INTERNSHIP REPORT

The Assessments of the Needs and Perspectives of the Dutch Care Groups and General Practitioners to Cooperate with the Profession of Lifestyle Coaches

Provide insights into the barriers and facilitators for Dutch care groups and general practitioners to cooperate with the profession of lifestyle coaches

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Executive Summary

An increasing number of Dutch citizens are overweight due to a sedentary lifestyle, the consumption of energy-rich food, increased stress and reduced sleep. In order to reduce those figures, Combined Lifestyle Interventions (CLIs) have become included within the Dutch basic healthcare insurance since the first of January 2019, and are often executed by lifestyle coaches. These lifestyle coaches can be contracted by care groups, which are healthcare organisations, within the primary healthcare settings, that facilitate chronical care programs. In order for participants to start a lifestyle intervention executed by lifestyle coach, a referral of their general practitioner (GP) is needed. Although lifestyle coaching has been included within the Dutch basic health insurance, the added value and professional competencies of a lifestyle coach are not yet acknowledged nationwide and consequently used. Therefore, this research aimed to contribute to the implementation of the profession of accredited lifestyle coaches by providing insights in the different barriers and facilitators of the Dutch GPs and care groups to cooperate with the profession of lifestyle coaches.

What are the barriers and facilitators that the Dutch general practitioners and care groups experience in cooperating with the profession of the lifestyle coach?

Within this research, The Theory of Planned Behaviour (TPB) has been applied, which describes that initiating and performing a behaviour is determined by a person's intention that is based on someone's attitude, subjective norms and their perceived behavioural control. Someone perceived behavioural control is described as a person's resources, opportunities and skills to perform that particular behaviour and also directly influences behaviour. During this research, interviews of six GPs and seven care groups have been conducted. The interviews were transcribed, coded and analysed afterwards.

The results of this study showed that both the care groups and the GPs held a positive attitude towards lifestyle intervention executed by lifestyle coaches. Additionally, most care groups and GPs had the intention to cooperate with lifestyle coaches, but experienced barriers in their perceived behavioural control. Subsequently, only two GPs indicated that they referred patients in the past, additionally, five of the seven care groups were contracted but indicated that they felt unsure if they will contract lifestyle coaches in the future. Barriers for Dutch care groups were, the low working rate for lifestyle coaches without recognition of the organizational costs for care groups, the current no-follow policy among health insurances, and a deviant payment system in where care groups are not able to send their invoices. The perceived barriers for GPs were the lack of patient's motivation to start behavioural changes and the GPs lack of knowledge to refer to lifestyle coaches.

In general, Dutch care groups and GPs had the intention to cooperate with lifestyle coaches, but experienced barriers in their perceived behavioural control. These findings suggest several courses of action for the Ministry of Health and health insurance companies to adjust policies. Regarding the Dutch care groups, there is an essential need in the change of the working rate of lifestyle coaches, a free payment system that is applicable within their current system and a follow policy among Dutch health insurances. Regarding GPs, strategies have to be developed to strengthen the network of lifestyle coaches among GPs. Moreover, our findings suggest that health promotion is needed to improve awareness of the importance of adopting a healthy lifestyle among the Dutch population.

The intention to cooperate with lifestyle coaches is high among Dutch primary healthcare. However, the future implementation of the profession of lifestyle coaches is threatened by several barriers that are mostly originated from policies constructions. In order to make the first prevention intervention within the basic health insurance a success, it is important that all entities agree on the long-term objectives of this intervention, namely reducing the healthcare expenditures and a healthier Dutch population. Consequently, it is of great importance that all entities collaborate and communicate in order to make the first prevention intervention within the basic healthcare insurance a success.

List of Abbreviations

AVLEG	=	Academy For Lifestyle and Health
BMI	=	Body Mass Index
CLI	=	Combined Lifestyle Intervention
CLIs	=	Combined Lifestyle Interventions
GP	=	General Practitioner
GPs	=	General Practitioners
NzA	=	Dutch Healthcare Authority
POH	=	Nurse Specialist
RIVM	=	Dutch National Institute for Public Health and the Environment
TPB	=	Theory of Planned Behaviour
RVZ	=	Dutch Council of Public Healthcare
VTV	=	Public Health Future Exploration
WHO	=	World Health Organisation
ZIN	=	Dutch Healthcare Institute

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1 Introduction

1.1 The Effect of The Rising Numbers of Obesity on Healthcare Expenditures

An increasing number of Dutch citizens are overweight. According to the Dutch Public Health Future Exploration (VTV), 49 per cent have a Body Mass Index (BMI) between 25 and 30. VTV predicts that these numbers will increase from 6,6 million to 9,1 million in 2040 (62 per cent of the total population in 2040) (Hilderink & Verschuuren, 2018). According to the Dutch Health Insitute (ZIN), the rise of overweight Dutch citizens is attributed to an increasingly sedentary lifestyle and the consumption of more energy-rich food (Van der Meer et al., 2009). Furthermore, recent research has demonstrated the effect of increased stress and reduced sleep on weight gain (Vgontzas, et al., 2008). These numbers will have a significant effect on healthcare expenditures. As a result, the Dutch Institute for Public Health and Environment (RIVM) estimated that in 2040, the healthcare costs will be doubled with a total of 174 billion euro a year. Consequently, new effective prevention interventions have become available in order to reduce the number of Dutch citizens that are overweight (De Vries & De Weijer, 2018). It is important to note that it is currently unknown whether prevention will actually reduce healthcare expenditures. Some researchers expect that initially, the healthcare spending will rise but eventually will lead to a decrease in healthcare expenditures. However, the exact impact of prevention remains unclear (Van den Berg, et al., 2014). Nevertheless, prevention interventions have proven to have other social benefits, such as the improvement of labour force participation (Van den Berg, et al., 2014). Consequently, since the first of January 2019, Combined Lifestyle interventions (CLI) that focus on permanent behavioural change and weight reduction have been included in the Dutch basic health insurance (De Vries & De Weijer, 2018).

1.2 Combined Lifestyle Interventions

Combined Lifestyle Interventions is developed with the aim to acquire and maintain a healthy lifestyle by focusing on permanent behavioural change. The inclusion in the Dutch basic health insurance is a result of a couple of successful pilot projects, among others initiated by the Dutch health insurance CZ and lifestyle coaches (RIVM, 2018). Already in 2009, ZIN successfully performed a pilot test which showed that CLI is the most effective intervention for weight-related health risks. However, due to the unclarity of the size and content of the intervention, the CLI had to be further developed and therefore it did not become practically applicable (De Vries & De Weijer, 2018). However, since the first of January, the Dutch government included three CLIs in the basic health insurance, namely CooL, Beweegkuur and Slimmer (Leefstijlinterventies, 2018). Consequently, every Dutch citizen is referred by a general practitioner, can start this intervention. In addition, the Dutch government has invested 6,5 million euros for the first year (De Vries & De Weijer, 2018). Combined Lifestyle Interventions are often executed by a lifestyle coach that guides the patients to help achieve their goals.

1.3 Lifestyle Coaches

A lifestyle coach is a professional who coaches its' participants to become competent in the self-management of their health and well-being. Lifestyle coaches work in accordance with the aim of the definition of Positive Health, developed by Machteld Huber (BLCN, 2016). This concept re-defines health as 'the ability to adapt and to self-manage, in the face of social, physical and emotional challenges' (Huber et al., 2011). Therefore, lifestyle coaches have a major contribution to the national intention to shift the focus from sickness and care to health and behaviour, thereby reducing the dependency on the current healthcare system. By means of coaching and practical skills training, the participant becomes able to translate goals into actions (BLCN, 2016). In addition, a lifestyle coach shares knowledge on nutrition, physical activity and other components that are essential for a healthy lifestyle such as sleep (AVLEG, 2018). The CooL is executed by a single professional, a lifestyle coach. In comparison, within Slimmer and Beweegkuur, lifestyle coaches can be co-executors of the interventions in a team of specialists (Leefstijlinterventies, 2018).

