Year: 2012

Attitudes, barriers and facilitators for health promotion in the elderly in primary care

Badertscher, N; Rossing, P; Rieder, A; Herter-Clavel, C; Rosemann, T; Zoller, M

Abstract: QUESTIONS UNDER STUDY: Effective health promotion is of great importance from clinical as well as from public health perspectives and therefore should be encouraged. Especially regarding health promotion in the elderly, general practitioners (GPs) have a key role. Nevertheless, evidence suggests a lack of health promotion by GPs, especially in this age group. The aim of our study was to assess self-perceived attitudes, barriers and facilitators of GPs to provide health promotion in the elderly. METHODS: We performed a qualitative focus group study with 37 general practitioners. The focus group interviews were recorded digitally, transcribed literally and analysed with ATLAS.ti, a software program for qualitative text analysis. RESULTS: Among the participating GPs, definitions of health promotion varied widely and the opinions regarding its effectiveness were very heterogeneous. The two most important self-perceived barriers for GPs to provide health promotion in the elderly were lack of time and insufficient reimbursement for preventive and health promotion advice. As intervention to increase health promotion in the elderly, GPs suggested, for example, integration of health promotion into under and postgraduate training. Changes at the practice level such as involving the practice nurse in health promotion and counselling were discussed very controversially. CONCLUSION: Health promotion, especially in the elderly, is crucial but in the opinion of the GPs we involved in our study, there is a gap between public health requirements and the reimbursement system. Integration of health promotion in medical education may be needed to increase knowledge as well as attitudes of GPs regarding this issue.

DOI: 10.4414/smw.2012.13606

Established in 1871
Swiss Medical Weekly
Formerly: Schweizerische Medizinische Wochenschrift
The European Journal of Medical Sciences

Original article | Published 11 July 2012, doi:10.4414/smw.2012.13606
Cite this as: Swiss Med Wkly. 2012;142:w13606

Attitudes, barriers and facilitators for health promotion in the elderly in primary care

A qualitative focus group study

Nina Badertscher[a], Pascal Olivier Rossi[a], Arabelle Rieder[b], Cathrine Herter-Clavel[b], Thomas Rosemann[a], Marco Zoller[a]

[a] Institute of General Practice, University of Zurich, Switzerland
[b] Primary Care Unit, Faculty of Medicine, University of Geneva, Switzerland

Summary

QUESTIONS UNDER STUDY: Effective health promotion is of great importance from clinical as well as from public health perspectives and therefore should be encouraged. Especially regarding health promotion in the elderly, general practitioners (GPs) have a key role. Nevertheless, evidence suggests a lack of health promotion by GPs, especially in this age group. The aim of our study was to assess self-perceived attitudes, barriers and facilitators of GPs to provide health promotion in the elderly.
METHODS: We performed a qualitative focus group study with 37 general practitioners. The focus group interviews were recorded digitally, transcribed literally and analysed with ATLAS.ti, a software program for qualitative text analysis.
RESULTS: Among the participating GPs, definitions of health promotion varied widely and the opinions regarding its effectiveness were very heterogeneous. The two most important self-perceived barriers for GPs to provide health promotion in the elderly were lack of time and insufficient reimbursement for preventive and health promotion advice. As intervention to increase health promotion in the elderly, GPs suggested, for example, integration of health promotion into under and postgraduate training. Changes at the practice level such as involving the practice nurse in health promotion and counselling were discussed very controversially.
CONCLUSION: Health promotion, especially in the elderly, is crucial but in the opinion of the GPs we involved in our study, there is a gap between public health requirements and the reimbursement system. Integration of health promotion in medical education may be needed to increase knowledge as well as attitudes of GPs regarding this issue.

