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4. Sport, Health and Public Policy in the U.K.

Ivan Waddington

I. Exercise, Sport and Health

The ideology linking sport and health has a long history and has been widely promulgated in official and semi-official health publications in Britain (Smith and Jacobsen, 1988; Department of Health 1993). How valid is this ideology?

Many studies have shown that moderate, rhythmic and regular exercise has health benefits, including improved cardiovascular function, better control of obesity and decreased blood pressure (Coronary Prevention Group, 1987; Royal College of Physicians, 1991).

At first sight, the health benefits associated with sport seem clear. However, these benefits relate specifically to what Smith and Jacobsen (1988:126) called »moderate, rhythmic and regular exercise«, such as brisk walking, running or swimming for 20-30 minutes three times a week. The activities considered to constitute, in health terms, »adequate« exercise, vary from one study to another, but include manual work in the house and garden (Morris *et al*, 1980), dancing (BMA, 1992) and climbing of stairs (Paffenbarger *et al*, 1986). Thus what these studies document is a beneficial effect on health of *moderate*, or even gentle, forms of exercise; as the British Medical Association (1992:19) has noted, several studies »have suggested that only rather low levels of activity are necessary to confer some degree of protection against heart disease«.

This point is important; we cannot assume that the health benefits of moderate exercise will also be associated with exercise which is more frequent, of longer duration and of greater intensity, for such exercise may generate substantial health »costs« in terms of additional stresses or injuries. The fact that a 30 minute gentle swim three times a week has health benefits does not mean that running 100 kilometers a week is similarly good for one's health. Indeed, one American study, which found that death rates decreased as levels of physical activity increased, also found a reversed trend at the highest levels of physical activity, a result which may reflect »actual increased hazards associated with vigorous activities« (Paffenbarger *et al*, 1986). A New Zealand study of competitive athletes, who were presumably engaged in relatively intensive training, also found a positive association between exercise and a large number of symptoms, including wheezing, chest pressure, retching and incontinence of urine and stool (Sullivan *et al*, 1994).

These data suggest that, in terms of their impact on health, we need to differentiate between general physical activity (eg walking up stairs), non-competitive exercise (eg jogging

or swimming to »keep fit«) and sport, for the patterns of social relations associated with these differ, and these social differences have important implications for health. For example, the social relations of modern sport involve increasing competitiveness and an increased emphasis on winning; consequently, and unlike those who take part in non-competitive exercise, those who play sport are, particularly at the elite level, often subject to strong constraints to continue playing while injured, or to play with pain killing injections »for the good of the team«.

However, we need to differentiate not only between general physical activity, non-competitive exercise and sport, but also *between* sports, for example between contact and non-contact sports, and between mass sport and elite level sport, for the demands which they place on our bodies – and the associated health costs – vary considerably. These differences can be explored *via* an examination of the epidemiology of sports injuries.

II. The epidemiology of sports injuries

Sports injuries are common and must enter into any account of the health »costs« and »benefits« of sport and exercise. A recent study estimated that there were 29.7 million sports injuries a year in England and Wales, the direct and indirect costs of which were estimated at £997 million (Sports Council, 1991:25, 31).

Some sports impose greater strains on the body than do others. Injury risks vary markedly from one sport to another; the highest risks are associated with contact sports. The Sports Council study (1991:33) found that rugby was the most dangerous sport with an injury rate of 59.3 per 100 participants per 4 weeks, followed by soccer (39.3), martial arts (36.3) and hockey (24.8). The activities with the lowest risks of injury were the non-contact and rhythmic (and largely non-competitive) activities involved in »keep fit« (6.5 incidents per 100 participants per 4 weeks) and swimming/diving (2.9). However, even relatively rhythmic and non-contact activities involve injury risks; in the USA, a third of the nation's 15 million joggers sustain a musculoskeletal injury each year and nearly a half of habitual runners experience lower extremity injury (Heil, 1995:3).

Though most sporting injuries are minor, many are more serious. The Sports Council (1991:18-19) found that 25% of new injuries and 31% of recurrent injuries required treatment by a health professional; 7% of injuries resulted in time off work and 11.5 million working days a year are lost in England and Wales as a result of sports injuries.

What conclusions can we draw about the relationships between exercise, sport and health? Clearly we need to differentiate between (i) exercise and sport, for they involve different patterns of social relationships and have different consequences for health and (ii) between types and levels of sport, with the distinctions between contact and non-contact, and between elite and mass sport, being particularly important.

These distinctions may help us to reconcile what, initially, may appear to be incompatible findings. Thus, on the one hand, there is clear evidence that regular and moderate exercise is good for health. On the other hand, Young (1993:373), writing of professional sport, may also be correct to claim that:

By any measure, professional sport is a violent and hazardous workplace, replete with its own unique forms of »industrial disease«. No other single milieu, including the risky and labor-intensive settings of miners, oil drillers, or construction site workers, can compare with the routine injuries of team sports such as football, ice-hockey, soccer, rugby and the like.

To summarise: in the case of rhythmic, non-competitive exercise, where participants are less subject to competitive constraints from team-mates and others to continue playing through pain and injury, the health benefits substantially outweigh the health costs. However, as we move from non-competitive exercise to competitive sport, and from non-contact to contact sport, so the health costs, in the form of injuries, increase. Similarly, as we move from mass sport to elite sport, the social constraints to train longer and more intensively and to continue competing through pain and injury also increase, with a concomitant increase in the health risks. The health-related arguments in favour of regular and moderate exercise are clear, but such arguments are less persuasive in relation to competitive sport, and much less convincing in relation to elite, or professional, sport.