Although the three CLIs are included in the current Dutch healthcare insurance, the added value and professional competencies of a lifestyle coach are not yet acknowledged nationwide and consequently referred to. In addition, according to the latest updated information, only 46 general practitioners are currently cooperating with lifestyle coaches and less than 20 Dutch care groups contracted the CLI CooL (artsenleefstijl, 2018). These figures show that there is room for improvement. In addition, because CLIs are now the preferential intervention for obese patients, patients who should receive treatment from a lifestyle coach are currently treated with interventions that might be less effective (Van Binsbergen et al., 2010). It is currently not known why general practitioners (GPs) are not referring to lifestyle interventions as much as previously expected. Additionally, very little is known about why care groups do not contract lifestyle coaches as much as previously expected. Therefore, this research aims to contribute to the implementation of the profession of accredited lifestyle coaches by providing insights in the different barriers and facilitators of the Dutch general practitioners and care groups to cooperate with the profession of lifestyle coaches. As a result, this research will end in recommendations provided for lifestyle coaches and policymakers that are connected with the implementation of the profession of lifestyle coaching in the Netherlands.

Therefore, this research aims to answer the question:

What are the barriers and facilitators that the Dutch general practitioners and care groups experience in cooperating with the profession of the lifestyle coach?

2 Contextual Background

2.1 The Rise of the Prevalence of Obesity in the Dutch Population

According to the Dutch Public Health Future Exploration (VTV), nearly half of the Dutch population is overweight which means that a total of 6,6 million Dutch citizens have a Body Mass Index (BMI) of 25-30. VTV predicts that these numbers will increase to 9,1 million in 2040 (62% of the total population in 2040) (Hilderink & Verschuuren, 2018). Additionally, 11,2% of the Dutch men and 12,4% of the Dutch women have obesity, which is a BMI between 30 and 39,9. Research has shown that weight gain is the result of an increasingly sedentary lifestyle, the consumption of more energy-rich food, increased stress and reduced sleep (Van der Meer et al., 2009; Vgontzas, et al., 2008). Although the number of overweight people increases in every socioeconomic class, the number increases faster in lower classes (Hilderink & Verschuuren, 2018). In addition, VTV has found an overlap between the regions with a high prevalence of unhealthy lifestyles and the regions with high social problems (Hilderink & Verschuuren, 2018). This suggests that interventions for obesity should focus on a broad range of components instead of the current focus on solely food intake and physical activity. Rather, a behavioural change is needed that also includes self-management in order to handle stress and environmental factors. Because, obesity leads to an increased risk of (chronic) diseases such as diabetes mellitus type 2, cardiovascular diseases, sleep apnoea, gallstones and several types of cancer, the rising prevalence of obesity directly increases healthcare expenditures (Van Binsbergen et al., 2010).

2.2 The Increase in Healthcare Expenditures

Due to an aging population, an improvement of the national welfare and an increase in innovative advanced technology, the Dutch Institute for Public Health and Environment (RIVM) estimated that within twenty years the healthcare costs will be doubled with a total of 174 billion euro (RIVM, 2018). Currently, chronic diseases among the elderly account for at least 33% of the Dutch healthcare costs (Hilderink & Verschuuren, 2018). Within the next twenty years, the largest increase is expected in the number of patients with diabetes, with an estimation of 400.000 new cases (Blokstra, et al., 2007). Due to the increasing number of chronic diseases, it is expected that more patients will utilize chronic and long-term care which will heavily burden the current healthcare system (Ursum et al., 2011). Machteld Huber and her colleagues (2011) criticize the 'diseased role' of chronically ill people that is based on the traditional understanding of health. The World Health Organization (WHO) still uses a traditional definition of health, stating that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p.1). Because the nature of diseases have changed considerably to a more increasingly amount of chronical illnesses, the WHO definition becomes counterproductive as it declares people with chronic diseases as definitively ill. In addition, the requirement of the WHO definition for ‘complete’ health would leave most of us unhealthy most of the time. Therefore, this definition unintentionally contributes to the medicalisation of society. Consequently, pursuing this statement of health will maintain rising healthcare costs (Huber et al., 2011). Therefore, Huber (2014) suggests that implementing a new concept of health might help to decrease healthcare costs. Research suggests that if health is focused on adaptability, self-management, and resilience, the dependency on the total healthcare system will be reduced (Huber., 2014; Lorig et al., 2001; Lorig et al., 1999). It is important to note that until now, no clear evidence has shown that the investment in this new concept will reduce healthcare expenditures. However, focusing on self-management, adaptability, and resilience has more social benefits, such as increased labour force participation (Van den Berg, et al., 2014). This new concept of health requires a shift from the traditional vision of healthcare to a healthcare system in which the behaviour and health of the patient become central.

2.3 From Sickness and Care to Behaviour and Health

In 2010, the Dutch Council of Public Healthcare (RVZ) initiated a shift in healthcare from sickness and care to behaviour and health. Two factors made this shift necessary, namely the increasing healthcare costs due to

chronic diseases and the shortage of healthcare personnel (RVZ, 2010). The shift incorporates that the patients become active stakeholders in their own care and take responsibility for the self-management of their health (Visser & Alpay, 2014). In addition, there is a shift from the WHO definition of health to the new definition of Machteld Huber named, Positive Health (Alpay et al., 2015). According to Huber et al (2011), Positive Health is defined as "the ability to adapt and to self-manage, in the face of social, physical and emotional challenges". Positive Health focuses on the empowerment of the patient instead of relying on medicines to cure symptoms (Huber, 2014). Within this definition, patients become clients for which self-management skills are essential in order to maintain a constant standard of health (Alpay et al., 2015).

In addition, the role of the doctor changes from the provision of care to the role of coaching, supporting and initiating self-management interventions. Activities that include self-management interventions are stimulating and coaching permanent behavioural changes and make patients able to develop personal healthcare plans. These interventions require the collaboration of different healthcare professionals in order to enable patients to achieve personal goals (Alpay et al., 2015). The profession of lifestyle coaching focuses on the self-management of the patient and might, therefore, be a potential solution for the increasing demand for care.

2.4 Lifestyle Coaching

The development of the profession of a lifestyle coach is a result of the healthcare standard for obesity that is publicised in 2010 and describes the need for a central healthcare provider within the treatment for obese patients (Seidell, 2010). According to this healthcare standard for obesity, a central healthcare provider is a point of contact for the patient and other healthcare professionals and, additionally, ensures that the patient receives appropriate healthcare in accordance with a patients' individual healthcare plan that is developed by the patient itself and the central healthcare provider (Seidell, 2010). Consequently, the profession of lifestyle coaching focuses on the self-management of the participant and works in accordance with the elements of a central healthcare provider, described in the healthcare standard for obesity (BLCN, 2016). One of the essential elements of lifestyle coaching is that the participant, rather than the coach, determines the goals and is responsible for the process. Additionally, the aim of a lifestyle coach is to make sure that the participant becomes able to translate goals into actions (BLCN, 2016). Within this profession, coaching and practical skills training are central. However, the lifestyle coach also has sufficient knowledge of nutrition, physical activity, sleep and stress (AVLEG, 2018). Additionally, an essential element in the provision of lifestyle coaching is the maintenance of a social chart. This enables the lifestyle coach to refer participants to suitable local initiatives that will contribute to a sustainable, healthier lifestyle change (AVLEG, 2018).

Since the first of January 2019, three lifestyle interventions are included in the Dutch basic health insurance. Consequently, every Dutch citizen is referred by a general practitioner, can start this intervention. These lifestyle interventions are called combined lifestyle interventions (CLIs) and focus on acquiring and maintaining a healthy lifestyle for the overweight population (RIVM, 2018). The inclusion in the Dutch basic health insurance is a result of a couple of successful pilot projects initiated by the Dutch health insurance CZ and lifestyle coaches. The three CLIs are named Beweegkuur; Slimmer; and CooL (Leefstijlinterventies, 2018). CooL is a GLI that is executed solely by a lifestyle coach. Slimmer and Beweegkuur are executed by a group of healthcare professionals and often includes a lifestyle coach. Due to these successful pilots, CLI interventions are now the preferential treatment intervention for obese patients (Van Binsbergen et al., 2010). It is essential to note that a lifestyle coach has more to offer than solely combined lifestyle interventions for the overweight participant. Because lifestyle coaches have sufficient knowledge on all the components that are part of a healthy lifestyle, lifestyle coaching can be advisable for a broader range of participants that are in need of improvement in lifestyle (AVLEG, 2018). However, only the three CLIs are currently included in the Dutch healthcare insurance. Although the CLI is the preferential treatment for obese

patients, the added value and professional competencies of a lifestyle coach are not yet acknowledged nationwide and consequently referred to.

