

## Promoting walking and cycling as an alternative to using cars: systematic review

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### Abstract

**Objectives** To assess what interventions are effective in promoting a population shift from using cars towards walking and cycling and to assess the health effects of such interventions.

**Data sources** Published and unpublished reports in any language identified from electronic databases, bibliographies, websites, and reference lists.

**Review methods** Systematic search and appraisal to identify experimental or observational studies with a prospective or controlled retrospective design that evaluated any intervention applied to an urban population or area by measuring outcomes in members of the local population.

**Results** 22 studies met the inclusion criteria. We found some evidence that targeted behaviour change programmes can change the behaviour of motivated subgroups, resulting (in the largest study) in a shift of around 5% of all trips at a population level. Single studies of commuter subsidies and a new railway station also showed positive effects. The balance of best available evidence about publicity campaigns, engineering measures, and other interventions suggests that they have not been effective. Participants in trials of active commuting experienced short term improvements in certain measures of health and fitness, but we found no good evidence on effects on health of any effective intervention at population level.

**Conclusions** The best available evidence of effectiveness in promoting a modal shift is for targeted behaviour change programmes, but the social distribution of their effects is unclear and some other types of intervention have yet to be rigorously evaluated.

### Introduction

Driving cars contributes to traffic congestion, air pollution, and the risk of injury and death to road users, whereas walking and cycling pose little risk to others and provide opportunities for physical activity.<sup>1</sup> Increasing physical activity in the population has been described as the “best buy” for improving public health,<sup>2</sup> but we have tended to promote physical activity as leisure and through individual behaviour change.<sup>3</sup> Could we also achieve this through changes in the transport environment?

Shifting people’s approach to transport is now a common objective of transport policies, the overall aims of which may include managing congestion and improving air quality, road safety, and access to services. Various interventions have been advocated or implemented, but evidence of the actual effects of proposed measures is rarely cited, and we cannot assume that apparently sensible measures will be effective or free from harmful effects.<sup>4–8</sup> To date, systematic reviews have tended to concentrate on relatively narrow questions about safety.<sup>9</sup> We carried out a systematic review of the best available evidence on the effects of population level interventions to promote a shift from using cars towards walking and cycling.

### Methods

We searched electronic databases and websites, bibliographies, reference lists, and our own archives for published and unpublished documents in any language, combining groups of search terms representing cars, walking or cycling, and a change in mode of transport (see [bmj.com](http://bmj.com) for further details of methods). We then invited experts to contribute additional references.

We included controlled or uncontrolled prospective studies and controlled retrospective studies of urban population or area level interventions in which outcome measures included changes in the distribution of choice of mode of transport among local people. We also sought evidence of effects on health and data on the distribution of effects between social groups. We assessed studies against 10 common validity criteria based on existing checklists (see table A on [bmj.com](http://bmj.com)).<sup>10–12</sup>

The interventions, study designs, and outcome metrics used were heterogeneous (see table B on [bmj.com](http://bmj.com)). Formal statistical synthesis was not possible, but for some studies we were able to summarise effects using a common metric: the absolute percentage share

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*BMJ* 2004;329:763–6



This is the abridged version of an article that was posted on [bmj.com](http://bmj.com) on 22 September 2004: <http://bmj.com/cgi/doi/10.1136/bmj.38216.714560.55>



Details of the search strategy and study selection, references to primary studies included in the review (w1–w51), five tables of study data, and a flow chart can be found on [bmj.com](http://bmj.com)

of all trips that were shifted from cars to walking and cycling combined (see full paper on [bmj.com](http://bmj.com) for box with details of calculation).

## Results

We screened 5606 references and assessed the full text of 399 documents in seven languages (see figure on [bmj.com](http://bmj.com)). Twenty two studies met our inclusion criteria: three randomised controlled trials, seven non-randomised controlled prospective studies, 11 uncontrolled prospective studies, and one controlled retrospective study. We categorised studies according to the main focus of the intervention assessed. Within each intervention category, we have reported interventions in decreasing order of overall study validity, citing results of statistical tests if authors reported them or if we could estimate confidence intervals from reported data (table). Additional data can be found in table C on [bmj.com](http://bmj.com).

### Targeted behaviour change programmes (six studies of four interventions)

These programmes aimed to change people's travel behaviour by offering an intervention only to a motivated subgroup of the population or by offering information and advice tailored to people's particular requirements, or both.

