Obesity Research & Clinical Practice xxx (2020) xxx–xxx

Contents lists available at ScienceDirect

Obesity Research & Clinical Practice

journal homepage: www.elsevier.com/locate/orcp

Research Letter

Delays in healthcare consultations about obesity — Barriers and implications☆

ARTICLE INFO

Keywords:
Obesity
Misconceptions
Barriers

ABSTRACT

Background: The prevalence of obesity continues to rise, affecting nearly a third of Australian adults in 2017–18. The stigma and bias people with obesity (PwO) experience is one of the barriers hindering the dialogue between PwO and their Health Care Professionals (HCPs). The results from the ACTION IO Australian cohort are reported here. Identification of local barriers can inform strategies to improve access to quality obesity care within Australia.

Methods: The ACTION-IO study was an online cross-sectional survey conducted in 11 countries during June–October 2018. In Australia 1,000 community based adult PwO (body mass index ≥30 kg/m based on self-reported height and weight) and 200 HCPs involved with direct patient care (seeing ≥10 patients with obesity/month) completed the survey.

Results: There was a mean delay of 8.9 years from when a PwO first started to struggle with their weight, and the initial discussion with an HCP about this. HCPs acknowledged weight loss efforts in only 38.5% of their patients, although 74.6% of PwO had attempted weight loss. Most PwO (82.0%) assumed full responsibility for their weight loss. HCPs identified short appointment times (60.5%) and the cost of obesity medication, programmes and services (58.5%) as barriers to weight management conversations and weight loss, respectively. Most PwO want their HCP to raise the issue of weight with 64 % reporting finding such conversations positive and helpful.

Conclusion: Compared to global results, Australian PwO took 3 years longer to seek medical care about their weight. Better recognition of obesity's impact and targeting barriers to care are needed.

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Introduction

The prevalence of obesity continues to rise, affecting nearly a third of Australian adults in 2017–18 [1]. Despite being an Australian National Health Priority Area since 2008 [2], <1% of general practice consultations focus on obesity [3].

The Awareness, Care and Treatment In Obesity maNagement - International Observation (ACTION-IO) study was conducted to assess perceptions, attitudes and behaviours towards obesity management in people with obesity (PwO) and healthcare professionals (HCPs). Primary results from the global dataset have been reported previously [4]. Results from the Australian cohort are reported here. To our knowledge, this is the largest Australian survey of PwO and HCPs to date.

Methods

Methodology for the study (NCT03584191) has been reported previously [3]. Results from the Australian cohort are reported here. 1000 community-based adult PwO (body mass index ≥30 kg/m^2 based on self-reported height and weight) and 200 HCPs involved with direct patient care (seeing ≥10 patients with obesity/month) completed the survey. Those specialising in general, plastic or bariatric surgery were excluded. A third-party vendor (KJT Group [Honeoye Falls, NY, USA]) conducted the survey and was responsible for data collection and analysis.

Results

1000 PwO and 200 HCPs completed the survey in Australia. Respondents' characteristics are show in Table 1. More than half of PwO had Class I obesity (55.9%, 544/1000). Yet two-thirds (66.4%, 683/1000) of PwO considered themselves to have a normal weight or overweight.

Only 53.2% (555/1000) of PwO had discussed their weight with an HCP in the past 5 years, with more than half having initiated the conversation themselves (54.3%, 308/555). There was a mean gap of 8.9 years from self-concern about weight (at mean age 39.9 years) to weight management discussions with their HCP. The main reasons PwO reported not discussing weight management with their HCP were the belief that it was their own responsibility (54.5%) (Fig. 1).

HCPs cited obesity-related comorbidities as the principal reason for initiating weight management discussions (80.0%). The top reasons HCPs provided for not discussing obesity was perceiving

☆ Trial registration: Clinicaltrials.gov, NCT03584191.

