

## THE STUDY ABOUT SPORT AND HEALTH: A CRITICAL REVIEW OF THE UK SITUATION

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**Abstract:** *This paper presents the concepts in particular regular exercise decreases the risk of cardiovascular mortality, delays the development of high blood pressure, helps to control bodyweight, improves bone health, helps maintain strength, coordination, balance and cognitive functioning, reduces the risk of cancer and enhances the immune system, and reduces the risk of depression and has positive benefits for mental health (NHS, 2001).*

**Keywords:** *regular exercise, health, the immune system.*

### INTRODUCTION

Physical activity is widely accepted as being beneficial to health (Parliamentary Office of Science and Technology, 2001; Gratton, 2004). The World Health Organisation (WHO, 2003) estimates that mortality, morbidity and disability attributed to non-communicable diseases amounts to 60% of all deaths worldwide and are expected to rise to 70% by 2020. The World Health Organisation (WHO, 2003) also suggests that appropriate physical activity is a strong means of preventing non-communicable diseases and is a cost-effective method to improve public health. Worldwide more than 60% of adults do not engage in sufficient physical activity beneficial to their health. Less than one-third of adolescents are sufficiently active to benefit their present or future health.

The health benefits of exercise are widely known in the developed world yet despite the well documented and undisputed health benefits of regular exercise the evidence suggests that large sections of the population do not engage in sufficient levels of exercise to maintain physical and mental health. Governments have been largely ineffective in developing initiatives and strategies to deal with the growing problems resulting from insufficient exercise.

WHO (2003) also stresses the importance of physical activity for children. They suggest that patterns of physical activity acquired in childhood are more likely to be maintained in adulthood and unhealthy lifestyles adopted at a young age are likely to persist in adulthood.

### THE UK SCENE

The Department of Health (1999) found that 60% of men and 70% of women do not reaching the recommended levels of physical activity to maintain health (optimal levels are described as 30 minutes of moderate activity on 5 days per week). Rowe *et al* (2004), drawing on data from the Department of Health (1999) study, provide information on physical activity levels in

England. Within the overall statistics the data indicates that women exercise less than men, that exercise reduces with age for both men and women and that exercise reduces with social class for both men and women.

Acheson (1998) states that, although death rates have fallen among both men and women and across all social groups in UK over the last 20 years, the difference between the top and the bottom of the social scale has widened. Regarding morbidity, the differences between social groups are substantial. For example, among professional men aged 45 to 64 years 17% have a long-standing illness compared with 48% for unskilled men. Among professional women 25% have a long-standing illness compared with 45% for unskilled women. Other age groups reflect similar patterns.

The greatest contributor towards overall physical activity is through 'occupation' providing 68% of the total activity hours (Rowe *et al*, 2004). Interestingly in a post-industrial society increasing numbers of people are employed in sedentary occupations and so physical activity through occupation is of decreasing importance and needs to be supplemented by leisure-time activities. Sport activities contribute a mere 8% of activity hours. The Department for Media, Culture and Sport (2002) has set a target of 70% of the adult population being 'physically active' by 2020, based on activity levels in Scandinavian countries.

### ECONOMIC COSTS OF A SEDENTARY POPULATION IN UK

DCMS (2002) puts the cost of physical inactivity in England at £1.89 billion per year comprising costs to health care (£326 million), costs of absence from work (£785 million) and costs of premature death (£780 million). DCMS estimates that a 10% increase in physical activity would save £500 million per year. Based on the methodology used in studies carried out in USA (Colditz, 1999) and Canada (Katzmarzyk *et al*, 2000) Gratton (2004) estimates that the health

costs of inactivity in UK amounted to £1.7 billions in 2002 (2.5% of the health care budget of £8.1 billions), indicating that the DCMS figure of £500 millions to be massively under-estimated. Gratton (2004) also reports that sports participants have a much lower probability of being absent from work than non-participants and estimates £3.94 billions as the economic cost of absence from work by non-participants. Increasing levels of participation would not eliminate this cost but would reduce it to the level of participants, giving an estimated cost of inactivity through days off work in UK of £1.3 billions. Similarly, using the methodology of Katzmarzyk et al, (2000) Gratton uses the number (34,000) of premature deaths due to inactivity in UK to estimate the costs through loss of earnings, which amounts to £803 millions.