2.5 The General Practitioners and Lifestyle Coaches

Dutch General practitioners (GPs) are part of the Dutch primary care and are usually the first health professional that a patient visits when in need of medical care. The actions of GPs are based on four core values that are inextricably linked to each other, namely medical-generalist, patient-oriented, continuous and collective (NHG, 2011). These core values imply that GPs are the first and constant point of contact for patients and that individualistic care is needed. Additionally, GPs strive to work together with other health professionals in order to deliver high-quality care (LHV, 2019). Although GPs strive to cooperate with other health professionals in order to deliver high-quality care, AVLEG has noted that the GPs' referrals to lifestyle intervention are not a broadly applied practice so far. According to the research from the University of Groningen, only 52% of the GPs within their sample, referred patients to a lifestyle intervention in the past, while at the same time 81% of the GPs indicated that they had the possibility to refer (Bouma, A., 2018). Additionally, this research showed that a little less than half of those GP's held perceptions of lifestyle interventions that were not positive. In addition, the referral behaviour of GPs seems significantly related to GPs perceived subjective norms about lifestyle interventions and GPs perceived difficulties in referring to lifestyle interventions (Bouma, A., 2018). It is of substantial importance that the motivation and referral behaviour of GPs improves so that 3.2 million Dutch citizens get the preferential treatment intervention and thus, sufficient care (Van Binsbergen et al., 2010). Therefore, information is needed about the perspectives of general practitioners towards lifestyle coaches and additionally the needs of the GPs to change their referral behaviour. Currently, 81% Of the Dutch GPs are connected with one of the 115 existing care groups. This is a rather new healthcare entity which is developed after 2007 (De Jong et al., 2012).

2.6 The Dutch Care Groups and Lifestyle Coaches

As a result of the increasing number of chronic diseases, the Dutch government started to implement a new funding system in 2007, named bundled payment (De Jong et al., 2012). Due to the high risk of comorbidity, patients with chronic diseases are in need of multidisciplinary and specific care (Schellevis, 1993). As a result, bundled payment has enabled integrated care, which combines the different components of chronic care in one product or service instead of single interventions. As a result, health insurers were able to buy high quality, affordable care from multidisciplinary grouped healthcare providers that offer care in accordance with specific healthcare standards. Consequently, integrated care resulted in the establishment of care groups (De Jong et al., 2012).

A care group is an organisation where healthcare providers are unified and is responsible for the coordination and the delivering of contracted care in a specific region. A care group contracts several components of healthcare programs that are offered by individualistic healthcare institutions. Eventually, these packages of specific programs and services are contracted to health insurers (De Jong et al., 2012). Currently, there are 115 Dutch care groups, mostly specialized in chronic care for diabetes, chronic obstructive pulmonary diseases, and cardiovascular diseases. In addition, 81% of the GPs are connected with one of the 115 care groups (Zaat, 2019). Although most of the care groups are specialized in diabetes which is highly correlated with obesity, the last updated information showed that less than 20 care groups are currently contracted to the CooL lifestyle intervention (Wang et al., 2016; Arts en Leefstijl, 2019). This might be partly due to the insufficient budgeting of the Dutch government for 2019, which reserves 6,5 million euro in the first year (Rijksoverheid, 2018). The RIVM estimated that 3,5 million Dutch citizens are eligible for participating in one of the three CLIs, which will cost health insurers for each individual approximately 812,97 euro (NzA, 2019). Therefore, the investment of the Dutch government covers just 0.2% of the total amount of money that is needed in order to implement the intervention nationally. Although the Dutch secretary of the state of public health has emphasized that the limited national budget should not be a restrictive factor, this might be an

explanation why, currently, care groups do not want to contract lifestyle coaches (AD, 2019). However, this issue has not been scientifically addressed so far. Therefore, information is needed about the perspectives of care groups towards lifestyle coaches and CLIs in order to improve their motivation to cooperate.

3 Theoretical Background

Currently, there is still little empirical qualitative evidence on factors that influence the intention of general practitioners (GPs) and Dutch care groups (not) to support lifestyle interventions. It is of significant importance to obtain insights into these intentions in order to understand what barriers lifestyle coaches are currently facing. Intentions are assumed to capture all the motivational factors that influence behaviour. In other words, if the intention is high to engage in a certain behaviour (e.g. referring patients or contracting lifestyle interventions), the performance of this behaviour is very plausible (Ajzen, I., 1991). The different factors that influence intentions and thus behaviour are described in the theory of planned behaviour.

3.1 Theory of Planned behaviour

The theory of planned behaviour (TPB) is a theory that is based on the theory of reasoned action (TRA) (Ajzen, 1991). In accordance with TPB, TRA asserts that the most important determinant of behaviour is the behavioural intention. These intentions are based on an individuals' attitude towards performing the behaviour and their subjective norm that is associated with the behaviour (Montano & Kasprzyk, 2015). However, TRA does not take into account situations where an individual is not fully in charge of their behaviour. Therefore, TPB was developed. Figure 1 illustrates the model of the theory of planned behaviour.

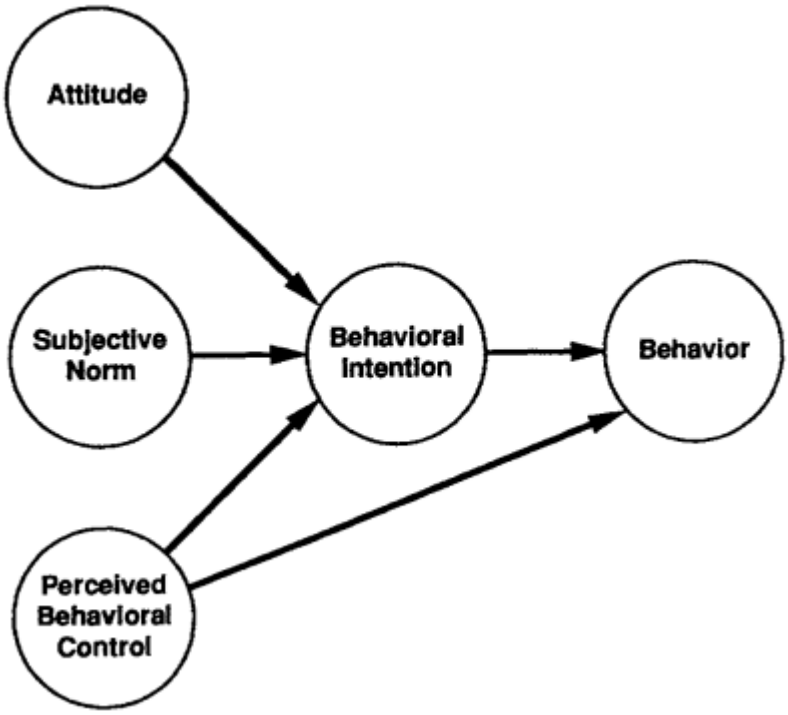

Figure 1. The Model of the Theory of Planned Behaviour (Ajzen, 1991; Francis, 2004)

TPB is one of the most frequently used perspective of initiating and performing a behaviour (Bouma, 2018). It postulates that doing or not doing a particular behaviour is a function of salient information that is relevant to the behaviour. Although people can have multiple beliefs about a behaviour, a person is only able to analyse eight or nine beliefs at any given moment (Ajzen, et al., 1991). In the TPB, these beliefs mostly determine peoples' motivational factors to perform or not perform a behaviour.

3.1.1 Intentions

The set of motivational factors (attitudes, subjective norms and perceived behavioural control) together are named a persons' intention (Ajzen, et al., 1991). According to TPB, the most important factor for engaging in a certain behaviour is still the individual's intention. This illustrates how hard individuals are willing to try in order to perform the behaviour. The perceived behavioural control not only influences an individuals'

intention to engage in a particular behaviour, but it also directly influences the behaviour itself. It is important to note that the predictive value of attitude, subjective norm and perceived behavioural control on someone's intention varies across behaviours and situation. Therefore, general statements about their relative importance are impossible to make (Ajzen, 1991).