III. Sport and policy making in the UK

Houlihan (1991:30) points to the fragmentation of sports policy making in the UK; in a two month period in 1989, parliamentary questions relating to sport were answered by ministers representing five different government departments. The Department of Health is only one of many departments with an interest in sport, and there is little evidence to suggest that considerations of health are at the forefront in determining government sports policy.

The lack of co-ordination in public policy can be seen in the government's recent policy document *Sport: Raising the Game*, described by the Prime Minister as »the most important set of proposals ever published for the encouragement and promotion of sport« (DNH, 1995:1). The document was published by the Department of National Heritage (DNH), which includes the Ministry of Sport, and was sent out with a supporting letter from the Secretary of State for Education. This might seem to suggest a carefully co-ordinated policy, but closer examination suggests that the policy is based largely on myth, and also ignores important recent research.

As Roberts (1996b) has noted, government policy is based upon the idea that there has recently been a marked decline in sporting participation by young people, especially in schools. The government says it is »a serious cause for concern that sport no longer commands the place it once did in school life« and adds »the amount of sport played outside formal school hours has...declined in recent years. We are determined to...put sport back at the heart of school life« (DNH, 1995:6-7).

However, Roberts notes that it is »impossible to square the analysis in *Sport: Raising the Game* with the governments' own research evidence«. He notes that three recent surveys show that, contrary to the government's assumptions, schools have been *extending* their sports teaching and that young people now play *more* sport in and out of school than in earlier decades. Government policy, he writes, »prescribes a cure for a fictitious illness. School sport in Britain has been a recent success story, not a disaster zone, if success can be measured in terms of the numbers of pupils playing and continuing to play after leaving

school« (Roberts, 1996b:105). Moreover, he points out that this information, which could have provided the basis for a more realistic sports policy, was available to government prior to the drafting of the policy statement; indeed, all of the research was conducted by the government's own Office of Population Censuses and Surveys.

Drawing upon these national surveys, Roberts (1996a: 52) observes that:

Young people's participation rates may still fall well beneath the requirements for health promoting sport for all but they are much higher than in the past. This is not to deny that most children may be doing insufficient sport to benefit their cardio-vascular health....However, if young people's fitness has declined in recent years, this must owe more to their diets or their more frequent use of private mechanical transport or something other than a flight from sport.

He notes that one national survey found that 82% of 18-21 year olds visited pubs, while a third of young people smoke, and suggests that these features of young people's lifestyles »should probably command more attention from the ›health lobby‹ than their sports participation« (1996a: 52). Such issues, however, raise delicate problems for the government and many sporting bodies; the government derives huge tax revenues from the sale of alcohol and tobacco and has often been criticised for its failure to take stronger action to restrict the advertising of tobacco products, while many sporting bodies and competitions are sponsored by the manufacturers of alcohol and tobacco products.

Government policy has also sought to prioritise certain kinds of physical activities within schools. In this context, it is necessary to know that the National Curriculum in Physical Education (NCPE) which is taught in all schools involves six elements: competitive games, athletics, swimming, gymnastics, dance and outdoor education. It is clear, however, that powerful people within government, notably the Prime Minister and the Minister for Sport, are unhappy with aspects of the NCPE and are seeking to prioritise traditional competitive team games such as football, rugby, netball and hockey, at the expense of other activities (Penney and Evans, 1994).

However, the Prime Minister's view again reflects an ignorance of what goes on in schools, for schools already heavily prioritise competitive sports, particularly team games. A recent survey (Penney and Evans, 1994) found that in the physical education programmes for pupils aged 13-14, over 24 weeks per year were spent on competitive games and almost 9 weeks on athletics. In contrast, boys spent only one week (girls spent three weeks) a year on dance, and boys and girls spent under one week a year on outdoor education.

It is worth noting that the traditional emphasis on team games, which the government now seeks to emphasise still further, has never been very effective in encouraging young people to continue playing sport after leaving school. Of the six activities in NCPE, those in which people are most likely to be involved on a lifelong basis are dancing and outdoor education; many people continue to dance in middle and even old age, while walking is the most popular form of physically based leisure activity in Britain (Social Trends, 1993). Yet it is precisely these two areas which receive least time and attention within the physical education curriculum, and government policy designed to privilege competitive sports even more will have the inevitable effect of further marginalising dance and outdoor education. Government policy thus prioritises precisely those physical activities in which people are

least likely to be involved after leaving school, while marginalising those in which they are most likely to be involved. Those activities which the government seeks to prioritise are also mainly competitive contact sports, which carry the greatest health »costs« in the form of injuries, while those which are being marginalised are those which offer substantial health benefits but with fewer health »costs«. One might question whether this is the most rational policy for improving the health of young people.

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5. Dimensionen der Gesundheit und der Einfluß sportlicher Aktivitäten

Joachim Winkler

1. Einleitung

Es hat viele Versuche gegeben zu belegen, daß Sport gesund ist und daß Bewegungsmangel ein Risikofaktor beim Entstehen von Herz-Kreislaufkrankheiten darstellt. Es besteht