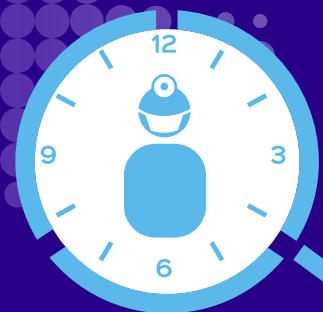


REPORT CARD ON ACCESS TO **OBESITY TREATMENT FOR ADULTS IN CANADA 2019**

obesitycanada.ca/report-card



Notice and Disclaimer

No part of these materials may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without prior written permission from Obesity Canada-Obésité Canada. This booklet is provided under the understanding and basis that none of the publisher, the authors or other persons involved in its creation shall be responsible for the accuracy or currency of the contents, or for the results of any action taken on the basis of the information contained in this book or for any errors or omissions contained herein. No reader should act on the basis of any matter contained in this booklet without obtaining appropriate professional advice. The publisher, the authors and other persons involved in this booklet disclaim liability and responsibility resulting from any ideas, products or practices mentioned in the text and disclaim all and any liability and responsibility to any person, regardless of whether such person purchased this booklet, for loss or damage due to errors and omissions in this book and in respect of anything and of the consequence of anything done or omitted to be done by such person in reliance upon the content of the booklet.

Parts of this material are based on data and information provided by the Canadian Institute for Health Information. However, the analyses, conclusions, opinions and statements expressed herein are those of the author and not necessarily those of the Canadian Institute for Health Information.

How to cite this document:

Obesity Canada-Obésité Canada. *Report Card on Access to Obesity Treatment for Adults in Canada 2019*. Edmonton, AB: 2019, April.

Primary Corresponding Author:

Mayank Rehani, MSc
Obesity Canada-Obésité Canada
2-126 Li Ka Shing Centre for Health Research Innovation,
University of Alberta,
8602-112 Street, Edmonton, AB T6G 2E1
E-mail: rehani@obesitynetwork.ca

For general inquiries: info@obesitynetwork.ca

Acknowledgements

Obesity Canada-Obésité Canada (OC) was responsible for the design, data collection, analysis and interpretation of the report. The *Report Card on Access to Obesity Treatment for Adults in Canada 2019* was made possible unrestricted grants from FOCUS partners including, Novo Nordisk Canada Inc., Nestlé Health Science Canada, Medtronic, Ethicon, and Bausch Health. FOCUS partners have also contributed in-kind support towards dissemination and promotion of this report.

OC would like to extend a special note of gratitude to Ms. Sateen Werner and Dr. Jo-Anne Gilbert who assisted with data collection for this report. OC also acknowledges the assistance and insights provided by the following Canadian experts who volunteered their time and expertise to gather and interpret data as part of the Scientific Working Group and the Knowledge Translation Advisory Committee.

Scientific Working Group:

Dr. Arya M. Sharma (University of Alberta, Obesity Canada)
Dr. Jean-Eric Tarride (McMaster University)
Dr. Laurie Twells (Memorial University of Newfoundland)
Dr. Marie-France Langlois (Université de Sherbrooke)
Dr. Sara Kirk (Dalhousie University)
Dr. Ximena Ramos Salas (Obesity Canada)
Brad Hussey (Obesity Canada)
Mayank Rehani (Obesity Canada)

Knowledge Translation Advisory Committee:

Nora Madian (Novo Nordisk Canada Inc.)
Adam Marsella (Novo Nordisk Canada Inc.)
Karen Chopra (Nestlé Health Science Canada)
Stephane Marcott (Medtronic)
Maximiliano Iglesias (Ethicon, Johnson & Johnson)
Christine Kwok (Bausch Health)
Members of the Scientific Working Group

Design: Patti Whitefoot-Bobier
Web design: Robert Fullerton/Datascares
Translation: Gilles Giraud

Table of contents

Introduction	6
Who Are We?	7
Changes in the Obesity Landscape Since 2017	8
Methodology	9
Executive Summary	10
Recognition of Obesity as a Chronic Disease and Public Policy	11
Access to Behavioural Interventions and Interdisciplinary Teams for Obesity Management	13
Number of Healthcare Professionals in Canada with Certification in Obesity Medicine	15
Access to Medically Supervised Weight Management Programs with Meal Replacements	19
Access to Prescription Anti-Obesity Medications	21
Access to Bariatric Surgery	25
References	32

Introduction

Obesity is a progressive chronic condition, similar to diabetes or high blood pressure, which is characterized by abnormal or excessive fat accumulation that impairs health.¹ As a leading cause of type 2 diabetes, high blood pressure, heart disease, stroke, arthritis, cancer and other health problems, obesity can have serious impacts on those who live with it. It is estimated that one in 10 premature deaths among Canadian adults age 20 to 64 is directly attributable to obesity.² Beyond its effects on overall health and well-being, obesity also affects peoples' social and economic well-being due to the pervasive social stigma associated with it. As common as other forms of discrimination — including racism — weight bias and stigma can increase morbidity^{3,4} and mortality.⁵ Obesity stigma translates into significant inequities in access to employment, healthcare and education, often due to widespread negative stereotypes that persons living with obesity are lazy, unmotivated or lacking in self-discipline.⁶

In 2006, the Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children⁷ (the Canadian Clinical Practice Guidelines) were released to assist physicians and health professionals with supporting patients with obesity. In 2015, the Canadian Medical Association declared obesity to be a chronic medical disease. Many organizations — including Obesity Canada-Obésité Canada, the Canadian Medical Association, the American Medical Association and the World Health Organization — have since also declared obesity to be a chronic disease.

Recognizing obesity as a chronic disease is more than a symbolic gesture. It confirms the need to shift away from considering obesity to be merely the result of poor lifestyle choices toward a socio-ecological model of health that carries with it an obligation to our health systems and society to prevent and treat it as we do other chronic diseases.

In 2017, Obesity Canada-Obésité Canada sought to quantify and qualify access to publicly provided medical care for obesity, as well as interventions covered by private health plans and released the first Report Card on Access to Obesity Treatment for Adults in Canada 2017.⁸ The purpose of the current report is to update the findings of that Report Card and identify what progress, if any, has been made in terms of access to obesity treatment over the past two years.

Can obesity be treated?

Like many other chronic conditions, obesity is treatable. The 2006 Canadian Clinical Practice Guidelines⁷ recommended the application of the following interventions for adults living with obesity: lifestyle intervention (dietary intervention, physical exercise therapy, and cognitive behaviour therapy), pharmacotherapy and bariatric surgery.


A recent systematic review⁹ of obesity management in primary care showed that improvements in clinically relevant health outcomes could be achieved by multi-component interventions delivered over the long term by an interdisciplinary health team. The impact of treating obesity in controlling and, in some cases, improving a wide range of clinical conditions including osteoarthritis, diabetes, sleep apnea, hypertension, urinary incontinence and infertility has also been demonstrated in recent research.¹⁰




Who are we?

Obesity Canada-Obésité Canada, previously known as the Canadian Obesity Network-Réseau canadien en obésité, is Canada's authoritative voice on evidence-based approaches for obesity prevention, treatment and policy. Currently, Obesity Canada-Obésité Canada has more than 20,000 professional members and over 25,000 public supporters. Our mission is to improve the lives of Canadians affected by obesity through the advancement of anti-discrimination, prevention and treatment efforts. Our goals are to address the social stigma associated with obesity, change the way policy makers and health professionals approach it and improve access to evidence-based prevention and treatment resources.