3.1.2 Attitudes

An individuals' attitude towards certain behaviour refers to the degree to which a person has a (un)favourable evaluation or appraisal of that behaviour (Ajzen, 199). In other words, attitudes are a function of the beliefs and evaluation about the expected outcome of the specific behaviour based upon two factors. First, the *behavioural beliefs* of an outcome, which is the beliefs of an outcome that occurs as a result of the behaviour. Secondly, the *evaluation* of that outcome placed in context (Conner & Sparks, 2005). The behavioural beliefs are divided into the affective beliefs and the instrumental beliefs. The instrumental beliefs focus on the rational consideration of the outcomes of performing a behaviour in terms of benefits and costs (French, et al., 2005). In contrary, affective beliefs focus on the emotional experiences that are linked to behaviour in terms of the produced positive or negative feelings (Lowe, et al., 2002). The sum of the evaluation of all the behavioural beliefs together reflects a persons' attitude. Research has shown that personal attitudes towards the investigated behaviours are tended to overshadow the influence of perceived social pressure (Ajzen, 1991).

3.1.3 The Subjective Norms

The subjective norm describes the external social pressure that an individual perceives when initiating a behaviour (Ajzen, 1991). This perceived pressure is based on the individuals' belief about how other people would like the individual to behave, taking into account if those people would approve or disapprove that particular behaviour. Subsequently, these beliefs are described as normative beliefs. Additionally, the social pressure is based on the motivation of the individual to comply with the group (Francis, 2004). As stated previously, behavioural intention can only find full expression in behaviour *if* the person has no practical constraints to the adoption of a given behaviour (Godin & Kok, 1996). This illustrates the perceived behavioural control.

3.1.4 Perceived Behavioural Control

Perceived behavioural control is the extent to which a person feels capable to perform the action and it refers to the perception of that person about the level of difficulty of that action (Francis, 2004; Ajzen, 1991). Evidently, the perceived behavioural control is determined by its actual behavioural control, such as the resources and opportunities available that influences the performance of behaviour (Ajzen, 1991). However, internal factors, such as a person's confidence about how well one can execute the action based on skills, previous situations and available information, have also shown to influence a person's perceived behavioural control (Godin & Kok, 1996). This confidence is named self-efficacy and affects decisions on behaviour, the level of effort that is made and the resiliency of a person after a disappointment (Godin, & Kok, 1996). Each control belief is multiplied by its perceived power to facilitate or inhibit the behaviour and the sum of the products is a person's perceived behavioural control. The theory of planned behaviour has been used to understand social behaviours in different fields of science and is recently applied to the referral behaviour of GPs to lifestyle interventions (Godin & Kok, 1996; Bouma et al., 2018).

3.2 The Theory of Planned behaviour Applied to GPs' Motivation to Referral

In 2018, Bouma et al (2018) did a cross-sectional study among GPs using a survey to investigate the GPs motivation to refer to lifestyle interventions. She used the TPB and applied this to the context of general practitioners. Figure 2 illustrates her conceptual framework.

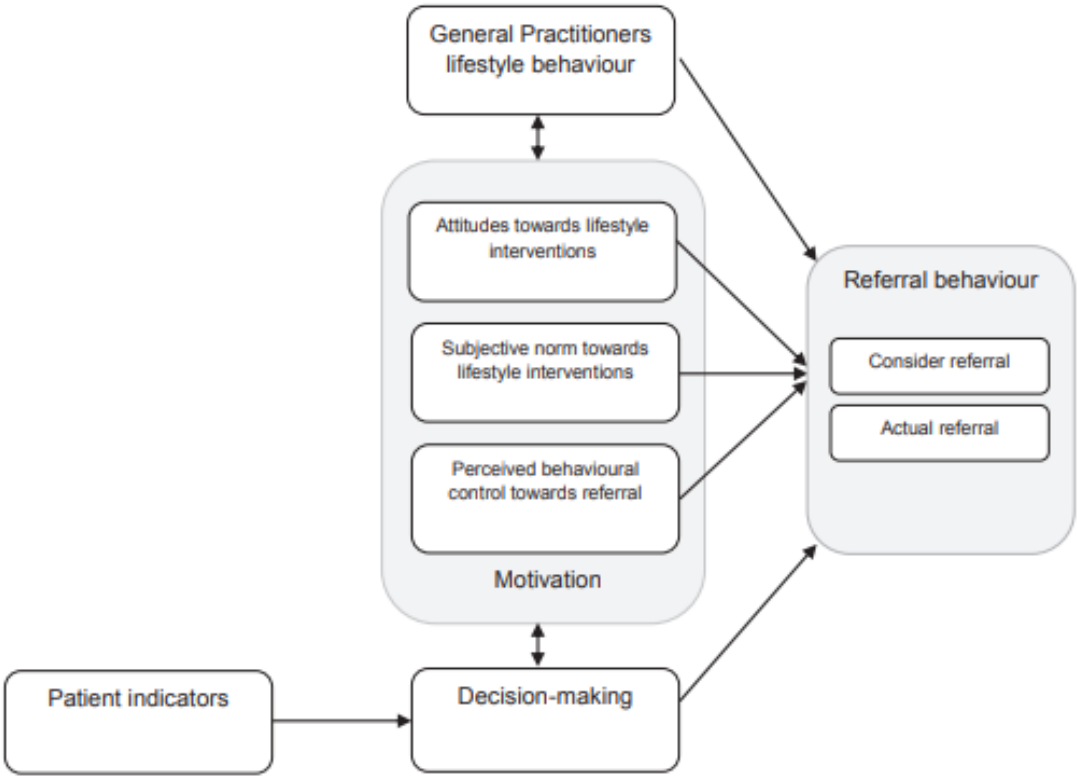

Figure 2. Factors that influences referral to lifestyle intervention based on the Theory of Planned Behaviour (Bouma, 2018).

The framework shows that in addition to the GPs' intention to referral (in the figure intention is named motivation), the general practitioners own lifestyle behaviour, patient indicators and decision-making influences the referral behaviour. Bouma (2018) showed that the personal perception of a GP about lifestyle and his or her health behaviour influences the motivation of the GP (not) to refer. In addition, patient indicators, such as high motivation, low level of physical activity and a bad eating behaviour is also of significant importance in the decision-making of behaviour. Decision-making is defined as the a GP's perceived appropriateness and effectiveness of a lifestyle intervention. In the model of Bouma et al (2018), the referral behaviour of the GP is based upon two components, considering referral and actual referring. Considering referral is conceptualised as the consideration whether a follow-up service is needed. The actual referral is conceptualised as, asking the patient the question if he or she wants to be referred to lifestyle intervention.

For the purpose of this research, the conceptual framework of Bouma et al (2018) is used.

3.3 Conceptual Framework

The conceptual framework of this research is based on the theory of planned behaviour and the conceptual framework of the research that is done by Bouma et al., (2018). Her research investigated the GPs' motivation to refer to lifestyle interventions which makes the model already applicable to the context of this research.

Because this research focuses on the barriers and facilitators of GPs *and* Dutch care groups, two slightly different conceptual frameworks are used.

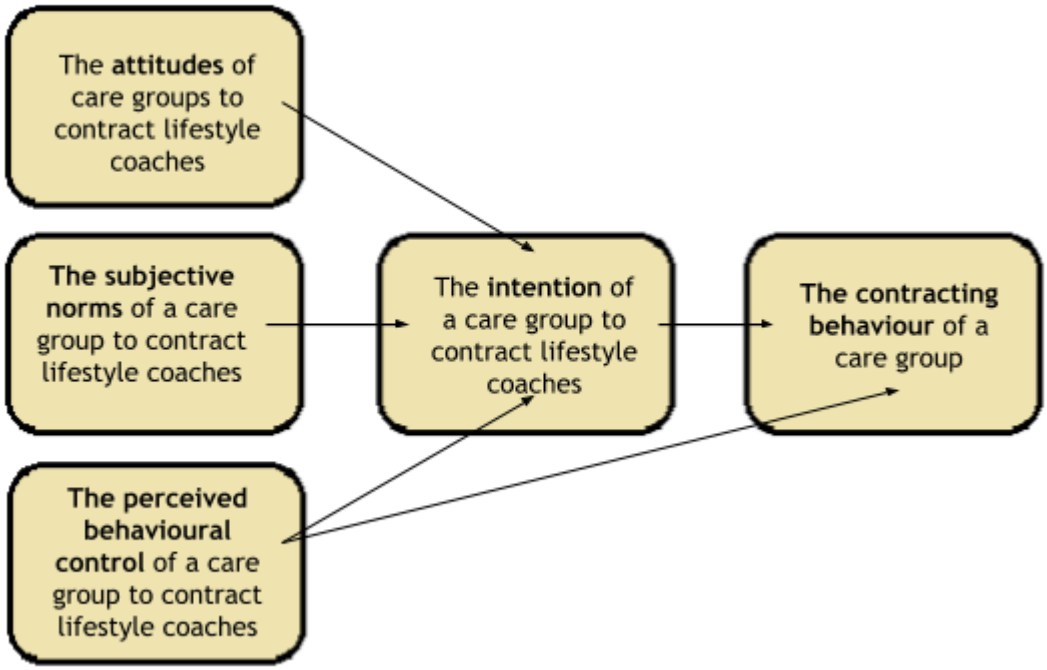

Figure 3. Conceptual model of Dutch care groups that contract lifestyle coaches.