https://doi.org/10.1016/j.orcp.2020.08.003
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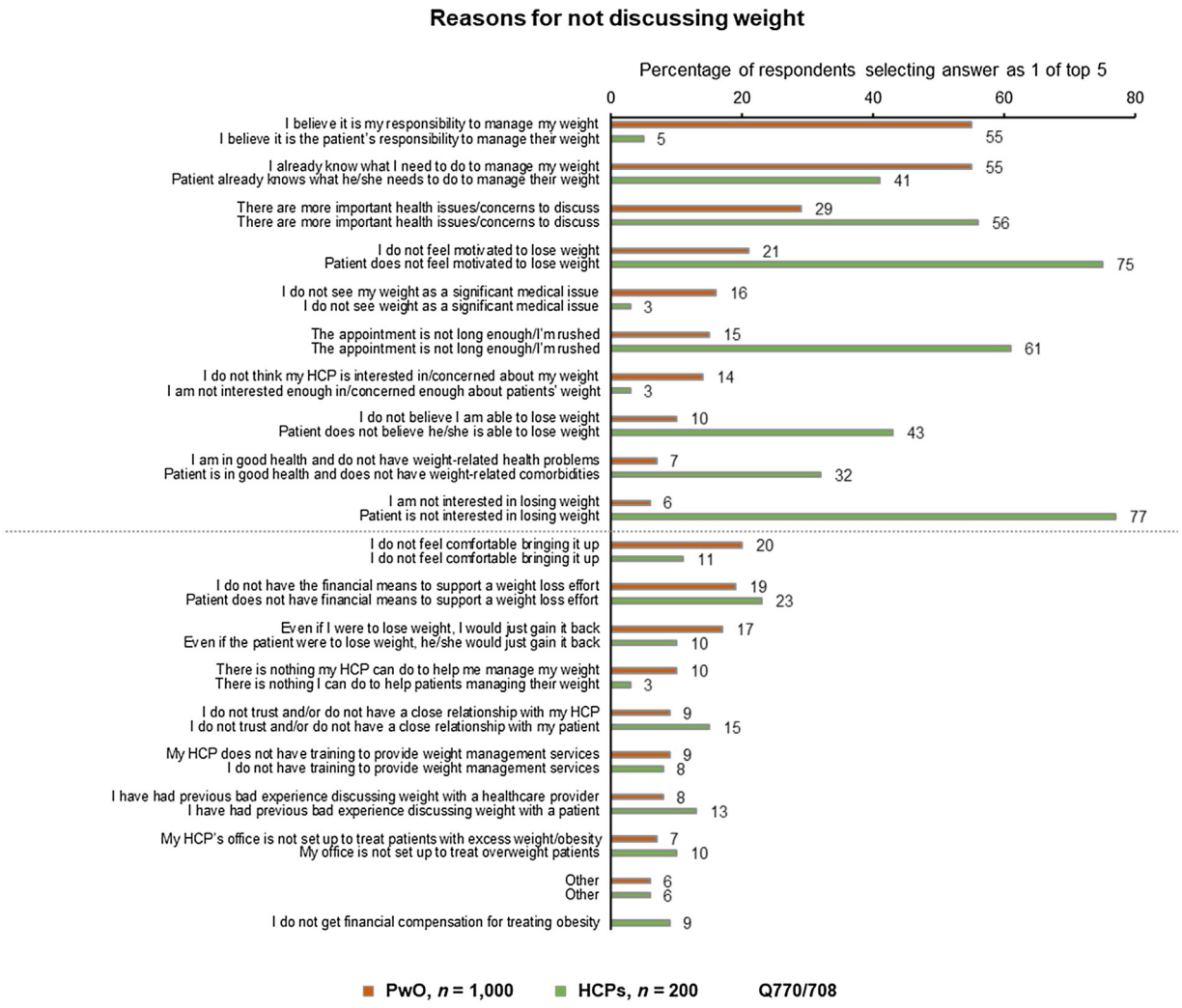

Fig. 1. Reasons for not discussing weight with an HCP (PwO, orange) or patient (HCPs, green); reasons with at least 10% difference between PwO and HCPs are presented above the dotted line, all other reasons are presented below. *Abbreviations*: HCP, healthcare professional; PwO, people with obesity.

patients to not be interested (76.5%) or lack motivation to lose weight (74.5%) and limited appointment time (60.5%) (Fig. 1).

Most HCPs reported unhealthy eating habits (92.5%) and lack of exercise (86.0%) as barriers to weight loss, whereas fewer PwO considered these to be important (51.1% and 64.0%). Only 51.0% of HCPs and 31.6% of PwO considered genetic factors a barrier.

For PwO who discussed their weight with HCPs, more than one-third found such conversations very or extremely helpful, and 64% had positive feelings after such discussions (Fig. 2).

Discussion

The Australian cohort took an average of 3 years longer to discuss their weight with an HCP compared to the global dataset (8.9 vs 6 years). Despite almost half having Class II or III obesity, 66.4% of PwO did not perceive themselves as having obesity. Inadequate self-awareness of obesity, and its complications, could be a barrier to seeking effective obesity treatment.

