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The healthy option: a route to funding

As an advocate of non-sporting health interventions, Dr William Bird was perhaps an unlikely star of the recent Sport and Recreation Alliance conference but his message of how to package physical activity for physicians outlined a huge opportunity for the sport, leisure and culture sector. *The Leisure Review* reports.

How does a general practitioner look at life? The question was posed by Dr William Bird, a GP in West Berkshire, to the delegates attending a workshop session at the recent Sport and Recreation Alliance conference. The answer, he suggested, is that they think of most things in terms of deficiencies, things that can be added to a patient to relieve them of their symptoms and return them to good health. However, for all the advances in medical science and all the medical interventions now available one deficiency, that of physical activity, stands out. Although rickets is becoming increasingly common again in the UK as children spend less time outside and the symptoms of physical activity deficiency – increased risk of low self-esteem and poor moods, weight gain, poor sleep, muscle wasting, constipation, increased risk of falls among the elderly and accelerated cognitive decline – are well known so why is the promotion and facilitation of physical activity all but ignored by the vast majority of GPs around the country? The answer to this question, Dr Bird explained, is largely down to language.

As chair of the Physical Activity Health Alliance, a strategic health adviser to Natural England and chief executive of Intelligent Health, a company that promotes the concepts of green gyms and health walks, Dr Bird has a better insight than most into how the National Health Service works and why physical activity is consistently under-valued as a viable, effective and sustainable health intervention. What happens when sport goes to the NHS for funding? A few examples from his audience showed that sport can make successful applications but they also served to illustrate that the reaction from the medical profession is haphazard, largely unstructured often difficult to understand. GPs, Bird explained, are usually looking for something that they can prescribe to the patient that is safe, effective, clinically proven and cost-effective. If it comes supported by some well-designed packaging and an expensive marketing campaign so much the better. While sport and physical activity are widely recognised as major contributors to health, if they are to establish themselves as a serious option among GPs they have to meet those GPs' needs and package itself appropriately.

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Bird's solution is Fitirex, a registered brand name for a new drug, also known by its generic name of physical activity, that can be marketed to GPs. The marketing material for Fitirex positions this new brand as a natural supplement for 'PA deficiency' with a wide application and clinically proven results. For example, in a practice of 10,000 people 6,600 will have PA deficiency but 7,100 will not recognise their own symptoms. Give Fitirex to 60 men over 60 years old with PA deficiency and one less will die every year compared to the control group. Treatment with Fitirex results in a 30% reduced risk of death, a 35% reduced risk in cardiovascular disease (CVD) coronary heart disease (CHD) and stroke, 35% reduced risk in type 2 diabetes, 35% reduced risk in hip fracture, 80% reduced risk in osteoarthritis disability, 30% reduced risk of colon cancer, 20% reduced risk in breast cancer and reduced risk of Alzheimer's disease. Dosing guidelines are low doses for recovery for those new to it, a moderate dose for general use and a high dose only for experienced users. In addition there are no known side effects for low doses and very few for moderate.

Speaking the language of medical intervention is the key to marketing Fitirex to GPs, Bird explained. The cost of PA deficiency to the NHS is some £1 billion a year, which should get some attention, but one also needs to be able to talk in terms of the 'QALY', which is shorthand for a quality-adjusted life year, and is an accepted reference point within the NHS. The NHS's own calculations (qv Let's Get Moving, published by DoH c2009) show that achieving 1 QALY via the use

of statins costs £17,000, via smoking cessation £5,500; and via physical activity £440. NICE, the National Institute for Clinical Excellence, accepts costs of up to £30,000 per QALY for any treatment or intervention and therefore 68 patients can be treated with Fitirex for the cost of one standard intervention.

“Given figures like these, which idiot is going to spend that money on statins?” Bird asked, before answering his own question: “GPs and the NHS. This means we need to be smarter about how we sell to physical activity to health. And how do you sell Fitirex to a GP consortium? You start with a diagnosis.”

The evidence is available for many of the most common ailments. In relation to depression in 2004 the chief medical officer’s report on physical activity said it was as effective as anti-depressants. With regard to diabetes, clinical trials have shown that physical activity can delay onset of diabetes for an average of 3.6 years [qv Li, G Lancet 2008; 371:1783-89] and that physical activity achieves better results in preventing the development of diabetes among those with impaired glucose intolerance tests than treatment with diet or anti-diabetic drugs [qv Gilles et al BMJ 334 19.1.2007]. For hip fracture a study has shown that a prescription of Fitirex to a group of women showed no hip fractures among the half exercising regularly compared to five in the non-exercising control group [qv Bensen WG, Roux, C New England Journal of Medicine 2002; 344: 333-340].

There are plenty of similar examples and studies but the NHS’s own figures for expenditure on heart attack prevention serve to illustrate the potential. For £30,000 the NHS can prevent one heart attack with statins, two with smoking cessation and 38 with physical activity but, despite physical activity being by far the most cost-effective approach investment, still favours statins and smoking cessation. The issue, Bird argued, is that those working to promote physical activity, whether through sport or more general recreation, need to ensure they are credible – which is where the clinical evidence helps – and they need to be able to package and repackage their offer until something sticks. With primary care trusts, target the director of public health or at GP level try the practice manager. Bird admitted that it is not easy but the potential benefits, whether for sport and recreation professionals or GPs’ patients, are enormous.

“Think of physical activity as a package,” Bird said. “Make sure you think in terms of patients with conditions and for public health you need data, especially in deprived areas. From numbers you get cost-benefit and from cost-benefit you get funding.”

Download a pdf of the Let’s Get Moving, a Department of Health document published in September 2009

Dr Bird’s presentation at the SRA conference is available at via the SRA website at www.sportandrecreation.org.uk

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