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Discussion Paper

**THE ACCREDITATION OF HEALTH  
PROFESSIONALS  
WHO PRESCRIBE  
EXERCISE AS THERAPY**

**By**

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## Quick overview

This paper explores the need, or otherwise, for accreditation of health professionals who prescribe exercise as therapy and suggests how to go forward. Key ideas, conclusions and propositions that drive this discussion are:

1. The case is strong for exercise prescription as a therapy to receive equal funding status as given to pharmaceutical prescriptions.
2. Without a consistent measure of competency across all exercise-prescribing professions, it is difficult to identify and monitor those health professionals who are competent to prescribe exercise as therapy, or to allocate resources to them. The negative alternative is to allocate exercise prescription funding to an exclusive few professions, and excluding all others.
3. Exercise prescription already happens across a diverse and sometimes competing range of exercise and health professions. Many have their own specific professional accreditation needs. The current situation is fragmented and there needs to be some uniformity, in order to move forwards with point #1. However, a single “one size fits all” accreditation scheme will not satisfy the needs of so many diverse professional organisations. The sobering reality, though, is that it would be difficult to present a convincing case to funding agencies for exercise prescription to receive funding status that is equal with pharmaceutical prescriptions, if there is not a consistent measure of trans-profession competency.
4. Exercise, in many cases, may be as simple as encouraging a regular walk around the block. However, minimum and consistent standards of professional competency ensures an informed problem-solving approach to exercise prescription (As opposed to mindless prescription by numbers), high margins of safety and the confidence that responses will be appropriate if things go wrong.
5. If exercise prescription dispensing receives taxpayer and insurer funding, the General Practitioner is the natural coordinator and gatekeeper of the process. The General Practitioner is already ideally qualified and placed to fulfill this role, due to their traditional relationship with the public, their qualifications, outright numbers and their widespread geographic location.

6. A proposed College of Health and Fitness Professionals will represent the interests of all health professionals who prescribe exercise as therapy. While not replacing existing professional organisations, or current and pending accreditation systems, the College will provide an over-arching framework for accreditation of health professionals. In addition, it will develop and promote guidelines for consistent exercise prescription across all professions, including such matters as guidelines and procedures for the sharing and security of confidential patient information between diverse health and fitness professionals.
7. The College will negotiate with health services purchasing agencies, on the behalf of its accredited members, to provide exercise therapy services by way of service agreements.
8. The promotion and formation of a College of Health and Fitness Professionals has to be the initiative of the medical and health professions, rather than the fitness and sports science sectors. This is because the prescription of exercise as therapy is, conceptually, a medical intervention for the prevention, treatment, rehabilitation and management of health issues. The principal funding for establishing a College of Health and Fitness Professionals, and any subsequent programmes and interventions should come out of health funding, rather than from other sources, such as recreation and sports funding.
9. The proposed next step forward is the formation of a Coalition of Health Professional Organisations who will invest resources to prepare a working paper prior to convening a meeting of all stakeholder organisations, including Government agencies. The purpose of the Stakeholders meeting will be to discuss the Coalition's findings, resolve outstanding issues and to agree on a way forward to finally establishing a College of Health and Fitness Professionals.

## **Introduction**

There was strong agreement among those consulted while putting this discussion paper together that there should be some form of accreditation of people who prescribe exercise. The following quote from one respondent, while it is focusing on the gym industry, pretty well sums this up:

*"I strongly support the recommendation to accredit health professionals who prescribe lifestyle and fitness. It continues to astound me that fitness centres/ gyms etc can be*

*opened by anyone (regardless of qualifications/ experience), equipment used by anyone (regardless of supervision/guidelines in the use of equipment/ assessment of personal fitness) and that there is no real process of monitoring the advice given. People without any form of personal accreditation can give fitness, dietetic, lifestyle and counseling advice. From a straight accountability issue and from a business perspective, I cannot understand why businesses take this risk - not to mention the ethical issues.”*

The evidence in favour of prescribing exercise as a therapy for the prevention, treatment and management of a growing list of ailments is overwhelming and growing by the day (US Surgeon General 1996; King 2000; Dr Harriette Carr (MBCChB August 2001).

This paper describes the “big picture” and investigates several important issues, including questioning the need for accreditation in New Zealand. Why design an accreditation system in the absence of need? If exercise is not being prescribed all that much by health professionals, where is the evidence that accreditation will improve prescription rates and quality?

Fitness New Zealand is finalising an accreditation system for gym instructors and personal trainers. The system that the industry intends to introduce will be an adaptation of existing internationally accepted standards for accreditation. Their efforts should result in most, if not all, gym instructors and personal trainers who are working in New Zealand fitness centres accredited within several levels of competency. We need to explore the implications of this for health professionals who prescribe exercise.

Who prescribes exercise as therapy? Fitness instructors, personal trainers, massage therapists, nutritionists, doctors, physiotherapists, occupational therapists, podiatrists, chiropractors and many others who provide health and fitness services. Since the case is strong for including exercise within a holistic approach to therapy and health promotion, how do we encourage the widespread use of exercise prescription, while ensuring that it is both effective and safe?

If the accreditation needs of, for example, fitness instructors, physiotherapists and general practitioners are different in quite specific ways, is there the need for a unifying scheme that embraces, but does not control or replace existing, or planned accreditation schemes?

If medical clinics are going to provide fitness services, including a gym facility in some cases, what is the experience from overseas? Is the model viable in the New Zealand setting?

Is the professionalisation of getting fit and staying healthy confusing what is surely a simple formula, discouraging the public from action without first

hiring an expert, such as the Personal Trainer? Will accreditation create more exercise experts? Will more experts result in further confusion of a simple message and making complex a simple process? Will it result in further burdens of cost on the consumer and taxpayer? How should we package the product and empower the consumer to take responsibility to act and change behaviours?

Should exercise have equal status, including taxpayer and insurer subsidies, to the same level as received by prescription medicines? If it is an effective option to reduce elevated blood pressure, can a doctor prescribe exercise that is subsidised? Can a doctor refer an overweight patient to a subsidised “exercise clinic” as an alternative to, or including, a pharmaceutical prescription, or surgical procedure? If this should be, then how does one assess and recognise the competency of health professionals to prescribe exercise with uniform safety and effectiveness across so many professions?