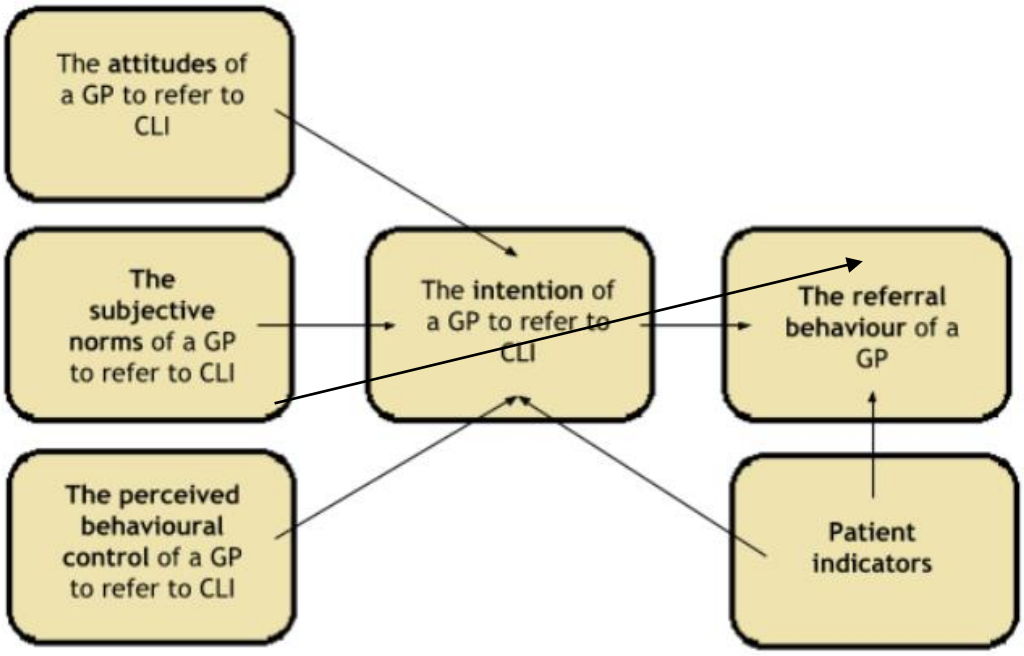

Figure 4. Conceptual Model of GPs' that refer to lifestyle coaches

Because the research of Bouma et al., (2018) is a cross-sectional study, and additionally, this research is focused on qualitative research by means of interviewing, the model of Bouma in the context of GPs is slightly simplified. First, due to limited time, this research excluded the lifestyle behaviour of GPs and care groups in

order to deepen the knowledge of the intentions of GPs and care groups. Second, decision-making is excluded since we hypothesized that the effectiveness and appropriateness is also linked with a GP's attitude towards referring patients to lifestyle coaches. Third, referral behaviour is conceptualised as one concept instead of the distinction between actual and considering referring. This is because this study will make use of semi-structured interview design which makes it hard to link different factors to either considering or actual referral. Therefore, referral behaviour is conceptualised as, asking the patient the question if he or she wants to be referred to lifestyle intervention. Additionally, the contracting behaviour of care groups is conceptualised as, having agreements with a lifestyle coach to cooperate in the form of a contract. Because, currently, CooL is the most preferential CLI which is only executed by a lifestyle coach, lifestyle coaches and CLIs are used inextricably.

This research aims to answer the question:

What are the barriers and facilitators that the Dutch general practitioners and care groups experience in cooperating with the profession of the lifestyle coach?

This question is subdivided in the questions that are described down below:

Dutch care groups

1. What is the contracting behaviour of Dutch care groups?
2. What are the general intentions of Dutch care groups to contract lifestyle coaches?
3. What are the general attitudes of Dutch care groups to contract lifestyle coaches?
4. What are the general subjective norms of Dutch care groups to contract lifestyle coaches?
5. What is the general perceived behavioural control of Dutch care groups to contract lifestyle coaches?

General practitioners

6. What is the referral behaviour of Dutch general practitioners?
7. What are the general intentions of Dutch general practitioners to refer patients to lifestyle coaches?
8. What are the general attitudes of Dutch general practitioners to refer patients to lifestyle coaches?
9. What are the general subjective norms of Dutch general practitioners to refer patients to lifestyle coaches?
10. What is the general perceived behavioural control of Dutch general practitioners to refer patients to lifestyle coaches?
11. Wat are the perceived patient indicators for GP's to refer to lifestyle coaches?

4 Methods

This chapter is focused on the justification and effects of the utilised methodology and explains how this research is conducted, including sampling strategies and instruments, data collection and data analysis. It also addresses the issues related to the ethical conduct of research.

4.1 Study Design

To the best of our knowledge, the different barriers and facilitators of the Dutch general practitioners (GPs) and Dutch care groups to cooperate with lifestyle coaches were not yet explored and therefore this research made use of the methodology of grounded theory. This is a qualitative approach that 'discovers, develops and provisionally verifies a theory through systematic data collection and analysis of data pertaining to that phenomenon' (Strauss and Corbin, 1998:23). Therefore, this research was focused on an inductive approach by means of qualitative research with semi-structured interviewing. Semi-structured interviews are non-standardized and although it uses a list of topics and questions, the structure of the questions may change and additional questions may be included during the interview (Gray, 2013). This type of interview design allowed the researcher to focus and expand on the perspectives and ideas of the respondent. Because the objective of this research was to provide insights into the different barriers and facilitators of the Dutch GPs and Dutch Care groups, semi-structured interviewing was the most suitable for this research.

4.2 Study Population

For this research, a purposive sample of six GPs and seven board members of different care groups was interviewed. This non-randomized type of sampling was used because only a few respondents were interviewed and therefore it was of crucial importance that the respondents were able to provide in-depth information of interest for this research. Different criteria between GPs and care groups were used to choose the samples.

4.2.1 The Sample of General Practitioners

For this research, a list of 100 randomly selected GPs was made that contained information on the gender and geographical locations. These randomly selected GPs were contacted and invited by letter to join the study on their referral behaviour to lifestyle coaches. A reminder was sent after a week. During the sampling of GPs, we focused on an equal distribution of geographical locations where lifestyle coaches were not yet implemented and where lifestyle coaches were implemented. Based on sample saturation, decisions were made to contact new GPs.

4.2.2 The Sample of Board Members of Dutch Care Groups

The Dutch organisation '*Arts en Leefstij'l* maps online the social chart of the care groups that, currently, have contracted lifestyle coaches. Based on this map, two sample groups were made with one group of care groups that was contracted with lifestyle coaches and one group that was not in contract with lifestyle coaches. The different care groups were contacted and will be asked to participate. The recruitment of care groups stopped when, at least, three care groups of both sampling groups were willing to join the research. It was of crucial importance that the respondents of the care groups were responsible for contracting the care so that the data was valuable in the context of this research.

4.3 Data Collection

Semi-structured interviews were used to obtain in-depth information on the barriers and facilitators of GPs and Dutch care groups in the cooperation with lifestyle coaches. These interviews were approximately one hour and took place at a location where the respondent felt comfortable. The semi-structured interview was based on the concepts of TPB (Ajzen, 1991). At the beginning of the interview, the respondent was asked to

fill in an informed consent. After the interview, the data was transcribed and sent to the respondents so that the respondents could examine whether the data was correctly interpreted by the researcher.