Favourable responses from PwO about weight loss discussions should encourage HCPs to initiate communication earlier. Of Australian HCPs, 60.5% cited short appointment times as a barrier to weight management conversations, 7% more than the global cohort (54%). This indicates a need for Medicare Benefits Schedule item numbers specific to obesity and its complications.

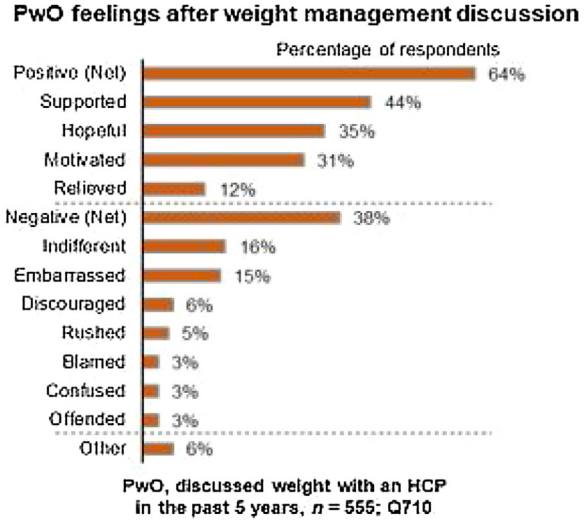

Fig. 2. PwO feelings after discussing their weight with an HCP. *Abbreviations*: HCP, healthcare professional; PwO, people with obesity.

The most common barrier for PwO to initiating conversations with HCPs was the belief that weight management was solely their responsibility. Three quarters of HCPs perceived that their patients

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Table 1
Demographics and characteristics.

Characteristic	PwO (n = 1000)	HCPs (n = 200)
Recruitment and qualification		
Total survey invitations sent	46,511	6324
Respondents	4424 (9.5%)	394 (6.2%)
Respondents who qualified	1150 (2.5%)	245 (3.9%)
Respondents who qualified and completed survey	1000 (2.2%)	200 (3.2%)
Age, years[a]	61 (18–88)	51 (30–78)
Gender[a]		
Male	500 (50.0%)	140 (70.0%)
Female	499 (50.0%)	60 (30.0%)
Other	1 (0.1%)	
BMI classification[b]		
Respondents		
Underweight (<18.5 kg/m^2)		3 (1.8%)
Healthy weight (18.5–25 kg/m^2)		98 (58.7%)
Overweight (25–29.9 kg/m^2)		57 (34.1%)
Obesity Class I (30–34.9 kg/m^2)	544 (55.9%)	5 (3.0%)
Obesity Class II (35–39.9 kg/m^2)	220 (18.5%)	2 (1.2%)
Obesity Class III (≥40 kg/m^2)	236 (25.5%)	2 (1.2%)
Number of comorbidities[b]		
0	132 (13.9%)	
1	184 (22.6%)	
2	204 (18.9%)	
3	195 (18.3%)	
≥4	285 (26.3%)	
Income, AUD[a]		
<$26,000	154 (15.4%)	
$26,000–<$80,000	536 (53.6%)	
≥$80,000	310 (31.0%)	
Place of residence[a]		
Metropolitan	747 (74.7%)	
Rural or remote	253 (25.3%)	
HCP category		
PCP		101 (50.5%)
Specialist		99 (49.5%)
Cardiologist		50 (25.0%)
Endocrinologist		41 (20.5%)
Internal medicine (non-PCP)		4 (2.0%)
Hepatologist/gastroenterologist		2 (1.0%)
Other		2 (1.0%)
Obesity specialist[c]		
Yes		106 (53.0%)
No		94 (47.0%)

AUD = Australian dollar; BMI = body mass index; HCP = healthcare professional; PCP = primary care physician; PwO = people with obesity. Data are mean (range) or number (%).

[a] PwO data are reported for the final unweighted sample.

[b] PwO percentages are reported for the weighted sample.

[c] A physician who meets at least one of the following criteria: at least 50% of their patients are seen for obesity/weight management, or has advanced/formal training in treatment of obesity/weight management beyond medical school, or considers themselves to be an expert in obesity/weight management or works in an obesity service/clinic.

had low motivation to lose weight, whereas only 21% of PwO did not feel motivated.