Exercise prescription, as pointed out by several respondents, is just part of a mix of legitimate lifestyle therapies, of which diet carries growing weight of evidence for its therapeutic value. Should a health professional prescribe exercise for the promotion of health without equal emphasis on dietary measures? Should we tack diet onto the end of an exercise programme, or should it be the other way around? Should there not be levels of accreditation for the many different health professionals who offer dietary advice? For the sake of manageability of this exercise, should we focus on exercise prescription only?

This discussion paper works through the issues and offers possible solutions, including the proposal to form a trans-disciplinary “College of Health and Fitness Professionals”.

## **What is the case for accreditation in New Zealand?**

### **For**

- New Zealand is following overseas trends and becoming an increasingly litigious society. Accreditation with the use of informed consent and disclaimer procedures might offer protection against a health professional being successfully sued
- The NZ Heart Foundation has guidelines for exercise prescription for people with heart disease. Exercise programmes for people with heart

disease will soon need to meet, or exceed these guidelines, beginning with instructor competencies

- The suggestion has been made that GP's are unsure of who to refer patients to for exercise prescription and that accreditation might address this issue (Jowsey 2000; Owen Brunel 2001)
- Where there was just one physical education course in 1980, there is now a plethora of sports science, gym and physical education courses in New Zealand. What is the measure of consistency between these and the competency of their graduates to prescribe exercise?
- An accreditation programme may be necessary for exercise to be accepted as a legitimate form of medical prescription that can tap into the reservoir of public and private health dollars
- It is suggested that GPs and allied health professionals need post-graduate accreditation because their formal training may not have included exercise prescription to any significance

## **Against**

- New Zealand educational and training standards are already very high by international standards and accreditation is just another unnecessary cost burden on health professionals that will be passed onto consumers
- There is no documented evidence of need; nobody has been sued, ACC legislation reduces this possibility, and there is no evidence that there are deaths or injuries from exercise prescription that would be prevented/reduced by accreditation
- Exercise prescription should be simple – we need to get back to basics. We do not need accreditation for this. Accreditation is just further unnecessary professionalisation
- Doctors already have the training - they just need to be better resourced and given encouragement and incentives to prescribe exercise
- Let the market decide, it is argued, and powerful market forces will drive standards upwards

## **Conclusion**

The case falls on the side for accreditation because:

- OSH workplace safety regulations are pushing in that direction and cannot be ignored

- ✘ To be viable, prescribing exercise as a medicine needs to receive health sector funding. An accreditation system is one way to identify those eligible for funding and may be necessary for quality control and accountability
- ✘ Special skills and training are needed for specialist rehabilitation such as for cardiac conditions and these skills will need to be consistent with Heart Foundation and other guidelines
- ✘ Sense needs to be made of the proliferation of qualifications that claim to confer competency to prescribe exercise, including those qualifications coming in from overseas

## **The Green Prescription (GRx)**

The Hillary Commission (now called “SPARC”) launched the GRx in November 1998. The GRx encourages doctors to prescribe exercise. According to information gathered late in 2002, Pharmac (<http://www.pharmac.govt.nz>) is a co-sponsor of the programme, covering about 50% of the budget. Administration at the regional level is by the regional sports trusts (<http://www.sport.org.nz/rst.html>). They also help to coordinate SPARC’s “Push-Play” programme (<http://www.hillarysport.org.nz/pushplay/indexpp.html>) which promotes a simple message of increasing daily exercise through incidental activity. This is done on the weight of evidence that such exercise has health benefits for many ailments ranging from depression to colon cancer(Carr 2001)

The key GRx players are:

- ✘ General Practitioners
- ✘ Practice Nurses
- ✘ Patients
- ✘ Activity providers (Regional sports trusts)

Doctors are supplied customised GRx prescription pads and a folder of support material. Regional Sports Trusts employ an “Active Living Coordinator” with an 0800 hot line (0800 ACTIVE: 0800 228 483) that patients can call for advice. The Coordinator matches the patient with an exercise programme. Most patients, it appears, put into action the recommendations of the GP without calling the hot line. The Active Living

Coordinator usually doubles as the “Area Manager” who is responsible for promotions and GP visits, similar to the duties of a drugs rep.

Although the research is contradictory, the GRx does not appear to be having a significant impact on patient behaviours:

- ✦ One survey(Gribben, Goodyear-Smith et al. 2000) generously estimated that 48-65% of targeted GPs used the GRx. But, it did not state how often – an essential statistic. New unpublished research reportedly claims 98% awareness among GPs.
  - GRx rates, as a percentage of total prescriptions, would, however, appear to be insignificant – this needs research investigation
- ✦ In an informal survey in 2001 of Fitness New Zealand members, none could recall ever receiving a GRx referral
- ✦ Although its programmes are exercise rehabilitation-oriented and, despite being the largest contractor of exercise-based injury rehabilitation services to ACC and the Cancer Society in the Wellington Region, Sports-Wide Ltd has never had a GRx referral.
  - Referrals and joinings from other sources, in contrast, are from 160 to 220 per month.
- ✦ To have a significant effect on population health trends, the GRx would have to have an impact on exercise habits similar to that of the fitness industry
  - With a regional population of about 350,000 people, the GRx would have to influence the exercise habits of at least 1,000 additional Wellingtonians per month.
- ✦ Quality research of the GRx is lacking. What evidence there is tends to indicate that the GRx, or its equivalent, has minimal impact on patients’ exercise patterns(Patrick and et al. 1994; Swinburn and et al. 1997; Gribben, Goodyear-Smith et al. 2000; Jowsey 2000; Smith 2000)

### **Why is the Green Prescription underutilised?**

- ✦ With an annual budget of about \$700,000 per year, the GRx is woefully under-funded when compared to total health expenditure:
  - Government figures are as follows(Health 2001):
    - Nominal health and disability expenditure was \$8,952 million 1999-2000.

