

Social distancing and COVID-19: an unprecedented active transport public health opportunity

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Social distancing measures to control the spread of COVID-19 are themselves likely to have had a negative impact on health and inequalities,¹ but they could be an

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unprecedented public health opportunity in other ways.

Social distancing is likely to limit public transport capacity for the foreseeable future. Staggered work times and flexible working may alleviate some public transport crowding, but travel will still be necessary. Alternatives to increase transport capacity will be required, particularly in crowded cities where increased personal car use is unfeasible and potentially environmentally unfriendly.

Up to 90% of active commuters walking or cycling have been shown to meet the minimum physical activity guidelines, with evidence of a consequential lower risk of CVD and mortality, all-cause mortality and cancer outcomes.² Other benefits include environmental change and improvements in mood and self-esteem.³ However, commuters may choose to increase personal car use, potentially reducing physical activity levels with negative health and environmental impacts.

More than 80% of journeys into London in the morning peak used rail-based services in 2019, only 11% of the UK adult population is thought to cycle at least once per week (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870647/tsgb-2019.pdf) and 59% of car journeys are less than 3 miles long⁴ so there is enormous scope for

expanding active travel and improving health outcomes. Cycling and walking have increased during the COVID-19 pandemic⁵ as people simultaneously travel and socially distance, suggesting that these activities are already becoming a more common element of daily life. Encouragingly, this growth is across genders, most age groups and all social classes, which suggests the potential for a fundamental societal shift. However, an increase in active commuting is likely to be more difficult for some groups, including those with long commuting distances, the socioeconomically disadvantaged and the disabled.

The UK Government has recognised this opportunity announcing a £2 billion investment package to create a new era for cycling and walking that includes a £250 million emergency active fund (<https://www.gov.uk/government/news/2-billion-package-to-create-new-era-for-cycling-and-walking>) and vouchers for bicycle repairs. Proposals include pop-up bike lanes, wider pavements, a 'bike tube' network in London and 150 miles of protected cycle track in Manchester. This money needs to be spent wisely. While the policy and funding for macro-level cycling and walking infrastructure alterations are important and have a strong evidence base, other micro-level physical environment changes and societal actions should not be neglected despite the paucity of evidence,⁶ particularly if sustained behaviour change on a population-based level is the goal. These changes fall into a number of categories, including environmental restructuring, education, enablement, coercion and persuasion.⁶ Examples include free cycle training courses to improve cycling skills and confidence, provision of work changing facilities and free bicycle use for National Health Service staff during the COVID-19 pandemic in the UK.

Such changes need to be implemented locally using cross-sector collaboration and shared decision making based on addressing local barriers to change and identifying those strategies likely to be most impactful. Local Government Public Health resources have understandably been focused on the COVID-19 response, but action now to drive infrastructure change and embed it with behavioural change interventions and social marketing is needed. This will strengthen the social

narrative that walking and cycling are safe in the context of social distancing and that these alternative transport methods are also of benefit in potentially reducing COVID-19 mortality risk factors such as type 2 diabetes. The benefits of a focused Public Health plan with clear messaging on cycling have been shown in Denmark⁷ and some cities have already identified opportunities to invest in cycling (<https://www.nic.org.uk/wp-content/uploads/Running-out-of-Road-June-2018.pdf>). Some cities like Birmingham have used COVID-19 to accelerate emergency transport plans (https://www.birmingham.gov.uk/downloads/file/16305/emergency_birmingham_transport_plan) to further capitalise on the societal shift in active transport and embed long-term change into the infrastructure as a positive legacy of the outbreak and part of the recovery of the economic and social future.

Sport and Exercise Medicine (SEM) has an important part to play in seizing this opportunity. SEM professionals are well placed to work on cross-sector collaboration while continuing to support healthcare professionals in promoting and prescribing physical activity by maximising existing practical Moving Medicine resources (<https://movingmedicine.ac.uk/>) and the detailed Motivate 2 Move evidenced base (<https://gpcpd.heiw.wales/clinical/motivate-2-move/>). SEM professionals can be agile adjuncts to local partnerships focused on moving populations into regular physical activity. The specialism could easily focus on physical activity rehabilitation of patients with COVID-19 or supporting the safe return of sport, both admirable aims, but it will miss an opportunity if it fails to step up to demonstrate its population-level physical activity competencies.

This is a unique moment in time in which we can achieve a fundamental shift in physical activity in the UK and potentially across the world. It is essential that the opportunity for Public Health, Sport and Exercise Medicine and a broader range of stakeholders to collaborate to achieve this shift is not lost.

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