Physical activity promotion in primary health care

What is the problem?

In Australia, more than one third of the burden of disease could be prevented by reducing or eliminating exposure to risk factors such as harmful use of alcohol, tobacco use, physical inactivity, and metabolic risk factors (e.g. high blood pressure).[1]

Australia's Health Tracker highlights concerning levels of physical inactivity: 47.3% of Australian adults (18-64 years) do not achieve the recommended level of 150 minutes or more of aerobic activity per week.[2,3]

In Australia and other high-income countries, physical inactivity and chronic disease rates vary by socio-economic status.[4-7] Australia's Health Tracker by Socio-Economic Status[8] (see Figure 1) drew attention to the association between socio-economic status and physical inactivity levels.

People living in areas of greater disadvantage experience additional barriers to participation and have a lower supply of quality exercise facilities and supports than those living in affluent areas.[9]

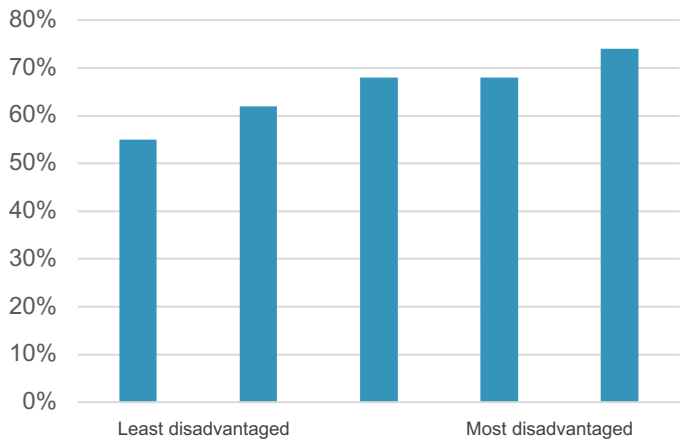

Figure 1. *The proportion of physically inactive adults by socio-economic disadvantage*[8]

Key messages

- Significant burden of non-communicable diseases can be prevented if more people were physically active.[1]
- Physical activity counselling and referral in primary health care is (cost) effective and a 'best buy' strategy for increasing physical activity levels.[10]

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Interventions to promote physical activity in primary health care

Practitioners in primary health care can support people to become physically active. Primary health care is an ideal setting to promote physical activity.

To increase physical activity, best evidence supports targeting physically inactive patients through routine screening of patients for inactivity[11], followed by advice from a general practitioner (GP) and referral to appropriately trained practitioners for physical activity counselling.[12]

In 2006, the Australian Government introduced *Chronic Disease Management Plans.*[13] These plans are funded through Medicare and enable GPs to coordinate and organise multidisciplinary health care for patients with chronic conditions.[13]

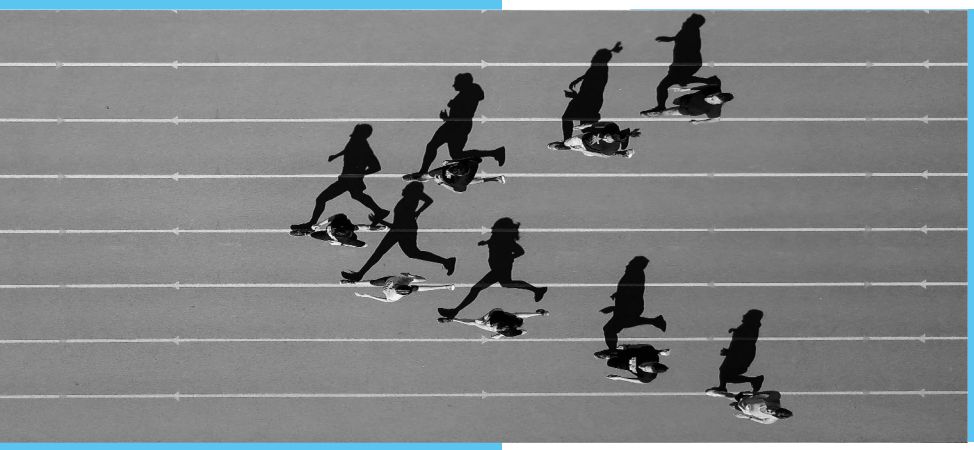
Plans allow GPs to refer patients to Accredited Exercise Physiologists (MBS item 10953)[14] to help individuals for whom physical activity is appropriate for the management of their condition.[15] Patients are able to claim a rebate for a maximum of five visits per year.[13]

However, physical activity advice and counselling in primary health care in Australia is constrained by "limited implementation".[16] Primary health care practitioners experience a range of barriers that prevent them from adopting physical activity promotion interventions.[13,17,18]

Australian data shows that GPs refer their patients for physical activity counselling at a rate of only 0.14% of patient encounters.[19] Further, GPs are less likely to refer priority groups such as older adults and people from non-English speaking backgrounds[19] for physical activity counselling.