- Private expenditure on health insurance was \$561 million,
- Household expenditure on health was \$1,375 million and
- Expenditure by the “not for profit” sector was \$32 million.
- It appears that the Government subsidy for prescription medicines was about \$725 million for the year 1999-2000.
  - This does not include the cost of other forms of dispensation and uses of pharmaceuticals. This figure was located by the author
- ✚ The GRx is in direct competition with the drugs industry
  - Although the GRx has backing from Pharmac, it is a non-starter in this competition. It is not even at the same competition venue (More about this later)
- ✚ GPs generally know their communities very well. They have their networks in place. If a GP wants a patient to take up aquarobics, for example, she/he will refer the patient directly to that programme. If a GRx pad is used, it is not recorded in prescribing statistics as far as the author can tell
- ✚ If the 0800 number service *fails to deliver good service*, the GP will probably go elsewhere next time, such as directly to the fitness programme providers who they are familiar with and have good working relationships.
  - The Coordinator is not always available when the person calls and delays may ensue. The coordinator may be a recent graduate - inexperienced and unfamiliar with the programmes and resources in their community
- ✚ Starting an exercise programme is akin to buying a new car – the purchaser wants to drive it out of the showroom. If there are delays in getting started, they will either go elsewhere, or give up. A perceptive GP will refer directly to a trusted service provider to prevent unnecessary delays.

## **Accreditation trends and developments in the fitness industry**

### **Fitness New Zealand (FNZ)**

*In 1983, the author was the first gym operator to employ only graduates in physical education, or the equivalent, and the first to use the term "Health and Fitness Consultant". Before then, there were no more than a handful of graduates employed in the industry. He was a founding executive member of FNZ and was involved in the planning meetings that established SFRITO. He was also a member of the first FSAG that wrote the original ITO unit standards for the fitness industry.*

FNZ began operation in the late 1980's and now represents the major and most of the minor players in the commercial fitness industry. FNZ represents mostly gym owners and an increasing number of personal trainers. Members have a collective marketing budget estimated to be about \$20 million annually to encourage people to join a gym for exercise.

FNZ gyms have approximately 450,000 New Zealanders as paying members (more than 20% of adults, or 12% of total population). This does not include participants in programmes such as municipal pools and gyms, or community fitness programmes or sports clubs. Membership is growing annually, making FNZ the single largest and most influential player in the promotion of health and fitness in NZ.

Although FNZ is not an employers organisation, its members now make up the largest employer group of graduates in exercise science and physical education and are the main drivers of course content of tertiary fitness and sports science training programmes. The industry currently employs about 4,000 full-time and 3,000 part-time people.

FNZ recognises the need for accreditation for fitness instructors and for specialist areas such as injury and cardiac rehabilitation. It is presently working with SFRITO to introduce a close variation of internationally recognised accreditation schemes for fitness instructors, already established in other countries, including the United Kingdom and Australia. This will be via a charitable company that will operate at arms length of the FNZ.

### **Sports, Fitness and Recreation Industry Training Organisation (SFRITO)**

SFRITO formed in the early 1990's. FNZ is the main industry shareholder in SFRITO. The recreation industry has shareholding in this industry training organization (ITO) but appears to have a less influential presence

than FNZ. SFRITO reports to a sub-committee of FNZ – the Fitness Sector Advisory Group (FSAG). SFRITO prepares unit standards at the direction of FNZ through FSAG and administers the subsidy of, registration and quality control of industry training. SFRITO has funding from the Government for its ITO training programmes which a workplace can access through fitness industry employees that are registered trainees.

### **Fitness Sector Advisory Group (FSAG)**

The fitness sector’s training needs are relayed to SFRITO by the FSAG. The membership of FSAG does not presently have any sports medicine or rehabilitation representation on it.

This may be due, in part, to the underestimation of the significance of the fitness industry by the health sector and sports and recreation bureaucrats. This raises the possibility that the description of training needs in the unit standards for specialist fitness and rehabilitation qualifications risk being inadequate for rehabilitation and patient safety with special reference to cardiovascular risk. It is unfortunate, for example, that the Heart Foundation has developed guidelines for cardiac rehabilitation without formal consultation with the industry that may be one of the main stakeholders in their implementation.

FNZ and its SFRITO FSAG are exploring introducing several levels of accreditation for fitness industry workers that will be something like the following:

#### **■ Level one**

- This is the entry-level unit standard “floor walker” qualification. This may be the Certificate level

#### **■ Level Two**

- This is the entry-level unit standard for personal trainer and fitness consultant qualifications. This may be the Diploma level

#### **■ Level Three**

- This is the highest level for qualifications and will be a requirement for working with special needs groups, including rehabilitation and advanced fitness testing. This may be the Degree and Post-Graduate level but may be inadequate due to insufficient input from sports medicine and rehabilitation agencies.
  - There may be a fourth level added for specialist qualifications

The author understands that SFRITO may spend several hundred thousand dollars on this project over a five-year period.

The author further understands that most of the main tertiary training institutions have had initial discussions with FNZ about how to link with their proposed accreditation system.

## **Does Government appreciate the size and importance of the fitness industry?**

Government does not demonstrate that it is aware of the extent of the contribution of the fitness industry to health promotion, or of its potential partnership role in health promotion.

- ❑ Neither SPARC, or its earlier version (Hillary Commission), has had little in the way of formal discussions with FNZ about accreditation or anything else
- ❑ The Government's health strategy report (King 2000) failed to recognise the role of the fitness industry or the significance of its contribution
- ❑ The Government does not appear to consider consumer and business expenditure on health and fitness programmes as being "Health Care". An example of this is the placement of a Fringe Benefit Tax on in-house employee fitness programmes and employer subsidised fitness programmes because such programmes were seen as being principally a perk, rather than health benefit. This tax has contributed to the demise of employer-funded health and fitness programmes in New Zealand
- ❑ The reports that have laid the Government's blue-print for promoting activity in NZ (Commission 2000; Commission June 1998) [http://www.hillarysport.org.nz/pdfs/pa\\_taskforce\\_report.pdf](http://www.hillarysport.org.nz/pdfs/pa_taskforce_report.pdf) and [http://www.hillarysport.org.nz/pdfs/hc\\_publications.pdf](http://www.hillarysport.org.nz/pdfs/hc_publications.pdf) have only two sentences referring to the fitness industry. There is just one reference to Fitness NZ - in a table.