The Walk In to Work Out self help package for commuters was evaluated in a randomised controlled trial in Glasgow (Scotland). The intervention group reported a significant net increase in mean time spent walking to work each week.<sup>w1 w2</sup> The TravelSmart programme is based on giving households a tailored selection of resources such as leaflets, timetables, maps,

and free trial bus tickets. Prospective studies in Perth (Australia),<sup>w3-9</sup> Frome,<sup>w10</sup> and Gloucester (England)<sup>w11</sup> found positive shifts of 5.5% ( $P < 0.01$ ), 3.6%, and 4.4% of all trips, respectively.

In Århus (Denmark), volunteer suburban car commuters were given a free bike and bus pass for a year in the Bikebusters programme. In an uncontrolled study, participants reported a positive shift of 25% of all weekday trips after 11 months.<sup>w12-14</sup> An uncontrolled study in Adelaide (Australia) showed no clear evidence of a positive shift associated with the Travel Blending programme.<sup>w15-18</sup>

### Agents of change and publicity campaigns (four studies)

These interventions were applied to whole groups of people undifferentiated by motivation or personal travel circumstances. A cluster randomised controlled trial in primary schools in Camden and Islington (London) found that pupils in 10 intervention schools that received one year's input from a school travel coordinator were no less likely to travel to school by car than those in control schools (odds ratio 0.98, 95% confidence interval 0.61 to 1.59).<sup>w19</sup> In Maidstone (England), a controlled repeated cross sectional study of households on trunk route corridors showed that two years after a publicity campaign on sustainable transport, the only significant change was a decrease in cycling trips in the intervention area ( $P < 0.05$ ).<sup>w20</sup>

Two uncontrolled studies from the United States showed little or no evidence of a positive shift after a community publicity campaign or a workplace intervention.<sup>w21 w22</sup>

Summary of evidence of effectiveness of interventions to promote modal shift

Study	Validity score	Nature of comparison	Evidence for shift from cars towards walking and cycling*			
			Significant positive effect	Positive effect of uncertain significance	Inconclusive or no effect	Negative effect of uncertain significance
<b>Targeted behaviour change programmes</b>						
Glasgow <sup>w1 w2</sup>	9	Controlled	Yes	—	—	—
Perth, Australia (TravelSmart) <sup>w3-9</sup>	7	Controlled	Yes	—	—	—
Frome (TravelSmart pilot) <sup>w10</sup>	9	Controlled	—	Yes	—	—
Gloucester (TravelSmart pilot) <sup>w11</sup>	9	Controlled	—	Yes	—	—
Århus <sup>w12-14</sup>	7	Uncontrolled	—	Yes	—	—
Adelaide <sup>w15-18</sup>	4	Uncontrolled	—	—	Yes	—
<b>Publicity campaigns and agents of change</b>						
Camden-Islington <sup>w19</sup>	8	Controlled	—	—	Yes	—
Maidstone <sup>w20</sup>	7	Controlled	—	—	Yes	—
Phoenix <sup>w21</sup>	5	Uncontrolled	—	Yes	—	—
Eugene <sup>w22</sup>	4	Uncontrolled	—	—	Yes	—
<b>Engineering measures</b>						
Delft <sup>w23-30</sup>	7	Controlled	—	Yes	—	—
Detmold-Rosenheim <sup>w31-33</sup>	6	Uncontrolled	—	—	—	Yes
Stockton <sup>w34</sup>	5	Uncontrolled	—	—	—	Yes
England (20 mph (30 km/h) zones) <sup>w35</sup>	5	Uncontrolled	—	—	Yes	—
Boston <sup>w36-40</sup>	4	Uncontrolled	—	Yes	—	—
England (bypasses) <sup>w36 w37</sup>	3	Uncontrolled	—	—	—	Yes
<b>Financial incentives</b>						
California (cashing out) <sup>w41 w42</sup>	8	Controlled	Yes	—	—	—
Trondheim <sup>w43 w44</sup>	7	Uncontrolled	—	—	—	Yes
<b>Providing alternative services</b>						
San Francisco <sup>w45-47</sup>	7	Controlled	—	—	Yes	—
Voorhout <sup>w48</sup>	7	Uncontrolled	Yes	—	—	—
California (telecommuting) <sup>w49</sup>	4	Controlled	—	—	—	Yes

\*No studies had significant negative effects.

