Obesity management in Australian primary care, where has the general practitioner gone?

Running title – Obesity management by general practitioners

ABSTRACT

Obesity is a chronic condition with significant health and economic consequences that requires more effective management in Australia. General practitioners (GPs) currently act as care co-ordinators in line with national guidelines for overweight and obesity. Australian patients indicate that they would appreciate more involvement from their GP in the management of obesity and this is in line with international findings. Not all patients have access to specialist obesity services or affordable allied health care due to location, cost and time, particularly in rural and remote areas where there is a greater prevalence of obesity. Empowering GPs to use their skills as expert generalists to manage obesity is an option that should be explored to improve access for all individuals. GPs will require evidence-based tools to assist them in structuring obesity management within their own general practice environment.
Summary statement

What is known about the topic?

• General practitioners are caring for a growing number of people who are living with obesity.

What does this paper add?

• The expert generalist skill set of general practitioners could be better used to provide person-centred care for people with obesity with the support of evidence-based tools.
Obesity is a major public health issue in Australia that contributes to the rising prevalence of chronic diseases such as type 2 diabetes, cardiovascular disease and osteoarthritis (National Health and Medical Research Council 2013). Obesity increases an individual’s physical and psychological health burden and adds $21 billion in direct costs to Australia’s annual economic burden (Chen et al. 2011). Clearly, there is a need to take immediate and ongoing action to reduce the prevalence of obesity in Australia.

There is increasing evidence that obesity should be viewed as a chronic condition (Fildes et al. 2015), requiring ongoing management rather than a one-off “cure”. Primary care has been the cornerstone of chronic disease management in the Australian healthcare system with the recognition that ongoing care from a trusted practitioner improves outcomes (Harris and Zwar 2007). Obesity is specifically managed in 0.7 per 100 encounters in Australian general practice (Britt et al. 2014), but is also managed as part of consultations for other conditions including diabetes, lipid disorders and arthritis.

Review of international guidelines for the role of general practitioners (GPs) in obesity management shows great variation in what is expected of the profession. Australian guidelines suggest a role of recognition and onward referral (National Health and Medical Research Council 2013). The New Zealand guidelines recommend GP delivered care within a community context (New Zealand Guidelines Group 2012). Conversely, there is no mention of general practice in the World Gastroenterology Organisation guideline (Mathus-Vliegen and Toouli 2011). In this review of the literature we investigate the current role of the GP in
obesity management, and explore reasons for expanding the role of GPs in supporting patients with obesity to reduce their risk for chronic disease.

**FEATURES OF GENERAL PRACTICE**

General practice is an internationally recognised medical speciality that provides person-centred, longitudinal, and coordinated whole-person healthcare to individuals in their communities (Kidd 2013). The Australian Patient Experiences Survey found 86% of those over the age of 15 years visited a GP at least annually with increasing frequency of access with age (Australian Bureau of Statistics 2013). The survey also showed that of those who had seen a GP in the previous 12 months, more than 70% reported that the GP always listened carefully to them, always showed them respect and always spent enough time with them (Australian Bureau of Statistics 2013). Most Australians attend a regular GP or general practice thus providing good continuity of care (McRae et al. 2011). Australian GPs enjoy high rates of patient satisfaction and these therapeutic relationships could be better utilised in obesity care.

Currently, over 85% of all GP consultations are bulk billed with no point of care cost to the patient (Australian Bureau of Statistics 2013). Allied health services, such as dietetics and exercise physiology, are subsidised by Medicare only in the context of a chronic disease management plan and require the presence of co-morbidities (Foster et al. 2009). Uncomplicated obesity does not qualify for subsidised services in allied health which may make these services inaccessible for some patients. The lower point of care cost to the
patient may make GP-delivered obesity care more accessible especially for patients of low socioeconomic background.

CURRENT GUIDELINES

The Australian National Health and Medical Research Council (NHMRC) guidelines for the management of overweight and obesity in primary care recommend a usual healthcare practitioner, such as a GP, be involved as a care coordinator. The guidelines state the healthcare practitioner should recognise the condition of obesity, provide opportunity for ongoing anthropometric measurement and basic advice about nutrition and physical activity (National Health and Medical Research Council 2013). The healthcare practitioner is advised to have a low threshold for referring on to an allied health provider for further management. Specialist involvement is suggested if the patient has co-morbidities or a Body Mass Index (BMI) over 35kg/m². Considering the prevalence of overweight and obesity, referral of most patients to specialist care is unlikely to be a practical reality. It is clear that better support is needed for GPs to manage patients with overweight or obesity.

Obesity management cannot be “one size fits all” as each patient has personal barriers to care and access to specialist obesity services are not available to the majority of Australians living outside the major capital cities (National Rural Health Alliance 2004). The financial cost of seeking these services can be high especially for patients who are overweight but lack the co-morbidities which allow access to Medicare rebates for allied health interventions (Pearce-Brown et al. 2011). The time cost to travel, meet and follow up with different health providers can make services unattainable or unacceptable for some patients (Tan et al. 2006;
Pearce-Brown, Grealish et al. 2011; Arai et al. 2015). Providing general practice based options for obesity management will improve access for patients.

There is evidence that GPs are patients’ preferred source of information relating to obesity (and nutrition more generally), even over specialists such as dietitians (Ball et al. 2014). In a survey of Australian general practices, 78% patients (n=227) thought their GP did have a role to play in weight management and 78% were also keen on regular review with their GP (Tan et al. 2006). Internationally the role for GPs as a respected information source regarding nutrition and obesity care has been recognised for decades (Hiddink et al. 1997).