## **The role of General Practitioners**

There are approximately 3,500 General Practitioners (GPs). They are widely distributed throughout the country and are usually the first point of call for people when ill or injured – and they have well-established administrative systems with health services purchasers. The GP is in a good position to influence and change behaviours that affect health.

GPs have had their role progressively narrowed and, at times, undermined by health sector changes and developments, including the trend towards role specialisation in health.

While there is increasing acceptance of the importance of promoting holistic health, there is an even stronger trend to more specialisation and professionalising medicine, fitness and health. This trend may be at loggerheads with a holistic health approach – unless there remains competent and well-resourced generalists, who can coordinate, interpret and implement specialist knowledge and services. The GP is the obvious “specialist generalist” to call upon to coordinate the provision of these services.

A parallel example is that of the high-performance sports coach whose role is unintentionally undermined by the growing influence of specialised sports scientists. The coach is in a role similar to that of the GP. In each case, Coach and GP need to be the captain at the helm of the ship - otherwise the result performance may stagnate while costs go up.

The growth of Independent Practitioner Organisations and the introduction of bulk funding may facilitate health promotion and less prescribing of medications on their own, if it was possible to deliver exercise as a cost-effective alternative to pharmaceutical prescribing.

The best-placed primary health care professionals to prescribe exercise as therapy are GPs. If a patient with back pain, for example, has exercise prescribed as an intervention it is important that a medical practitioner review progress because failure to respond to the intervention may be indicative of an underlying pathology such as multiple myeloma.

## **Factors working against the General Practitioner prescribing exercise as therapy**

Swinburn(Swinburn and et al. 1997) identified time and remuneration as being important factors working against GPs prescribing exercise.

Jowsey(Jowsey 2000) identified lack of confidence in prescribing exercise as an additional factor. Let us explore these issues:

### **Time**

Most patients receiving exercise advice through a GP will benefit from concise and simple exercise messages. They do not need complex messages, and lengthy and exhausting programmes. A 15-minute GP consultation may include 5 minutes for exercise counseling and several essential follow-up

consultations to ensure compliance and to refine the intervention. Some of these follow-up consultations could be with the input of the Practice Nurse.

In his analysis of exercise counseling by Californian primary care physicians, Walsh (Walsh, Swangard et al. 1999) made the following conclusions:

*“Many primary care physicians are not asking about, counseling about, or prescribing exercise for their patients. Since primary care physicians are in the best position to provide individualized exercise prescriptions for their patients, future research should focus on training physicians in effective counseling techniques that can be done as brief interventions”.*

The author used to write and administer the ACC’s “5 Minute Talk” safety educational resources for workplace health and safety managers. It is possible to convey simple, relevant health messages in five minutes, including a “call to action”. The GP, or Practice Nurse can reinforce and add to the health messages with follow-up appointments over a month or two – or for as long as is necessary to bring about lasting change, habituation and measurable health benefits.

## **Remuneration**

The US Surgeon General (General 1996), lists more than sufficient evidence to justify the prescription of exercise as a medicine for many ailments, especially for those that have strong associations with ageing and lifestyle. Adequate remuneration and the existence of accredited programmes to refer into will encourage the prescribing exercise as a therapy, whether it is on its own or complementary to drugs prescription and other treatments.

## **The role of the drugs industry**

Otherwise known as the pharmaceutical industry, the drugs industry is an aggressive, influential and highly sophisticated marketer of drugs-based medicine. While they might pay occasional lip service to exercise and diet, they regard the fitness industry as a potential competitor for the millions of health dollars that they presently monopolise. It promotes a blinded mindset among the public for passive medicine based around the instant gratification of the “Magic Bullet”. Exercise and diet, in stark contrast, require the active participation of the patient with delayed gratification for a lot of effort. The widespread media promotion of pharmaceutical treatments for “lifestyle” ailments without attending to negative lifestyle factors (smoking, overweight, lack of exercise, etc) further undermines efforts to promote a holistic, lifestyle-based approach to healthcare.

This sadly detracts from the massive and positive contribution that modern pharmaceuticals, such as antibiotics have made to public health.

For as long as the drugs industry remains dominant and unchallenged by exercise, diet and other lifestyle alternatives, the GP will continue to have to preferentially prescribe drugs medications. Pharmac promotes several interventions(Pharmac 2002) but these are grossly under funded when compared to it's expenditure on drugs prescriptions subsidies.

### **Is there a place for the Green Prescription?**

The case is strong for a GRx scheme. Sadly, it has had insignificant impact on patient behaviours in its present form.

### **Is accreditation of GP's necessary for them to prescribe exercise?**

A GP undertakes at least six years of intensive medical training. Few would have the time, energy or inclination to undergo further training and accreditation assessments for what is a nil extra financial return.

Prescribing exercise, in most cases, can be a simple 5-minute process. Simple messages, with follow-up appointments by the doctor and/or practice nurse should be the rule. If a patient has complex needs, this is when referral to specialist services happens. GPs are already qualified and experienced enough to provide these basic services – they just need the resources and better rewards for doing their job. The GP is especially skilled in diagnostic procedures and problem solving to develop solutions for what may be complex individual needs. If a GP is to prescribe exercise and coordinate the services of other exercise service providers, their accreditation for exercise prescription may require that they attend a short course that reviews the essentials of safe and effective exercise prescription, strategies for motivation and clinic-based supervision, and that ongoing training in exercise prescription is included in CME credits.

### **Clinic-based fitness advisory services and facilities**

It does seem to be a good idea to place a fitness advisory service and fitness centre within a medical practice, relieving the GP of the need to implement the exercise prescription. While the synergy seems obvious, can it work?

### **International trends**

Arguably, the biggest trend in the USA fitness industry over the previous 10 years has been the growth of clinic and hospital-based fitness centers. Some

of these have been on a grand scale. They were the way of the future. This may not now be the case. Indications are that many of these facilities are having money troubles. To avoid closure, established mega-fitness centre operators, such as Bally Inc. are now taking over their operation and introducing the commercial gym model.

### **Are these viable models for New Zealand?**

If this model struggles in the United States, one would assume that they are unlikely to work in a country with a fraction of the wealth and population.