There is strong evidence that the economic costs of inactivity are substantial (Gratton, 2004). Government policies to promote increased physical activity in the UK population would have considerable impact on the reduction of direct health care costs to the National Health Service and indirect costs of absence from work and premature deaths. However, the strategic priorities to date have focused on increasing participation in traditional organised sports, and particularly among children and older adults.

There is currently little promotion of informal, non-competitive sport, particularly for the older generation, unlike the Scandinavian countries where participation in informal, non-competitive sport is much higher than in UK, with the resulting improvement in general health and economic benefits.

Gratton (2004) concludes that, in UK, the evidence suggests that the health inequalities between different socio-economic groups have increased in the last 25 years: the lower socio-economic groups have lower health status than the rest of the population and these also groups have the lowest sport participation. The focus on promoting participation in organised, competitive sport has had little impact on these populations. Gratton (2004) also concludes that the economic costs of inactivity are far higher than previously estimated, particularly in relation to direct costs to the National Health Service. Policy intervention to increase participation by the older age group and the lower socio-economic groups needs to be concentrated on informal, non-competitive sports where it will yield the highest health benefits. Unfortunately this strategy is in conflict with the primary strategy for funding the high performance sport and formal, competitive sport enjoyed mostly by the higher socio-economic groups and younger adults.

#### **SPORT AND OBESITY**

The British press has recently reported alarming statistics for obesity levels among adults

in UK, and particularly among children, with the warning that child obesity is a national health ‘time bomb’ for the future (Chapman, 2007). Others have indicated that the causes of obesity are far more complex and include diet and lifestyle as key contributory factors (Martin, 2007).

Statistics for obesity indicate that UK is top of the European Obesity League and second only to USA worldwide. It is predicted that, unless radical steps are taken, more than 50% of the UK population will be clinically obese by 2030, resulting in the first drop in life expectancy for 200 years and estimated to reduce life expectancy by at least 8 years. 15% of children fewer than 10 years of age are obese compared with 10% in 1997. Alongside this alarming statistic is the predicted rise in associated conditions such as diabetes, strokes, heart attacks and kidney failure. In 1980 8% of adults were obese: by 2006 obesity levels reached 23% of adults. Currently 23% of UK women are obese; the fattest in Europe. Among men 22.3% are obese; marginally behind Malta. Martin (2007) reports that the impending health catastrophe resulting from rising levels of obesity is brought about by aggressively-marketed fatty fast foods as well as inactive lifestyles.

The cost of obesity already costs the National Health Service more than £1 billion per year and unless something drastic is done about the obesity situation these health costs will increase considerably in future years, yet there is little being done by government to address the problems and a lack of a national strategy to tackle the complex issue of obesity. There is debate about the part that diet plays in obesity. Generally nutrition has improved consistently over the last century. Today there are more obese people than starving people. Not so long ago obesity was associated with affluence but today the predominance of obesity is higher in the lower socio-economic groups, with the decline in the importance of the family, the rise in single working parents, the increasing pace of life in western society and the easy availability of convenience foods. Successive governments over the last 20 years or so have contributed to the problems through their social and educational policies (e.g. the decline in the status of physical education, removal of school playing fields, the decline in competitive sports in schools, the lack of investment in informal sports and facilities, the encouragement of the break-up of families through social policies and the failure to control food advertising).

#### **TACKLING THE CHILD OBESITY PROBLEMS**

The government’s typical response to the child obesity problem has been to focus on the lack of sport and physical education in schools as the cause of the problem and has set in place a strategy to improve the provision of facilities and

programmes to tackle the problem. Physical Education in schools has become a primary target with 2 hours of physical education being included as a compulsory part of the national curriculum for children less than 16 years of age.

Wilkin (2007) indicates that the amount of Physical Education provided at primary school (ranging from 1.8 hours to 9 hours per week) has made no impact on obesity levels. He states that results from research indicate the government's focus on provision of facilities and a minimum level of Physical Education in schools is at best misguided.

