Getting Scotland on the move? Reflections on a 5-year review of Scotland’s national physical activity strategy

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ABSTRACT
The public health risks of physical inactivity have led many national governments to develop policies that aim to increase population levels of physical activity. There is however, little evidence available about the effectiveness of such strategies and physical activity leaders may also face challenges in securing sufficient levels of political will and lasting investment for physical activity. This article reports on a review of a national physical activity strategy in Scotland after 5 years of implementation and offers lessons that may assist policymakers, practitioners and communities seeking to mobilise political commitment and leadership for physical activity in their own countries.

GLOBAL RESPONSES TO PHYSICAL INACTIVITY
Increasing global levels of physical inactivity are rightly described by Murray,¹ to be one of the biggest challenges facing public health in the 21st century. Internationally, inactivity is estimated to cause around 21–25% of breast and colon cancer, 27% of diabetes and approximately 30% of ischaemic heart disease, with physical activity (PA) also fundamental in achieving energy balance and weight control.²

Over the past decade global institutions have called for countries to invest in PA policy development and implementation. The 2004 WHO Global Strategy on Diet, Physical Activity and Health,³ Global Strategy for the Prevention and Control of Noncommunicable Diseases,⁴ and the recent Political Declaration from the United Nations,⁵ all recommend that Member States develop national policies based on multisectorial action.

Many countries have responded to this call with national PA policies now evident worldwide. A review in the European region alone, for example, identified 49 national policy documents from 24 countries published since 2000.⁶ Yet evidence about the effectiveness of such policy commitments is more elusive. Although a few countries have reported on developments in their own territories,⁷–⁹ limited examples of a systematic assessment of a PA policy are available. Despite this growing attention to PA policy both nationally and globally, it is also evident that PA faces challenges in securing sufficient levels of political will and lasting investment⁸–¹⁰ with even countries that have a history of weight control.⁷

Therefore our aim was to outline key lessons from a review of a national PA policy in Scotland, undertaken after 5 years of its implementation that may assist policymakers, practitioners and communities seeking to mobilise political commitment and leadership for PA in their own countries.

SCOTLAND’S PHYSICAL HEALTH STRATEGY
Let’s Make Scotland More Active (LMSMA) published in 2003 was Scotland’s first national PA strategy and set targets for 50% of all adults aged over 16% and 80% of all children aged 16 and under to meet the minimum recommended levels of PA by 2022.¹¹ To support national leadership and coordination of the strategy, a PA coordinator role was established in a national government department with resources also allocated to organisations working across sectors (eg, cycling, forestry and health). A number of projects that aimed to increase awareness and uptake of PA across priority groups (eg, teenage girls), settings (eg, schools) and communities (eg, walking initiatives) were funded across the country. LMSMA was also unique in identifying from the outset that the national targets be reviewed every 5 years as part of an overall review of the strategy’s implementation.

REVIEWING 5 YEARS OF LMSMA
Scotland is one of the few countries to have undertaken a systematic, in-depth review of a national PA policy. In 2008, the then Scottish Executive commissioned a review of LMSMA as one of a set of reviews of public health policies aimed at providing information to senior civil servants and ministers on the short-midterm impacts of policy.¹² The aims of the review were to evaluate influence and impacts of LMSMA after 5 years of implementation and recommend policy priorities to maximise improvements in population PA levels.

In summary, the review process involved five main stages: (1) commissioned research to assess policy impact and influence at the national and local levels including: interviews with a sample of 16 officials from national government and agencies (eg, health, education and environment), reviewing national plans and strategies from these sectors and an audit of local PA strategy development across Scotland’s 32 local authorities; (2) synthesising findings from evaluations of seven major PA projects to assess the reach and impacts of the projects; (3) a review of population monitoring data to

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assess whether or not Scotland was on track to meet the PA targets set for 2022; (4) identification of new PA evidence or guidance (published since LMSMA) that could require changes to be made in the future policy focus and (5) events to engage the PA workforce in assessing progress made and identifying priorities for future policy implementation.

An international sportsman and broadcaster, recognised for his public advocacy of PA chaired the review group and review members included policymakers, a national health promotion agency (who acted as the Secretariat) and independent academic experts. The group engaged with the PA workforce across Scotland, interpreted the results of the review process, developed recommendations and reported these directly to senior civil servants.

Below, we provide a summary of the review’s key findings of relevance to PA policy development. The final reports presenting the review methodology, detailed findings and recommendations are available from the review webpages.15

KEY FINDINGS FROM THE REVIEW

At a national level, the review found evidence of supportive policies or strategies for PA (in addition to LMSMA) in place across both health and non-health sectors. Interviews with national stakeholders (eg, policymakers and PA agencies) confirmed that the existence of a national strategy and the national coordinator’s role was influential in supporting cross-sector working with sectors such as education, transport and environment, although gaps were identified in the existence of supportive PA policies for older people and in addressing issues of inclusion more generally.

At a local level, the national PA policy also stimulated local strategy development across Scotland. Of the 32 local authority regions in the country, 29 were identified to have local PA strategies in place with the vast majority developed since LMSMA was published. Yet beyond local strategy development, there was limited evidence from the review that the national level commitment to PA and regional strategy development had led to an increased priority to PA within mainstream services and sectors. It was also often unclear at the local level who was responsible for leadership and accountability of PA strategy implementation with information about funding also lacking from policy documents.