FIND OUT MORE AT
obesitycanada.ca

 ObesityCan

 facebook.com/ObesityCanada



Noteworthy Changes in the Obesity Landscape in Canada since 2017

1. Launched in April 2017, the Certified Bariatric Educator program has certified 80 healthcare professionals in Canada on obesity medicine.
2. In September 2017, Canadian Obesity Network-Réseau canadien en obésité gained the status of a registered charitable organization in Canada.
3. In March 2018, Health Canada approved Contrave® extended-release tablets for use as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults.
4. In June 2018, the Canadian Obesity Network-Réseau canadien en obésité officially changed its name to Obesity Canada-Obésité Canada.
5. In November 2018, the Yukon Medical Association became the second provincial/territorial medical association to declare obesity a chronic medical disease following Saskatchewan (2015) and the Canadian Medical Association (2015).
6. In December 2017, Obesity Canada and the Canadian Association of Bariatric Physicians and Surgeons began the process of creating new Canadian guidelines on the treatment and management of obesity in adults. The new guidelines, which reiterate that obesity is a complex, relapsing chronic disease, will be launched in 2019 and will provide evidence-based recommendations for the prevention and management of obesity in adults.
7. In January 2019, the Lancet Commission report on “The Global Syndemic of Obesity, Undernutrition, and Climate Change” was released.¹¹ The commission concluded that obesity is now one of the largest contributors to poor health in most countries in the world. It was estimated that in 2015, excess body weight affected two billion people worldwide and accounted for approximately four million deaths and 120 million disability-adjusted life years. The estimated annual costs of obesity are US\$2 trillion, representing 2.8% of the world’s GDP. Despite three decades of calls by national and international organizations to implement obesity policies, implementation has been patchy at best.
8. Obesity is now widely recognized^{12–15} as a complex, relapsing chronic disease that requires more than simplistic solutions such as promotion of healthy eating and physical activity. However, among federal, provincial and territorial policy makers, obesity continues to be treated as a risk factor and not as a chronic disease.

Methodology

The scope of this report was limited to services available in publicly funded healthcare systems in Canada. Publicly accessible resources and documents were researched extensively for evidence of policies, guidelines, and services for obesity treatment and management in each province and territory. OC also conducted a thorough review of scientific literature on the access to obesity treatment and management in Canada. The areas of inquiry for this report were inspired by the 2006 Canadian Clinical Practice Guidelines,⁷ with a focus on public access to the following obesity treatment and management options for adults:



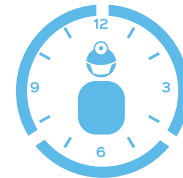
Access to specialists and interdisciplinary teams for behavioural intervention



Access to weight management programs that include meal replacement



Access to anti-obesity medications* through public and private means



Access to bariatric surgery and wait times

Survey instruments were also designed to acquire information on provincial and territorial policies and services, private drug benefit plans offered by the health insurance industry and bariatric surgical services and wait times. Industry experts and a scientific working group comprised of health researchers with expertise in obesity reviewed the data collection framework and survey instruments. Interviews based on the survey instruments were conducted with representatives of health insurance companies, healthcare staff in bariatric surgical centres and representatives of provincial and territorial governments or health service authorities.

Data on the number of persons with obesity, the number of bariatric surgeries and coverage rates in private drug benefit plans for anti-obesity medications* were acquired from Statistics Canada, the Canadian Institute for Health Information (CIHI) and TELUS Health Analytics, respectively. Data collection occurred between June 1, 2018, and February 28, 2019.

* The term anti-obesity medication is the standard language used in chronic disease management frameworks. This term does not imply actions against people with obesity.

Report Card on Access to Obesity Treatment for Adults in Canada 2019: Executive Summary

- Since the 2017 Report Card, obesity has not received official recognition as a chronic disease by the federal government or any provincial/territorial governments, despite the recognition from the Canadian Medical Association's and the medical professional associations in Saskatchewan and Yukon.
- Obesity continues to be viewed as a self-inflicted risk factor, which affects the type of interventions and approaches that are implemented by governments or covered by private health benefit plans.
- There are no official guidelines or policies for obesity treatment and management in adults in any province or territory.
- Some provincial and territorial governments are prioritizing obesity prevention efforts and promoting healthy living initiatives.
- There is a profound lack of interdisciplinary teams for obesity management at the primary care level.
- There are only 67 American Board of Obesity Medicine-certified physicians in Canada.
- Since its inception in April 2017, 80 healthcare professionals in Canada have received the Certified Bariatric Educator designation offered by Obesity Canada-Obésité Canada. This highlights the growing awareness/need among healthcare professionals for education in obesity medicine.
- Patients are expected to cover the cost of meal replacements within medically supervised weight management programs, which can run between \$1,000 and \$2,000 per month.
- Anti-obesity medications are not covered by provincial public drug benefit programs or any of the federal public drug benefit programs.
- Coverage for anti-obesity medications through private drug benefit plans is available to fewer than 20% of individuals who have such plans.
- Bariatric surgery is available to one in 171 adult Canadians living with severe obesity per year. In 2017, it was available to one in 183. Although the provision of bariatric surgery seems to have improved overall, in some provinces the number of surgeries conducted has dropped in recent years.
- Patients referred to bariatric surgery can wait up to eight years before meeting a specialist or receiving the surgery.

In an effort to reduce weight bias and stigma, Obesity Canada has developed:

- (1) A *Weight Bias Analysis Tool for Public Health Policies* which is available free of cost and is included in the online appendices of this report, and;
- (2) Guidelines on using **People First Language** and **appropriate images**: <https://obesitycanada.ca/resources/people-first-language/>



Recognition of Obesity as a Chronic Disease and Public Policy

In October 2015, the Canadian Medical Association declared obesity to be “a chronic medical disease requiring enhanced research, treatment and prevention efforts.”¹⁶ The declaration was praised by people living with obesity as well as healthcare and academic professionals, who supported the recognition of obesity as a disease may help precipitate a shift in thinking of obesity away from a lifestyle choice to a medical disease with an obligation to prevent and treat it like other chronic diseases. There was also a call to continue to advocate for public policy, education and awareness and to address weight discrimination in Canada.



2019 Findings

- › Since the declaration, none of the provincial or territorial governments has officially recognized obesity as a chronic disease.
- › In January 2019, Health Canada released Canada’s revised food guide that provides guidelines and considerations for healthy eating and overall nutritional well-being. The food guide recognizes that a high body mass index (BMI) is one of the leading risk factors for disease burden, as measured by death and disability combined. However, it does not recognize obesity as a chronic disease, but rather a risk factor for other chronic diseases.¹⁷
- › In October 2018, Statistics Canada published the results of the Canadian Health Measures Survey 2016, 2017 in a report entitled *Obesity in Canadian Adults, 2016 and 2017*.¹⁸ This report:
 - › Does not consider obesity to be a chronic disease.
 - › Claims that “Obesity has remained stable over 10 years (2007 to 2017).”
 - › Claims that “Obesity increases with age.”
 - › Does not use person-first language when addressing people with obesity.

