

21 District Health Boards

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Stephen McKernan
Director-General
Ministry of Health
P O Box 5035
WELLINGTON

Dear Stephen,

Bariatric Surgery Business Case

Thank you for the opportunity for CEOs to provide feedback on the proposal to increase access to bariatric surgery.

Overall DHBs are in general agreement that Bariatric Surgery should be made available for 0.5% of the prevalent morbidly obese population, but there are a number of concerns raised, in particular:

- Additional costs for DHBs for "wrap-around" services and other associated services.
- The capacity of the sector overall to meet the anticipated levels of service delivery.
- The need to develop a specific scoring tool.

DHBs suggest that attention to the following will be important in the implementation plan:

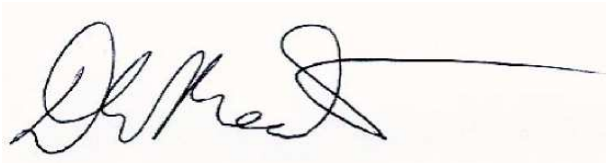
1. Local capacity - current, required, and issues
2. Additional (unfunded) costs such as the wrap around services, additional surgery post-bariatric procedure, transport, and accommodation.
3. Targets, local prioritisation and need
4. The prioritization tool.
5. The composition and terms of reference of the national implementation group.

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A summary of the feedback from DHBs on each of the 15 recommendations is attached.

We look forward to working with the Ministry on the funding and implementation of this service.

Yours sincerely

A handwritten signature in black ink on a light beige background. The signature is cursive and appears to read 'D Meates'. A long horizontal line extends from the end of the signature to the right.

David Meates

Chair, CEO Group

cc Julian Inch, DHBNZ CEO
DHB CEOs
Michael Johnson and Martin Kennedy, Ministry of Health

Bariatric Surgery Business Case

Summary of feedback from DHBs on each of the 15 recommendations

Note

1. *The cost of a 0.5% intervention rate is ~\$17.1 million in the first year in which the intervention rate is reached, as per the modelling provided in the business case, declining to a net cost of ~\$15.9 million in Year 2, ~\$14.5 million in Year 3, ~\$13.2 million in Year 4 and ~\$11.2 million in Year 5 as savings are realised.*

DHBs note the following:

- Whilst a 0.5% intervention rate is identified, these should not be seen as a target in its own right.
 - All follow up costs associated with bariatric surgery need to also be covered by elective services funding and that these costs (including the allied health professionals input) are included as an integral part of the total care package and CWD.
 - Intervention rate needs to be evidenced based.
 - Additional funding is required for the wraparound services.
 - Local capacity will need to be developed, and funding will be needed for this.
 - There will be significant costs associated with transport and accommodation; funding required for this.
 - Need to get the case selection right.
2. *Bariatric surgery should be prioritized using existing patient selection criteria and that this should occur alongside prioritisation for other general surgical procedures.*

DHBs note the following:

- Funding for Bariatric Surgery should be prioritised using nationally agreed patient selection criteria and should sit alongside other general surgical procedures.
 - It is up to the DHB of domicile to prioritize against other population need, and this should be appropriately reflected in the requirements.
3. *Based on expert opinion, DHBs may consider including wrap-around services as an adjunct to bariatric surgery. It is acknowledged, however, that there is currently insufficient evidence in the literature to support this more strongly. This is the subject of the Counties Manukau DHB pilot study.*

DHBs note the following:

- Wrap around services are important, particularly mental health and social work, for the success of either Bariatric surgery or other non surgical services.
- Management of obesity is linked to extensive support systems with sound clinical input, provided to both the person and the family/whanau.

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- Wrap-around services will require supportive funding both pre and post operatively. Local DHB services with additional resource would be best placed to do initial assessments and put forward candidates for consideration of surgery according to established guidelines. As well as the medical staff in surgery these would need to include allied health staff from nutrition, physical rehabilitation, and psychological support services. Personal communications from local staff, dieticians, and physicians who have worked overseas in units caring for patients pre and post bariatric surgery indicate very significant input, especially pre and in the immediate (12 months) post surgical period. The psychological problems with change in body image, return to workforce, altered health, and social reorganisation can be very traumatic for the individual who requires prolonged support.
- There are additional potential lifelong interventions that may be needed if long term problems with malabsorption develop or a complication of surgery which is permanent. The wrap-around service may therefore not only be related to sustaining the patient immediately post-op.
- The issue of post Bariatric surgery plastic intervention is one that as acknowledged in the business case, did not have a sound base in the literature in terms of rate of intervention to formulate precise potential cost to the public sector and/or capacity requirements. This will also be a key piece of work for the National Implementation Group.

