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# Middle-aged Australians' perceptions of support to reduce lifestyle risk factors: a qualitative study

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## Abstract

Increasingly, middle-aged people are demonstrating lifestyle risk factors that increase their risk of developing chronic disease. Reducing lifestyle risk in middle age can significantly reduce future morbidity and mortality and improve quality of life. Understanding peoples' perceptions of health support is important to inform health professionals and policymakers regarding strategies to support lifestyle risk reduction. This paper seeks to explore middle-aged Australians' perceptions of support for lifestyle risk reduction. Thirty-four middle-aged Australians were interviewed using a semi-structured interview schedule. Interviews were audio-recorded, transcribed and analysed using thematic analysis. The overarching theme 'support for healthy lifestyles' comprised three subthemes. 'Engagement with general practice' highlighted gender differences in why people attend and what impacts their access to general practice. 'Providing information' emphasised participants' experiences of lifestyle risk communication in general practice. Finally, 'Sources of support' revealed participants' current health advice-seeking behaviours. Findings highlight a need for general practices to better engage middle-aged people in behaviour change and educate them about the role of general practice in prevention and health promotion. Consistent messaging across the community and strategies that focus on gender-specific concerns are likely to ensure that middle-aged people are able to make informed choices about seeking support for lifestyle risk reduction.



## Keywords

australians', study, perceptions, support, risk, factors:, lifestyle, qualitative, middle-aged, reduce

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**Title:**

# Middle-aged Australians' perceptions of support to reduce lifestyle risk factors: a qualitative study

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**ABSTRACT**

Increasingly middle aged people are demonstrating lifestyle risk factors that increase their risk of chronic disease. Reducing lifestyle risk in middle age can significantly reduce future morbidity and mortality and improve quality of life. Understanding peoples' perceptions of health support is important to inform health professionals and policy makers regarding strategies to support lifestyle risk reduction. This paper seeks to explore middle aged Australians perceptions of support for lifestyle risk reduction. Thirty four middle aged Australians were interviewed using a semi-structured interview schedule. Interviews were audio-recorded, transcribed and analysed using thematic analysis. The overarching theme 'support for healthy lifestyles' comprised three sub-themes. 'engagement with general *practice'* highlighted gender differences in why people attend general practice and access challenges. *'Providing information'* emphasised participants' experiences of lifestyle risk communication in general practice. Finally, *'*sources of *support'* revealed participants current health advice seeking behaviours. Findings highlight a need for general practices to better engage middle aged people in behaviour change and educate them about the role of general practice in prevention and health promotion. Consistent messaging across the community and strategies that focus on gender specific concerns are likely to ensure that middle aged people are able to make informed choices about seeking support for lifestyle risk reduction.

**Key words:** health promotion, health risk behaviours, Lifestyle Modification/ Health Behavior Change, Nursing, Prevention, Primary Care

## INTRODUCTION

Chronic conditions are a leading cause of the death and disease burden internationally, with cardiovascular disease (CVD) the number one cause of death globally (World Health Organisation 2017). Those at risk of CVD and other chronic conditions are likely to present in primary care with a range of risk factors including hypertension, obesity, and elevated cholesterol (Zwar *et al.* 2017). Lifestyle risk factors, such as smoking, poor diet, limited physical activity, and excessive alcohol intake, often play a significant role in increasing CVD risk (World Health Organisation 2017). These risks are often easily identified in routine health screening by general practitioners and general practice nurses (James *et al.* 2019; Stephen *et al.* 2019). General practices are the frontline primary care services that have traditionally acted as a gateway to the health system (Swerissen *et al.* 2018). While the health system has historically prioritised treating illness rather than prevention (Australian Health Ministers' Advisory Council 2017), primary care is increasingly important in reducing the burden of disease through early intervention to reduce lifestyle risk and promote healthy lifestyles in the community (Swerissen *et al.* 2018; James *et al.* 2019).

Currently, around 86% of Australians attend their general practice at least annually (Swerissen *et al.* 2018). Early identification of lifestyle risk factors can facilitate appropriate management, risk reduction and a decrease in premature morbidity and mortality (World Health Organisation 2017), as well as an improved quality of life, enhanced productivity and reduced health costs. Addressing risk factors such as obesity, lack of physical exercise, smoking and alcohol consumption can positively influence both individual and population health outcomes (Australian Health Ministers' Advisory Council 2017). A key group benefiting from lifestyle risk reduction are those in middle age, between 40 and 65 years (National Vascular Disease Prevention Alliance 2009).

