultation, develop a mental health plan and refer patients to a psychologist . Patients can then spend at least 6 sessions with a psychologist at a very affordable or free rate. **This one step** has greatly improved the management of mental health within general practice.

This same principal could be used for management of obesity within general practice. The government could allow the patient's usual GP to make a weight loss management program plan with their patient for a certain medicare item number (with a medicare rebate of $150). In forming the weight loss management program plan, GPs would need to measure the patient's body mass index, waist hip ratio, analyse the patient's normal eating and exercise patterns and check on underlying factors causing the obesity, including psychological and or endocrine factors, such as hypothyroidism. The GP would then arrange pathology investigations and referrals to a dietitian, psychologist, exercise physiologist, as appropriate to the individual patient. The practice nurse could also help the GP in preparing this GP weight loss management plan. I would suggest that this weight loss management plan item number would be claimable on a 2 yearly basis and allow subsidised access to 12 visits with a dietitian, exercise physiologist and or psychologist.

This model would be simpler than the GPMP / TCA consultations, as it allows GPs to arrange everything in one consultation and does not require feedback from the allied health providers on the same day. Simpler models in general practice reduce red tape and are more likely to be a success.

(2) **For patients in the "overweight" category (Adults BMI : 25-30 and children: BMI percentile > 85%): I would like them to have free or low cost access to group educational talks to dietitians and exercise physiologists.** This could be similar to the newly introduced medicare item number (713) for patients aged 40-49 found to be at risk for diabetes. These patients found to at risk for diabetes can be referred to the local division of general practice for a lifestyle modification program at low cost or no cost if on a concession card. The problem with the current item number is that the lifestyle modification program is not yet available and the age range for referral is too narrow.
I think the age limits should be removed completely for 2 reasons:

Firstly, confining a certain item number to a specific age range greatly increases red tape in general practice (GPs are interested in people and dealing with their medical conditions, rather than checking patient's specific age.)

Secondly, it is extremely important to deal with lifestyle issues resulting in increasing weight and obesity from a younger age. By the time, someone is "middle age," they already have a lifetime pattern of poor eating and exercise habits, which are more difficult to change.

(3) **Change the current GP consultation medicare rebate system into a 7 tier consultation time system.** This would encourage longer consults within general practice and better quality of general practice, enabling the GPs themselves to discuss more preventative health issues with their patients.

(4)**Assist state and council to increase the number of safe walkways, bikeways and bike racks, which would encourage the general population to increase their level of incidental exercise.**

(5) **Ban advertising for unhealthy eating and increase the number of advertisements promoting healthy eating and exercise.**

(6) **Make healthy nutritional low fat food more affordable.**

(7)**Provide funding for 100% of divisions of general practice to participate in the Autralian Primary Care Collaboratives Program,** which has already been shown to improve outcomes in management of patients with diabetes and coronary heart disease.

References:

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5. Australia's Future "Fat Bomb"; June 2008; Baker IDI heart and diabetes institute.
6. Consultation length in general practice: a review. A Wilson, Br J Gen Pract. 1991 March 41 (344): 119-122