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What future for physical activity?

***The Leisure Review* talks to Dr Charlie Foster about the current profile of physical activity within public health policy and what could be done to move physical activity up the policy agenda.**

Dr Charlie Foster is not, he points out at the outset of our conversation, a medic – his title reflects his career as an academic rather than a physician – but he does have a great deal of experience of working within health. Starting out as a PE teacher with a qualification from St Luke's College, Exeter, he then went on to work in corporate health and fitness with firms such as McKinseys and Ford before moving into hospital-based cardiac rehabilitation, workplace health promotion and then community health promotion. Formerly the director of the Centre for Public Health Evidence for Physical Activity for NICE at Loughborough University, he is now a member of the British Heart Foundation (BHF) Health Promotion Research Group at the University of Oxford where he leads two BHF-funded programmes of research on physical activity and obesity. As a member of the Physical Activity Guidelines Editorial Group, he has been a contributor to Let's Get Moving, the Department of Health document on physical activity promotion published in 2009, and more recently Start Active, Stay Active, a report on physical activity for health published on behalf of the four home countries' chief medical officers published in July 2011.

It was Foster's work on Let's Get Moving that brought him on to the radar of *The Leisure Review*. At the 2011 Sport and Recreation Association conference Dr William Bird spoke enthusiastically of the work of the BHF Promotion Research Group. Having covered Dr Bird's presentation in some detail, *The Leisure Review* was keen to pursue the development of physical activity promotion and Charlie Foster was happy to offer us the benefit of his perspective as someone working within the British health system.

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Settled into the common room of St Cross College, the Oxford University college of which Foster is a member, we pick up where Bird's message to the SRA conference left off. Bird's claims for the medical efficacy of physical activity – that if we had a drug with the proven effectiveness of physical activity only an idiot would not prescribe it – are powerfully persuasive but is there any prospect of physical activity being taken seriously by the health establishment?

"William operates in a medical system that believes in rational choices but the irony is that while medical prescribing is based on evidence it is also an art," Foster says. "The medical profession are trained to think mechanistically about pathways and in their own best interests they feel that patients will respond better to a pharmaceutical intervention than a lifestyle one. We've seen this in high blood pressure for a while. First intervention should be lifestyle change but almost inevitably they end up being prescribed anti-hypertension drugs because they get more bang for their buck instantly."

Nor is it just a question of the medical profession's perspective. While Bird's preference for physical activity over drug intervention may be preferable, long-term lifestyle change is much harder to achieve.

Foster concurs: "Lifestyle change is harder to adopt but there are also expectation differences. The medics are not expected by the patients to talk about lifestyle and medics themselves are not expecting to talk about it. People want to be fixed. They don't want to commit to a longer term fix. It's actually quite threatening because people take inactivity as a personal criticism.

"Medics are reluctant to open that particular conversation, perhaps because they themselves don't actually see or value what physical activity can generally do. I teach medical students at Oxford and in a five-year course they have one hour on prevention with about 25 minutes of that on physical activity. So we are always struggling to make an integrated case for prevention in a system that is

about treating illness. William has been fantastic as an advocate. Because he is a medic he tends to get listened to by other medics. They tend to learn better from their own than from others. We can put elegant papers in the British Medical Journal and the early adopters will pick them up but it is very difficult to integrate it into practice."

Foster's own vision of the integration of physical activity into practice includes bringing exercise promotion into pre-surgical advice for any kind of orthopaedic surgery and making sure physical activity is part of post-operative rehabilitation. Physical activity, he argues, needs to be instilled into hospital protocols way beyond its current presence in cardiac rehabilitation and physiotherapy.

But the question remains: given that William Bird's arguments are properly evidenced, medically valid and highly persuasive, why is physical activity still generally regarded as one of the "alternatives" to conventional medical practice?

"Physical activity is out in the weeds but it is not for a lack of good epidemiology: there is the Association of Physical Activity and Health. It's in the weeds because the economic case is missing, cost-saving at a practice level that has been genuinely pushed. If physical activity was a drug there would be a company that owned the patent and they would invest in a workforce to promote it. Unfortunately we don't have that. I think it's a different skill set to convince commissioners of services – and they are now going to be general practitioners – to commission prevention. Where is the return on investment for them? We have to beef up the case for return on investment from physical activity promotion."

Foster offers the example of statins, which were trialled in the mid-1990s and are now an established element of GP prescribing. However, despite the reports in the BMJ and the enthusiastic backing of the pharmaceutical industry, including its highly experienced sales teams, statins still took ten years to be embedded within accepted medical practice.