In Australia, CVD is the leading cause of disease burden in people aged 45-64 (Australian Institute of Health and Welfare 2018). Whilst a reduction in CVD deaths has been achieved across all age groups in recent decades, the decline in mortality has been least amongst the

middle age groups (Australian Institute of Health and Welfare 2017). This evidences the importance of exploring the potential for gains in the health care of this section of the community.

Reducing lifestyle risk is complex, with behaviour change being impacted by a range of factors. These include socio-economic status, health literacy, mental health, ability to effect and sustain behaviour change and individual or societal attitudes and beliefs (Forhan *et al.* 2013; James *et al.* 2019). Key factors in achieving behaviour change are engagement with individuals within a service user perspective (Mallya *et al.* 2008), and engagement with communities to prevent and better manage chronic conditions and lifestyle risk (Australian Health Ministers' Advisory Council 2017; World Health Organisation 2017; Australian Institute of Health and Welfare 2018). However, there is a paucity of research exploring ways that middle aged Australians engage with general practice, or the facilitators and barriers to engaging middle aged Australians in lifestyle risk reduction (Hibbard and Green 2013; Verdon 2013).

Given the ageing population and the high prevalence of lifestyle risk among the middle aged, it is timely to examine the perceptions, attitudes and beliefs of middle aged Australians to help reduce the impending growth in preventable chronic disease. This paper is drawn from a larger study exploring lifestyle risk among middle aged Australians, and describes the overarching theme ‘support for healthy lifestyles’. This theme explores lifestyle support provided by health professionals and others to middle aged Australians, and describes the perceived role of general practice in lifestyle risk reduction. Due to the volume and heterogeneity of data, further findings relating to participants’ perceptions of healthy lifestyles is reported elsewhere (Authors own).

## METHODS

### Setting and participants

Participants were recruited from two Primary Health Networks in South Western Sydney and South Eastern NSW, Australia through snowball and convenience sampling. These PHNs were selected for their socio-economic diversity and geographical proximity to the research team.

English speaking men and women between the ages of 40 and 65 years, were invited to participate by four research officers who were registered nurses with experience in community based health care.

**Data collection**

Data were collected through semi-structured interviews using a qualitative descriptive approach. An interview guide was developed based on a review of the literature and input from the research team (Table 1). Face to face interviews were conducted by four experienced female Registered Nurses (RN), at a mutually convenient time and place. At the commencement of each interview, researchers also collected demographic and basic lifestyle information. Interviews were audio recorded and transcribed verbatim by a professional transcription company for analysis. Field notes were collected by each interviewer to assist in the interpretation of data. A pseudonym was allocated to each participant to ensure confidentiality.

**TABLE 1** Interview schedule

- How would you rate your current health?
- What health services do you currently use? GP? Allied health (Physio/OT/Exercise Physiology)? Fitness?
- What factors do you think increases a person's risk of cardiac disease (heart problems, heart attack, angina etc)?
- Do you have any of these risk factors? (Have you ever had a health assessment by a GP or nurse to measure your risk?)
    a. If yes – are you taking steps to manage these? What / Why not? How much do you think that this impacts on your life? Health?
    b. If no – have you had a health assessment to check if you have any factors (e.g. cholesterol, high blood pressure)?
- Have you ever spoken with a health professional about your risk of cardiac disease? (e.g. cholesterol, high blood pressure, unhealthy weight, smoking)
    a. If so – who did you talk with? What about? Was it helpful? Why / why not?
    b. If no – why not?
- If you had concerns about your heart health or risk of poor heart health who might you talk to? (health professionals (specify), family, friends, no-one, health line, gym trainer)
- What could health services do differently to assist you to optimise your health?

NOTE: Data for this paper is predominantly drawn from responses to the final three questions, with data from the earlier questions reported separately given the different focus.

### Data analysis

Transcripts were analysed using a process of thematic analysis (Braun 2006). This involved the researchers identifying and analysing patterns within the data, to facilitate emergence and reporting of themes. Transcripts were independently coded by four researchers, using Microsoft Word, with themes that emerged from the data. These codes were discussed and compared by all researchers until agreement was reached.

