

Obesity: Not sexy enough to treat?

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Above: Dr. Nicholas Christou, president of the Canadian Association of Bariatric Physicians and Surgeons: "We are actually targeting the consequences of the disease rather than dealing with the disease itself."

Last year, Ontario launched a \$75-million initiative to increase its capacity to perform bariatric procedures. Widely held negative beliefs about obesity and weight-loss surgery may contribute to why other provinces haven't followed suit

MONTREAL Consider the following scenario: Two 40-year-old mothers, each with three children, require life-saving surgery, one a bariatric procedure for obesity and the other a mastectomy for breast cancer. Who is more likely to get treated in Canada's publicly funded system?

Ask Dr. Nicholas Christou, past president of the Canadian Association of Bariatric Physicians and Surgeons, and he'll tell you quite apoplectically that it won't be the obese woman. The reason? "Because society views her as a big fat slob who should go on a diet. Why should we pay for her surgery?"

That, Dr. Christou said, is the conundrum and the challenge obese patients face when they look to their provincial governments to cover the cost of a bariatric procedure. Despite being the only effective treatment option available to some obese patients, a group that, incredibly, makes up one-fifth of the population, "politically, it's not a sexy enough issue for them to fund."

Even an 80-year-old requiring a coronary artery bypass will take priority over the obese 40-year-old mother of three, he added. "These are the social issues we have to deal with."

"It's not enough to say that somebody is eating too much. You actually have to look at why that person is eating too much. And that's exactly when things become very complicated."

Perhaps even more complicated for these patients is the bleak reality that the average wait time for a bariatric procedure in Canada is more than five years—a time span that can mean certain death for some, particularly those who have survived to middle-age.

Adding to the problem is the fact that weight-loss surgery faces similar types of bias and stigma because of its bad history.

"This used to be a horrible operation," Dr. Sharma said, but laparoscopic advancements made in the last five to 10 years have reduced the risk of dying from this procedure from one in 100 to one in 1,000 to 2,000.

"You're not cutting through 12 inches of fat anymore and hoping everything is going to heal together. These patients are in and out of the hospital in a matter of days and, in fact, the banding operation used in many centres is done as day surgery. The chances of dying during obesity surgery or seeing severe complications have come down drastically.

"But it's not zero," he stressed, "and it will never be zero because these are big patients and they're sick patients."

It's a hardly a secret, Dr. Sharma added, that high levels of obesity have caused dramatic rises in illnesses such as diabetes, heart disease, stroke, hypertension and some cancers. So even if the public doesn't believe obesity deserves treatment, at the very least society should recognize it makes no economic sense to deny these patients access to bariatric surgery, he said.

"It's the only known treatment that will reduce your risk of dying of cancer by 60% or that will reduce your risk of dying from a diabetes complication by 90%, or reduces total mortality by 40% to 60%. There's almost nothing else we do in medicine that's so effective and has such a dramatic impact on one's health, apart from maybe giving somebody antibiotics for their pneumonia."

Indeed, "there are better data today for doing bariatric surgery than there are for doing bypass surgery," echoed Dr. Arya Sharma, scientific director of the Canadian Obesity Network (CON). But policy-makers and the public remain unsympathetic to the plight of the obese, he said, largely out of ignorance. They don't understand that

obesity is a highly complex chronic disease, with causes rooted in a patient's biology, metabolism and mental health.

Remarkably, though, Canada only performs about 1,000 procedures per year in public hospitals, according to Dr. Christou, which means the country is only touching the tip of the iceberg in terms of dealing with the demand in the population. (Private-pay clinics likely account for 1,500 to 2,000 procedures per year.)

“What I find ironic as a bariatric surgeon who advocates passionately to get this operation more accessible in Canada is that we are actually targeting the consequences of the disease rather than dealing with the disease itself,” Dr. Christou said. For instance, he pointed out, “we are putting all this effort, especially here in Quebec, to get hip replacements guaranteed when at least 48% of the patients in Quebec who might be candidates are morbidly obese. So you go in and replace a hip in a morbidly obese individual and within six months to a year that prosthesis is already damaged or sometimes completely destroyed.”

According to the CON, obesity costs in 2001 represented \$4.3 billion—2.2% of Canada's total health-care budget or 0.4% of Canada's GDP. This estimate, however, only accounts for health-care costs of obesity, and does not consider productivity loss, reductions in taxation revenue as patients leave the workforce, or the increased costs associated with social programs. For instance, 2005 Statistics Canada figures reported that approximately 16% of employed adult Canadians, or more than two million people in the workforce, were obese—up from 12.5% in the mid-1990s.

