A recent World Health Organization (WHO) strategy discusses the global control of the non-communicable disease (NCD) epidemics, which are currently responsible for some 60% of deaths worldwide.\(^1,2\) The paper recognizes the improvements in treatment but puts heavy emphasis on prevention. It points out that there are a few common factors behind several of the major NCDs; these lifestyle-related factors should be the central target for global efforts in NCD prevention. Physical activity is one of the factors, diet and tobacco use being the two others.

Physical activity is important in the prevention of diabetes, cardiovascular diseases, osteoporosis and in control of obesity. At the same time populations not only in Britain and the industrialized countries, but worldwide, have become more and more sedentary due to changes in work, in transportation and in watching TV.

How can we encourage patients, individuals and populations to be more physically active, is a key question in modern public health. Different kinds of studies, like the present one are welcome. This study is concerned with the role and potential of primary health care in physical activity interventions.\(^3\)

The study was a well-planned randomized trial, which is a fashionable way to obtain evidence on intervention effectiveness. The authors should, indeed, be congratulated for good work. However, at the same time the study shows well the limitations of a ‘clean single intervention randomized trial’ in assessing the potential of lifestyle interventions.

There are two main problems. First, physical activity and other health-related lifestyles are usually deeply enrooted in the community, in its social and even physical environment, and individuals generally tend to continue their established habits. Thus, changing these habits by a restricted individual-centred intervention will even at its best have very limited results. Thus this kind of study shows nothing about the potential of a more comprehensive public health intervention, in which the health service interventions are combined with possible broad involvement of the community in including some environmental modifications.\(^4\)

Second, the experimental designs put severe limitations on studying the actual potential of physician’s advice and brief interventions. In this particular study volunteers were recruited by questionnaire. They were randomized, and the intervention was delivered by health promotion specialists. The baseline questionnaire and the fact that everybody participated in the study might have had an impact (the control group also had an increase greater than expected) over the potential of the comparison. There may also be some spill-over effects in the community. Above all, this set up is far from the situation where a concerned general practitioner—knowing his/her patient—gives carefully individualized advice and intervention to the patient and agrees about follow-up.

Thus, in spite of its obvious merits, the study unfortunately adds rather little to our understanding of the usefulness of risk behaviour counselling in primary health care. We know that the impact of simple counselling even at its best is limited but considering the small costs, it may still be very cost effective. Work in primary health care should be combined with more comprehensive activities in the community—and ultimately with national policies.\(^5\) This does not mean that studies to help develop feasible and useful intervention modalities in primary health care would not be needed. Indeed, a study finding that interactive counselling is more useful than simple giving of information and advice is a useful one.

The study also relates to the broader aspects of evidence in health promotion. It is common place, and rightly so, to say that we need more evidence on the effectiveness of health promotion. But we should critically ask what kind of evidence are we looking for and put the issue in broader public health perspective. Heavy emphasis on the randomized trial leads to overemphasis of simple intervention modalities and undermines the obvious role of broader complex interventions, involving...
community-based comprehensive programmes, national policies, etc. This fact, combined with the financial resources of the pharmacological industry to pursue randomized clinical trials tends to lead to overemphasis on drug interventions—even if development of effective drugs is most welcome. As some have put it ‘part of the evidence gets over emphasized, while much evidence gets little attention’.

This problem is particularly pertinent to the developing world where a great increase in the chronic disease epidemics is currently taking place. Due to major economic constraints, the public health potential in fighting those epidemics is in primary prevention, and in counteracting the negative trends in especially physical activity, dietary habits and tobacco use. In doing so comprehensive strategies combining public policy with broad health promotion measures involving counselling by primary health care are undoubtedly needed.

References
3 Hillsdon M, Thorogood M, White I, Foster C. Advising people to take more exercise is ineffective: a randomized controlled trial of physical activity promotion in primary care. *Int J Epidemiol* 2002;31:805–15.