"We do have some fantastic advocates and early adopters who do use physical activity as part of their general practice treatment but it's not sufficiently embedded," Foster says. "There's a culture, particularly in medicine and perhaps in local authorities, that says if I'm investing my money in an area but I won't see the direct benefit of that to my organisation why should I pay for the benefits that other people might accrue?"

Transport, he suggests, is a good example. Oxford City Council might raise parking charges and invest in public transport facilities to encourage more people to walk and cycle, all of which would be positive in terms of physical activity promotion. However, transport engineers talk in terms of economic footfall and do not recognise the physical activity dividend as benefits within their own understanding of a scheme's value; physical activity remains secondary and tangential. Similarly there are numerous cost-saving interventions available to GPs that may be more beneficial to a particular practice. Dieticians, community psychiatry services or smoking cessation services may well be more attractive than long-term investment in physical activity.

Foster's explanation offers something of a conundrum for the sport, leisure and culture sector where there has long been an assumption that the key to physical activity promotion, and of course recognition of the role that the leisure sector can play in delivery of physical activity opportunities, would involve medics providing the evidence to persuade government of the need to increase investment. The suggestion here, however, is that it could be the reverse: the medical profession needs persuading, not of the efficacy but of the economics.

Foster agrees: "It could easily be the reverse. It could be about, for example, the general community benefit of having a cycle lane built through their practice area by the local council but they may now be expected to contribute to it."

One of the main problems at the moment, Foster suggests, is that the recently introduced changes to the NHS has created a new structure and a new dynamic that no one yet understands. It is, he concedes, all a bit of a mess at the moment.

"It is almost like we're giving a Greek play to people who don't read Greek and asking them to make a performance of it," he says. "Local authorities are wondering who they are going to work for – the Health and Wellbeing Board or the GP commissioners – where is the money stream and what the lines of

accountability are. That's all still unknown. Meanwhile, they have to protect the sports development folk who are probably the last bastion of physical activity promotion and we have to convert them from just thinking about sport. It's a big challenge."

With doctors required to work to very tight schedules when seeing patients over the course of busy days in a general practice, might one presume that such consultation timescales are not conducive to taking a holistic, lifestyle approach to health promotion?

Foster concurs: "I think you're right and it's probably not cost-effective for a GP to do that. It is probably more cost-effective for someone who has a sports science degree and counselling skills to listen in and help someone change their behaviour, a bit like a dietician would do."

He also suggests that while there is no doubt that physical activity is a cost-effective intervention the key question still remains: cost-effective for whom? In addition, the arguments for physical activity promotion have to be sufficiently compelling to persuade GPs to invest their time and energy in it. Research into GP referral rates show that there are huge difference in physical activity referrals among GPs working in the same practice, which suggests that some GPs just do not think it is important. This could come down to the 25 minutes of training on physical activity provided to medical students but is also related to the effectiveness of the marketing of pharmaceutical interventions.

"There's no equivalent of the drugs promotion industry for public health in general practice," Foster says. "I think that is going to be a real problem. Who is going to do it? Is the local authority sports development officer going to have to wander down to the GP commissioning board and persuade them to do exercise referral? There is a failure to genuinely engage general practice. It's not all their fault and I don't think it's all their responsibility either. I think local authorities should actually pick up this ball. I think every decision a local authority makes – about planning, about transport, social care, housing – will have a direct or indirect health impact and that needs to be monitored and marshalled by the public health professionals in the local authority. The director of public health will be sitting within the local authority but whether or not they will have that function I don't know; but in my view they should."

Invited to play fantasy prime minister and draw up his own list of policies for implementation, Foster does not hesitate. First up is designing places where people want to live and work, places that are safe from traffic and that enable people to play, walk and cycle in a reduced-traffic environment. Second is embedding physical activity into the pre- and post-operative care protocols, along with community-based rehabilitation on a long-term, lifestyle model. Third is a different approach to the management of chronic disease in general practice.

"When someone goes for a repeat prescription they need to be able to talk to someone with the skills to genuinely change their behaviour," Foster argues. "You need a professional who can do that but someone who is not a medic. They are too expensive. There should be someone to help patients. We all used to go to the dentist for everything dental but now they have hygienists. That is the model we could use and of course a hygienist is paid far less than dentist. We produce thousands of sports science graduates a year. Where are they all going to go? This is where they could go, like dental hygienists.

"It's about behaviour. People who deliver sport are coaches. They are not necessarily degree-trained but they have things that people respond to. The have inspirational and leadership qualities. That is what you need when you want people to change their behaviour. Ultimately GPs will do what they are paid to do. If they were paid to provide a chronic disease risk factor management service within their practice they would be influenced by sports scientists and dieticians. It would be brilliant."

The British Heart Foundation Health Promotion Research Group can be found online via the website of the Oxford University Department of Public Health

Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers can be found online via the Department

of Health website

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