Physical activity may be good for you but we are not the key players

Lets get real. General practice cannot cure the cycle of creeping inactivity, bulging waistbands and obesity. This is a medical problem with a potentially huge healthcare burden but, it does not have a medical solution.

We need to be clear about what we can do, because it is easier to pass responsibility to the medical profession, and primary care in particular, than face up to the implications of making a serious commitment to those changes necessary to reduce overall calorie intake and increase the population's physical activity.

Physical inactivity is a social problem. It is a function of our computerised, mechanised and immobilised society. We are a low activity convenience society fed by high calorie convenience foods. The primitive hunting and gathering instincts are focused more on the struggle in the shopping centre, than on any physical activity. Doctors cannot solve this problem.

General practice is the care of the individual. Our attempts at health promotion in primary prevention have had remarkably little success. Cardiovascular risk-factor reduction looked to have potential, and the problems we addressed were important and relevant. But, the impact was minimal. Even well-funded nurse-led innovative projects like OXCheck had modest impact with major resources.[1] Such findings were in keeping with the major systematic review of randomised controlled trials, which suggested that risk-factor interventions had a limited role and that other government-led interventions could be more effective.[2] And, if we wish to improve diet and physical activity levels, there are important lessons to be learned from our interventions in smoking.[3]

Evidence from high quality observational, cross-sectional and cohort studies is clear. Physical activity is good for you, and obesity is associated with inactivity. But, that does not mean that interventions to increase activity will be successful in reducing obesity. Efforts to increase physical activity through primary care have had limited success. A number of studies have shown that it is possible to create programmes to increase physical activity (including exercise prescription), address barriers, record advice given, and intention to increase activity — but most are process studies and few have long-term outcomes. The most recent systematic review (Cochrane) on efforts to increase physical activity[4] has shown that interventions to increase physical activity are, at best, moderately effective. Similarly, methods to reduce obesity include efforts to change overall lifestyle with specific interventions advising combinations of diet and exercise. Lifestyle interventions have shown only small amounts of weight loss of marginal clinical relevance and while we have little evidence of what works in preventing and treating obesity, research does show us what doesn't.[5]

GPs themselves have a realistic view of what is possible. GPs believe that obesity is the responsibility of the patient and do not consider obesity management to be within their professional domain.[6] Patients think otherwise. They tend to blame an internal control problem and would like a professional-based solution, but doctors favour a patient-led approach.[7]

There is an Olympic dimension. The 2012 Olympics focuses greater emphasis on the benefits of sport and exercise. Indeed, the Royal College of General Practitioners has been pivotal in creating the new Faculty of Sports and Exercise Medicine and establishing specialist training. We could easily be swept along by this groundswell of enthusiasm and commitment to sport and there is a danger that well-meaning leaders of our profession might agree to the unrealistic inclusion of obesity management through exercise promotion in the Quality and Outcomes Framework.

This is a public health issue. The barriers to physical activity are not issues limited to personal health care. They are predominantly environmental, social, and societal. The solutions are multidisciplinary and cross-departmental. Providing bicycle lanes, making showering facilities available in the workplace, funding creches at the leisure centres, reversing the erosion of sporting activity in schools and the sale of public sporting amenities are not health issues, but have health implications related to physical activity. Making it a primary care problem is the easy option, directing the public gaze away from the need for more integrated and much more expensive social and environmental factors. Let us not be foolish enough to accept responsibility for a task we cannot deliver. There are many aspects of practice where we can make a difference. This is not one.

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