Additional factors work against their viability in New Zealand. New Zealand is the most “Gymified” country in the world with 20% of the adult population already belonging to a gym. It is also the most competitively priced in the Western world with average annual membership fees ½ those found in the UK or USA. New Zealand has always been equal to the best in terms of quality. NZ leads the world in aerobics (Les Mills’s Jazzercise is the largest fitness to music franchise in the world). New Zealand’s gym programmes are generally several years ahead of those in UK fitness centers in terms of quality. Every town in New Zealand with a population exceeding 5,000 has a fitness centre. Average annual gym fees in New Zealand are about \$600. This mix of value and quality gives little room to move in terms of pricing and market position.

Because a clinic-based service has no subsidy, and because it generally works with lower than average income populations, it cannot expect to charge more than the well-equipped and staffed gym just down the road.

Although there may be a few exceptions, a fitness advisory service and/or a small gym in a medical centre will not be viable for the following reasons:

- ❑ Average incomes in a commercial gym are about \$50/hr for a personal trainer consultation and \$17 per hour for a gym instructor.
- ❑ With wages, rent, utilities, reception and other overheads, plus return on investment, the hourly income per chargeable fitness consultant hour needs to be a minimum of from \$80-110/hr for the facility owner.
- ❑ A commercial gym can generate this income through economy of scale, aggressive and imaginative advertising and careful management of consultant downtime.
- ❑ A medical clinic-based service may generate only about \$50/hr per consultant without including non-chargeable time which can be as high as 50-70% if not strictly managed

- ❑ Unless there are two or more fitness consultants employed, there is costly disruption to clinic services whenever there is illness, leave or a resignation.
- ❑ A \$10-20,000 gym will have difficulty competing against a nearby gym that may have a swimming pool, plus \$500,000 of equipment, 40 staff and sophisticated and aggressive advertising and marketing programmes.
- ❑ Can New Zealand really afford duplication of what is already there?

To help illustrate the difficulties these clinics might face, a parallel illustration is the recent establishment of Otago University's Human Performance Centre at the Westpac Trust Stadium in Wellington. This centre services the Central Academy of Sport. Additional income was to come through services such as executive fitness testing and advisory services to the business community.

Several important business factors work against its viability:

- ❑ It occupies some of the most expensive real estate in Wellington, so it has higher base overheads than its competition
- ❑ It is in competition with commercial fitness centres in Wellington
- ❑ It is in competition with the Dominion Clinic and Wakefield Sports Medicine Centre which provide athlete and executive medicals and stress testing
- ❑ Its competitors are hardened and successful commercial operators with well-established working and contractual relationships with business and the community.
- ❑ The fitness market in Wellington is mature, so the Stadium Centre has to compete for market share, rather than rely on market growth – a very tough task. The author understands that:
  - Corporate fitness testing income has not eventuated
  - \$80,000 per annum was to come from Academy testing in 2002. The reality is about 10% of this.

Clinic-based fitness advisory services face similar scenarios and would probably require subsidy to survive.

### **How a GP-based exercise prescription might work**

For the purposes of this exercise, there are three categories of exercise prescription: for the patient with low risk, the patient with moderate risk and

the patient with high risk. Exercise for an uncomplicated case with low risk is essentially for the reduction of identified health risk factors for the prevention of, or slowing the onset of disease. Supervision needs for a low risk patient are minimal. A patient with a history of poor exercise adherence who is overweight and/or showing signs of increasing blood pressure, for example, may be considered low risk and may benefit from a walking or swimming programme with several follow-up progress appointments with their GP.

Exercise for the patient with a history of poor exercise adherence and moderate risk factors may benefit from referral to one or more health professionals with the accreditation and facilities to provide for their exercise needs under supervision. In the case of referral to accredited health professionals, the GP would continue to coordinate the provision of services and monitor progress. An obese 50 year old person with raised blood pressure exceeding 150/100, insulin dependent diabetes and an arthritic knee would be an example of a patient with complex needs and high risk safety issues; whereas an obese 25 year old insulin dependent diabetic with 130/90 blood pressure would be a relatively uncomplicated moderate risk candidate. A standardised system of health risk classification can be devised for health risk assessment, based on assessment tools such as the Par-Q activity readiness questionnaire (Physiology 1994) or the ACSM risk stratification (Nieman 1999). The following is a hypothetical illustration of a GP-based system:

#### **■ For patients with low risk**

- 15-20 minute appointment that includes exercise prescription utilising home and community resources
- Five 10 minute progress checkpoint consultations, possibly involving the Practice Nurse over the following three months
  - Remuneration at standard medical fees rate with or without subsidy
- Annual review with general medical checkup and further intervention/follow-up, if warranted
  - Cost may be about \$200 for the first year and \$80-120 over the next year

#### **■ For patients with moderate risk**

- The doctor may refer the patient to a fitness programme with health professionals accredited to a level that is adequate to cater for moderate risk. The referral will outline the identified health risks and the expected outcomes.
- The programme may be full or part funded for as long as six weeks with assessment and reporting procedures back to the GP
  - Cost may be about \$400 and \$80-120 over the next 12 months for the cost of several ongoing follow-up checks
- For patients with high health risk and complex needs
  - The doctor would refer the patient for an initial assessment to a fitness programme providers and other health professionals, such as a nutritionist, with the accreditation to cater for high risk patients.
  - The assessments results are discussed in a case conference and a multidisciplinary treatment plan is devised with the participation of the patient.
  - The programmes costs are included in a report with recommendations to the funding body
  - Once approval is received to proceed, the programme kicks into action
    - Duration may be up to 12 weeks with several follow-up sessions over the next 12 months.
    - Programme costs are dependent on individual needs, but may average about \$5,000 per patient
    - It may be necessary to have programmes for high risk patients managed by trained Case Managers who may contract their services directly to the funding organisation, or through the medical practice.

## **Is there a need for a College of Health and Fitness Professionals?**

No single organisation presently represents and promotes the interests of the diverse range of health and fitness professionals. Sport Science NZ and Sports Medicine NZ would be the closest to providing a broad trans-disciplinary coverage of health and fitness professionals.

Prescribing exercise is but a part of several lifestyle factors affecting health and physical performance. Exercise alone is not the complete answer but part of a mix of lifestyle interventions including diet. It is not just sports medicine. It is not just diet. It is not only strength and conditioning.