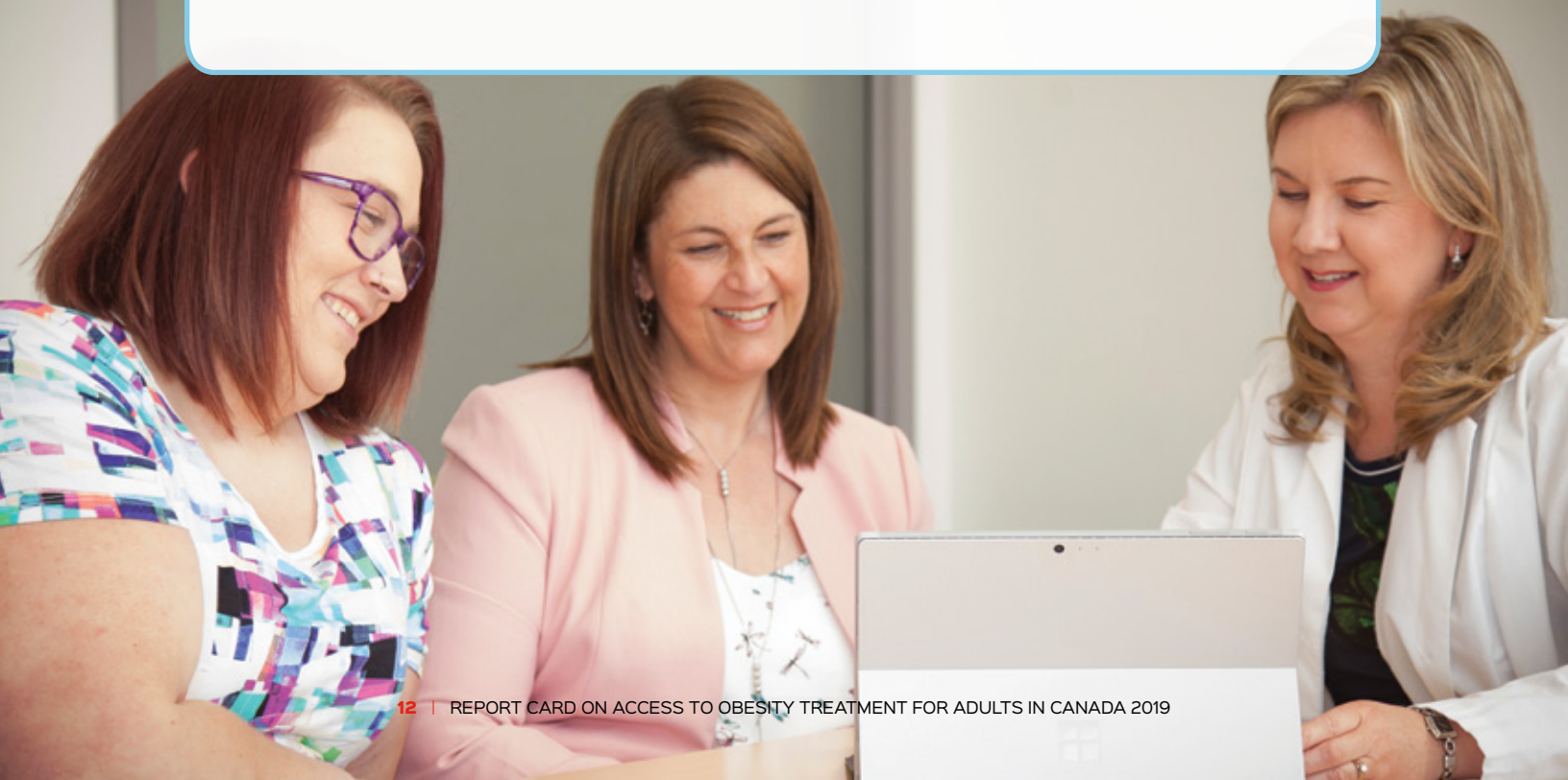
Recognition of Obesity as a Chronic Disease and Public Policy



- › In November 2018, the Yukon Medical Association voted unanimously to recognize obesity as a chronic medical disease requiring enhanced research, treatment and prevention efforts. The association hopes this recognition will trigger further steps to tackle the disease among policy makers, governments and health care professionals.¹⁹
- › In 2015, the Saskatchewan Medical Association recognized obesity as a chronic disease.

Key message

The lack of recognition of obesity as a chronic disease continues to have a significant impact on adults living with obesity in Canada. Canadians affected by obesity are left to navigate a complex landscape of weight-loss products and services, many of which lack a scientific rationale and openly promote unrealistic and unsustainable weight-loss goals.





Obesity Canada has developed a searchable online database of certified obesity management healthcare professionals, pediatric and adult obesity management clinics, and bariatric surgery centres in Canada.
<https://locator-obesitycanada.ca>

Access to Behavioural Interventions and Interdisciplinary Teams for Obesity Management



The Canadian Clinical Practice Guidelines⁷ recommend a comprehensive set of interventions for adults who are living with obesity that includes using a combination of behaviour modification techniques, cognitive behavioural therapy, activity enhancement and dietary counselling. In addition, the guidelines recommend that primary health professionals work with other healthcare providers to develop comprehensive weight-management programs for adults with overweight or obesity to promote and maintain weight loss.

Obesity management in primary care can produce improvements in clinically relevant health outcomes through multi-component weight-management interventions delivered over the long term by an interdisciplinary healthcare team.⁹ There is also evidence that medically supervised programs that have an interdisciplinary team component increase the likelihood of meaningful weight management. Reports from Canadian clinics with an interdisciplinary approach to obesity management have demonstrated that almost half of patients attained clinically significant weight reductions^{20,21} in as little as six months.²²

For the purposes of the *Report Card on Access to Obesity Treatment for Adults in Canada 2017 and 2019*, an interdisciplinary team for obesity management was defined as a team composed of some combination of a physician, dietitian, nurse/nurse practitioner, exercise therapist/kinesiologist, social worker and/or psychological counsellor working together with the goal of providing weight management/obesity management for adults in the community.

Access to Behavioural Interventions and Interdisciplinary Teams for Obesity Management



2019 Findings

- › Of the health services provided at the primary care level for obesity management, dietitian services are the most commonly available to Canadians with obesity.
- › Access to exercise professionals, such as exercise physiologists and kinesiologists, at the primary care level continues to be limited throughout Canada.
- › Access to mental health support and cognitive behavioural therapy for obesity management at the primary care level is limited throughout Canada. Bariatric surgery programs often have a psychologist or social worker that offers mental health support and cognitive behavioural therapy to patients on the bariatric surgery pathway, but the availability of these supports outside of these programs is scarce.
- › Centres where bariatric surgery is conducted also have interdisciplinary teams that work within the bariatric surgical programs and provide support for patients on the surgical pathway.
- › Alberta and Ontario have provincial programs with dedicated bariatric specialty clinics that offer physician-supervised medical programs with interdisciplinary teams for obesity management.
- › Among the territories, only Yukon has a program with an interdisciplinary team focusing on obesity management in adults.
- › The Partners for Healthier Weight clinic in Nova Scotia, which was the only medically-supervised weight management clinic in that province, was closed in 2017.²³

Key message

There is a profound lack of interdisciplinary teams for obesity management in Canada.

Number of Healthcare Professionals in Canada with Certification in Obesity Medicine



Canadian Clinical Practice Guidelines⁷ recommend that continuing medical education activities be developed to provide physicians and health professionals with the skills they need to counsel people confidently in healthy weight management. A 2018 article²⁴ highlighted the benefits of certification for healthcare professionals as passing an intensive exam demonstrates knowledge and ability to provide evidence-based medical care to patients with obesity. Being board-certified is the accepted designation of professionalism in medicine.

In 2017, we reported that the American Board of Obesity Medicine (ABOM) provides a certificate in managing obesity for physicians (including those in Canada) who pass the organization's examination. Certification as an ABOM diplomate signifies specialized knowledge in the practice of obesity medicine and distinguishes a physician as having achieved competency in providing obesity care. The first ABOM certification exams were offered in 2012.