Key words: *primary care; general practitioner; health promotion in the elderly; barriers; facilitators*

Questions under study

It is likely that with positive health behaviour under most conditions functional health will improve [1, 2], diseases will be avoided and the quality of life will improve. In Switzerland there is an increasing elderly population [3] in good health. An effective health promotion in this increasing population is relevant from a clinical as well as from a public health perspective [4]. Due to the trusting relationship between elderly people and their GP, the GP can play a key role in health promotion. However, evidence suggests a lack of health promotion provided in the elderly in primary care [5, 6]. International studies found manifold barriers to providing health promotion [5, 7–13], but most studies did not focus on health promotion in the elderly. In addition, if they did, they addressed very specific interventions. Furthermore, previous studies from Switzerland focused on specific aspects of health promotion (such as interventions for physical activity promotion [14], the development of a health risk appraisal questionnaire [15, 16] or interventions with home visits for disability prevention [17]). GPs' attitudes to health promotion in the elderly in general have not been assessed so far in Switzerland.
In this article, we use the term "health promotion" in its narrow sense. In this sense, it aims to modify health behaviour in such a way as to reduce the risk for diseases. In contrast to prevention, health promotion not only focuses on avoidance, early detection and treatment of specific diseases, but more on general lifestyle counselling for topics such as exercising or healthy eating.
Health promotion in the elderly focuses on the quality of life and on the possibility of living at home as long as possible. It has been shown that a reduced or delayed nursing home admission can reduce health care costs [17], which is important from a public health and economic point of view. The aim of our qualitative focus group study was to assess attitudes, possible barriers to and facilitators of GPs to provide health promotion in the elderly. As with our focus group interviews, we asked about personal experiences, believes and attitudes of the GPs regarding health promotion

in the elderly. We cannot provide results on general aspects on this topic but merely about self-perceived barriers and facilitators of health promotion in the elderly.

Methods

Participants

A qualitative focus group study with a total of 37 general practitioners (GPs) was conducted. To reflect the German speaking and the French speaking part of Switzerland, the focus groups were conducted in both areas. Of the five focus group interviews, three were conducted in Zurich with GPs working in and around Zurich. Two focus group interviews were conducted in Geneva with GPs working in and around Geneva. All focus groups were composed of six to nine GPs. GPs were recruited by sending a letter to a random sample of GPs from an existing address database. The GPs who agreed to join the study were allocated to the different focus groups according to certain socio- demographic attributes (e.g. practice location, age and gender) to assure that balanced groups were created. The GPs received 150 CHF for their participation.

Focus group interviews

After a literature search, we elaborated a semi-structured interview guide with open-ended questions. For the focus group interviews in Geneva, the interview guide was translated into French. As an introduction to the discussion, we asked questions concerning the opinion of the GPs about health promotion in the elderly in general. As special interest, we focused on incentives and barriers for the GPs to conduct health promotion in the elderly. The focus group interviews were conducted during the summer of 2010. Each focus group interview lasted approximately two hours. Three focus group interviews were carried out in Zürich by staff members of the Institute of General Practice at the University of Zurich, while two focus group interviews were carried out in Geneva by staff members of the Primary Care Unit at the University of Geneva.

Data analysis

The focus group interviews were recorded digitally and transcribed literally including nonverbal expressions. The French focus group interviews were translated into German after transcription. Two researchers read and analysed the focus group interviews independently with Atlas.ti, a software programme for qualitative text analysis. Based on the interview guide, a category system was elaborated, as shown in table 1. After the coding procedure, a synthesis of all important findings was compiled in discussions with three researchers, one of them an experienced GP. The data material resulting from these discussions served as a basis for interpretative work and the building of theories.

Results

Demographic data

The age of the participating GPs ranged from 40 to 69 years, with a mean age of 56.1 years as shown in table 2. Working experience of the GPs varied from one to 35 years with a mean of 18.6 years. Twenty eight of the GPs were working in an urban or suburban area, nine in a rural area. All GPs were working in a primary care practice; some of them had an additional education in geriatrics.

Physician factors

Barriers for GPs to provide health promotion in the elderly

The most important reason for GPs to omit health promotion in the elderly was the constant lack of time in daily practice [*"In my practice, I am always pressed for time. We have a very rural practice, I am completely overloaded*

Table 1: Categorical system with main categories.