4.4 Data Analysis

After transcribing the data and when approved by the respondents, data analysis was done by means of open, axial and selective coding. These types of data analysis were focused on labelling the data based on overarching themes that eventually construct a theory (Gray, 2014). Data analysis based on open, axial and selective coding was done in ATLAS. Based on these theories, conclusions and recommendations were made for AVLEG.

4.5 Validity and Reliability

The validity of the data was protected by the feedback that was provided through expert checks. These expert checks were meetings with contact persons of AVLEG that were familiar with the context of this research. In addition, all the transcribed data was checked by the respondents in order to examine whether the data was described correctly. Furthermore, the data was evaluated in the context of previous research. Lastly, in order to protect the inter-respondent consistency which increases the internal validity of this research, an interview guide was used for all respondents (Appendix 1 & 2). The reliability of the data was protected by interview programmes developed by the VU. Interview programmes reduced interview bias and taught the researcher to keep an open mind while interviewing (Gray, 2013). In addition, space triangulation was used, which is the data collection derived from multiple sites (Gray, 2013).

4.6 Ethical Considerations

At the beginning of the interview, the respondent was fully informed about the content and objective of the research, the reason why the respondent was asked to participate and how the data was handled. In addition, the respondent was told that anonymity and confidentiality were guaranteed and that he or she was able to withdraw at any time during the data collection. An informed consent was signed in order to confirm that the respondent understood the full information that was provided. Because the research did not touch highly sensitive topics, no ethical clearance was needed. However, the interviewer was aware that the respondent had to feel comfortable during the interview.

5 Results

In this chapter, the themes derived from the data collection are described. First, the themes of the care groups are described in order of how recurrent the themes are in the data. After this, the results of the general practitioners (GPs) are given. All the themes are listed in this paragraph together with additional quotes of the respondents.

5.1 Themes of the Care Groups

The results of this research derived from seven care group, by which five care groups indicated that they contracted lifestyle coaches. Six of the seven care groups held a positive attitude towards lifestyle coaches and had the intention to contract lifestyle coaches. All care groups experienced barriers in their control beliefs, especially focused on different policies. The following figure shows general information of the respondents:

Respondent	Location	Contracted	Lifestyle Coaches
1	Brabant	✓	3
2	Brabant	✗	0
3	Limburg	✓	5
4	South-Holland	✓	11
5	Brabant	✗	0
6	South-Holland	✓	2
7	Brabant	✓	11

Figure 5. General information of the respondents

The thematic analysis of the data shows a wide range of themes, including *no-follow policy; a deviant payment system; a low working rate for lifestyle coaches with no financial compensation for the organizational handling of the care groups; too much uncertainties and unclarities; positive effects of lifestyle interventions; sceptical statements of lifestyle interventions; lifestyle within the organisation; different perspectives of general practitioners; advantages of contracting lifestyle coaching by care groups;*

5.1.1 No-Follow Policy

Analyses of the data revealed that all care groups experienced difficulties in the decision of healthcare insurance companies not to follow each other's policy. In general, there are mutual agreements between insurance companies that others will follow the contract of the healthcare provider and the preferent healthcare insurance in that region. However, this is not obligatory and does not apply for contracting lifestyle coaches. All the respondents indicated that the no-follow policy is a considerable barrier for their contracting behaviour. A consequent that was mentioned is the unnecessary large administrative burden for the care groups, due to the long contracting phase with all the insurance companies. This is illustrated by the following quote:

R3: "I want that other insurance companies follow the preferent one. This will save us so much time. It has cost me hours, all those different contracts."

Additionally, the administrative burden for care groups increases even more due to the no-follow policy, because all the contracts use widespread different preconditions between healthcare insurance companies. There are, for example, differences in declaration requirements, differences in requirements that lifestyle coaches have to meet, differences in the quality indicators that care groups have to deliver, and differences in the duration of the contract (e.g. one year versus the duration of the whole program). Furthermore,

insurance companies pay different rates for lifestyle coaches. This further increases the administrative handling for the care groups because invoices need to be done manually, due to different tariffs for the participants. The following quote support this theme:

R2: "I want others to follow if I make contract agreements with one of our two preferent insurance companies, otherwise it is just not executable. This no-follow policy is madness, it costs you so much administrative burden and differs too much in working rate, content, and accountability!"

5.1.2 A Deviant Payment System

According to all the respondent, there is currently a deviant payment system in which care groups are not able to invoice their costs. Normally, care groups make use of a system that is based on chronical care, named VECOZO, and in that system, chronical care standards are applied. The invoices that care groups have to deliver to health insurance companies have to be based on paramedical standards. Because the processes within VECOZO are not designed for paramedical standards, care groups are currently not able to invoice their costs. This is a major barrier to the contracting behaviour of care groups. Consequences of this barrier are that a care group have to deliver their cost either via a new system that has to be purchased. However, care groups emphasized that purchasing a new system is not desirable, because they do not want to work with another system outside their own. Another possible consequence is that care groups have to deliver their invoices manually via software, such as word, pdf, excel. This further increases the administrative burden that the care groups already face due to the no-follow policy. The following quote illustrates this:

R1: "Our processes as a care group are currently based on chronic care that includes chronic care standards. This is automatically arranged by an organization that handles our invoices. We don't have a paramedic standard and our processes are not able to invoice this. If we decide to upscale the program, we have to invoice the costs manually for 1000 to 2000 patients. This means we need one extra person for four or five days in the week just for invoices."

In addition, the payment system contains eight payment titles, based on group sessions versus individualistic sessions and the frequency of the meetings during different phases. Normally, care groups use integrated care by which health insurance pay one tariff for healthcare programs at the beginning of a year, followed by recalculations at the end of that year. The eight payment titles enlarge the administrative processes of the care groups. The following statement describes this barrier:

R1: "Eight payment procedures, just for one patient, that is just so frustrating. We will start now but this is not a sustainable solution."

5.1.3 A Low NzA Tariff

All the respondents emphasized the low NzA tariff as a major barrier in order to contract lifestyle coaches. Not only are the rates for the lifestyle coaches minimal, additionally, but there is also no compensation for the organizational handling of the care groups. Therefore, some care groups decide to take a percentage of the wages of lifestyle coaches. Other care groups facilitate the lifestyle coaches without any compensation included for the care groups. According to care groups, not every insurance company offers hundred pro cent the NzA tariffs, although the NzA tariff is already low. The following quote illustrates the barrier for the care groups:

R2: "The NzA tariff does not recognize the organization of the processes and the facilitation of declarations. I believe that health insurances have decided that they pay the organizational support of care groups from the NzA tariff that initially was meant for executing the GLI. There has to come a realistic NzA tariff, especially for

the lifestyle coaches. There is also compensation needed for care groups for facilitating the processes and supporting where necessary."

Furthermore, care groups fear that lifestyle coaches eventually will stop executing the GLI due to the low rates which makes it hard for care groups to guarantee continuity for other healthcare professionals. The NzA tariff only recognizes the effort of lifestyle coaches to execute the GLI but does not include all the extra costs that a lifestyle coach makes in order to start. These extra costs are for example the registration in BLCN in order to receive the accreditation, applying for licenses and enrolling in a quality register. All these preconditions are extra costs and make it difficult for lifestyle coaches to make their work profitable. The quote below illustrates this fear:

R4: "I fear that at the end of the year, lifestyle coaches will take stock and decide to stop because it is not profitable for them. If that happens, we are not able to guarantee continuity for our general practitioners, which is their biggest precondition. We already have to win the trust of our general practitioners so we take risks by executing this. We already had some switches in lifestyle coaches and that just costs so much time."

Care groups emphasized that it is essential to increase the rates for lifestyle coaches, with a recognition of the NzA that implementing lifestyle coaching within the current healthcare system takes organizational time that includes costs.