Prescribing exercise ranges from the needs of young children, the elderly, the injured and the ill – then to the extremes of the high performance athlete competing at altitude, for example. There is presently no unified representation for these professionals (such as a college of health and fitness professionals). This is an important issue when discussing the subject of accreditation.

## **Current situation and trends for related professional organisations**

### **🇳🇿 Coaching NZ**

This organisation once represented coaches and ran coaching education programmes. It is now in recess due to lack of support from coaches. SPARC is presently baby-sitting their coaching education programme - but for how long? Coaches consequently have no organised representation beyond the confines of their sporting code.

### **🇳🇿 Physical Education New Zealand**

Physical Education New Zealand (PENZ)

<http://www.penz.org.nz/news.asp?sectID=news&pgID=2> actively promotes and develops physical education within New Zealand, and supports educators and others within the sector. This is achieved through offering professional development opportunities to educators so they can upgrade their skills, offering an advisory service for specific areas of the curriculum, advocacy at national and local levels, producing a magazine and academic journal, offering networking opportunities and contracts for service for such things as resource development. A large proportion of members come from primary, secondary and tertiary institutions, with the balance made up of students, international journal subscribers and other interested individuals and corporations. PENZ currently has more than 900 members.

### **🇳🇿 Sport Science New Zealand**

Sport Science New Zealand (SSNZ)

<http://www.sportscience.org.nz/index.html> formed in 1990 originally as the Sport Science and Technology Board (SSTB), dedicated to promoting the research, distribution, development and proper use of sport science to

improve the performance of New Zealand sports people (1995 Annual Report).

In the past SSNZ has had the responsibility of managing the Hillary Commission and later the Sports Foundation's research programmes. SSNZ has presented national 'road shows' of professional development opportunities aimed at heightening the profile of sport science and improving the education of sport scientists, coaches and athletes. SSNZ has had a long history of delivering this country's premier sport science and coaching conference, which it continues to deliver today. Another service that SSNZ offers New Zealand sport involves a Quality Assurance Programme whereby sport scientists of six different disciplines (Anthropometry, Biomechanics, Exercise Physiology, Physical Conditioning, Sports Nutrition and Sports Psychology) and sport science laboratories are checked to ensure that they remain up to date in knowledge and practice. This checking process follows an initial registration requirement where entry criteria are set to recognise qualified sport scientists and properly equipped and staffed laboratories. The Quality Assurance Programme, as a whole, acts somewhat as a trademark of quality where athletes, coaches and the public have some protection against the practice of unqualified or unprofessional providers and facilities.

SSNZ has a membership of 170 accredited individuals from the various disciplines (above) and a further 11 accredited laboratories where athletes are tested. SSNZ total membership is 278 members and its national office is located in Wellington.

## **🇳🇿 Sports Medicine New Zealand**

Sports Medicine New Zealand (SMNZ) is a multidisciplinary organisation for all health professionals and other groups and individuals interested in community health, with special reference to the principles of sports medicine and exercise science.

SMNZ began in Dunedin in July 1963. It affiliated with the International Federation of Sports Medicine (FIMS) in 1965. As such, it is one of over fifty organisations worldwide.

The 12 branches of SMNZ are autonomous and form the membership. These branches are in Whangarei, Auckland, Hamilton, Tauranga, Napier, New Plymouth, Palmerston North, Wellington, Nelson, Christchurch,

Dunedin and Invercargill. A council consisting of the national executive committee and a representative from each branch administers the organisation. The SMNZ national office is in Dunedin.

The author's membership of SMNZ began in 1972 when he served on the Otago Branch Executive. Thirty years later, membership numbers have not followed professional growth, essentially remaining static. Membership is currently 700 New Zealand members and 80 international members. The majority of the membership comes from the medicine and physiotherapy fields but also includes those from the fields of podiatry, psychology, nutrition, science, etc. It was predominantly a doctor's organization in 1972. Today it is very much a medical and allied health professions organisation. SMNZ has a close association with the New Zealand Olympic Committee.

### **■ Fitness New Zealand**

This industry sector organization has been described earlier ([#Fitness New Zealand](#)). FNZ represents mostly the interests of gym owners and, by default, health and fitness instructors. It is proceeding with setting up an accreditation system for its members. It is intending to keep at arms length from the end process, having set up a separate charitable company to run the system (with an advisory board made up of health professionals, industry experts, employee, and employer reps).

### **■ The Physiotherapy Board of New Zealand and the New Zealand Society of Physiotherapists**

The Physiotherapy Board of New Zealand registers physiotherapists in NZ and issues annual practising certificates as required under the Physiotherapy Act 1949. This legal responsibility will continue under the proposed Health Practitioners Competence Assurance Legislation.

The New Zealand Society of Physiotherapists (NZSP) is the professional association for NZ physiotherapists and has been in existence since 1950. Membership is voluntary and continues to grow, currently standing at 2,050. There are 11 regional Branches of NZSP and 11 Special Interest Groups covering private practice and 10 different clinical areas of physiotherapy (e.g. cardiothoracic, hand therapy, neurology, occupational health, paediatric, sports and orthopaedics).

Membership of NZSP is very relevant to the daily practices of the physiotherapist. NZSP is involved in many activities for the benefit of its individual members and the physiotherapy profession. These include producing a newsletter (11 times a year) and the NZ Journal of

Physiotherapy (3 times a year), developing and promoting guidelines and standards of physiotherapy practice, lobbying government, ACC and other policy makers on issues relating to physiotherapy, and developing and implementing marketing programmes.