### Ethical considerations

The University of Wollongong Human Research Ethics Committee (Approval HE2017/288) provided approval for the study prior to commencing data collection. All participants provided informed, written consent to participate and were advised that they could end the interview at any time.

## RESULTS

### Participant characteristics

Thirty four semi-structured interviews were conducted. Whilst saturation was reached after 30 interviews, a further four interviews were conducted to ensure that no new themes emerged from the data. The mean duration of interviews was 14.8 minutes (SD 6.3). Participants ranged in age from 40-65 years (mean 53 years), with 52.9% (n=18) male. The highest level of education achieved varied from completion of Year 10 (n=6; 18%), Trade certificates (n=14; 41%), undergraduate (Bachelor) degrees (n=5; 15%) through to graduate certificates / diplomas (n=9; 26%)(Table 2). Just over half of participants were employed full-time (n=19; 55.9%) and most were non-smokers (n=29; 91.2%). Only 38.2% (n=13) reported undertaking over an hour of vigorous physical activity each week that causes them to breathe heavily.

**TABLE 2** Participant Demographics and Lifestyle Risk

| | N | % |
|---|---|---|
| Highest Education Level | | |
| High School | 5 | *15.2* |
| TAFE/Trade Cert | 14 | *42.4* |
| Bachelors Degree | 5 | *15.2* |
| Graduate Cert/Graduate Diploma | 9 | *27.3* |
| Employment Status | | |
| Disability pension | 1 | *2.9* |
| Employed full time | 19 | *55.9* |
| Employed part-time/casual | 8 | *23.5* |
| Unemployed | 6 | *17.6* |
| Exercise duration per week | | |
| None | 7 | *20.6* |
| Less than 30 min | 6 | *17.6* |
| 30-60 min | 8 | *23.5* |
| Over 60 min | 13 | *38.2* |
| Current Smoker | | |
| No | 29 | *91.2* |
| Yes | 3 | *8.8* |

**Thematic structure**

The overarching theme of *'supports for healthy lifestyles'* provides insight into how middle aged people perceived that they are supported to achieve healthy lifestyles. Three sub-themes were evident, namely; (i) Engagement with general practice, (ii) Providing information, and (iii) Sources of support.

**Engagement with general practice**

All participants described having access to a general practitioner who provided support for their primary care needs. Male participants generally indicated that *"seeing the doctor"* was an exceptional event, which normally only occurred when they were ill:

*"I'll go there (to GP) if I'm sick, not for a check-up"* (Mark).

"*I'd probably have to have something wrong with me to.. go to the doctor"* (Gary).

This contrasted with female participants who described making more regular, proactive visits.

> *"I'd likely go to a GP once, twice a year"* (Jill*).*
>
> *"once a year when I go for my annual check-up, that's when I think about it (own health)"* (Sue).

The value of visiting general practices was recognised by some participants as positively influencing their health. *"He's (GP) great. Very approachable"* (Sue), "*Optimises my health - my GP does a pretty good job"* (Joan).

Many participants only mentioned 'seeing the doctor' with some unaware of other health professionals in the practice. "*I don't actually even know what allied health is"* (Pat). Others, however, described accessing podiatrists and diabetes educators to assist them in maintaining good diabetes control, and seeing general practice nurses (GPNs) for health assessments. Accessing their general practice was widely reported as problematic by participants, with difficulties getting appointments and time factors identified as barriers to engaging with health professionals:

> *"He's (GP) always running late and there's always a waiting room full and when you get in there, you're 40–45 minutes late"* (Mark).
>
> *"You ring up to go see him and you can't get in, you've got to make an appointment nearly two weeks out to see him. I keep saying to him, yeah, but I don't need to go see him* (in) *two weeks' time or two weeks ago, I need to get in now"* (James).

Additionally, continuity of care in terms of seeing the same health professional was seen as important and impacted the choice of service provider. *"I went to a medical centre and you don't see the same doctor…. So now I see a regular doctor, all the time"* (Lyn).

**Providing information**

GPs and GPNs were described by some participants as discussing health promotion opportunistically, including how healthy lifestyle habits can impact on health:

*"He's* (*GP*) *spoken to me about health in general, and as a result of that, by having an overweight body and blood pressure, that it does affect the things of a stroke and then also the heart. So he has explained that there's a correlation between it"* (Dave).