4. *There is a mix of public and private capacity available to provide the service.*

DHBs note the following:

- The recommendations suggest an adhoc approach to determining where and how bariatric surgical units are developed. This has the real danger of re-creating non sustainable services.
- It would appear that current capacity in NZ is insufficient and the reserve available to specifically train people to work in surgery centres is limited. Further work is urgently needed on this.

5. *Funding is available through additional Elective Services initiatives to undertake bariatric surgery.*

DHBs are concerned about the capacity of the sector overall to meet the anticipated levels of service delivery on a consistent basis and without a negative impact upon other services.

DHBs note the following:

- Funding for surgery should come from within elective services initiatives.
- The funding that we believe could be used is the "additional" electives funding not base.
- 2008-09 elective funding is already committed, and so is not available funding for bariatric surgery in that allocation.

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- There must also be appropriate recognition of the resource inputs to achieve the output – very specifically that the CWDs are sufficient. Ideally the surgery should be in addition to existing throughputs, and be funded via electives, however we recognise that some DHBs (us included) do not have access capacity (manpower, theatres, beds etc).
 - There was nothing in the business case about post-operative indications regarding need for extensive plastic surgery which is more expensive than the bariatric surgery but could be important to achieving all of the potential gains.
6. *Further research into non-surgical interventions is required for those who are not suitable for surgery, although such research is outside the scope of this business case.*
- DHBs note that the potential "additional" cosmetic surgical costs needs to be appropriately allowed for.
7. *Normal project assurance will apply.*
- DHBs suggest a 1.0 FTE resource, funded by the MOH, to project manage the first year's workplan of the National Implementation Group.

Support

8. *Funding being made available for a standard care pathway (bariatric surgery and dietary advice) for bariatric surgery based on the strength of the findings of the business case.*
- DHBs are concerned about where the funding for these additional costs will be made available from.

Agree

9. *DHBs use their existing nationally recognized general surgery prioritisation criteria to assign priority for bariatric cases amongst their wider general surgical cases.*
- DHBs note the following:
- We have not seen any evidence that the general surgical prioritization tools have been tested to compare the prioritization of bariatric against general surgery.
 - There is doubt that the existing general surgery tool will cope with the factors involved in this type of surgery, especially if trying to hit a 0.5% intervention rate. A specific scoring tool might be needed.
10. *The standard care pathway for bariatric surgery be publicly funded in New Zealand for the management of those who are morbidly obese.*
- DHBs have significant concerns about the lack of linkages with service such as mental health and counseling.
11. *To achieve geographic equity, each DHB agree to aim for an intervention rate of 0.5% of its morbidly obese population — at current estimates this equates to 915 bariatric procedures nationally.*

This was generally agreed, if additional electives funding is to be applied.

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12. *Provision of bariatric surgical units be dependent upon each DHB or region having the surgeon capacity and volume, and the physical capacity, required for a clinically and financially viable service.*

DHBs note the following:

- There should be a requirement to attain regional agreement as to how bariatric surgery will be configured within the region rather than leaving it up to DHB by DHB judgment.
- Significant work is required to develop the national capacity for any increased intervention rate.

13. *The development of bariatric surgical units follow the guidelines of the International Federation for the Surgery of Obesity guidelines for Bariatric Institutions.*

Agreed.

14. *A National Implementation Group be established to support the implementation of bariatric surgery. This Group would in principle, subject to capacity issues, be led and supported by the Ministry of Health's Elective Services Team.*

DHBs note the importance of the work of the National Implementation Group to monitor progress to 0.5% intervention rates and the capacity to manage, both in the public and private sectors and whether this intervention rate should be increased over time. The Implementation Group process will also be critical to developing Guidelines for each Bariatric surgical unit, further develop the pathway of care and evaluate the outcome of the CMDHB study with respect to whether wrap around services generate a more favourable patient outcome.

DHBs query whether this should be Ministry led, and if so, then would this be more appropriate via the Long Term Sector Framework team.

15. *There will in time be a nationally funded longitudinal study of equity of access, outcomes, and other key performance indicators to plan for the future of the service. This study should be initiated and coordinated by the National Implementation Group.*

DHBs note that a national programme of data collection and database to assess outcomes should also be a priority of the National Implementation Group.