One such initiative is Sports Partnerships with Schools, which are groups of schools working together to increase sporting opportunities for children. By 2006 there were 8,000 schools involved in the initiative. Schools can choose from a wide variety of activities – 43 sports in total – and benefit from high quality teaching, more competition and more out of school sporting opportunities. Typically Sports Partnership with Schools involves a Specialist Sports College at the centre of the network including 8 secondary schools and 45 primary schools. Under the scheme each partnership receives a grant of £270,000 per year for 3 years. Currently there are 222 partnerships with 1,243 School Sport Coordinators employed in secondary schools to organise the programme and 6,664 link teachers employed in the primary schools.

Initial research on the Sports Partnerships with Schools initiative reveals that over the first 3

years of the programme up to 90% of pupils spent at least 2 hours each week in high quality physical education and sport, compared with 52% of children from schools that were not involved in the programme. Analysis of schools involved in the Sports Partnership reveals:

- On average 14 different sports are offered
- A sports day in 94% of schools
- Provide formal links with community sport clubs (soccer, 76%; cricket 51%; gymnastics 36%)
- Provide soccer (97%); athletics (93%); gymnastics (22%)
- Involve 36% of children in competitions between schools.

Charles Clarke (Secretary of State for Education) states *“The survey shows that school sport is entering a new league. For years it was run down by lack of investment of over £1 billion. We are now putting in the resources and sport is on the increase. We intend to improve every aspect of school sport – buildings and pitches, teaching quality and links with sport clubs”*.

However what the programme does not provide are specialist physical education teachers in primary schools and focuses on the use of peripatetic sport coaches and a programme of mostly formal and competitive sport. There are no results yet on the impact of the programme on the health of children, particularly those obese children who are at greatest risk through inactivity.

## CONCLUSIONS

Despite strong evidence of the link between physical activity and health government strategies that focus on providing sport activities for children and adults has had limited effect on improving health and reducing obesity. It is clear that effective programmes designed to increase physical activity among the inactive population could have considerable health benefits and provide substantial financial savings in health care costs far in excess of the investment involved but it is naïve to think that exercise alone can solve the problems. Even more so it is naïve to think that sport can solve the problems. Health and obesity are complex problems that require a coordinated approach. To date much of government expenditure has been on promoting traditional, organised and competitive sports in schools and in the community but these programmes have not been successful in reaching the majority of the population, particularly children, older adults and lower socio-economic groups – precisely those people who are least active and therefore most at risk.

Recently government organisations have woken up to this shortfall and started to provide alternative programmes designed to attract these specific groups through joint initiatives between government departments and agencies (Comptroller and Auditor General, 2001; Department of Health, 2004). The health and child obesity problems are also associated with lifestyle and diet, which themselves are a factor of socio-economic status. For the first time in history obesity is more commonly associated with the lower socio-economic groups who were, in earlier times were not affected due their relative poverty and under-nourishment. The pendulum has changed direction.

The upper socio-economic groups are nowadays more conscious of their body image, more likely to adopt an exercise regime and attend gymnasiums to work out, not so much for health benefits but for image: it is fashionable to have good looks and a trim body. The irony is that recent government policies designed to get mothers back to work, through provision of a range of financial incentives, has had the effect of reducing the health of this group and the children. The economic problems of families, particularly the high cost of housing in UK and the amount of family debt has virtually ‘forced’ parents (mostly mothers) back to work as early as possible. The vastly increased pace of life and the economic problems that lower socio-economic

groups face has resulted in a massive increase in unhealthy diets, with parents having little time to prepare wholesome and healthy meals for their children.

Coupled with the TV and computer attractions it is little wonder that many children are obese; the problem is of the government's making, yet they put the blame on lack of sport and physical education as the cause. Many people have campaigned against fast food and unhealthy drink advertising but the government has been slow to react and control advertising so that children are bombarded with advertisements for unhealthy food and drink products, sometimes by influential sport role models sports.

Until government, parents and sport organisations recognise the complexity of the health problems and there is a serious coordinated attempt to address the causes of the problems sections of the UK population will continue to remain unhealthy and obese, with the concomitant effect on the national economy.

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