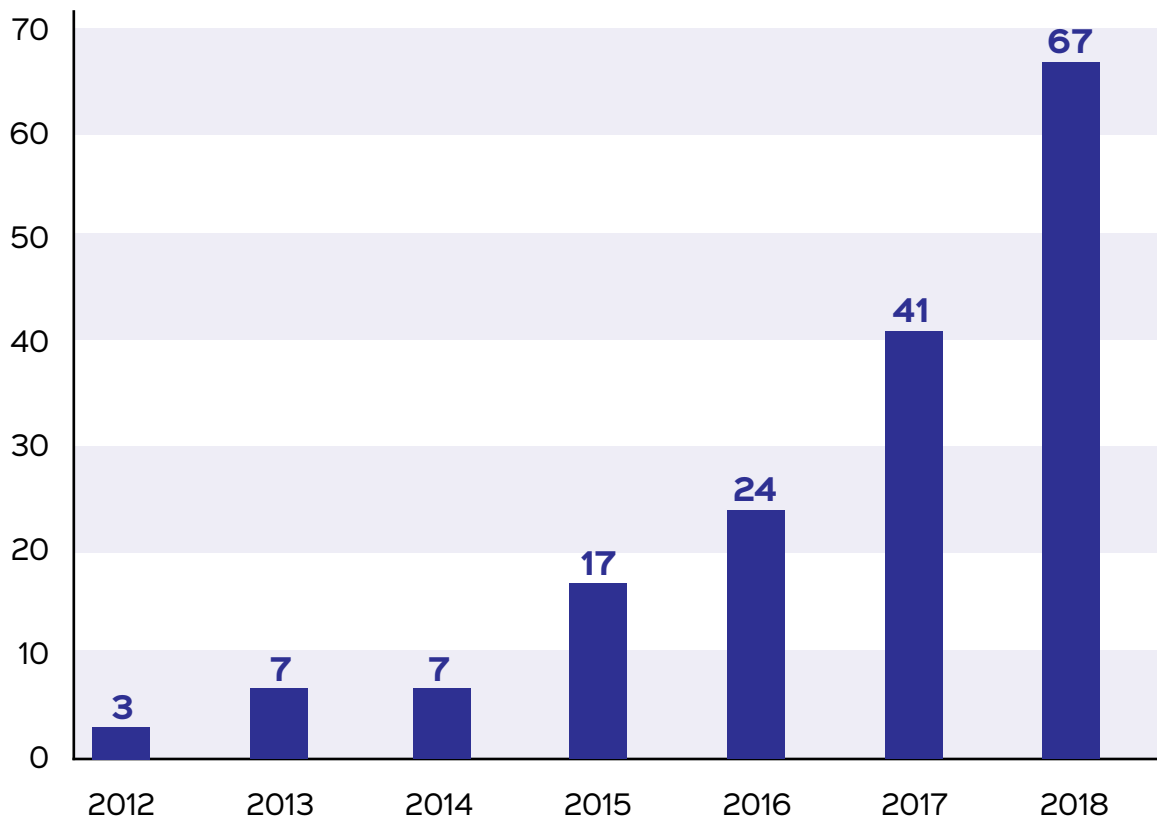
2019 Findings

ABOM-Certified Physicians in Canada

- › There are now 67 ABOM-certified physicians in Canada, up from 41 in 2017. This includes three physicians who were certified by the American Board of Bariatric Medicine prior to the establishment of ABOM.
- › Thirty-four of these physicians are in Ontario, 12 in Alberta, 11 in British Columbia, four in Quebec, three in New Brunswick, two in Nova Scotia and one in Prince Edward Island.
- › There are no ABOM-certified physicians in any of the territories, Saskatchewan, Manitoba, or Newfoundland and Labrador.
- › Of the 67 ABOM-certified physicians, 32 practice internal medicine and 29 practice family medicine. Other specialties include surgery (2), pediatrics (2), emergency medicine (1), and obstetrics & gynecology (1).
- › There are only six active nursing professionals in Canada with the Certified Bariatric Nurse designation (offered by the American Society for Metabolic & Bariatric Surgery): five in Alberta and one in Ontario.

Number of Healthcare Professionals in Canada with Certification in Obesity Medicine

Number of ABOM-Certified Physicians in Canada (2012–2018)



In addition to the Certified Bariatric Educator program, Obesity Canada has trained:

- › 486 dietitians through the Obesity Canada/Dietitians of Canada Learning Retreat on the Principles and Practice of Interdisciplinary Obesity Management for Dietitians;
- › 251 healthcare professionals through the Advanced Obesity Management Program; and
- › 211 healthcare professionals through OPTimizing Treatment and Management of Obesity (OPTiMO) program.

Number of Healthcare Professionals in Canada with Certification in Obesity Medicine