### Engineering measures (six studies)

Repeated cross sectional household studies in Delft (Netherlands) and Detmold and Rosenheim (Germany) evaluated the effects of improving and extending cycle route networks. In Delft there was a 3% increase in cycling mode share in the intervention area compared with the control area.<sup>w23-30</sup> In Detmold and Rosenheim, households reported a negative shift of 5% of all trips (Detmold) and zero shift (Rosenheim) after five years.<sup>w31-33</sup>

An uncontrolled repeated cross sectional study in secondary school pupils in Stockton (England) reported a negative shift of 2% in their usual mode of travel to school 17 months after a new cycle route was opened in the town.<sup>w34</sup> Uncontrolled studies in England and in Boston (United States) showed little or no evidence of a positive shift after various traffic restraint schemes.<sup>w35-40</sup>

### Financial incentives (two studies)

A controlled repeated cross sectional study in California evaluated a directive to “cash out” the cost of subsidising workplace parking (by offering at least equivalent subsidies to staff who commute by modes other than driving). Employees at eight intervention workplaces reported a positive shift of 1% of commuting journeys after one to three years ( $P < 0.01$ ) compared with no significant change in one control workplace.<sup>w41 w42</sup> In Trondheim (Norway), a toll ring was introduced for motor vehicles around the city centre. An uncontrolled household panel study found a negative shift of 2.6% of all trips after one year.<sup>w43 w44</sup>

### Providing alternative services (three studies)

A controlled repeated cross sectional study of the City CarShare club in San Francisco (United States) found that members were no more likely to report a positive shift after nine months than aspiring members still waiting to join.<sup>w45-47</sup>

In Voorhout (a commuter town in the Netherlands), an uncontrolled household panel study found a positive shift of 5.0% of all trips ( $P < 0.001$ ) one year after the first train station was opened in the town.<sup>w48</sup> A retrospective study in California (United States) showed no evidence of a positive shift associated with neighbourhood telecommuting centres.<sup>w49</sup>

### Effects on health (six studies) and social distribution of effects (11 studies)

We only found robust evidence of effects on health in two randomised controlled trials of the effects of active commuting in selected volunteers (see table D on [bmj.com](http://bmj.com)). The Walk in to Work Out trial in Glasgow (Scotland) showed significant net increases in sample mean scores on the mental health, vitality, and general health subscales of the SF-36 after six months.<sup>w1</sup> A smaller trial in Tampere (Finland) showed significant net improvements in maximum aerobic power, maximum treadmill time, and heart rate and blood lactate concentrations at submaximal standard workload after 10 weeks.<sup>w50 w51</sup>

Findings on social distribution of effects were insufficient to permit any meaningful synthesis (see table E on [bmj.com](http://bmj.com)).

## Discussion

### Principal findings

In this systematic review of interventions to promote a population shift from using cars towards walking and cycling we found evidence from a few relatively well conducted studies that targeted programmes can change the behaviour of motivated subgroups.<sup>w1-14</sup> At a population level (in the main TravelSmart study) this resulted in around 5% of all household trips being shifted from cars to walking and cycling. Evidence that other types of intervention have been effective is inconsistent, of low validity, based on single highly contextual studies, or non-existent.

### Strengths and weaknesses of the review

We sought population level evidence to answer a public health question. We therefore searched for a wide range of evidence from diverse sources. We may still have missed some relevant evidence because of poor indexing in some databases. A common objective of synthesising evidence is to pool results and derive generalisable estimates of effect size, but we could not do this because the interventions and studies we found were heterogeneous.

### Strengths and weaknesses of the available evidence

In general, the most robust evidence of effectiveness was concentrated around interventions targeted at motivated groups of volunteers. Neither these interventions nor their observed effects are necessarily applicable to larger, less selected populations. Many of the other studies were of poor quality or were poorly reported.

