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August Focus

EXERCISE AND HEALTH

Many of the papers in this month's *Journal* deal with major non-communicable diseases and a range of 'lifestyle' factors associated with them. The Cambridge risk score, derived from routinely collected patient data that can readily be extracted from general practice records, has been shown by Chamnan and colleagues (page 590) to perform well as a predictor of cardiovascular events. It may well find a place in practice to identify patients at elevated risk, who can then be targeted for tailored risk-reduction interventions. The importance of dealing with risk factors is dramatically highlighted by Iversen and colleagues (page 563) who have conducted a further analysis of data collected in the course of the RCGP Oral Contraception Study. They conclude that, assuming causality between (as opposed to association with) lifestyle risk factors and mortality, 60% of the deaths recorded in the study could have been prevented by stopping smoking, exercising more, losing weight, and reducing alcohol intake. Inactivity and obesity were the two factors most strongly associated with mortality.

In our editorials two authors consider the extremely difficult problem of promoting exercise and, thereby, better physical and mental health. Peter Davies challenges us as individuals to learn more about giving an 'exercise prescription' and to act as role models (rather than as 'dire warnings'!) for our patients. The linked paper on childhood asthma and exercise (page 578) shows us just how complex the negotiations can be around encouraging or discouraging physical activity and how important it is for primary care teams to possess expertise in this area.

Helen Smith, reflecting on the Oral Contraception study data, extends her analysis to the problems of changing the so-called modifiable risk factors, that many regard as intractable. Echoing Davies, she also challenges us both as individuals and as a society to devise effective interventions aimed at promoting exercise and health. In an intriguing qualitative study of patients with type 2 diabetes, Peel and colleagues (page 570) confirm the imprecision of advice on exercise received from health professionals and the frequent lack of interest or encouragement with which it is delivered. They explore motivation to exercise in some detail and their finding that linking exercise to existing or planned interests and activities such as dog walking is an effective way to increase physical activity is important. It is a powerful reminder of the need to listen to patients and to negotiate management strategies that fit with their ideas and make sense in relation to their lives.

It is, of course, one thing to train and motivate health professionals and quite another to do the same for patients — notwithstanding the analogy between pay for performance in GPs' contracts and the use of financial incentives to encourage patients to lose weight or stop smoking. Health inequities and socioeconomic inequalities enter the equation. How do you encourage dog walking in areas where the streets are unsafe? How readily can poor, fragmented, and poorly supported families transform their eating habits? How can fatalism and self-neglect be replaced by a belief in a healthy, enjoyable future? There are, of course, many excellent examples of successful local and community interventions that have addressed just these problems, but they have rarely been replicated systemically. Indeed, the underlying causes of health inequalities go deep, and are hard-wired into many western societies where, in the last 10–15 years, the economic gap between the poorest and richest sectors has continued to widen, and with it inequalities in health status and life expectancy. This then raises questions about the role of society and the state in promoting the health of individuals, and thereby, the public health and leads into contentious territory. We may denigrate the 'nanny state' but still insist on a national welfare safety net. We may defend our individual freedoms to smoke and drink, but demand unconditional care from the NHS when things go wrong. At the time of writing this, a mother and father in an affluent area of London are being threatened with action by the social services if they continue to allow their children to cycle the 1.2 km journey to school unaccompanied. Health and safety concerns can easily become decoupled from common sense. This is a moral and political maze in which primary care — individuals and institutions — needs to take a position, that should probably be a more engaged one than simply picking up the medical pieces of social injustice.

In his recent book *Ill Fares The Land* (Allen Lane, 2010) the eminent modern historian Tony Judt examines the successes and limitations of social democracy over the last 30 years and makes a passionate plea for the re-engagement of citizens with politics based on a sense of collective purpose that goes beyond the present obsession with the financial bottom line and is informed by values and aspirations rather than commercial pragmatism. The book contains a particularly persuasive chapter on the social responsibility of a state to run, and not outsource and asset strip, a rail network. The analogy with health care is unlikely to escape many readers.

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