5.1.4 Too Much Uncertainties and Unclarities

Some care groups have pointed out that there were too many uncertainties and unclarities when it became clear that the GLI would be included in the basic health insurance. According to the care groups, this decision was made late in the year which consequently led to the that health insurance companies quickly had to make policies. This might have resulted in many unclarities for the care groups, such as the big diversity in policies, the uncertainty of financial handling, and, additionally, the discussion if the GLI has to be seen as a product with or without VAT. Within this research, the care groups that did not have contracts with lifestyle coaches emphasized that this was the reason why they decide not to collaborate with lifestyle coaches. The quote below illustrates the barrier:

R5: "The start-up of the GLI was very unclear. There was a no-follow policy and too much diversity in preconditions. Furthermore, we felt that the financial processes were not yet arranged well enough. Therefore, we decided not to contract lifestyle coaches in the first year."

Additionally, some respondents indicated that they felt sceptical about the future position of the CLI within the basic health insurance. These respondents have experienced in the past that the government initiates health interventions but that these interventions do not always last after new elections. Therefore, some care groups stated that they are still waiting in order to see how the CLI will unroll over time:

R2: "Eventually we decided not to do it. Too many uncertainties, too many things that are not system-technically well organized. Too many uncertainties and too much diversity in policies and preconditions. I have heard from other care groups that they feel the same. They are also still waiting because of the past experiences that … After a while, there will be new elections and we fear that the CLI will be excluded from the basic health insurance. Therefore, everyone is quite practical and wants to see how the CLI develops in the future."

5.1.5 The Positive Effects of Lifestyle Interventions

Six of the seven care groups believed that lifestyle interventions executed by lifestyle coaches have added value compared to current health interventions. Although there was one respondent that felt neutral about

lifestyle intervention, the respondent was also able to name positive components of the lifestyle intervention. Different positive components of lifestyle interventions were named during the research, such as the holistic approach of the intervention, given that all the facets of lifestyle are included (e.g. physical activity, nutrition, sleep, stress, and relaxation). The following respondent describes this positive effect:

R2: "The added value of the CooL intervention is that every facet of lifestyle is discussed. So not just nutrition and physical activity, but also sleep, stress management, and relaxation. All those components are connected with each other and therefore we truly believe in the intervention."

According to some respondents, another positive component of the GLI were the group sessions, in which the respondents felt that the participants could find companions and support. Care groups have experienced that the participants were able to contain their motivation longer and that they started activities, such as walking groups. The following quote describes this group component:

R1: "We noticed that the group element in the intervention is very effective, especially for certain target groups, such as the low SES. We do not have an intervention with such a group dynamic in our current healthcare programs."

Additionally, care groups emphasized that the connection with the social domain might result in a sustainable behavioural change of the participants. The respondents described that overweight is often a result of underlying problems, such as stress due to for example loneliness or high debts. Because municipalities often have programs designed for social problems, the connection with the social domain is seen as important. Additionally, care groups also see this connection as a possible solution for the increasing demand for GPs, as they hope that the intervention will lead to fewer patients consults.

R7: "Sometimes, in the individual consults of the lifestyle coach, the participant tells the lifestyle coach that they are lonely or are in debts. Municipalities often have courses or professionals for social problems like these and therefore the interface between lifestyle coaches and municipalities are very valuable. This might lead to a more sustainable behavioural change and therefore fewer doctor-appointments."

Another element that might result in a more sustainable behavioural change, according to the care groups, is the awareness of the participants that they are responsible for their own lifestyle. Because a lifestyle coach rarely gives advice to participants, they are forced to integrate the provided information within their own life in order to create their own goals and objectives. The following quote illustrates this effect:

R4: "This program takes a lot of time in order to make participants aware of their own choices. It is not possible to accomplish your lifestyle goals in twenty weeks, that is just the start. As a lifestyle coach, you do not tell the participant what to do. In comparison, the participant is responsible for their own decisions and I believe that that is the difference between the GLI and other interventions where there is always a healthcare professional with an advising role."

Furthermore, care groups indicated that the lifestyle coach has enough time to see the participants. A lot of care groups have experienced that GPs and POH are in need for a healthcare professional that is focused on lifestyle changes because general practices are currently not able to fulfil these demands of their patients, due to lack of time. Furthermore, some care groups emphasized the potential positive effects of a two years program, which makes the lifestyle coach able to focus on the individual needs of the participants and to guide the participant for a longer time period. Below is a statement that describes this:

R7: "The POH and the general practitioners just don't have enough time to guide the participant for two years. The intake already takes one hour and a groups session a whole afternoon. There are a lot of motivated participants here so the POH and the general practitioners really need lifestyle coaches."

5.1.6 Sceptical Statements of Lifestyle Interventions

Although six of the seven care groups were rather positive about lifestyle interventions, some sceptical statements were made. Some care groups indicated that the effects of the pilot phase were minimal and that the long-term effects were still unclear. These care groups especially felt that the amount of weight loss was minimal. However, they acknowledged the improved quality of life of the participants. The following quote illustrates this statement:

R2: "People say that the effects of the intervention are minimal. This might be the case by weight loss, but I believe that feeling comfortable in your own skin and the reduction of loneliness is equally important. That's harder to measure, but I believe that the program reflects those effects!"

Another sceptical note of a care group was that a lifestyle intervention would be valuable for more target groups than overweight people and emphasized that the combined lifestyle intervention currently exclude those people. This statement is described below:

R3: "It is not really a disadvantage, but I believe that CooL is more applicable than just for the overweight population. This way of working might help other areas in healthcare as well."

Furthermore, some care groups stated that the content of CooL is rather open which might have consequences for the diversity in quality nationwide. Nonetheless, care groups also stated that they appreciate the open construction because it makes them able to shape the intervention in the way the care group wants. The following quote illustrates this sceptical note:

R4: "The CooL intervention is rather open, which is an advantage for us because it gives us more freedom and it suits our way of working. Additionally, we already have a lot of experience. In comparison, if we look at lifestyle coaching nationwide, I believe that for individual lifestyle coaches or for care groups without experience, it might be more difficult to ensure quality."

Some care groups indicated that there are not enough lifestyle coaches available in the region. However, these care groups emphasized that this amount is increasing. Additionally, some of these care groups were advanced in the process of implementing the GLI and already had several lifestyle coaches contracted. The following quote illustrates the shortages of lifestyle coaches:

R7: "The intervention is going very well, there are a lot of people who want to start. Currently, I am busy to contract more lifestyle coaches, because, in terms of registrations, things are going well, but there are too little lifestyle coaches in this region."

There was one care group that felt neutral about lifestyle intervention. This respondent stated that the components of a lifestyle intervention could be integrated within current healthcare professions and that the emergence of lifestyle coaches will only lead to increasing fragmentation of the current healthcare system. The respondent acknowledged that there is a need for improved cooperation between the first line and the social domain and that lifestyle coaching might distinguish itself by mapping this social chart. However, the respondent believed that this cooperation is needed in more healthcare areas than just overweight people, for example, 'GGZ'. The following quote describes this statement:

R5: "As a care group we are hesitating whether we have to contract lifestyle coaches because we believe that there is already so much in the field of healthcare. Therefore, we think that it might be better to integrate the elements of lifestyle coaching in the profession of current healthcare professionals instead of creating a whole new profession."

5.1.7 Lifestyle within The Organization

All respondents indicated that lifestyle is an important element in chronical care, and therefore, lifestyle is seen as important within the organization. Six of the seven care groups had the intention to contract lifestyle coaches, whereas, one care group indicated that the organization was still hesitating if they had the intention to contract lifestyle coaches. This care group indicated that the organization was still doubting about their role within the prevention and indicated that, perhaps, this would be more the responsibility of the social domain. This is illustrated by the following quote:

R5: "There are more and more questions about lifestyle, thus, as a care group, we are trying to figure out our role and responsibility within lifestyle. The question is: Is it really our responsibility or should it be placed somewhere else?"

The contracted care groups emphasized that it is necessary to appoint someone within the organization that is passionate about, and convinced of, the added value of the combined lifestyle intervention. According to the respondents, not every GP is convinced of the added value of lifestyle coaches, therefore, a care group needs someone that is able to explain the reasons why the organization have decided to contract lifestyle coaches.

R3: "Preferentially, you want someone in the organization that knows all the in's and out's, someone who knows why the care group does this, what they want to accomplish, and is passionate about the ideas behind lifestyle coaching. If someone visits the general practices, he or she has to be able to explain this."