Coding categories
A. Ethical aspects of health promotion in the elderly
B. Financial aspects of health promotion in the elderly
C. Accessibility and target population
D. Role of GPs in health promotion in the elderly
E. Fields of health promotion in the elderly
F. Barriers for GPs to provide health promotion in the elderly
G. Barriers for patients to accept health promotion in the elderly
H. Incentives for GPs to provide health promotion in the elderly
I. Incentives for patients to accept health promotion in the elderly
J. Possible interventions to advance health promotion in the elderly
K. Interface problems in health promotion in the elderly
L. Other important aspects
Coding system: Categories for the coding process, used with the ATLAS.ti software.

Table 2: Demographic data of participating GPs.

Attribute	**Value**
Age	40–69 years (mean 56.1 years)
Practice experience	1–35 years (mean 18.8 years)
Sex	56.8% female (n = 21) 43.2% male (n = 16)
Practice region	24.3% rural (n = 9) 75.7% urban/suburban (n = 28)
Some of the participants' socio demographic data.	

with acute problems and diseases, and I have absolutely no time for prevention and health promotion." (1/131, GP6, m, 56 y)]. Acute problems dominated the consultation; as a consequence, health promotion advice was given a lower priority. Another important barrier detected in our sample was the fact that numerous GPs were very sceptical about the effectiveness of health promotion in the elderly [*"I think what puts me off doing it is my skepticism… I don't really believe in it." (1/118, GP9, f, 50 y)*]. Some of them suspected that high costs would be generated without any benefit for the health or the quality of life of elderly patients. Furthermore, the GPs stated that as long as there is no adequate reimbursement for health promotion in the elderly, they will just not provide it [*"If he gets 200 CHF and has to do work worth 400 CHF, he says: 'I just don't do it!'"(1/245, GP1, m, 57 y)*].

Facilitators for GPs to provide health promotion in the elderly

One of the most important pre-conditions for the majority of the GPs to provide health promotion in the elderly was sufficient reimbursement by the healthcare system for the time and effort they spent on health promotion [*"I must say, I think it's all about the money. If the GP gets additional money for health promotion advice, he suddenly provides it." (1/183, GP1, m, 57 y)*]. Furthermore, some GPs stated that without support from the government and health insurances, they were not willing to provide health promotion in the elderly [*"For us GPs it is important, that the politics and the health insurances support us. Otherwise, nothing will change." (1/274, GP6, m, 56 y)*].

Role of GPs in health promotion in the elderly

Most of the GPs were convinced that primary care would be the optimal setting for health promotion in the elderly, because a GP is very often a person of trust for the patients [*"I consider that health promotion is important in general practice… Hardly anyone is as close to the patient as the GP. We are often not aware of that!" (1/60, GP6, m, 56 y)*]. Due to the lack of reimbursement and their high workload, they very often stated that they just do not have the capacity to provide extensive health promotion. As a consequence, they regarded themselves more as coordinators of different external health promotion offers than as direct providers of health promotion themselves [*"I mean, we don't have to do everything ourselves. We can act as coordinator or as advisor… as the one who keeps the overview!" (3/265, GP20, m, 45 y)*].

Possible interventions to increase the GPs' performance of health promotion in the elderly

In addition to an adequate reimbursement of health promotion advice, it could be attractive to develop time saving working tools for GPs [*"If it is to be helpful, it has to save time. If I can get important information about the patient's nutrition, for example, with three or four questions, I would be very glad." (3/151, GP1, f, 49 y)*], for example a short assessment tool as well as a checklist with important themes of health promotion in the elderly. Some of the GPs complained of a lack regarding the content but also regarding specific skills in health promotion due to the fact that they had no opportunity to learn these things during their medical education. As a result they suggested integrating health promotion into under and postgraduate training. It was also discussed if delegating some care responsibilities to health promotion programmes could unburden the GPs from the heavy workload; opinions therefore were quite controversial. Some GPs stated that they did not want to delegate any of their responsibilities [*"I have a time problem that could be solved by delegating some responsibilities. But for me, this is no good solution… I have another philosophical idea of medicine; I want to provide holistic medicine, I want to see the whole patient..." (1/156, GP6, m, 56 y)*] while other GPs considered the possibility of delegation as helpful [*"I just don't have enough time, and I appreciate everyone who takes over a responsibility for anything. I also would like to be the "doctor for everything" but I just can't…" (1/161, GP9, f, 50 y)*]. Institutions that take over a responsibility for leisure activities and social contacts of elderly patients could be helpful in preventing, for example, social isolation and unburden the GP from this challenge. However, for the GPs' acceptance of any health promotion programme, it is extremely important that the administrative workload is kept as low as possible [*"It has to be very simple. Not too complicated… Few aspects and not too much administration for us GPs..." (1/290, GP3, f, 47 y)*].

