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Submission No. 114
AUTHORISED: 10/5/06 G.

Mr Alex Somlyay MP.
Chairman,
House of Representatives
Standing Committee on Health and Ageing,
Parliament House Canberra.

RE **INQUIRY INTO HEALTH FUNDING**

March 23rd 2006

Dear Mr Somlyay,

Appended please find my submission to the subject committee.

With the geometric progression of the cost of pharmaceutical agents and the cost of providing cardiovascular services to the Australian population I believe that my submission is most timely.

Over the last two decades I have shown significant clinical and pathological benefits of a unique form of exercise in patients with high risk of cardiac events and the prevention of further events in patients who have suffered myocardial damage.

A major advantage in this exercise is that it requires only three sessions per week of twenty to twenty five minutes to significantly:

In Primary Prevention	Reduce risk of developing cardiovascular disease
In Secondary Prevention	Reduce risk of a further cardiac insult by 35-40%
In The General Population	Improve physical fitness and wellbeing.

With the escalating costs of lipid lowering therapy by taking advantage of the recent recommendations contained in the Australia's Health Workforce Review reduce the need of pharmacological therapy in Primary Prevention by at least 30% and a further 16% in those requiring secondary prevention.

I commend this submission for your committee's consideration,

Yours sincerely,

M A Neaverson
Appended Volumes 1-7
5 DVD "A Patient's Perspective"

Executive Summary:

This submission addresses the Fourth and Fifth considerations as outlined in the terms of Reference.

In addition it takes cognizance of the wish of the Government to address the continuing deterioration in life-styles of the Australian Population. In so doing it draws attention to the need to be specific in relation to the depth of screening in order to be cost effective.

Geographical isolation in Australia brings with it reduced medical services and to this end it recommends that a Preventive Programme designed to address the major risk factors within the population be considered.

This programme, in use for over two decades within Hospital Environs, is now available on the Internet and coupled with telephone and e-mail contact with case managers and multidisciplinary consultants can be undertaken in the home by the majority of Australians. (www.neocardia.com)

Such cost could be covered by Recommendation 8.3 in the recent Australia's Health Workforce recommendations viz

"The Australian Government should increase the range of MBS services for which a rebate is payable when provision is delegated by the (medical or non-medical) practitioner to another suitably qualified health professional. When delegation occurs:

- ***The service would be billed in the name of the delegating practitioner; and***
- ***Rebates would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances."***

The provision of such a programme would also meet the recommendation 10.1

" The Australian Health Ministers' conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular rural and remote areas. Progress in achieving this objective should be monitored as part of the proposed regular evaluations of the National Health Workforce Strategic Framework"

In order to ensure that unnecessary costs are generated in the life style screening an anagram is proposed (vide infra) which delineates those at greatest risk and those who should therefore be admitted into a Multidisciplinary Exercise and Management Programme which has been shown to provide improved clinical endpoints (Volume 3).

The cost of lipid lowering pharmaceutical preparations continues to escalate despite the fact that the popular "statin" group of drugs fails in over 40-50% to reach the target lipid levels shown to be of benefit in reducing morbidity and mortality.

This may be associated with poor compliance, ineffective drug, drug interactions, or inadequate dosage.

Currently the Pharmaceutical Benefits Advisory Committee calls for six weeks of dietary change with low fat diet prior to the initiation of lipid lowering therapy. Unfortunately it is unlikely that six weeks of diet change will have a significant effect on total or LDL- cholesterol levels and for this, and perhaps other reasons, scant attention is paid to this requirement by the medical profession.

This submission would recommend that these recommendations be amended to include a six week exercise programme together with education and dietary modification prior to initiation of lipid lowering pharmacological agents. Such programme should have been shown to demonstrate both clinical and lipid lowering effects prior to its approval. (Volume 3)

We have included calculations in this submission which reflect a 19% decrease in the requirement for statin therapy should this amended be enforced.
(See Volume 4)

Cost savings of over $130 million could be achieved.

Physical inactivity is known to be associated with many other chronic disease profiles and exercise will improve these morbidities.

Contained in this submission is data from The 33rd Bethesda Conference Report Preventive Cardiology : How Can We Do Better. This American Conference of the reviews cost Benefits of Preventive Programmes – clearly exercise has very significant cost-effective benefits. (See Volume 7).

Recommendations:

1. **Consideration be given to making the Nu-Life Cardiac Programme available to those patients at risk of developing (Primary Prevention), or having developed cardiovascular disease (Secondary Prevention) through the Internet** www.neocardia.com**.**

2. **Consideration be given to provide financial incentives to General Practitioners or approved other non-medical Professionals to monitor patients undertaking the programme.**

3. **Such other non-medical professionals should only be approved after training at a Hospital or other facility utilising the Nu-Life Cardiac Services Exercise Programme.**

4. **That the PBAC be approached to include the necessity for patients for Primary Prevention to undergo a period of Exercise Training and Lifestyle Change which has been demonstrated to provide adequate clinical endpoints**

5. **All patients having had cardiac events (Secondary Prevention) should be on statin therapy in addition to a suitable exercise programme.**

For Further Information:

February 20th 2006

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