Lack of time is often quoted as a barrier to the involvement of GPs in obesity care. Yet there has been no added benefit of longer periods of consultation when assisting patients to change other health behaviours such as alcohol intake (Kaner et al. 2007). This discourse around time does not recognise the journey that a GP takes with their patient, with each consultation a drop in the total time spent with the person over a lifetime (Gray et al. 2003).

For patients who want to work with their GP to manage their weight, there are few Australian resources. Primary Health Networks (PHNs) provide some programs to manage people with chronic conditions but most require a patient to have a co-morbidity, and are not delivered within the general practice setting. The Heart Foundation, in conjunction with PHNs and other partners, has piloted “Heartlink” which aims to reduce patient’s cardiovascular risk but the program did not involve the patient’s GP other than referral (Volker et al. 2014).
PERSON-CENTREDNESS

A core tenant of general practice is that care should be person-centred (Kidd 2013). Person-centredness is treatment that takes into account the target health issue as well as co-morbidities and social circumstances that may impact on the person. The patient’s values and desires for their health remain central to any defined treatment or management process (Starfield 2011). The person-centred approach to obesity care is not mentioned in methodology for current interventions based in primary care (Wadden et al. 2014) and thus interventions may not be harnessing the power of this fundamental part of good general practice care. A person-centred approach that is offered as part of quality general practice care will provide a respectful environment for the issues surrounding obesity to be discussed and managed.

As part of person-centredness, GPs determine the priority and timing for any intervention for obesity (Stange 2009b). Patients often present with multiple reasons for a consultation and few have only a single issue that is impacting on their health (Britt et al. 2014). The GP needs to be able to consider all aspects of a patient’s situation to prioritise the most pressing health need. Other considerations such as family influences, health priorities and social circumstances may rightly impact on a GP’s decision to explore obesity management in a consultation (Stange 2009b). In the interests of excellent patient care there are times when a GP should not address obesity in a consultation, for example acute distress or illness, but instead should include it is part of an ongoing management plan.
EXPERT GENERALISM

The defining feature of an expert generalist is their ability to provide whole-person care and to do this in a context of person-centredness (Reeve et al. 2013). This translates to being a health practitioner who can manage all health concerns no matter what body system is affected, whilst taking into account the wishes and values of the person at the centre of the management plan (Reeve et al. 2013).

For the successful management of obesity three specific areas need to be targeted: nutrition, physical activity and behavioural interventions (National Health and Medical Research Council 2013). A GP has modest training in all three areas and can manage obesity in the context of other health conditions and behaviours – for example smoking, alcohol use and a high stress lifestyle. GPs also demonstrate good attitudes towards continuing education in these areas (Crowley et al. 2015). They can leverage change in one area to assist the patient to change in the areas of nutrition and physical activity. The methods used to assist with behaviour change in obesity are already employed with good effect by GPs in other related areas such as smoking cessation and alcohol use (Kaner et al. 2007; Stead et al. 2013).

A tailored management plan for obesity should be coordinated, taking into account co-morbidities, mental health conditions and the person’s social context. The generalist is in the best position to do this. Fragmentation of care has been recognised as a burden when looking at disease states requiring tertiary care (Stange 2009a). Similarly benefits for the patient may potentially be lost if different “parts of obesity” are managed in a fragmented way. The current NHMRC guidelines for management of obesity bypass the expert
generalism offered by GPs utilising them solely as “screeners” and “referrers” to more fragmented and less available allied healthcare. The impact of being cared for by an expert generalist is rarely explored within the context of obesity management. This may be a “missing link” in attempts to develop innovative strategies for obesity management in primary care.

**OBESOGENIC ENVIRONMENT – PUBLIC HEALTH PARTNERSHIP**

All health conditions, including obesity, are influenced by the patient’s social determinants of health that are in turn affected by factors specific to the community in which they live (van Weel et al. 2008). This reality requires community awareness and action on the part of GPs. GPs can work alongside public health initiatives to support environments that improve individuals’ health status.

Recognition of the “obesogenic environment” is essential in understanding the barriers to weight management (Swinburn et al. 1999). A good example of the interaction between general practice and public health is the success of smoking cessation. GPs increased individual management of patients to help them stop smoking, but also strongly advocated and supported public health interventions. Currently there are disincentives for patients to eat healthily and be physically active, leaving the individual to contend with their environment without the aid of a strong public policy framework to contain obesity.

Too often GPs are pursuing prevention while society is full of counter-incentives – like the obesogenic environment (Swinburn et al. 1999). This is a GP leadership issue as
environments that support healthy lifestyles make individual interventions more feasible and effective when they are super-imposed on population directed public health action. GPs must continue to look beyond the consultation room to the community their patients live in. Utilising their leadership skills GPs can advocate for change in public health policies and legislation so that patients find the easiest choice to make is also the one that is best for their health.

**CONCLUSION**

GPs require resources to support their patients with obesity in their day to day clinical practice. This will enable them to refer to other health service providers only those patients who require a higher level of intervention when this is in line with the patient’s wishes for treatment. This will allow those patients most in need of allied health and specialist services the greatest time and support from these professionals. The expert generalism of GPs can be better used to manage patients with obesity in a holistic, person-centred manner. GPs can understand the person as a whole and recognise the barriers and motivators for individual patients to change their behaviour. GPs have a role at both the individual consultation level and in partnership with public health organisations in advocating for community environments that support healthy lifestyle behaviours.

**Conflicts of Interest**

The authors have no conflicts of interest to declare.


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