Patient factors

Barriers for patients to accept health promotion

In the opinion of the participating GPs, an important barrier for elderly patients to make use of external health promotion programmes was the limited accessibility of most of the programmes. As a significant proportion of the target population for health promotion in the elderly has decreased mobility, even a short journey to the neighbouring village or a timetable until late in the afternoon could be a substantial barrier [*"The problem was, they had to go to the neighbouring village… This was an enormous problem for the elderly people, I could convince very few of them." (1/205, GP3, f, 47 y)*; *"The main problem of the elderly is mobility… I often don't even look for an external health promotion programme, because I have patients who cannot move from their flat..." (5/107, GP33, m, 56 y)*]. Some GPs stated that as long as health promotion in the elderly is not widely established and accepted in society, patients often misunderstand health promotion efforts as discrimination [*"I mean nobody wants to be parked in the "old corner". It is just very discriminatory for them… If somebody still is in a good health condition." (2/93, GP18, f, 56 y)*].

Facilitators for patients to accept health promotion

Accessibility is the most important aspect of health promotion programmes for the elderly. This contains the accessibility in a regional sense as well as regarding the content of the programme. Providing information over the internet for instance, may not reach a substantial proportion of the target group. To increase the interest for health promotion in elderly patients, GPs suggested giving the patients some kind of voucher for a health promotion visit to their GP [*"This would be a good idea… To give them a voucher when they are 50 years old... So the patients, who did*

not visit their GP for four or five years can go and acquire health promotion advice." (1/244, GP3, f, 47 y)]. In addition, vouchers for external health promotion programmes (such as walking groups or dancing afternoons) were discussed. The GPs stated that it is important that all kinds of external health promotion programmes should be enjoyable instead of just representing formal instructions to motivate the elderly patients [*"…so you should not teach the patients too much, it has to be fun, also for the elderly patients!" (1/113 GP2, f, 54 y)*].

Discussion

Main findings

Among the participating GPs, definitions of health promotion interventions in the elderly widely varied. The opinion regarding the effectiveness of health promotion in the elderly was very heterogeneous. The most important self-perceived barriers for GPs to provide health promotion in the elderly were the lack of time in daily practice, insufficient reimbursement of preventive and health promotion advice and scepticism about the effectiveness of health promotion in the elderly.

Lack of time, low priority and skepticism about the effectiveness of health promotion

GPs mentioned the lack of time in daily practice as an important reason to omit health promotion in the elderly. During consultations, the solution of acute problems is, in most cases, much more important than giving health promotion advice. More than 10 years ago manifold studies [5, 7, 9–13] had already found the lack of time and the quite low priority to be the main barriers to health promotion. The demographic shift with an increase of chronic conditions and multimorbidity has increased the "tyranny of the urgent", worsened by an increasing shortage of GPs in Switzerland [18]. As another important barrier, numerous GPs stated that they doubt that health promotion is effective and not cost effective. Knowledge about effective health promotion in the elderly still might be not sufficient among most of the GPs and should be addressed in future.

Insufficient reimbursement

GPs clearly stated that one reason for the low priority of health promotion in their daily work is the lack of reimbursement. Indeed, in Switzerland there is to date no invoice item for health promotion advice. In a fee for service system, this is crucial if health promotion is to be provided. There is an obvious gap between official statements by the government about the importance of providing health promotion in the elderly and the reality, reflected in a reimbursement system, which fails to address this aim in any way. Insufficient reimbursement has already been found in previous studies to explain the lack of health promotion in the elderly [5, 7, 9–12].