*"They (GP Practice) call me in if there's any problems showing up in results and then talk me through what my options are"* (Emma).

Participants noted that the advice provided did not necessarily translate into behaviour modification or risk factor reduction:

*"(*GP*) gives a bit of advice. Nothing that I don't already know or already do. She's (GPN) always telling me to give up smoking but she's not one to pressure…"* (John).

*"He just says, oh you should lose weight"* (Mark).

*"He probably says I'm a little bit overweight for my age and that sort of thing and probably suggests to eat properly, but he (GP) doesn't give a great deal of - any advice on what I should be doing"* (Paul).

Specific information and explanations, on the other hand, were described as influential in encouraging changes in lifestyle. *"It* (information from the GP and diabetes educator) *was helpful because it made me aware of things I wasn't aware of. How to address things"* (Jed).

Other participants identified that they needed to be proactive in raising issues and asking for advice:

"*I probably should ask for it I suppose. They (GP) don't freely give it. I don't ask a lot of questions so he doesn't really tell me a lot. I just go and get the... prescription - and he checks blood pressure and that's about it"* (Paul).

*"I'm usually the one that instigates it with the GP. I say, look I want to - it's been two years since we checked about my heart, can I have my blood pressure taken again?" (*Elaine).

Relying on consumers to raise a conversation about lifestyle issues is problematic as several participants were reluctant to do this. As John described: *"I'm pretty shy on asking for advice".*

**Sources of support**

Male participants in particular, indicated that seeking support about healthy lifestyle from health professionals was not something they thought about. It *"just hasn't occurred to me to talk to them (health professionals) about it, because I just wasn't there for that reason, I suppose" (*James*).* Similarly Adrian explained; "*spoken to a health professional about cardiac risk factors?…..It's just something I've never thought of to be honest with you"*.

More commonly, participants spoke of utilising personal networks of family and friends first before seeking professional advice, with male participants saying that they would often discuss health concerns with their wives.

*"in the shed with my mates. We talk about men's health"* (John).

*"Possibly my sister, she's a nurse, I'd probably - talk to her now...I'd rather talk to someone that really does know what they're talking about* (Adrian).

*I'd bring it up with my wife"* (Don).

*"I'd talk to my wife and I'd probably speak to all the guys - all your mates ..have a chat to them because they're the best psychiatrists around"* (Matt).

In terms of health promotion information several participants described how *"there's a lot of information around"* (Matt*) and "it's all pumped through the media now and there's advertising for this"* (Dave). Others, however, believed there was a gap in the availability of specific information relating to lifestyle risk factors:

*"There's not a lot of literature…when you turn 50 they send out the prostate stuff, maybe they should send out cardiac stuff for men too, .. when you turn 50,*

*start getting a bit serious about your cardiac health as well instead of just being checked out for your prostate and your bowel and all that sort of stuff"* (James).

## DISCUSSION

This study explored the perceptions of middle aged Australians towards support for lifestyle risk reduction, the role of primary care professionals and experiences of engagement with general practice. Despite the increasing prevalence and awareness of some chronic conditions and their impact on quality of life, our study indicates that there is potential to improve the support provided to middle aged Australians by general practices in order to promote behaviour change and reduce lifestyle risk.

Male participants, in particular, did not view general practice as a source of lifestyle risk advice and did not visit their general practice unless they were unwell or prompted to attend. (Lu and Harris 2013; Schlichthorst *et al.* 2016)In contrast, several female participants described working with GPs to achieve their health goals and engaging in screening programs. While conclusions around gender differences cannot be drawn from a single qualitative study Previous studies have also observed gender differences in types and levels of engagement with health professionals (Schlichthorst *et al.* 2016). Visits to the doctor by men have been previously described as being event focused (such as filling a script) or when there were specific health problems rather than to monitor health or address lifestyle risks . These findings highlight the need for health professionals to think beyond levels of health literacy and consider gender related processes for accessing and engaging with populations for the provision of preventative care and identification of lifestyle risks (Ricciardelli *et al.* 2012; Hedelund Lausen *et al.* 2018). this study also demonstrated a need to more widely enhance the understanding of the role of primary care in health promotion within the community and raise the profile of general practice as a source of lifestyle risk advice and support for behaviour change. While the existing literature describes aspects of general practice that are important to the community (Brennan *et al.* 2019), there is much less clarity about peoples' understanding of the role and scope of

general practice. In their work on consumers' perceptions of nurses in general practice, Halcomb *et al.* (2013) found that greater clarity around the nurses' role, scope of practice and services may have increased service uptake. Particularly, given the shifting models of care and changing health system, strategies to enhance clarity around the services and capacity of general practice are likely to raise awareness and enhance service use.