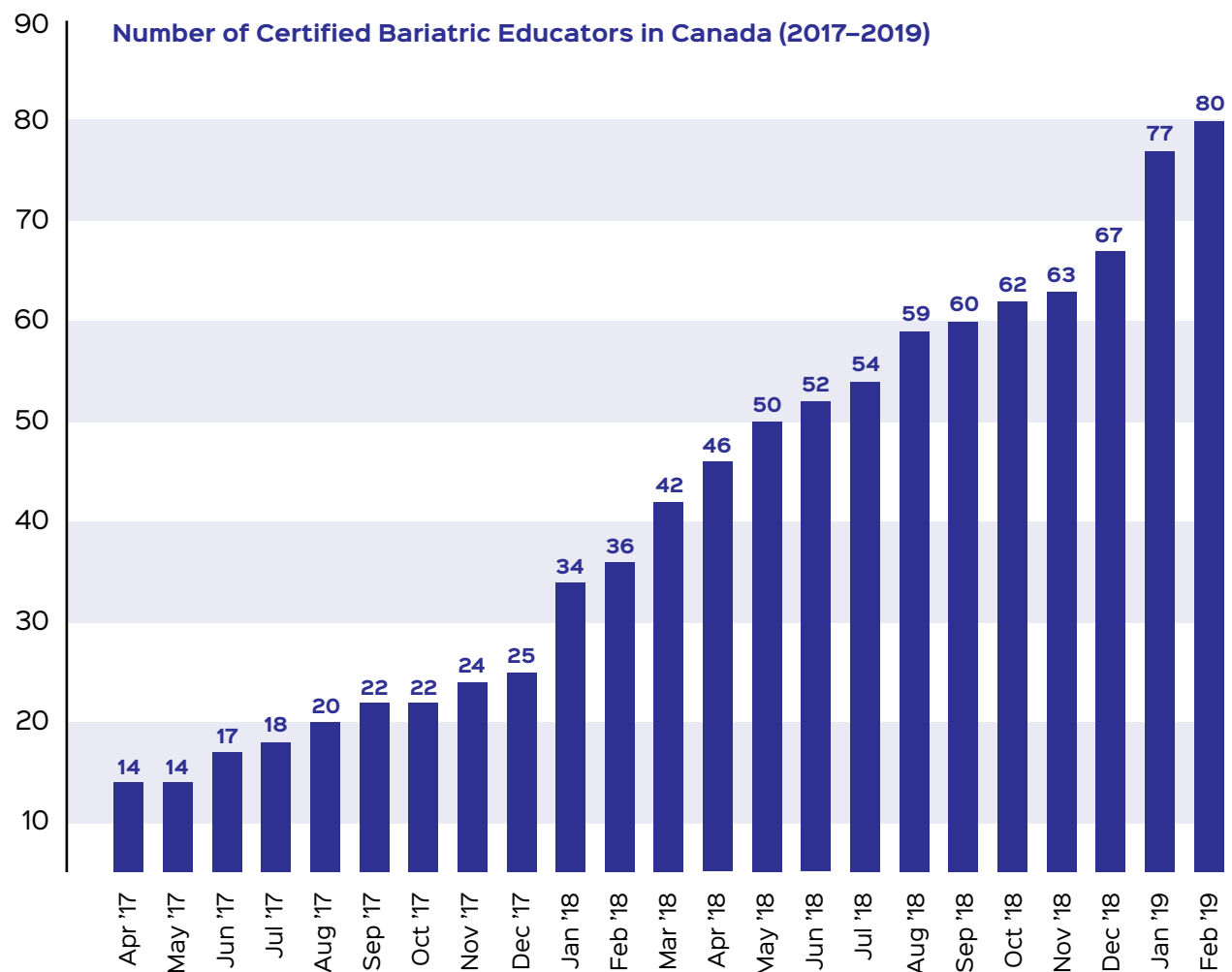


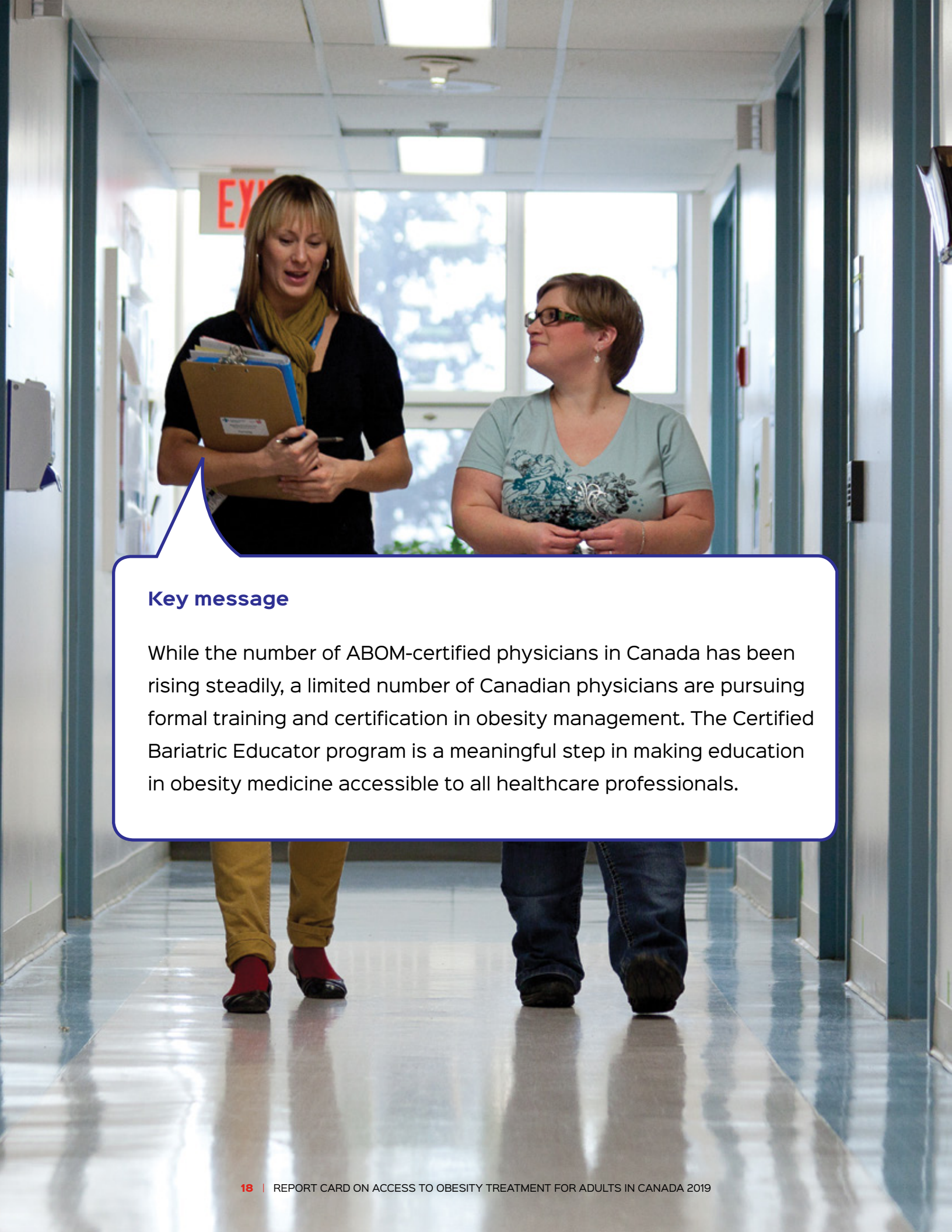
2019 Findings

Certified Bariatric Educators in Canada

Recognizing the need for capacity building among healthcare professionals who provide obesity care, Obesity Canada launched the Certified Bariatric Educator (CBE) Program in April, 2017.

- There are now 80 Certified Bariatric Educators in Canada.
- Of the 80 CBEs, 43 are in Ontario, 17 in Alberta, six in Nova Scotia, five in Quebec, three in New Brunswick, two in British Columbia, and one each in Manitoba, Newfoundland and Labrador, Nunavut and Prince Edward Island.
- The 80 CBEs include 41 dietitians, 22 registered nurses, 10 pharmacists, three nurse practitioners, two physicians, a psychologist and a social worker.





Key message

While the number of ABOM-certified physicians in Canada has been rising steadily, a limited number of Canadian physicians are pursuing formal training and certification in obesity management. The Certified Bariatric Educator program is a meaningful step in making education in obesity medicine accessible to all healthcare professionals.

Access to Medically Supervised Weight Management Programs with Meal Replacements



Canadian Clinical Practice Guidelines⁷ recommend that meal replacement products and programs can be recommended as a component of an energy-reducing diet for some adults interested in commencing a dietary weight-loss program.

In Canada, weight management programs with meal replacement are comprehensive, behaviour-based, medically supervised programs that closely monitor and assess progress towards better health and well-being, in conjunction with comprehensive patient education and support.



2019 Findings

- › Meal replacements are used as part of medically managed weight-loss programs and are often used as a pre-surgical weight loss tool for patients on the bariatric surgery pathway.
- › The Optifast® Weight Management Program is a one- to two-year medically supervised program that uses a 900-calorie a day meal replacement exclusively for the first 12 weeks and is delivered by an interdisciplinary healthcare team in specialty clinics throughout Canada.
- › The active weight-loss phase of the Optifast® Program consists of weekly group visits for 24 to 26 consecutive weeks, and the maintenance phase continues into the second year.
- › Regional Health Authorities that offer the Optifast® Weight Management Program cover the costs associated with the medical supervision (diagnostic tests and clinicians); however, the cost of the meal replacements is an out-of-pocket expense for patients. Currently in Ontario, a typical patient pays \$253.00 for one month of meal replacements.²⁵

Access to Medically Supervised Weight Management Programs with Meal Replacements



- › Patients are expected to pay between \$1,000 and \$2,000 for the meal replacement portion of the Optifast® Weight Management Program, depending on the length of the maintenance phase.
- › The cost of meal replacements within weight management programs is not covered by any provincial drug benefit program or private drug benefit plan. Such costs are considered an ineligible expense for Health Spending Accounts with private health benefit plans and are not an eligible expense in the Medical Expense Tax Credit offered by the Canada Revenue Agency.

Key message

Canadians who may benefit from medically supervised weight-management programs with meal replacements are expected to pay out of pocket for meal replacements. This is in sharp contrast with coverage available under provincial drug benefit programs for complete nutrition formulas for other chronic diseases, such as diabetes, cystic fibrosis and cancer.

Access to Prescription Anti-Obesity Medications

The Canadian Clinical Practice Guidelines⁷ recommend the addition of a pharmacologic agent to assist in reducing obesity-related symptoms for some adults who are not attaining or who are unable to maintain clinically significant weight loss with dietary and exercise therapy alone.



Pharmaceutical treatment of obesity is considered appropriate for adults with (a) a BMI ≥ 30 kg/m² or (b) a BMI ≥ 27 kg/m² in the presence of other risk factors (e.g., hypertension, diabetes, dyslipidemia, or excess visceral fat). In 2018, Health Canada approved²⁶ a naltrexone/bupropion combination (Contrave®) for the treatment of obesity in adults in Canada. The other two anti-obesity medications approved for adults in Canada are orlistat (Xenical®) and liraglutide (Saxenda®).



2019 Findings: Public Coverage

- › None of the anti-obesity medications (Xenical®, Saxenda® or Contrave®) are listed as a benefit on any provincial/territorial formulary and none are covered under any provincial public drug benefit (or Pharmacare) programs.
- › Special-access programs in some provinces adjudicate coverage for non-formulary medications based on individual case review; however, coverage for anti-obesity medications through these programs is not guaranteed and is, in fact, rare.
- › Anti-obesity medications are not covered in any federal public drug benefit programs.
- › Xenical® is covered under the Canadian Forces Health Services Program (CFHSP) through an exception mechanism and Xenical®, Saxenda® and Contrave® are also covered under the Public Service Health Care Plan (PSHCP) without carrier approval. The CFHSP and PSHCP are private drug benefit plans that are available to federal public service employees.
- › This is in contrast to the coverage of medications for other chronic diseases (such as diabetes) in provincial formularies. According to a report published by Diabetes Canada in October 2018,²⁷ formularies in all provinces and territories and the Non-Insured Health Benefits Program cover between 11 and 31 medications, depending on the jurisdiction.

Access to Prescription Anti-Obesity Medications

Grades for Access to Public Coverage of Anti-Obesity Medications in Canada in 2019 and Change in Grade Since 2017

Grading criteria for the public coverage of anti-obesity medications (Public Coverage)

Grade Criteria

A	All Pharmacare programs cover all medications.
B	All medications are covered by more than one of the Pharmacare programs.
C	At least one of the medications is covered by more than one of the Pharmacare programs.
D	At least one of the medications is covered by one of the Pharmacare programs.
F	No Pharmacare programs cover any medications.

