



The “supporting weight management in primary care” programme

*The Western Bay of Plenty PHO (WBOPPHO), in conjunction with the University of Auckland, has launched a pilot weight management programme for primary care. The programme uses a brief opportunistic approach to make it easier for health professionals to engage with patients with weight- or diet-related health issues. The programme provides health professionals with support material that covers diet, exercise and stress management. The format of the intervention is similar to the “ABC” smoking cessation tool, which is familiar to most primary care clinicians. The three-tiered approach focuses on: **A**sk, **B**rief advice and **O**ffer ongoing support or onward referral – “**ABO**”. If this approach proves successful in the pilot programme, the ABO toolkit will be made available nationally.*

The scale of the problem

Obesity is a major global health challenge. The proportion of adults who are overweight or obese has increased substantially over the past 30 years, and there have been no reports of “success stories” from any nation during this time.¹ In New Zealand, it is estimated that over one-third of adults are obese – this includes nearly one-half of Māori and over two-thirds of Pacific peoples.²

There have been many major studies on lifestyle interventions to aid with weight management and diabetes prevention, along with findings from “real life” programmes in the community. However, there is little evidence that these interventions result in large-scale (i.e. population level), long-term improvements in weight loss (and maintenance) or metabolic health indicators, such as type 2 diabetes.^{1,3,4}

This raises the questions of whether researchers and clinicians have the biology of human physiology, nutrition and physical activity basics correct and/or whether the socioeconomic environment is just too difficult to get people to change to healthier lifestyles. There is evidence that both issues have played a part in nations failing to improve normal weight maintenance and metabolic management for their populations.

How the ABO programme can make a difference

The WBOPPHO programme adopts a sympathetic approach to weight management that helps patients understand how our obesogenic society, via aggressive marketing, promotes the consumption of energy-dense food. Through the weight management programme, people are given planning advice so they can find time in their busy lives to overcome their obesogenic environment and regularly eat healthy and nutritious food.

The basis for the dietary advice provided by the ABO programme is evidence that populations that consume large quantities of unprocessed, high-nutrient foods have good metabolic health and central weight management.^{5,6} An important part of the programme is that health professionals acknowledge that people often find it difficult to choose to eat these high-nutrient foods as they prefer refined, energy-dense food.⁷ Health professionals are encouraged to think of this preference for energy-dense food as a type of “addiction”; this approach highlights similarities with how smoking cessation is being managed in primary care.



Overcoming barriers to weight-loss interventions

A key part of the weight management programme is to help health professionals overcome barriers to discussing weight- or diet-related issues with patients.

These barriers include:

- Fear of offending patients
- Discomfort at bringing up the issue of weight if the health professional themselves is overweight
- Not being able to offer a service due to lack of knowledge

In order to provide a non-judgemental opportunity for people to discuss issues relating to weight or body shape, it is important that all patients, of any size, can be weighed and measured during the consultation. This may necessitate purchasing a new set of scales, particularly in communities with large numbers of Māori and Pacific peoples who have some of the highest rates of morbid obesity (BMI >40 kg/m²) and super obesity (BMI >55 kg/m²) in the world.⁸

Asking patients if they have any concerns about weight management

Health professionals can initiate discussions with patients about body weight or dietary patterns by asking one or two open-ended questions to identify if the patient has any concerns. For example, “How do you feel about your body shape?”, or “Are you happy with your diet or eating patterns at the moment?” Patients who demonstrate a willingness to discuss body weight or diet-related issues should then be encouraged to do so using open, non-judgemental, reflective questions; the focus should be on making the patient feel heard.

Patients who are struggling with weight-related issues need to know that they are not alone, and that many other people are confronting the same problems. Talking about how society creates an obesogenic environment with prominent advertising and the ready availability of energy-dense food is likely to reduce any sense of isolation felt by these patients.

During the “Ask” phase of the intervention health professionals assess the patient’s current consumption of plant based, nutrient dense foods, such as vegetables, fruit and nuts, using validated questions.

Giving brief advice

The main dietary advice provided by the intervention is to encourage people to increase their intake of fruit and

vegetables (limiting high-starch vegetables such as potato). The goal is for these healthy forms of food to eventually replace “addictive” energy-dense foods. Calorie counting or weighing food is not part of the intervention as this may be perceived by the patient as being negative. A guiding, partnering approach is adopted in order to develop a management plan for the patient, as opposed to a “telling” approach.

A reduction in sedentary activities and an increase in the frequency and volume of physical activity is strongly recommended to all patients.

During the consultation an offer of annual weight, height, waist and hip measurements should be made, if these are not already being recorded. The patient is also offered routine blood tests, e.g. lipid profile, and then asked to return for a follow-up consultation to construct a plan for weight management and ongoing support.

Offering ongoing support or onward referral

Health professionals need to individualise weight-loss support according to patient requirements. For some patients dietary and exercise advice, along with a plan to maintain high levels of fruit and vegetable intake is sufficient. For other patients cognitive behavioural techniques are required to encourage patients to maintain healthy lifestyle changes.

Patients are contacted with reminders to attend quarterly follow-up consultations to encourage them to adhere to agreed behavioural changes.

Pharmacological assistance may be appropriate for some patients


Patients who are obese, i.e. a body mass index (BMI) > 30 kg/m², who are unable to achieve clinically significant weight-loss through diet and physical activity alone, may benefit from taking an anti-obesity medicine. None of these medications are currently funded in New Zealand.

Phentermine is a medicine that has not been extensively studied, despite it having a long history as an anti-obesity medicine. There have been concerns about the addictive potential of phentermine, as it is derived from an amphetamine base.⁹ There have also been concerns raised about phentermine because of an association with other anti-obesity medicines that have been previously withdrawn from the market due to their potential for causing cardiovascular and psychological adverse effects.^{9,10} Current anti-obesity medicine combinations, such as phentermine + topiramate or phentermine + lorcaserin, which are available overseas, continue to be widely studied and

research indicates that adverse effects due to phentermine are unlikely to be a problem short- or long-term in these medicine combinations.^{11, 12, 13}

Orlistat, a lipase inhibitor that blocks intestinal fat absorption, can produce modest weight loss in patients who have a high-fat diet.


Metformin may be an appropriate medicine for people who are overweight and who also have raised HbA_{1c} levels. Metformin is thought to counteract central obesity by normalising metabolism and is recommended for use in the treatment of people with intermediate hyperglycaemia (HbA_{1c} 41 – 49 mmol/mol) in New Zealand,¹⁴ however, it is not approved for use as an anti-obesity medicine.

 For further information see: “Managing patients who are obese: a growing problem for primary care”, Page 8.

Referral may be appropriate for patients with psychological issues

If a patient is suspected of having an obsessive-compulsive eating disorder (e.g. binge eating or bulimia), or delusional shape/weight thoughts (e.g. anorexia), they should be referred to a psychiatrist, psychologist or health professional with expertise in eating disorders. Fluoxetine is known to reduce binge eating, and is also associated with weight loss. Fluoxetine may be a treatment option for patients who are obese and who also have a mood disorder.^{15, 16}

The support material provided with the weight management programme includes contact details of community and culturally appropriate health professionals who are able to provide assistance to patients with issues relating to the psychological, social, dietary and physical fitness requirements.

 For further information or questions about the ABO programme, contact Dr Anne-Thea McGill:
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