Why not sports medicine in general practice?

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PERHAPS the most significant recent advance in anticipatory care has had little to do with general practice. The breakthrough has been due to the popularity of sport. For years we have tried to guide our patients towards preventive medicine and to taking more responsibility for their own health. In doing so we have promoted aspects of health that have been unpopular with the public or criticized by the media. Suddenly, there has been a mass realization of the medical value of exercise, and the media and public opinion are in agreement about the benefits to be gained from an active, healthy lifestyle (Cannon, 1982).

As yet general practice has paid little attention to sport and there is certainly no widespread movement towards incorporating sport into the everyday work of the family doctor. Even the College in their report on health and prevention in primary care almost totally ignore exercise as a means of promoting health (RCGP, 1981).

The big advantage of sport as a way of promoting health is that it is popular, topical and enjoyable. There is overwhelming evidence on the benefits of exercise (Fentem and Bassey, 1978). It has something to offer everyone in the community: the old, the young, the unemployed, the fit, the unfit, even those with chronic illness. However, those who would benefit most from sport are often those whom it is most difficult to motivate: the obese, the smoker and those in highly stressful, sedentary occupations. Are we doing enough for those at risk in our practices (Health Education Council, 1974)?

Even if we as general practitioners do not wish to encourage our patients to exercise, we must remember that there will be many who will do so anyway. We owe it to them to know enough about basic exercise physiology and its applications to be able to advise them on the composition and balance of simple training programmes on suitable, safe exercise, appropriate to somatotype, age, current fitness and health. The old advice to "take more exercise" is simply not enough any longer.

Does sport for all mean sport injuries for all, and how should we best cope with the recent near epidemic of sports injuries (Davies, 1981)? To prevent sports injury we must be aware of the mechanism and pattern of injury and use every opportunity to try and reduce risks.

In the event of an injury, the general practitioner is often the first medical contact. It is here that we must change our basic attitudes for, although minor in the context of life-threatening medicine, any injury, however small, is of major consequence to the sportsman or sportswoman. We owe it to our patients to have sufficient expertise in immediate management of sports-related injury to treat, rehabilitate and ensure return to active sport as soon as possible. The time-worn old advice to "rest up for a few days" is now not only outmoded but irresponsible.

How may we best integrate sport into general practice? The consultation has always been seen as the central tool of practice, and health education is seen as a fundamental part of the consultation (Stott and Davis, 1979). Have we ever discussed with our patients the benefits of even limited exercise?

Perhaps we should alter the composition of the primary care team (BMA, 1974). We could include the services of the physiotherapist, whether as a primary contact or on a referral basis (Ellman *et al.*, 1982). We could improve our liaison with other disciplines, the PE teacher in the schools, health educators and organizers of local sports and fitness clubs. Should we have open access to x-ray facilities, or shorter waiting lists for physical medicine? We could examine our appointment systems to ensure that the injured athlete has quick and easy access to primary care.

There is great scope for increasing the contribution of family medicine to the health and fitness of the community. A greater emphasis on promoting health does not require any fundamental change in the role of the family doctor, simply a greater awareness of the value of exercise and a greater willingness to care more efficiently for the injured athlete. Do we care enough for those who try to help themselves?

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GENERAL PRACTICE LITERATURE

NEW BOOKS

POVERTY, EQUALITY AND HEALTH

The Strategy of Equality. LeGrand, J. (1981). London: George Allen & Unwin. 191 pages. Price £12.50 (hardcover), £4.95 (paperback)

The Politics of Poverty. Donnison, D. (1981). Oxford: Martin Robertson. 239 pages. Price £3.50

Health and Wealth: an International Study of Health Care Spending. Maxwell, R. J. (1981). London: Lexington Books. 179 pages. Price £14.95

General practitioners pick up the pieces when governments fail to provide a healthy environment for their subjects. We are the doctors who have to cope with the stresses induced in people who have been condemned to live in tower blocks, we are the doctors who provide the terminal care for people who have not been protected from the tobacco menace, and we are the doctors who have to cope with the bereavements and injuries stemming from the failure of successive governments to implement seat belt legislation. Few, if any, governments since the war have achieved worthwhile housing targets and we are (or should be) fully cognizant of the resulting ill health and dis-ease. In football parlance we have become "the sweepers" of the Welfare State. What will bid fair to overshadow all the above loads for a long time to come will be unemployment and the real poverty that springs from it. It may well be that the technical indicators of economic success—productivity and the Public Sector Borrowing Requirement—are held to have been achieved and that the human price paid for it can be conveniently forgotten. That price will be structural unemployment of between two and three million people; they will include tens of thousands of people who have lost their jobs in their prime and will never work again, and tens of thousands more of young people who may never get jobs. The resulting physical, mental and social pathology will fall to general practice for amelioration and support. As we look forward to this bleak prospect three recent books give serious food for thought.

The first of these is by Julian LeGrand of the London School of Economics, whose book studies the extent to which the way we spend money may contribute paradoxically to increases in inequality. The second, by Professor David Donnison, lately Chairman of the Supplementary Benefits Commission, looks at the way in which a welfare state attempts to shield people from destitution and in doing so shows its prejudices. The third, a more technical work by Robert Maxwell of the King's Fund, provides us with a much needed way of accurately comparing health expenditures from country to country. The first two books should find a place on any health centre or group practice library shelf and the third should certainly be in the library of every postgraduate centre.

LeGrand shows that in health, education, housing and transport, policies designed to reduce inequality have failed to do so. Reviewing much evidence he suggests that "almost all public expenditure on the social services in Britain benefits the better-off to a greater extent than the poor, due to the insignificant role played by concern for equality in determining policy, such an outcome might be expected; it is also true for services whose aims are at least in part egalitarian such as the NHS, higher education, public transport, and the aggregate complex of housing policies." He surveys each area in terms of the amount of public expenditure, the way the service is used, the opportunities which it presents to its users, its accessibility and its outcomes.

With regard to the NHS he arrays the evidence to show that "equality of use for equality of need" has not been achieved (the highest socio-economic group receives 40 per cent more NHS expenditure per person reporting illness than the bottom one); equality of cost to the individual has not been achieved (and therefore there is inequality of access. Going to the doctor, to the Outpatients, or into hospital cost more in transport and lost wages for the lower socio-economic groups than the higher); and lastly, as the Black Report has shown, there are persistent inequalities of outcome. He examines the often stated theory that it would be better to give people money rather than services (in this case by reducing taxation and increasing social security payments). He concludes that if this were done, there would be greater inequality in council housing and rent rebates; in the NHS there would be little effect; but in higher education, owner-occupation and rail travel, there would be greater equality in both public expenditure and final income. With regard to the NHS, some of the relevant inequalities might be increased by reducing public expenditure.

He examines and rejects means-testing and compulsory patterns of utilization as strategies to reduce inequality. "The prospects for reform that involve neither means-testing nor reducing the role of individual users seem equally gloomy." He goes on to say: "The failure of public expenditure on the social services to achieve equality can be explained primarily by its inability successfully to counteract the influence of the more fundamental social and economic inequalities that still pervade British society." In 1976 the top 20 per cent of the population received 40 per cent of the total after-tax income, while the bottom 20 per cent received only 8 per cent. Before such inequalities in incomes can be tackled it is necessary to re-examine the ideologies of inequality (for instance, that it is

MacAuley—continued

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