The key limitations of this study are similar to the global study. A high proportion of Australian HCPs identified themselves as obesity specialists, which might have biased their responses.

Conclusion

New strategies and greater resource allocation are required to overcome the substantial barriers to equitable, effective and timely access to obesity treatment in Australia today. There is a gap of nearly 9 years between self-concern about weight and initial weight-management discussion with an HCP. Better recognition of obesity's impact and targeting barriers to care are needed.

Author contributions

Ian Caterson and Georgia Rigas contributed to the design of the ACTION IO study. All authors participated in interpretation of the data and drafting and revision of the manuscript. All authors reviewed and approved the final, submitted version.

Sources of funding

This study was sponsored by Novo Nordisk, which also provided financial support for medical editorial assistance from Isuru Wijesoma PhD and Abbie Saunders PhD CMPP of Articulate Science, Ltd. The authors would like to acknowledge Prof. Mark Harris for his comments on an early version of this manuscript and Dr Behnaz Carney for her medical editorial assistance from Novo Nordisk.

Ethical statement

The study was approved by the University of Sydney Human Ethics Committee.

Conflicts of interest

WAB received travel expenses, and GR, KW, JS and IDC received personal fees, from Novo Nordisk to attend the ACTION-IO Australia author meeting.

GR reports having received payment from Novo Nordisk and mdBriefcase Australia & Global, for participation in advisory boards and personal fees (lecture) unrelated to the submitted work; personal fees (lecture) from iNova Pharmaceuticals, ReShape Lifesciences (formerly Apollo Endosurgery), Johnson & Johnson, Medtronic (formerly Covidien), and non-financial support (clinical resources) from Device Technologies and W.L.Gore, outside the submitted work. She is the Senior Bariatric Medical Practitioner at a private bariatric medical and surgical unit in Australia.

KW reports grants, personal fees and non-financial support from Novo Nordisk outside the submitted work. She is clinical lead and manager of a public tertiary obesity service in Australia.

PS has received payment from Novo Nordisk for participation in advisory boards and a lecture unrelated to the submitted work.

WAB reports grants and personal fees from Novo Nordisk and W.L. Gore; personal fees from Merck Sharp & Dohme (MSD); grants from Johnson & Johnson, Medtronic and Applied Medical; grants from the National Health and Medical Research Council and Commonwealth of Australia outside the submitted work. She is also a surgeon who performs bariatric surgery.

JS reports personal fees from Novo Nordisk (Australia), Novo Nordisk (Denmark), Coloplast (Australia) and Coloplast Global (Denmark), DesignPsykologi (Denmark); she is on the advisory panel of SmartShape Centre for Weight Management outside the submitted work.

KP is employed by Novo Nordisk and owns shares in Novo Nordisk.

IDC reports personal fees from Novo Nordisk (as chair of the ACTION-IO steering committee), grants from Novo Nordisk, Rhythm Pharmaceuticals, SFI and Australian Eggs outside the submitted work, and personal (lecture) fees from Novo Nordisk outside the submitted work.

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Georgia Rigas [a,*]
Kathryn Williams [a,b,**]
Priya Sumithran [d]
Wendy A. Brown [e]
Jessica Swinbourne [c,f]
Katrina Purcell [f]
Ian D. Caterson [c]
[a] *Department of Bariatric Surgery, St. George Private Hospital, Kogarah, Sydney, Australia*
[b] *Nepean Hospital, Nepean Blue Mountains Local Health District, Kingswood, New South Wales, Australia*
[c] *Boden Collaboration, Charles Perkins Centre, University of Sydney, New South Wales, Australia*
[d] *Department of Medicine (Austin), University of Melbourne, Heidelberg, Australia*
[e] *Department of Surgery, Monash University, Melbourne, Australia*
[f] *Novo Nordisk, Baulkham Hills, New South Wales, Australia*

* Corresponding author at: Suite 3, Level 5, St George Private Hospital, 1 South Street, Kogarah, New South Wales 2217, Australia.

** Corresponding author at: Department of Endocrinology (Obesity), Nepean Hospital, Derby Street, Kingswood, New South Wales 2747, Australia.
E-mail addresses: georgiar@uppergisurgery.com.au (G. Rigas), kath.williams@sydney.edu.au (K. Williams).

3 August 2020

Please cite this article in press as: Rigas G, et al. Delays in healthcare consultations about obesity — Barriers and implications. Obes Res Clin Pract (2020), https://doi.org/10.1016/j.orcp.2020.08.003