Pharmacare programs in	Grade in 2017	Grade in 2019	Change in Grade
Provinces:			
British Columbia	F	F	No
Alberta	F	F	No
Saskatchewan	F	F	No
Manitoba	F	F	No
Ontario	F	F	No
Quebec	F	F	No
New Brunswick	F	F	No
Nova Scotia	F	F	No
Prince Edward Island	F	F	No
Newfoundland and Labrador	F	F	No
Territories:			
Yukon	F	F	No
Nunavut	F	F	No
Northwest Territories	F	F	No
Federal Drug Benefit Programs	C	C	No

Access to Prescription Anti-Obesity Medications



2019 Findings: Private Coverage

Roughly 60% of Canadians have private insurance, generally through employer-sponsored plans.²⁸ A customized report of coverage for anti-obesity medications in private drug insurance plans was produced by TELUS Health Analytics. The report was based on a sample which represents approximately 45% of lives – or 9,683,309 individuals – with access to private drug insurance that covers some costs of prescription medications in Canada. This report revealed that:

- › In a sample of 9.6 million Canadians with private drug benefit plans, only 10.4% – or 1,003,184 individuals – have plans that include coverage for anti-obesity medications. Publicly available information on the websites of Canadian insurers reveals that private drug benefit plans provide extensive coverage for medications for other chronic diseases, such as type 2 diabetes or hypertension. This is in sharp contrast to the coverage provided for anti-obesity medications.
- › Analysis of coverage rates reveals disparities between provinces and territories:

Province/Territory	Number of individuals in the sample	Number of individuals with coverage	Coverage rate
British Columbia	1,144,795	51,303	4.5%
Alberta	1,335,792	190,370	14.3%
Saskatchewan	461,112	68,438	14.8%
Manitoba	294,482	25,768	8.8%
Ontario	4,444,353	363,150	8.2%
Quebec	1,446,894	268,353	18.5%
New Brunswick	104,536	9,357	9.0%
Nova Scotia	197,404	18,817	9.5%
Prince Edward Island	41,303	544	1.3%
Newfoundland and Labrador	166,132	6,312	3.8%
Yukon	25,520	29	0.1%
Nunavut	14,613	126	0.9%
Northwest Territories	6,373	617	9.7%
Canada	9,683,309	1,003,184	10.4%

Source: TELUS Health Analytics Coverage Report (October 19, 2018)

Access to Prescription Anti-Obesity Medications

Key message

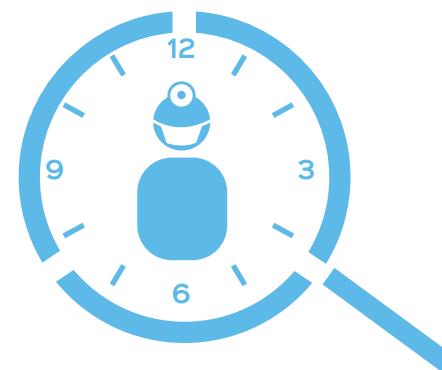
The proportion of the Canadian population with private drug benefit plans that has access to anti-obesity medications through these plans is still less than 20%. Those who rely on public coverage for their prescription drug costs do not have access to these medications and are left paying for them out of pocket. Given the effectiveness of anti-obesity medications for long-term weight management it is unacceptable that Canadians have limited access to these medications.



Access to Bariatric Surgery

The Canadian Clinical Practice Guidelines⁷ recommend that adults with clinically severe obesity (BMI ≥ 40 kg/m² or ≥ 35 kg/m² with severe comorbid disease) may be considered for bariatric surgery when behavioural intervention is inadequate to achieve healthy weight goals.

With appropriate patient selection, education and followup, bariatric surgery can offer sustainable weight loss (20% to 30% reduction) with substantial reductions in morbidity and mortality (40% to 89% reduction^{29–33}) and marked improvements in mental health and quality of life.³⁴ Not everyone who qualifies for bariatric surgery may be eligible and, as is the case with any surgery, bariatric surgery is also associated with some risks and complications. Complication rates associated with bariatric surgery are between 10% and 17%, the reoperation rate is approximately 7% and the mortality rate is low (between 0.08% and 0.35%).³⁵



2019 Findings: Access to Surgical Care for Obesity

- › Bariatric surgery is performed in all 10 provinces by some 120 surgeons in 33 centres. There are no centres in any of the territories. The number of centres performing bariatric surgeries has not changed since an environmental scan was conducted in 2012.³⁶
- › Centres in many provinces do not accept out-of-province patients, which limits access to care for bariatric patients in provinces and territories with no surgical programs.
- › Gastric bypass and sleeve gastrectomy are the more commonly conducted procedures while a few provinces offer gastric banding.
- › The number of bariatric surgeries in Canada continues to rise, though not in keeping with the rapidly increasing prevalence of Class II (BMI: 35.00 kg/m²–39.99 kg/m²) and Class III (BMI: ≥ 40.00 kg/m²) obesity.
- › The number of bariatric surgeries in some provinces dropped in 2017–2018.
- › Bariatric surgery is available to one in 171 (0.58%) adult Canadians with Class II or Class III obesity per year. This is marginally better than the access to bariatric surgery reported in 2017.
- › There is significant inequality in access to bariatric surgery in Canada. It ranges from one in 96 adults in Quebec with Class II or Class III obesity to one in 1,073 adults in Nova Scotia.

Access to Bariatric Surgery

Number of Bariatric Surgeries Performed in Canada between 2009 and 2018

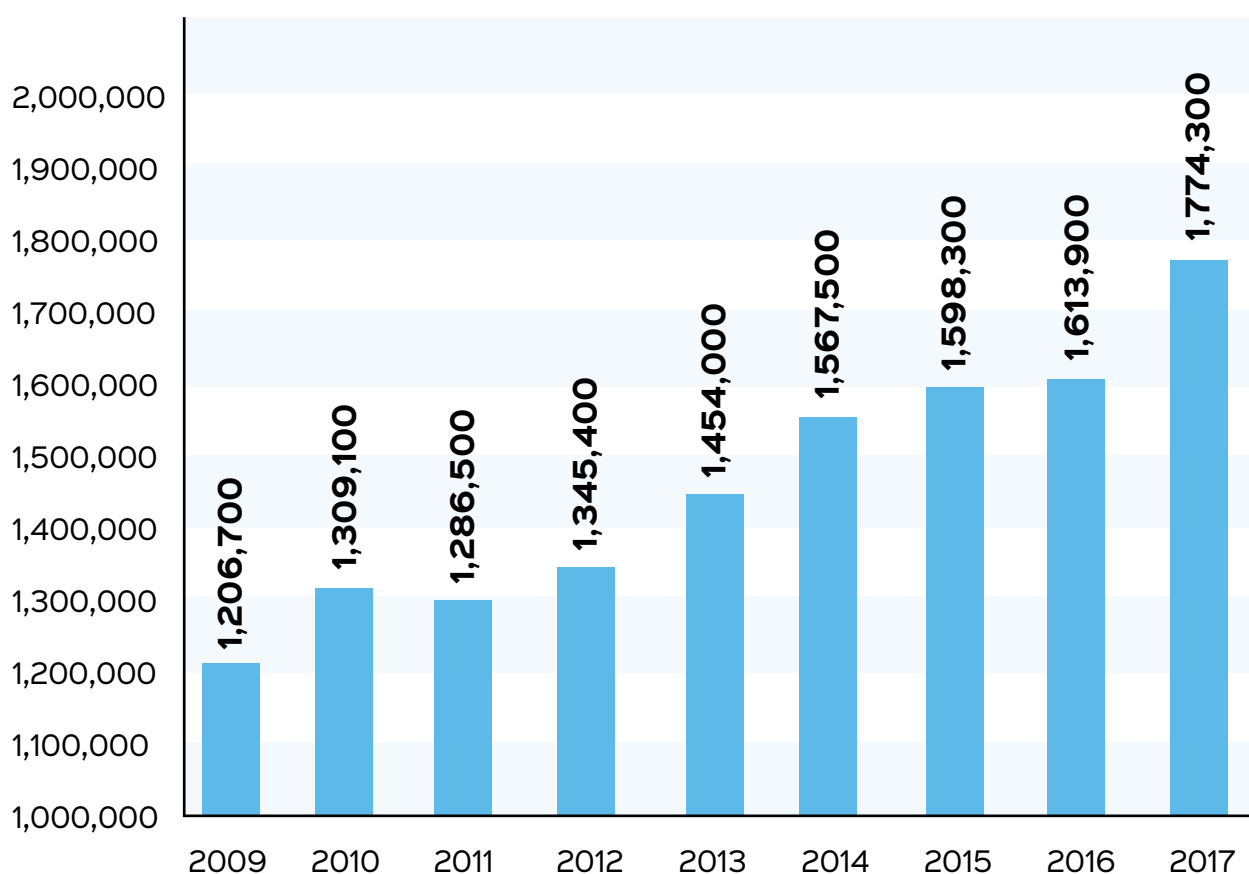
Province	2009–2010	2010–2011	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017	2017–2018
Prince Edward Island	0	0	0	0	0	1	0	0	1
Newfoundland and Labrador	0	0	38	84	108	104	101	133	115
Nova Scotia	59	61	51	62	62	47	51	67	64
New Brunswick	127	152	164	135	146	258	307	263	288
Quebec	1,496	1,759	1,894	1,988	2,411	3,250 ^a	3,337 ^a	3,466 ^a	4,005 ^a
Ontario	932	1,855	2,511	2,846	2,833	3,063	3,503	3,853	4,297
Manitoba	0	41	89	104	123	134	197	196	193
Saskatchewan	47	62	81	78	90	111	82	99	81
Alberta	296	378	438	514	540	596	635	816	933
British Columbia	179	129	149	178	212	341	370	360	388
Canada	3,136	4,437	5,415	5,989	6,525	7,905	8,583	9,253	10,365

Source: CIHI Report (October 19, 2018).

