

Physical Inactivity in Australia

Introduction

Physical activity is the body's movement that utilises energy and is performed by skeletal muscles. Physical inactivity is a driving force for the development of chronic illnesses.

Cardiovascular disease, impaired glucose tolerance, dementia, and osteoporosis are all more prevalent in individuals who are not physically active adequately (Amini et al., 2021). Physical activity boosts the immune system, enhances musculoskeletal and mental well-being, and lowers other potential risks, including being obese or overweight, having high blood pressure, and having high cholesterol. In Australia, physical inactivity is a significant contributor to the illness burden. Australians must attain adequate activity levels since they have a role in chronic illnesses (Nau et al., 2019).

This paper focuses on the nature and context of physical inactivity in Australia, vulnerable groups, implications for health equity, key players, strategies, and actions concerning physical inactivity in Australia.

Public Health Issues

Physical inactivity was responsible for 2.5 percent of Australia's total illness burden in 2015.

Individual illness burden from uterine cancer, diabetes, dementia, bowel cancer, coronary heart disease, breast cancer, and stroke was 10–20 percent due to physical inactivity. Sedentary behaviour affects more than 50 percent of all Australians. Several Australians remain inactive for a range of factors, such as poor health, injuries, and insufficient time. Due to the general nature of their professions and the length of screen time people have, many spend plenty of time lounging or sitting around. Nearly 50 percent of working professionals (44%) spend most of the workday sitting (Wilson et al., 2018).

Furthermore, according to new research, more than one-fourth of the world's adults (28 percent, or 1.4 billion individuals) have been physically inactive. However, in some counties, one out of every three adults is inactive. COVID-19 has established further barriers to physical activity, particularly in organised sports. Due to health issues and constraints – such as school closures, gymnasium shutdowns, and lockdowns – Australians have had to alter their physical activity levels and regularity. This has had the most significant impact on children. According to a study, while nearly three out of four adults expected to remain active in 2020, only one out of every six children did so (Rosenbaum et al., 2018).

Vulnerable Population

Individual traits, as well as the social context, impact physical activity habits. Whether or not a human is physically inactive is determined by demographic factors such as age, gender, and ethnicity and socioeconomic factors such as income and education (Wilson et al., 2018).

Violence, reduced air quality, high-density traffic, pollution, and a dearth of parks, walkways, and recreational facilities are all causes of environmental factors that may deter people from engaging in physical exercise due to enhanced urbanisation. As a corollary, urban populations have more roadways, vehicles, and road transport than rural populations, reducing biking and walking for transportation and recreation. Their neighbourhoods are more densely packed and have limited outdoor leisure areas (Woessner et al., 2021).

Moreover, they provide more exposure to beverage and food marketing through mainstream media, which has the potential to change individual preferences apart from traditional meals. Finally, urban areas have a higher proportion of inactive professions (including production and desk occupations) and a lower proportion of active jobs (including farming) (Wilson et al., 2018). Additionally, individuals living in poor economic conditions are at a higher risk of physical inactivity for several reasons, including low space availability for exercise. Adults with disabilities have significant difficulties walking, seeing, climbing stairs, hearing, concentrating, memorizing, and making decisions. Despite years of concerns about the possible detrimental health repercussions of a sedentary lifestyle, many adults across Western countries are physically inactive (Rosenbaum et al., 2018).

Implications for Health Equity

Discriminatory policies and programmes have culminated in increased economic hardship and poor accessibility to a nutritious diet and physical activity contexts in low-income ethnic and racial minority communities, such as highway construction, redlining, bank lending behaviour, and zoning ordinances. The World Health Organization advocated "joining a digital exercise plan" to be active at home amid shelter-in-place constraints, recognising the environmental limitations that prevent participation in physical activities in several areas (Amini et al., 2021). As a corollary, the sectors most closely associated with fitness, health, and leisure have created online workout programmes to assist people and families in increasing their physical activity at home. In low-income communities, unstable online services (dropping internet service and

difficulty rejoining the internet once disconnected) have also been reported. To alleviate inequalities in physical activity engagement, creative multi-level interventions to encourage physical activity are required (Reece et al., 2020).

Key Players

Physical activity is prescribed for secondary and primary prevention of non-communicable illnesses within health care, which is critical for health promotion. Medical physicians, physiotherapists, nurses, and kinesiologists are just a few healthcare professionals who can effectively encourage physical activity. In addition, the healthcare system builds mechanisms for analysing physical activity patterns, evaluating sedentary behaviour and physical inactivity, and evaluating the success of policies and measures to enhance physical activity (Pinto et al., 2020). Individual regular exercise counselling, as well as prescription, can effectively increase physical activity at individual levels and can thus be utilised in primary care to facilitate a healthy lifestyle, specifically among the populace that has been difficult to access and is at the highest threat of poor health caused by physical inactivity. Monetary rewards are among the strategies to encourage primary care providers to facilitate physical activity among their patients. Furthermore, paying a minimal fee for training may enhance patients' enthusiasm and, as a result, their compliance with the training sessions (Nau et al., 2019).

Strategies and Actions

To solutions that effectively encourage physical activity must be developed to lower the social and individual consequences of physical inactivity. Effective community advocacy necessitates the deployment of multi-component, culturally responsive interventions that enable people to remain active. To facilitate PA, community-wide campaigns should utilise the media, community outreach, and environmental modifications (Crosland et al., 2019). Such initiatives require significant collaborations with local groups and organizations, precise messaging that may be tailored to various parts of the population, and continuous exposure over a long period to be efficient. Policies and environmental assistance allow "downstream" well-being promotion efforts and individual behaviour change to take effect. The programme must have a significant educational aspect, be founded on theories, and emphasise behaviour modification through various activities (Castrillon et al., 2020).

Furthermore, physical activity standards differ depending on one's stage and age of life. Physical activity encouragement for children aged 5 to 17 must stress the utilisation of active community transportation, improved physical learning, and leisure time games and sports. For people aged 18 to 64, integrating physical activity encouragement into workplace activities, domestic tasks, or planned exercise is effective. Physical function in individuals aged 65 or older may vary considerably. Moderate-intensity exercises can be arranged into short sessions for those with poor fitness levels to meet standards for staying active (Bellew et al., 2020).

Conclusion

It can be concluded that physical inactivity is partially due to inadequate engagement in any kind of physical exercise during the recreational time and also to a rise in sedentary lifestyles throughout daily existence. To succeed, individuals must build a strategy to assess and gain from other programmes to efficiently find and disseminate best practises. The healthcare system cannot accomplish it independently; it must collaborate with communities. The constraints of individual behaviour change and the barriers of addressing environmental barriers that hinder a population-wide endeavour from shifting from a sedentary to an active lifestyle must be addressed.

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