For major PA projects funded at a community level, there was evidence (where projects were supported by robust monitoring and evaluation data) of projects reaching large numbers of people and that these projects had achieved short-term gains in PA levels among participants. However, inconsistent quality of data across many evaluations meant that the contribution that projects had made to changing knowledge about and attitudes towards PA was relatively unknown after 5 years and it was also unclear whether the projects were reaching those who were inactive.

Moving to the review of Scotland’s national PA targets, while the proportion of adults overall in Scotland meeting recommended levels had increased over both the first 5 years of the strategy (2003–2008) and the long term (1998–2008), differences in PA levels were evident between population groups. By 2008, men remained more likely to meet recommended guidelines than women; men and women in younger age groups were more likely to meet guidelines than older adults and people living in the most deprived areas of Scotland were least likely to meet the activity guidelines compared with more affluent areas. A significant reduction in PA levels for children (2–15 years) were also observed over the 5-year period and appeared to reflect a significant reduction in the proportion of girls meeting recommended PA levels compared with boys.

LESSONS LEARNT FROM 5 YEARS OF PA POLICY IN SCOTLAND

While the findings above demonstrate positive achievements in terms of the influence of the strategy on national cross-sector working, a key conclusion from the review group was that the scale of action at the local level was deemed to be insufficient to achieve an impact on population PA levels. Three key issues can be identified in relation to this challenge: (1) translating national policy commitments for PA into local action, (2) leadership for PA and (3) robust monitoring and evaluation. We reflect on each of these in turn.

Translating political will into local action

LMSMA’s policy review offers evidence that national policies consistent with international PA guidance are important vehicles for encouraging action on the PA agenda. The coordination of the strategy from within national government helped mobilise interest in PA priorities nationally and helped to initiate and grow partnerships beyond health. In this respect, the attention to PA in Scotland since the review (evidenced by the coordination of PA under the CMO directorate, appointment of a national champion in 2011 and inclusion of PA as a national performance indicator) are positive signs of this continued political commitment for PA nationally.1 In this respect the recent development of a national implementation plan in Scotland based on the principle of the ‘seven best investments’ for PA is also to be welcomed as a mechanism to support cross-sector collaboration.16

Yet if strategies are to achieve population level impacts, this requires political commitment and investment at the local as well as the national level. The review of LMSMA showed that the strategy had been far less successful in securing investment for action on PA by local delivery agencies and decisionmakers. This gap between intent and action at different levels of government, suggests that insufficient political commitment and resources was being given to PA. This is a critical policy finding given the contribution of service provision in sectors such as transport, planning, recreation and education (as well as health) to PA goals and where responsibility for planning and delivering services may rest at the local level.

A recent policy development that aims to increase this commitment to PA within local planning arrangements is the inclusion of PA as one of six key policy priorities for Single Outcome Agreements set between local community planning partnerships (CPPs) and the Scottish Government. These agreements are intended to mobilise public, voluntary, community and private sector resources to support the planning and delivery of better outcomes for communities and require CPPs to set a clear strategic focus on each of these priorities within their local agreements.17 While it is too soon to tell if the inclusion of PA as a priority has led to increased attention to PA within local planning, this development should provide additional leverage in supporting aspirations for ‘transformational, not incremental’ change in PA population levels.17 18

Developing local, national and global leadership for PA

The Toronto Charter launched in 2010 responded to the need for greater mobilisation of political commitment towards PA at local, national and global levels and presents the case for investing in PA to promote health, gain many other co-benefits and reduce future healthcare costs.19 That there is growing
international interest in the public health importance of PA is demonstrated by the translation of the Toronto Charter into at least 22 languages and hundreds of pledges of support from individuals and organisations.20

Yet to achieve large-scale change requires a commitment to acting on PA beyond those who already recognise its health benefits. Amid economic austerity, Hunter,21 argues that political astuteness and advocacy are key capabilities that all public health professionals require to make their case alongside more traditional competencies. This is even more so for PA where the major interventions needed to address the environmental determinants of inactivity require actions outside of the health sector and PA professionals may face apathy or political ambivalence.22

Building more powerful alliances with political and community partners on environmental sustainability and transport planning agendas is necessary and gives important impetus to advance the profile of PA.23

Greater evidence on effectiveness and equity of policy actions

The review process highlighted the need for attention to learning about the short-mid-term impacts of policy and for monitoring and evaluation systems that set short-term goals to inform national action.14 Other than the national targets set for 2022, LMSMA did not establish key shorter/medium-term indicators making it difficult to measure progress in the shorter term including the contribution of different sectors to achieving PA goals.

After 5 years, inequities in PA levels also persisted among women, girls and older adults as well as in areas of lower socioeconomic status. More systematic and robust evaluation of PA initiatives and performance monitoring of local PA strategies would have helped by proving important evidence (that was lacking from the review) on whether specific PA initiatives were reaching and engaging with people who were inactive and the effectiveness of different initiatives and approaches in reducing the gap in PA levels between population groups.

CONCLUSIONS

Scaling up national efforts to increase population levels of PA is a major health priority in efforts to reduce chronic disease.24 25 To ensure that national strategies have an impact on population health, policy implementation must be matched by sufficient political will and resource, both locally and nationally. Ensuring a greater focus for interventions on the wider environmental determinants of PA is not only important in addressing inequalities by reaching whole populations but also provides PA advocates with an opportunity to develop powerful coalitions with non-health sectors. Timely and robust monitoring and evaluation systems are needed to identify whether strategies are working to reduce inequalities within populations and to contribute to building greater evidence on the effectiveness of these policies as a means of securing lasting change.

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REFERENCES