An interesting finding in this study related to participants describing how they needed to instigate conversations about lifestyle risk, or who felt that they had not been given information as they hadn't directly asked for advice. While opportunistic behaviour change conversations have long been promoted as a key public health strategy internationally (Keyworth *et al.* 2019), participants reported not receiving opportunistic health education in their primary care consultations. This lack of opportunistic conversations may also have contributed to the participants' perceptions of the limited role of general practice in health promotion. Barriers to undertaking lifestyle risk conversations in primary care have been reported in the literature (James *et al.* 2019; Keyworth *et al.* 2019). A major issue is that standard appointment times often do not provide sufficient time for effective communication about preventative health (Elmore *et al.* 2016). This highlights the ongoing concern that the fee-for-service funding model used in Australian general practice does not optimise the delivery of quality chronic disease management and lifestyle risk conversations (Royal Australian College of General Practitioners 2015). Both a lack of time and funding limitations inhibit the prioritisation of lifestyle risk conversations and interventions to reduce lifestyle risk factors (Authors Own). At a time when lifestyle risk reduction offers significant potential to reduce future health costs , it is timely to review funding models to support changes to facilitate general practices to prioritise this work.

For those who did receive advice from the GP, many described receiving broad instructions such as 'lose weight' or 'exercise more' rather than being guided towards specific strategies or the development of shared action plans (Lenzen *et al.* 2018) to promote behaviour change. The relational continuity that a person often achieves within general practice , would enhance their ability to use proven techniques such as motivational interviewing to explore lifestyle risk issues

over time . Motivational interviewing has been successfully used in primary care to promote behaviour change through personal commitment to agreed goals (Copeland *et al.* 2015; Zomahoun *et al.* 2017). (Copeland *et al.* 2015)(David *et al.* 2019)Shared decision making and commitment, and the development of action plans have also been identified as useful approaches in bringing about positive change in patients with chronic diseases (Lenzen *et al.* 2018). All of these techniques require not only health professional understanding of the approach, but also the development of communication skills and a conscious embedding of the technique within usual care (Lenzen *et al.* 2018). The lack of evidence to show that participants were receiving this kind of support in their consultations suggests a need to consider strategies, such as training and peer mentoring of primary care professionals to promote skill development and integration of this into everyday clinical practice.

Apart from health professionals, many participants spoke of the important role that family and friends play in providing health advice. Social networks have been identified to play an important role in a variety of health behaviours (Eggleston *et al.* 1995; Martin and DiMatteo 2017). These findings suggest a need to promote health literacy across communities to encourage development of healthy social norms, enhancing the quality of information shared and promoting engagement with the health system (Martin and DiMatteo 2017). Positive messages need to be purposely designed for specific population groups, and include relevant information about the availability of local professional supports to promote positive engagement with the health system.

**CONCLUSION**

Our study has highlighted that participants were experiencing ineffective preventative health advice from their general practices. It is evident that males tend to present to general practice for treatment and are less likely than females to present for a health assessment. Processes are needed to encourage men to engage with health professionals who have experience and skills in lifestyle risk conversations. The role of each PHC team member needs to be promoted so that available time to provide support for behaviour change and the development of meaningful

lifestyle goals is maximised.  At a national and local level, more attention needs to be given to creating awareness of the role of general practice in the adoption of healthy lifestyles and support for behaviour change. Further investigations are also required to establish GP and GPNs' knowledge and skills in promoting behaviour change within usual care, particularly in the middle aged group.

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**Conflicts of Interest**

Nil conflicts declared.

**Ethics Approval**

The University of Wollongong Human Research Ethics Committee (Approval No. HE2017/288) provided approval for the study prior to commencing data collection.

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