This brief presents evidence-based policy options to support physical activity promotion in primary health care to increase physical activity and reduce inequities in physical activity participation.

"Robust evidence shows that physical activity promotion interventions in primary health care are cost-effective and effective at increasing physical activity.[11,16,20]



> *"Reducing inequities requires that the additional barriers to participation faced by those who experience disadvantage are addressed.*[21, 22]

Addressing inequity in physical activity participation

There is a growing concern that health inequities in Australia will increase in response to the COVID-19 pandemic.[22] **Improving access to evidence-based interventions that are effective across social strata is likely to increase physical activity participation among disadvantaged groups and contribute to reductions in health inequities.**[16]

An approach such as proportionate universalism could be applied to address the additional barriers faced by people who experience disadvantage.[16] Proportionate universalism suggests that health actions need to be universal, not targeted, but with an intensity and a scale that is proportionate to the level of social or health need or level of disadvantage in general.[16,22] This approach has shown success in reducing health inequities.[24]

Proportionate universalism could be applied through strategies to increase the supply of exercise practitioners in disadvantaged areas, including rural and remote areas, where there is evidence of low supply of the eligible workforce and/or financial and other access barriers to the available workforce.

For example, research suggests that recruiting and training students from rural and remote backgrounds to become health practitioners can increase the distribution of health practitioners to areas of greater disadvantage.[25]

Proportionate universalism could also be applied by providing additional services to support physical activity for people who experience disadvantage in recognition of their additional barriers to physical activity.[16,21,26]

Additional services to support participation in physical activity for people who experience disadvantage acknowledges the complex needs of disadvantaged patients, who often experience multiple comorbidities.[21]

Policy options

Physical activity promotion in primary health care could target insufficiently active patients through routine screening of patients for physical activity levels, advice from a GP, nurse or potentially other health professional and a referral to appropriately trained practitioners for physical activity counselling.

- Based on the evidence that five sessions of physical activity counselling can effectively increase physical activity[27], a health care plan could provide for referral for up to five physical activity (counselling) sessions with an accredited health professional for physically inactive individuals.
- Additional physical activity health workforce capacity could be provided through expansion of the eligibility criteria for provision of physical activity (counselling) under the Medicare Benefits Schedule.[28]

Uptake, implementation, and sustainability of physical activity promotion in primary health care could be supported by the following:

- A greater focus on the importance of physical activity in medical training.[29]
- Inclusion of Accredited Exercise Physiologists/physical activity counsellors in primary care settings could be supported through practice incentive payments or targeted infrastructure funding.
- A national promotion program could be implemented through Primary Health Networks, for which dedicated funding would need to be ensured, to provide implementation guidelines and incentives to primary health care clinics.

To reduce inequities in physical activity, a proportionate universalism approach could be applied to physical activity promotion in primary health care.

- To encourage students from disadvantaged communities to train as Accredited Exercise Physiologists/physical activity counsellors, targeted additional scholarships and tuition waivers could be provided.
- Postgraduate Accredited Exercise Physiologists/physical activity counsellors could be encouraged to locate to disadvantaged areas through incentive arrangements based on medical placements[30], programs and schemes available to medical school students that have shown to be successful.[30]
- Additional counselling sessions could be provided for physically inactive people who experience disadvantage.
- Digital and telephone delivery of physical activity advice and counselling could be provided to increase the reach of physical activity advice and counselling for people living in rural and remote areas.

In the last three decades, physical inactivity has become a "policy problem" and an increasingly important public health issue.[31,32] Promotion of physical activity in primary health care is aligned with key national and international policies and initiatives.[33,34] Physical activity promotion is key for achieving Australia's 'Sport 2030' vision to be the "world's most active and healthy sporting nation".[34]

About us

The Mitchell Institute for Education and Health Policy at Victoria University is one of the country's leading education and health policy think tanks and trusted thought leaders. Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University and brings together leading health organisations and chronic disease experts to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for preventable chronic diseases designed to contribute to reducing the health impacts of chronic conditions on the Australian population.

Process

The Mitchell Institute's policy evidence briefs are short monographs highlighting the key evidence for emerging policy issues. We work with our partners in the Australian Health Policy Collaboration to seek expert advice on topics, content and context.

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