The psychosocial costs borne by individuals, families and communities who carry the burden of this disease should also be considered, the CON asserts.

Right now, more than 5.5 million Canadians are obese and 500,000 are morbidly obese, with millions more in the overweight category on the brink of becoming obese. Perhaps more alarmingly, more than 500,000 Canadian children are also obese.

So far, Dr. Christou said, Ontario has been the only province willing to make a significant attempt at addressing the country's shortcomings in this area. In July 2008, it announced \$741 million in new funding for a comprehensive, four-year diabetes strategy, of which approximately 10% will go toward access to bariatric services.

This \$75-million initiative is expected to increase the province's capacity for weight-loss surgery several fold over the next three years—a much-needed push, given 485 (74%) of the 654 bariatric procedures funded by the province in 2006/07 were performed out of country.

However, the weighty financial gesture should really only be viewed as repatriation of money and not “new funding,” Dr. Sharma said. Rather, he contended, Ontario simply recognized it was already spending a lot of money sending three-quarters of its bariatric patients to the U.S.; that understanding ultimately led to the funding announcement.

For its part, the Ontario government has said the funding will result in 1,470 gastric bypasses being performed at four centres of excellence in the province by 2011/2012.

Arguments about the true nature of the spending aside, Dr. Sharma said he’s nevertheless gratified to see at least one province formally recognizing that bariatric surgery needs to be more readily available in Canada. “It’s not new money, but it’s a start, and it’s important symbolically in the sense that you’ve actually earmarked money for bariatric centers.”

So, how does the rest of the country move forward following Ontario’s announcement last summer?

Centers of excellence

Good places to start, said Dr. Christou, who is generally considered Canada’s leading expert in obesity surgery, are the three other provinces that house the country’s handful of premiere public bariatric centers of excellence. They include two in Quebec, at McGill University in Montreal, where Dr. Christou practices, and at Laval University in Quebec City; the University of Alberta in Edmonton, where Dr. Sharma practices; and the George Dumont Hospital in Moncton, N.B. Rounding out the quintet is the Humber River Regional Hospital in Toronto.

Although Quebec performs the most obesity surgeries in the country per year, the average wait time for a procedure at Laval or McGill is 13 years, said Dr. Christou. He attributed this to the province not sending any patients out of country for the procedure.

Data from a 2008 CBC news investigation reported that 831 people underwent gastric bypass surgery or laparoscopic banding in hospitals in Quebec in 2007—but there were more than 4,300 people waiting between three and seven years for the procedure.

The same news source also reported the average wait time in Alberta from consultation to bariatric surgery was six weeks to 11 months (the province places the number at seven weeks to three months), with 109 people waiting. In New Brunswick, the average wait time or surgery was six months but the waiting list is 1,500 patients. The New Brunswick government could not confirm these numbers.

For now, Alberta has no plans to change its approach to bariatric surgery. John Templeton, a spokesperson for the province's department of health and wellness, said a number of initiatives to address diabetes are underway in the province, but it is not looking to expand support for gastric bypass simply because it is already covered when it is medically necessary. "I think our focus on wait lists is on other areas," Templeton said.

The same can probably be said for New Brunswick. Geneviève Mallet-Chiasson, a spokesperson for the province's department of health, could not confirm whether New Brunswick plans to expand its coverage, except to say there is only one surgeon in the province, Dr. Sylvain Beausoleil, who is available to perform the procedure. Wait times depend on his availability and operating room availability.

Some good news, however, does appear on the horizon for Quebec. Kate White, a spokesperson for the province's ministry of health, said to expect a "major announcement" sometime this spring regarding access to bariatric surgery in the province. Details of the plan are not yet available but, when asked if it will be as substantial as that announced last summer in Ontario, White said "yes."

Until all provinces begin investing in the establishment of bariatric centres of excellence, Dr. Sharma said, efforts to address obesity, which have largely focused on prevention, will fail.

"It's always important to recognize there's a big difference between the kind of things you do for prevention and the things you actually have to do for treatment. And that once you have the condition, the things you do for prevention don't benefit those people who already have the problem."

From an economic perspective, from a health outcomes perspective and from the impact of the successful obesity surgery on a person's life, the benefits of bariatric surgery is inarguable, he said.

"Anybody who stands up today and says he just doesn't believe in the surgery doesn't know what he's talking about. He hasn't read the literature, he doesn't know where this field is going and he has never met a patient who has had the surgery."