^a This figure was reported in a personal communication with a policy maker in Quebec. As part of the Agreement between the Government of Quebec and CIHI, the data transmitted by Quebec and held by CIHI may only be used for specific purposes. Therefore, CIHI was not authorized to provide us with the requested data.

Access to Bariatric Surgery

Number of Adults in Canada with Class II or III Obesity



Source: Statistics Canada, CCHS, 2009–2017. Reproduced and distributed on an “as is” basis with permission of Statistics Canada.

Access to Bariatric Surgery

Grades for Access to Bariatric Surgery in Canada in 2019 and Change in Grade Since 2017

Provinces	Adults who have obesity (Class II or III) ^a	Number of Bariatric Surgeries in 2017–2018 ^b	Number of Surgeries/1000 Adults who have Class II or Class III Obesity	Access to Bariatric Surgery in 2017	Access to Bariatric Surgery in 2019	Grade in 2019	Change in Grade
Newfoundland and Labrador	48,200	115	2.39	1 in 390	1 in 419	F	No
Nova Scotia	68,700	64	0.93	1 in 1,312	1 in 1,073	F	No
New Brunswick	64,100	288	4.49	1 in 168	1 in 223	F	No
Quebec	376,900	4,005 ^c	10.62	1 in 94	1 in 96	D	No
Ontario	663,800	4,297	6.47	1 in 178	1 in 154	F	No
Manitoba	82,700	193	2.33	1 in 339	1 in 428	F	No
Saskatchewan	86,500	81	0.94	1 in 806	1 in 1,068	F	No
Alberta	199,400	933	4.68	1 in 303	1 in 214	F	No
British Columbia	175,900	388	2.21	1 in 386	1 in 453	F	No
Canada	1,774,300	10,364	5.84	1 in 185	1 in 171	F	No

Footnotes:

^a Source: Statistics Canada, CCHS, 2017. Respondents aged 18 and over excluding pregnant women. Reproduced and distributed on an “as is” basis with the permission of Statistics Canada.

^b Source: CIHI Report (October 19, 2018).

^c This figure was reported in a personal communication with a policy maker in Quebec. As part of the Agreement between the Government of Quebec and CIHI, the data transmitted by Quebec and held by CIHI may only be used for specific purposes. Therefore, CIHI was not authorized to provide us with the requested data.

Grade Criteria

A	At least 1 in 10 adults who have Class II or III Obesity have access to bariatric surgery
B	At least 1 in 25 adults who have Class II or III Obesity have access to bariatric surgery
C	At least 1 in 50 adults who have Class II or III Obesity have access to bariatric surgery
D	At least 1 in 100 adults who have Class II or III Obesity have access to bariatric surgery
F	Fewer than 1 in 100 adults who have Class II or III Obesity have access to bariatric surgery



2019 Findings: Wait Times for Surgical Care of Obesity

- › Limited resources for bariatric surgery and an increasing number of referrals have led to unacceptable wait times.
- › A significant proportion of the wait time experienced by patients referred to bariatric surgery occurs between referral and consultation with a specialist. Patients in most provinces wait for two years or more, but the wait can be as long as four to five years.
- › Typically, wait time between consultation with a specialist and surgery is six to 12 months.
- › Nova Scotia has the longest wait time between referral and consultation (106 months) while having the shortest wait time between consultation and surgery (three months).
- › New Brunswick has been able to reduce the wait time between referral and consultation to eight months.
- › Wait times vary significantly between provinces.

Grading criteria for wait times between referral and consultation, and consultation and bariatric surgery were based on the benchmarks developed by the Wait Time Alliance. Wait Time Alliance physicians have been developing benchmarks and targets to identify the longest medically acceptable amount of time that a patient should wait before receiving treatment. In their latest 2014 national report card on wait times,³⁷ the Wait Time Alliance proposed benchmarks for acceptable wait times for common conditions/procedures, such as arthritis care, cancer care, cardiac care, emergency rooms, general surgery, joint replacement, plastic surgery and others. Although they did not provide benchmarks for bariatric surgery, two of the specialty areas that share similarities in treatment are general surgery and joint replacement surgery (since it is also an elective procedure). The benchmark, i.e., the maximum acceptable wait time, for a scheduled case of general surgery is 16 weeks. A “scheduled case” (also called “routine” or “elective”) was defined as a situation involving minimal pain, dysfunction or disability. In the field of hip or knee replacement surgery, the benchmark for consultation is three months and for treatment is within six months of consultation.

Access to Bariatric Surgery

Grades for Wait Times for Bariatric Surgery in Canada in 2019 and Change in Grade Since 2017

Provinces	Wait Time between Referral and Consultation	Grade in 2019	Change in Grade	Wait Time between Consultation and Surgery	Grade in 2019	Change in Grade
Newfoundland and Labrador	8 months	<i>C</i>	No	8 months	<i>B</i>	Improvement
Nova Scotia	106 months	<i>F</i>	No	3 months	<i>A</i>	Improvement
New Brunswick	48–84 months	<i>F</i>	No	Up to 12 months	<i>B</i>	Improvement
Quebec	24 months	<i>F</i>	No	6–12 months	<i>B</i>	No
Ontario	Referral to medical program: up to 24 months	<i>F</i>	No	6–12 months	<i>B</i>	No
Manitoba	72 months	<i>F</i>	No	6–8 months	<i>B</i>	Improvement
Saskatchewan	36 months	<i>F</i>	No	6–12 months	<i>B</i>	No
Alberta	18–24 months	<i>F</i>	No	More than 12 months	<i>C</i>	No
British Columbia	Up to 24 months	<i>F</i>	No	Up to 12 months	<i>B</i>	No

Grade Wait time

	From Referral to Consultation	From Consultation to Surgery
<i>A</i>	Less than 3 months	Less than 6 months
<i>B</i>	Between 3 and 6 months	Between 6 and 12 months
<i>C</i>	Between 6 and 9 months	Between 12 and 18 months
<i>D</i>	Between 9 and 12 months	Between 18 and 24 months
<i>F</i>	More than 12 months	More than 24 months

Access to Bariatric Surgery



Key message

According to the latest estimates (2017), there are 1,774,300 adults in Canada living with Class II or Class III obesity who may be eligible for bariatric surgery. Based on this information and the number of bariatric surgeries conducted in Canada in 2017–2018, it is evident that bariatric surgery is available to fewer than 1 in 171 (or 0.58%) of adults who might benefit from it. Although access to bariatric surgery has improved slightly since the last report, it has not kept pace with the increasing prevalence of severe obesity. Wait times for bariatric surgery in Canada are the longest of any surgically treatable condition. Patients who need bariatric surgery continue to be at significant risk of dying while waiting for treatment.²⁹ Despite an overall increase in the number of surgeries performed in Canada, the number of bariatric surgeries in some provinces dropped in 2017–2018. The current access to and wait times for bariatric surgeries in Canada is unacceptable.