## **Conclusions and suggestions**

1. A professional organisation will flourish, for as long as it is relevant to a health professional's ability to practice their trade and to make a dollar.
2. There are gaps in the representation of physical education professionals, fitness consultants, sports scientists, sports coaches and the emerging profession of exercise therapy. Fitness New Zealand's plans will only partially cover this.
3. If there is to be standardised accreditation of the diverse health professionals who prescribe exercise as therapy, a College of Health and Fitness Professionals can develop and administer the accreditation process
4. Organisations such as the Royal New Zealand College of General Practitioners, the New Zealand Society of Physiotherapists and Fitness New Zealand have their own specific accreditation requirements. A College of Health Fitness Practitioners can work with these, and other organisations, to coordinate and develop programmes of mutual interest, including accreditation
5. The College of Health and Fitness Practitioners could contract to run the Coaching NZ courses for SPARC and take over the GRx and Push-Play programmes. It could even contract to administer the ACC Sport Smart programme – all sources of income and reasons for being
6. The College can negotiate generic service agreements on the behalf of its members, with agencies such as with ACC to run programmes such as its Activity-Based Injury Rehabilitation Programmes.
7. The College can encourage, analyse and disseminate research to facilitate ongoing post-graduate training and to keep the focus on best practice
8. The College can establish a multi-sector advisory board to advise Government on health promotion. It can also be the primary driver for implementation

9. The College can organise conferences and other meetings on health and lifestyle, exercise and physical conditioning.

## **Developing an accreditation programme**

It is tempting to simply adopt exercise screening, testing and prescription guidelines from overseas such as the American College of Sports Medicine's Guidelines for Exercise Testing and Prescription(ACSM 1995) and their Health Screening and Risk Assessment Guidelines(ACSM 2000). Rather than blindly adopt a set of foreign guidelines, we need to write our own unified NZ guidelines that take account of our special circumstances. This includes considering the SFRITO setup and the need to have a trans-disciplinary application.

### **Key elements of a accreditation system if one were introduced**

If an accreditation programme were to be introduced, the ACSM certification programme for fitness instructors, exercise specialists and exercise physiologists <http://www.acsm.org/certification/index.htm> would worth looking at and their guidelines for health screening and risk stratification(ACSM 2000) would be a good starting template. Trans-disciplinary accreditation could be within three levels:

#### **■ Level One**

- Competency working with low risk populations and demonstrating a basic knowledge of safe and effective exercise prescription, motivating adherence and behaviour change, and including CPR and first aid. This may be equivalent to a certificate in exercise science

#### **■ Level Two**

- Competency working with moderate risk populations and demonstrating a more in depth knowledge of exercise physiology, risk assessment, exercise testing and exercise prescription. This may be equivalent to a diploma or degree in exercise science or physical education.

#### **■ Level Three**

- Competency working with high-risk populations and demonstrating advanced knowledge and skills for working with specific medical conditions. This may require a degree with post-graduate exercise science rehabilitation, or sports medicine qualifications.

Depending on the level of accreditation, evidence of study and assessment of competency and ongoing education would be required in the following areas:

- CPR and first aid
- Understanding the issues of “informed consent”
- Preliminary health risk assessment using easy and quick tools such as the Par-Q(Physiology 1994).
- Risk stratification using a tool such as the ACSM Guidelines (ACSM 2000) to place participants into low, medium or high risk.
- Basic to advanced assessment of cardio respiratory fitness and musculoskeletal function and integrity
- Basic to advanced exercise prescription, including prescribing for clients with complex/serious health issues
- Knowledge of nutrition basics for good health, including an understanding of special needs situations and populations, such as the elderly, the infirm, people with diabetes and high performance athletes.
- Training in supervision and motivational strategies. This would include learning about goal setting and knowing about the support programmes and educational resources that are available to them.

There would quite naturally be a bent towards cardiovascular risk assessment and ensuring cardiovascular safety during exercise participation.

Basic to advanced guidelines need to be researched and written for exercise assessment and prescription for people with special needs, or chronic ailments. Nieman(Nieman 1999) could be a good starting point, using Box 8.1 (Page 212) in which he outlines special safety tips for exercise prescription for people with chronic ailments. The ACSM has comprehensive position statements on exercise and health for special population such as older adults(1998) or adults with hypertension(ACSM 1993). These statements/guidelines would be good starting points for developing NZ guidelines.

Accreditation is by way of writing unit standards that outline the minimum competencies that are necessary to meet or exceed the industry guidelines.

Here is how we can develop our own NZ guidelines:

1. Convene an Expert Advisory Panel which will:

- a. Investigate and analyse existing accreditation programmes overseas
  - b. Investigate and analyse successful NZ accreditation programmes that may be suitable models
  - c. Investigate legal issues in the NZ environment, including ACC and OSH regulations
  - d. Investigate the Heart Foundation guidelines and other initiatives such as FNZ's fitness centre and instructor accreditation programme
  - e. Investigate and thoroughly understand the ITO system and consider how to marry accreditation with it – if this becomes necessary.
  - f. Investigate the practical issues of forming a College of Health and Fitness Professionals to administer the accreditation programme and other projects
  - g. Draw up a budget and timetable for implementation
2. Convene a Stakeholders' Conference representing the Government, industry, professional sectors and consumers. Their involvement in the final decision-making, write-up and preparation for implementation is a strategy for gaining buy-in and their cooperation.

## **Conclusions and recommendations**

Developing, introducing and maintaining an accreditation programme for health professionals is a complex and challenging exercise. Many issues that relate to accreditation need addressing concurrently and successfully. This includes the need for a healthy and robust environment that encourages and rewards the prescribing of fitness and other lifestyle interventions.

Here are some recommendations:

### **Establish a College of Health and Fitness Professionals**

This trans-disciplinary organisation would be similar in nature to the American College of Sports Medicine. It would represent health and fitness professionals via several advisory groups:

- Medical professionals
- Allied health professions – podiatry, physiotherapy, occupational therapy and nutrition – to name some

- Sports scientists
- Strength and conditioning specialists
- Coaches
- Fitness leaders

The College would set out to create and enhance multiple career paths for health and fitness professionals, promote ongoing research, professional training and the dissemination of knowledge. It would be an influential advocate for health and fitness professionals. It would take a leading role in ITO's, including assuming responsibility for accreditation.

The College would commercially contract to administer and develop health and lifestyle promotions such as the GRx, Push-Play and ACC's Sport Smart programme.

Membership has the potential to exceed 20,000 individuals, with a seven-digit budget.

### **Establish New Zealand industry guidelines for health risk assessment, exercise testing, exercise rehabilitation and strength and conditioning**

The College of Health and Fitness Professionals would be responsible for developing these guidelines and would do so through a process of research, collaboration and consensus.