Role of GPs in health promotion in the elderly

As Kligman [10] already stated in 1992, most of the GPs in our study were also convinced that GPs should play an important role in health promotion. Especially because of the trustful relationship between patients and their GP, the GPs could act as a role model for their patients regarding healthy lifestyle. In reality, because of their constant lack of time, GPs see themselves more in the role of a coordinator or advisor of health promotion programmes than in the role of a promoter.

Interventions to increase health promotion

Our study suggests that time saving working tools regarding preventive or health promotion topics could motivate GPs to provide more health promotion in the elderly, consistent with the findings of Travers et al. [5]. For example, the GPs proposed the development of short questionnaires to assess the nutrition situation. However, it is crucial that such instruments can be easily integrated in daily work [5, 13]. If they increase the administrative burden, GPs will not accept them, as they mentioned clearly in our focus group interviews. Some GPs' experiences that many patients misunderstand health promotion advice as discrimination, are a very important finding for future health promotion activities. Some GPs saw a chance in the building of integrated services together with practice nurses, specialised nurses and other health professionals. If health promotion in the elderly would be more integrated into under and postgraduate training, knowledge base and counselling

Table 3: Frequency of the most important quotations.

Physician factors	
Barriers for GPs to provide health promotion in the elderly	Lack of time (n = 31)
	Health promotion is not effective (n = 12)
	Health promotion generates high costs (n = 7)
	Deficient reimbursement (n = 16)
Facilitators for GPs to provide health promotion in the elderly	Better reimbursement (n = 8)
	Backup from governmental institutions (n = 9)
Interventions to increase the GPs' performance of health promotion in the elderly	Development of time-saving working tools (n = 9)
	Delegating assessed positive (n = 6)
	Delegating assessed negative (n = 4)
	Workload has to be kept low (n = 9)
Patient factors	
Barriers for patients to accept health promotion in the elderly	Limited accessibility of programs (n = 5)
	Misunderstanding health promotion as discrimination (n = 11)
Facilitators for patients to accept health promotion in the elderly	Giving the patients vouchers for health promotion (n = 5)
	Health promotion programs should be fun (n = 10)
	Good accessibility of programs and Information (n = 7)

skills about this topic could rise and the effect of health promotion advice from GPs could be more effective. Furthermore it will be crucial to spread knowledge and acceptance of the concept of health promotion in the whole society.

Limitations and strength

Our qualitative study has some limitations, e.g. the participating GPs only came from two important regions of Switzerland. As Switzerland is very heterogeneous in its demographic situation, maybe we missed some important local factors. Furthermore, qualitative studies always reflect individual perspectives and do not provide quantitative relations. Nevertheless, due to the importance of the topic, which will increase due to the demographic development in Switzerland, we are convinced that it is important to examine the beliefs and attitudes of GPs regarding health promotion in the elderly. The results from other countries date from several years ago and may differ due to substantial differences in the health care system, namely the reimbursement system. However, generalisability to other countries is restricted, as the Swiss health care system is based on fee for service, freedom of choice regarding the physician and delivers highly patient, but a low degree community oriented service, mainly in small independent practices.

Conclusion

Politicians and public health experts have been demanding health promotion especially in the elderly for many years and the demographic shift will increase the need even more. In the opinion of the GPs interviewed, there is an obvious gap between official statements, public health demands and the current reimbursement system which does not address these activities at all. Integration of health promotion in medical education may also be needed to increase awareness as well as skills of physicians regarding this important issue.

Acknowledgements: We would like to thank all the participating GPs for their useful inputs in the discussions. Furthermore, we are very grateful to Anke Schickel and Barbara Portner from the Institute for General Practice for their logistic support.

Funding / potential competing interests: This study was funded by cooperation between 12 cantons in Switzerland, the organisation “Health Promotion Switzerland” and the “Information Board for Accident Prevention”. The sponsor did not have any influence on the study design, content or evaluation of results.