References

1. James WP. WHO recognition of the global obesity epidemic. *Int J Obes*. 2008 Dec;32(Suppl 7):S120–6.
2. Katzmarzyk PT, Ardern CI. Overweight and obesity mortality trends Canada, 1985–2000. *Can J Public Health*. 2004;95(1):16–20.
3. Puhl RM, Suh Y. Health consequences of weight stigma: implications for obesity prevention and treatment. *Curr Obes Rep*. 2015;4(2):182–90.
4. Kahan S, Puhl RM. The damaging effects of weight bias internalization. *Obesity*. 2017 Jan;25(2):280–1.
5. Sutin AR, Stephan Y, Terracciano A. Weight discrimination and risk of mortality. *Psychol Sci*. 2015 Nov;26(11):1803–11.
6. Puhl RM, Heuer CA. The stigma of obesity: a review and update. *Obesity*. 2009;17:941–64.
7. Lau DCW, Douketis JD, Morrison KM, Hramiak IM, Sharma AM, Ur E. 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children. *Can Med Assoc J*. 2007;176(8):s1–13.
8. Canadian Obesity Network-Réseau canadien en obésité. Report card on access to obesity treatment for adults in Canada 2017 [Internet]. Edmonton, Canada; 2017. Available from: <https://obesitycanada.ca/publications/canadians-lack-access-obesity-treatments-support-report-card/>
9. Montesi L, El Ghoch M, Brodosi L, Calugi S, Marchesini G, Dalle Grave R. Long-term weight loss maintenance for obesity: a multidisciplinary approach. *Diabetes Metab Syndr Obes*. 2016;9:37–46.
10. Wolfe BM, Kvach E, Eckel RH. Treatment of obesity: weight loss and bariatric surgery. *Circ Res*. 2016 May;118(11):1844–55.
11. Swinburn BA, Kraak VI, Allender S, Atkins VJ, Baker PI, Bogard JR, *et al*. The global syndemic of obesity, undernutrition, and climate change: The Lancet Commission report. *Lancet* [Internet]. 2019 Feb;393(10173):791–846. Available from: [https://doi.org/10.1016/S0140-6736\(18\)32822-8](https://doi.org/10.1016/S0140-6736(18)32822-8)
12. Farpour-Lambert NJ, Baker JL, Hassapidou M, Holm JC, Nowicka P, O'Malley G, *et al*. Childhood obesity is a chronic disease demanding specific health care—a position statement from the Childhood Obesity Task Force of the European Association for the Study of Obesity (EASO). *Obes Facts*. 2015;8(5):342–9.
13. Yumuk V, Tsigos C, Fried M, Schindler K, Busetto L, Micic D, *et al*. European guidelines for obesity management in adults. *Obes Facts*. 2015;8(6):402–24.
14. Jastreboff AM, Kotz CM, Kahan S, Kelly AS, Heymsfield SB. Obesity as a disease: the Obesity Society 2018 position statement. *Obesity* [Internet]. 2019 Jan 1;27(1):7–9. Available from: <https://doi.org/10.1002/oby.22378>
15. World Obesity Federation. About Obesity [Internet]. 2019 [cited 2019 Mar 21]. Available from: <https://www.worldobesity.org/about/about-obesity%0A>
16. CMA recognizes obesity as a disease [Internet]. Ottawa, ON: Canadian Medical Association; 2015. Available from: <https://web.archive.org/web/20181023022440/https://www.cma.ca/En/Pages/cma-recognizes-obesity-as-a-disease.aspx>
17. Health Canada. Canada's dietary guidelines for health professionals and policy makers [Internet]. Ottawa, Canada: Her Majesty the Queen in Right of Canada; 2019. 62 p. Available from: <https://food-guide.canada.ca/en/guidelines/section-2-foods-and-beverages-that-undermine-healthy-eating/>
18. Statistics Canada. Obesity in Canadian adults, 2016 and 2017 [Internet]. 2018 [cited 2018 Nov 15]. Available from: <https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2018033-eng.htm>
19. Obesity Canada-Obésité Canada. Yukon Medical Association becomes second PTMA to recognize obesity as a chronic disease [Internet]. 2018 [cited 2019 Dec 22]. Available from: <https://obesitycanada.ca/con-news/yukon-medical-association-becomes-second-ptma-to-recognize-obesity-as-a-chronic-disease/>

20. Gagnon C, Brown C, Couture C, Kamga-Ngande CN, Hivert MF, Baillargeon JP, *et al.* A cost-effective moderate-intensity interdisciplinary weight-management programme for individuals with prediabetes. *Diabetes Metab.* 2011 Nov;37(5):410–8.
21. Kamga-Ngande CN, Carpentier AC, Nadeau-Marcotte F, Ardilouze J-L, Baillargeon J-P, Bellabarba D, *et al.* Effectiveness of a multidisciplinary program for management of obesity: the Unite d'Enseignement, de Traitement et de Recherche sur l'Obesite (UETRO) database study. *Metab Syndr Relat Disord.* 2009 Aug;7(4):297–304.
22. Wharton S, VanderLelie S, Sharma AM, Sharma S, Kuk JL. Feasibility of an interdisciplinary program for obesity management in Canada. *Can Fam Physician.* 2012 Jan;58(1):e32–8.
23. Canadian Broadcasting Corporation. Clinic closure leaves Nova Scotia with no obesity management programs. CBC News [Internet]. 2017 Aug 18; Available from: <https://www.cbc.ca/news/canada/nova-scotia/clinic-closure-leaves-nova-scotia-with-no-obesity-management-programs-1.4250873>
24. Alexander L. The benefits of obesity medicine certification. *Am J Lifestyle Med* [Internet]. 2018 Dec 17;13(2):161–4. Available from: <https://doi.org/10.1177/1559827618818041>
25. Ontario Bariatric Network. Optifast Pricing [Internet]. [cited 2018 Dec 20]. Available from: <http://www.ontariobariatricnetwork.ca/obn-members/obn-directives-protocols/optifast-pricing>
26. Valeant Canada. Valeant Canada announces Health Canada approval of CONTRAVE® extended-release tablets for chronic weight management in adults. Cision [Internet]. 2018 Mar 26. Available from: <https://www.newswire.ca/news-releases/valeant-canada-announces-health-canada-approval-of-contrave-extended-release-tablets-for-chronic-weight-management-in-adults-677910423.html>
27. Diabetes Canada. Formulary listings for diabetes medications in Canada [Internet]. 2018. Available from: <https://web.archive.org/web/20180929012617/https://www.diabetes.ca/publications-newsletters/advocacy-reports/provincial-territorial-formulary-chart>
28. Law MR, Kratzer J, Dhalla IA. The increasing inefficiency of private health insurance in Canada. *CMAJ.* 2014 Sep;186(12):E470–474.
29. Christou N V, Efthmiou E. Bariatric surgery waiting times in Canada. *Can J Surg.* 2009;52(3):229–34.
30. Christou N V, Sampalis JS, Liberman M, Look D, Auger S, McLean APH, *et al.* Surgery decreases long-term mortality, morbidity, and health care use in morbidly obese patients. *Ann Surg.* 2004 Sep;240(3):416–24.
31. Peeters A, O'Brien PE, Laurie C, Anderson M, Wolfe R, Flum D, *et al.* Substantial intentional weight loss and mortality in the severely obese. *Ann Surg.* 2007 Dec;246(6):1028–33.
32. Sjöström L, Narbro K, Sjöström CD, Karason K, Larsson B, Wedel H, *et al.* Effects of bariatric surgery on mortality in Swedish obese subjects. *N Engl J Med.* 2007;357:741–52.
33. Busetto L, Mirabelli D, Petroni ML, Mazza M, Favretti F, Segato G, *et al.* Comparative long-term mortality after laparoscopic adjustable gastric banding versus nonsurgical controls. *Surg Obes Relat Dis.* 2007;3(5):496–502.
34. Courcoulas AP, Yanovski SZ, Bonds D, Eggerman TL, Horlick M, Staten MA, *et al.* Long-term outcomes of bariatric surgery: a National Institutes of Health symposium. *JAMA Surg.* 2014 Dec;149(12):1323–9.
35. Chang S, Stoll CRT, Song J, Varela JE, Eagon CJ, Colditz GA. The effectiveness and risks of bariatric surgery: an updated systematic review and meta-analysis, 2003–2012. *JAMA Surg.* 2014;149(3):275–87.
36. Rosa Fortin MM, Brown C, Ball GD, Chanoine JP, Langlois MF. Weight management in Canada: an environmental scan of health services for adults with obesity. *BMC Heal Serv Res.* 2014 Feb 12;14:69.
37. Wait Time Alliance. Time to Close the Gap: Report Card on Wait Times in Canada. Ottawa, Canada; 2014.