### **Establish New Zealand guidelines for exercise prescription for specific medical conditions**

The College of Health and Fitness Professionals would develop best practice guidelines for exercise prescription for people with special needs conditions including:

- Musculoskeletal injury
- Arthritis
- Cardiovascular
- Diabetes
- Obesity
- Osteoporosis

- ✘ Mental illness
- ✘ Neurological disorders
- ✘ High performance athletes
- ✘ Juveniles and adolescents
- ✘ People with disabilities
- ✘ Athletes with disabilities

A whole area of endeavor could be devoted to the exercise, nutrition and lifestyle issues relating to ageing.

### **Build Partnerships with professional, Government, commercial and community providers of health and fitness services**

There is presently a lot of activity going on that appears to be poorly coordinated and one detects elements of suspicion of others' motives. The risk is a lot of wasted time, effort and money with little to show in the end.

Competition is healthy when it is in a climate of cooperation and respect. An example is the marathon runners who keep together as a group, sharing drinks knowing that each will pull the other to a higher level of performance by their working together – they do this with the knowledge that only one will be the outright winner in the end. The College of Health and Fitness Professionals would foster relationships that celebrate and thrive on dialogue and cooperative competition. It would do this by initiating dialogue and sharing of knowledge, ideas and plans.

### **Health and fitness promotion through Leveraging**

Leveraging is the concept of building a network of people, all doing the job on your behalf. Leveraging produces a synergy of effort in which the result is greater than the sum of the effort. Leveraging through the commercial fitness industry is a good example of where this concept will work for Government.

There is approximately one commercial fitness centre in every town of 5,000 or more people. They employ approximately 7,000 staff of whom many are health and fitness professionals. Their combined estimated promotional budget is \$20 million per year. What would be the effect if the Government, through the College of Health and Fitness Professionals, were to offer a dollar-for-dollar subsidy for health and fitness promotions on the following conditions?

- ✘ Fitness centre staff are College accredited and financial members of the College

- ✘ The subsidy is for specific health and fitness promotions

The cost may be just \$10 million per year but the promotional effect would be at least three times that.

### **Make General Practitioners the primary prescribers of exercise as therapy**

Strategies need to be developed that empower the GP and encourage the prescribing of exercise, diet and lifestyle interventions and their ongoing involvement in any interventions. This includes:

- ✘ Financial incentives to prescribe healthy interventions, including
  - Bulk funding of IPO's that rewards GPs for reduced expenditure on drugs prescribing and for prescribing of exercise and lifestyle
- ✘ Commencing an educational campaign directed at GPs on how to get across simple and effective health messages to patients
- ✘ A public educational campaign to create the expectation of patients that doctors' prescribing will include lifestyle advice for managing many conditions
- ✘ Provide GP's with attractive resources for getting across and reinforcing positive health messages

### **Foster close working relationships between general practitioners and fitness centers**

Fitness centers have the tertiary qualified staff and facilities to provide the expert support that a GP needs, if a patient's needs are complex, and/or time-consuming. Understanding the theory and practice of multi-disciplinary healthcare teams by all would facilitate this cooperative practice.

Education, training and accreditation programmes for GPs and fitness consultants, for example, will assist with building an atmosphere of trust and confidence between the professions, including being comfortable about sharing patient confidential patient details(Owen Brunel 2001).

Government subsidies for specified lifestyle interventions, such as a specific time-limited multi-disciplinary activity-based rehabilitation programme, will

be necessary to reduce the financial burden on patients (The author has 12 years experience with designing and implementing this kind of programme).

Linking this cooperative approach with the GRx, Push-Play, ACC Sports Smart and other programmes as a high-profile national promotional campaign will surely have a huge impact on population behaviours.

### **Give exercise and lifestyle interventions greater funding status than pharmaceuticals and aggressively promote them**

Sadly, the fitness industry loses many of its best people to the drugs industry, which recruits them to promote their asthma, weight-loss, blood pressure and lifestyle drugs. These highly trained sales reps shower doctors with gifts, free product samples, educational and promotional materials, conferences in exotic venues and they put on delicious morning teas for clinic staff. They visit armed with detailed breakdowns of doctors' prescribing habits and a pre-planned strategy for getting more prescribing of their brand. Direct advertising to the public of medicines backs up the efforts of the sales rep.

The Green Prescription, in contrast, is dull and boring in appearance and hopelessly under resourced. If the GRx coordinator can assemble a few doctors for a meeting, the only give-away is a draw for one pair of sponsored sports shoes. The GRx needs a multi-million dollar annual budget so it can:

- Monitor each GP's prescribing habits
- Recruit a highly trained sales force
  - Start by deliberately head-hunting the drugs industry's best sales manager to run the GRx programme
  - Head-hunt back the PE graduates now working for the drugs industry to work as GRx sales reps.
- Develop a wide range of colourful, attractive and motivating promotional materials
- Reward GPs financially for prescribing exercise, diet and lifestyle
- Organise/fund conferences and seminars for GPs in exotic places
- Promote the GRx on a huge scale to the public and doctors via multi media, including television

## **Simplify the process of improving fitness**

With the commercialisation and professionalisation of fitness, a mindset has developed within the public that one has to consult an expert and join a gym to improve their fitness. Getting fit can be as simple as placing one foot in front of the other. Even where serious health complications exist, employing a problem-solving approach while still keeping the message simple still applies.

In the spirit of “Push-Play” exercise, diet and lifestyle prescription initiatives should apply the author’s slight variation of the “KISS” Principal (Keep It Simple and Smart).

## **Aggressively and imaginatively promote healthy lifestyles as good medicine**

Prescribing healthy lifestyles is dull, boring and many consumers regard it as bit of a party-killer. It needs re-packaging and aggressive marketing to the public and health professionals (Refer to the Author’s [Life Force Indicators](#) as an example (Copy attached).

## **Where do we go from here?**

Organisations such as SSNZ or SMNZ have to seize the initiative for change. It is suggested that they sponsor a proposal to SPARC and the Ministry of Health, seeking their joint sponsorship of setting up an expert advisory panel to research and write a comprehensive report – “Exercise and Health in New Zealand – Accreditation, Prescription and Promotion”.

This report would examine the many issues relating to the prescription of lifestyle and exercise across the board – including high performance sports. This includes promotion and accreditation issues and investigating the need for an organisation to represent and promote the interests of all health and fitness professionals.

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