Authors’ contributions: All six authors made a substantial contribution to this manuscript i.e. study conception, data collection, data analysis or manuscript drafting.

Correspondence: *Nina Badertscher, MD, Institute for General Practice, University of Zurich, University Hospital Zurich, Pestalozzistrasse 24, CH-8091 Zurich, Switzerland, nina.badertscher[at]usz.ch*

References

1 Beswick AD, Rees K, Dieppe P, Ayis S, Gooberman-Hill R, Horwood J, et al. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. Lancet. 2008;371(9614):725–35.

2 Lee A. Health-promoting schools: evidence for a holistic approach to promoting health and improving health literacy. Appl Health Econ Health Policy. 2009;7(1):11–7.

3 Statistics SFOf: Scenarios for population development in Switzerland 2010–2060. 2010.

4 Gesundheitsförderung und Prävention im Alter in der Schweiz – Ergebnisse aus dem Gesundheitsprofil-Projekt [http://www.obsan.admin.ch/bfs/obsan/de/index/05/05.html?publicationID=2592]

5 Travers C, Martin-Khan M, Lie D. Barriers and enablers of health promotion, prevention and early intervention in primary care: Evidence to inform the Australian national dementia strategy. Australasian J Ageing. 2009;28(2):51–7.

6 Zyska Cherix A, Moix E, Meili M, Neuner S, Cornuz J, Spencer B. Perceptions and barriers to the implementation of prevention and health promotion in General Practice: a Study of Swiss GPs. In: WONCA 2009. Basel, Switzerland; 2009.

7 Brotons C, Björkelund C, Bulc M, Ciurana R, Godycki-Cwirko M, Jurgova E, et al. Prevention and health promotion in clinical practice: the views of general practitioners in Europe. Preventive Medicine 2005;40(5):595–601.

8 Dapp U, Anders J, Meier-Baumgartner HP, v Renteln-Kruse W. Geriatric health promotion and prevention for independently living senior citizens: programmes and target groups. Z Gerontol Geriatr. 2007;40(4):226–40.

9 Hudon E, Beaulieu MD, Roberge D. Integration of the recommendations of the Canadian Task Force on Preventive Health Care: obstacles perceived by a group of family physicians. Fam Pract. 2004;21(1):11–7.

10 Kligman EW. Preventive geriatrics: basic principles for primary care physicians. Geriatrics. 1992;47(7):39–50.

11 Lambe B, Collins C. A qualitative study of lifestyle counselling in general practice in Ireland. Fam Pract. 2010;27(2):219–23.

12 McAvoy BR. A scandal of inaction: how to help GPs implement evidence-based health promotion. Br J Gen Pract. 2000;50(452):180–1.

13 Sims J, Kerse NM, Naccarella L, Long H. Health promotion and older people: The role of the general practitioner in Australia in promoting healthy ageing. Aust N Z J Public Health. 2000;24(4):356–9.

14 van der Bij AK, Laurant MG, Wensing M. Effectiveness of physical activity interventions for older adults: a review. Am J Prev Med. 2002;22(2):120–33.

15 Stuck AE, Elkuch P, Dapp U, Anders J, Iliffe S, Swift CG. Feasibility and yield of a self-administered questionnaire for health risk appraisal in older people in three European countries. Age Ageing. 2002;31(6):463–7.

16 Stuck AE, Kharicha K, Dapp U, Anders J, Von Renteln-Kruse W, Meier-Baumgartner H, et al. Development, feasibility and performance of a health risk appraisal questionnaire for older persons. BMC Medical Research Methodology. 2007, 7.

17 Stuck AE, Minder CE, Peter-Wuest I, Gillmann G, Egli C, Kesselring A, et al. A randomized trial of in-home visits for disability prevention in community-dwelling older people at low and high risk for nursing home admission. Arch Intern Med. 2000;160(7):977–86.

18 Moore LG. Escaping the tyranny of the urgent by delivering planned care. Fam Pract Manag. 2006;13(5):37–40.