We chose to specify a shift in mode of transport between cars and walking and cycling as our key outcome measure, but relatively few primary studies have reported data about this outcome. Some interventions were not primarily designed to achieve this. Others may have been ineffective in our terms but successful in other terms, such as promoting public transport at the expense of other modes or promoting cycling at the expense of walking. Our difficulty in finding relevant evidence may reflect hitherto different priorities in the transport and health policy and research communities. Walking and cycling have long been marginalised in transport planning, and recognition of their potential wider social benefits remains limited.<sup>13</sup>

### Implications and unanswered questions

It is difficult to change longstanding and complex patterns of behaviour so the evidence that some in-depth, targeted interventions have achieved any measurable shift is encouraging. Our findings are consistent with a view that interventions that engage people in a participative process and address factors of personal relevance may be more effective than those that simply aim to raise awareness or impose changes in the physical and economic environments. Some less targeted types of intervention, however, remain to be rigorously evaluated, so this view reflects absence of evidence as much as it reflects evidence of absence of effectiveness.<sup>14</sup>

Ecological comparisons show that the proportion of walking and cycling journeys can vary between populations, both between and within countries, by an

### What is already known on this topic

Transport policies increasingly seek to reduce traffic congestion by discouraging car use and encouraging the use of alternative modes of transport, such as walking and cycling

We lack good evidence either on which interventions are likely to be effective in promoting a shift from using cars towards walking and cycling and on the actual effects of such interventions on population health

### What this study adds

Targeted behaviour change programmes can be effective in changing the transport choices of motivated subgroups, but the social distribution of their effects and their effects on the health of local populations are unclear

Evidence that other types of intervention have been effective is inconsistent, of low validity, based on single highly contextual studies, or non-existent

order of magnitude greater than the population effect size of any intervention included in this review.<sup>15-18</sup> It may be unrealistic to expect interventions to produce substantial effects in relatively inactive populations without addressing the other, potentially complex reasons for such variations, such as attitudes towards cars and bicycles. Combining interventions in a genuinely integrated urban transport policy might be more effective, but we currently lack evidence from intervention studies to support this assertion.

Our findings echo Wanless's more general observation that we know relatively little about the likely impact on health of interventions to influence the wider determinants of population health.<sup>19</sup> Many transport policy interventions constitute natural experiments, in which effects on population health could be evaluated using well designed studies assessing changes in physical activity and wellbeing, as well as adverse effects such as

injuries and the potential for widening social inequalities in health and determinants of health.

We are grateful to the numerous colleagues who commented on draft versions of our review protocol and reference list. We also thank David Cumming for advice on literature searching and those who provided clarifications and additional information about studies, particularly Solveig Meland, James Ryle, and Julie Whitehouse.

Contributors: See [bmj.com](http://bmj.com)

Funding: Chief Scientist Office of the Scottish Executive Health Department and the ESRC Evidence Network.

Competing interests: None declared.

Ethical approval: Not required.

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(Accepted 4 August 2004)

doi 10.1136/bmj.38216.714560.55

## Twitched

I first noticed twitches in my right calf muscle. I could both see and feel them. Over the next week the fasciculations developed in both legs, and I became increasingly worried. The suspicion of an anterior horn cell disease began to form, particularly as I have a close relative with an undiagnosed progressive disorder affecting those very cells. My concern was not without a basis.

I (slowly) convinced myself of the potential diagnosis of motor neurone disease. I had a heightened awareness of my fasciculations, combined with a growing conviction that my motor fitness was failing. My sleep and work started to be affected. I approached my colleague, with subsequent examination and referral. The neurologist made a thorough assessment and requested neurophysiology. The evening before my investigation, I considered, with my wife, the huge implications of a diagnosis of motor neurone disease and how our lives might radically change. Shortly into my neurophysiological assessment, normally recruiting muscles confirmed a diagnosis of benign fasciculations.

I had been spared, so it felt, and I could consider my experience in the light of a benign diagnosis. Fortunately, I was assessed and investigated within a short time with, most importantly, a reassuring outcome. Worry and patience cannot be easy bedfellows for patients having to wait for results. I now appreciate their anxieties even more. And what of my failing motor fitness? The ability of the mind to distort reality, when it is consumed with worry, is quite revealing.

The prospect of a degenerative process, during which I would lose motor control and independence, horrified me and has reinforced my empathy for those who must travel that road. We should not underestimate the level of fear with which our patients may approach us and how it might affect their presentation of symptoms. How someone faces his or her uncertain future with strength, stoicism, and often good cheer poses a personal question that, as yet, I cannot answer.

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