Furthermore, it is important to have knowledge of the content and policies within the organization in order to facilitate the organizational handling of the implementation and to shape the quality of the intervention. The contracted care groups emphasized that this knowledge was essential for the start-up of the CLI because it was a new intervention within healthcare and it was accompanied by many unclarities. Therefore, it took time to obtain enough knowledge within the organization in order to start. The following quote illustrates this:

R1: "It has cost me four months in order to have someone in the organization that had enough knowledge to implement the CLI. This person was 1,5 day a week occupied with the implementation plan, a communication strategy plan, and finding enough lifestyle coaches. This is behind us now so we can start. We have a lot of people with knowledge now."

5.1.8 Different Perspectives of General Practitioners

The care groups experienced different perspectives among general practitioners, ranging from GPs that were enthusiastic, neutral and sceptical towards lifestyle coaches. There were some care groups that experienced the enthusiastic perspectives as important for the decision to contract lifestyle coaches, however, this influence was not always clear, since, within each care group, the perspectives among GPs also varied.
Some care groups noted that the intention to contract lifestyle coaches originated from the needs of GPs to have an additional health professional for overweight patients. Those GPs indicated that they did not have enough time, skills, and knowledge in order to help those patients. Additionally, GPs felt that other health professionals also lack those three elements. In general, this group was enthusiastic about lifestyle interventions and some of those general practices already implemented lifestyle within their consultation

hours (e.g. walking groups). Additionally, those GPs experienced that there is also a need by patients to start with changing their lifestyle. This group is illustrated by the following quote:

R4: "The reason why we are motivated to start facilitating lifestyle interventions is that we are closely involved with the needs of our GPs and we kept hearing that GPs and POHs missed the knowledge and time to help patients change their lifestyle."

According to some other care groups, they experienced that most GPs felt neutral about lifestyle interventions. These care groups were either not contracted with lifestyle coaches or did not actively communicate among general practices, due to enough registrations to fill their CLI. The experience of these care groups was that GPs would not feel resistance to referring patients, but they also would not actively bring up lifestyle intervention as an option for their patients. The following quote describes this:

R6: "Since the first of January, patients are asking for a referral to GPs and I believe that GPs, in general, are willing to refer those patients. However, I do not think that GPs actively propose de CLI to patients that are willing to change their lifestyle. I have not heard that GPs felt resistance to refer though."

According to the care groups, there are always some general practices that are reserved to refer patients to a lifestyle coach, because these GPs believe that changing lifestyle is not part of their profession and lifestyle coaches should be part of the social domain instead of healthcare. Care groups also experienced that there are GPs that felt that they were already actively tackling lifestyle in their general practices and, therefore, did not saw the added value of a lifestyle coach. There was no care group that indicated that sceptical GPs was a reason not to contract lifestyle coaches. However, some care groups felt that communicating with those general practices was time-consuming and difficult. The following quote illustrates this:

R4: "There are GPs that are positive about lifestyle coaches, but there are also GPs who believe that it is not part of their profession and do not want to take part in it. It is important that care groups keep informing those GPs but do not force it, otherwise, they will start feeling resistance. There always will be GPs that give resistance but this group is getting smaller."

5.1.9 The Advantages of Lifestyle Coaches Contracted by Care Groups

All the contracted care groups emphasized the advantages for lifestyle coaches that are contracted by care groups. According to these respondents, the advantages are that lifestyle coaches are able to use the already existing networks of the care groups. Besides general practitioners and paramedical healthcare professionals, care groups are often in contact with the municipality, which is an essential stakeholder for the lifestyle coach. As consequences, the care groups emphasized that they can facilitate in the communication to the municipality and the general practitioners, which helps the lifestyle coaches to create publicity and support. Due to the limited time of the general practitioners, care groups have experienced that general practices tend to prioritize patient consults compared to the introductory meetings with a lifestyle coach. According to care groups, the existing relationship between care groups and general practitioners helps the lifestyle coach to be better known in practices, so that general practitioners are more likely to refer patients. Consequently, the facilitation of care groups might have a positive effect on the amount of registration for the intervention of lifestyle coaches. The following quote describes this advantage:

R4: "As a care group, we are the binding factor. My experience is that a lifestyle coach needs a care group that is really positive about lifestyle interventions because they have to knock on the doors of the general practices in order to generate support. The first step is always to ring the doctor assistant that, usually, has one job: to fill as much possible the consultation hours. Therefore, you only get in, if you are known at the practices."

5.2 Themes of the General Practitioners

The results of this research derived from six general practitioners, by which two have referred patients to a lifestyle coach. All the GPs had the intention to refer patients to a lifestyle coach, and additionally, most GPs held a positive attitude towards lifestyle coaches. Most GPs experienced barriers in their referral behaviour, due to control beliefs. These control beliefs were mostly the motivation of the patient and lack of knowledge. The following figure shows general information of the respondents:

Respondent	Location	Refering behavior	Care Group - CLI	Gender
1	Brabant	✓	✗	Female
2	South-Holland	✓	✓	Male
3	Brabant	✗	✗	Male
4	Drenthe	✗	✗	Female
5	North-Holland	✗	✗	Female
6	North-Holland	✗	✗	Male

Figure 5. General information of the respondents. The fourth column describes the GP's that are connected with a care group that contracts lifestyle coaches.

After analysing the data of the interviews with the GP, the following themes have arisen: *The motivation of the patient; Knowledge of the lifestyle coaching among GPs; The responsibility of the GP; Lifestyle within the organization; Advantages of a lifestyle coach; Sceptical notes of a lifestyle coach.*

5.2.1 The Motivation of the Patient

All the respondents indicated that the motivation of the patient is essential to start a lifestyle intervention and to achieve a sustainable behavioural change. Most of the GPs stated that this motivation is often absent in patients that are overweight or obese, but not every general practitioner agreed with this, as some GPs have experienced that patients are often more motivated than expected. However, all GPs agreed on, that, in general, people want to see quick results and if this result is not in the near future, people feel that they have to put too much effort for too little personal gain. According to GPs, this is due to the overall intrinsically laziness of people. The following quote illustrates this:

R3: "In my general practice, I notice that people are, in general, not patient and do not feel the need to invest much time and energy to change their lifestyle. Often, they just want medication or me to wave with my magic wand."

Although there were mixed perspectives on the degree of motivation of patients, all respondents agreed that the motivation for the overweight patient, without obesity, is seen as problematic because health gain due to lifestyle changes, such as a decrease in high blood pressure, is difficult for patients to experience. This is illustrated by the following quote:

R5: "I find it difficult to motivate patients that are overweight without them taking medication because their health gain is less visible. You do not necessarily feel high blood pressure."

In contrast, some respondents described that patients are more motivated than GPs normally expect, especially patients that take heavy medication. Those respondents described that sometimes general practitioners fill in themselves that patients would not be motivated, therefore, automatically assume that the patient prefers medication and does not question the patient about their motivation to change lifestyle. However, one respondent described that she always focuses on changing lifestyle in her consultation hours,

but that patients refuse to start anyhow. The following quote illustrates the perspectives of the respondents that felt that patients are more motivated than expected:

R5: "In general, I think the motivation of people is higher than expected. Sometimes, GPs believe that people are too old, too dumb, therefore not motivated. I have someone in my general practice that is 86 years and off medication due to lifestyle changes!"

Furthermore, some GPs emphasized that publicity by means of the media often leads to more awareness about lifestyle and they experienced that this positively affects the motivation of patients. Additionally, some respondents have noticed a shift in the mindset of their patients, by which more people are becoming motivated to change lifestyle instead of taking medication, due to more publicity on lifestyle. This is illustrated by the following quote:

R2: "It helps that there is more publicity on lifestyle, because it creates awareness and, therefore, increases the motivation of more patients. I really believe that the media has a big effect."

Although there were mixed perspectives of the motivation of patients in order to *start* a lifestyle intervention, all respondents acknowledged that is difficult for people to *maintain* behavioural change. According to the respondents, this is due to wrong expectations of how fast results are achieved and the disappointments during behavioural change. Additionally, GPs often experience that if a lifestyle initiative, such as a walking group, are finished, people tend to return to old behaviours. Therefore, some GPs indicated that they felt sceptical about lifestyle interventions. This is illustrated by the following quote:

R4: "We organise walking groups because it is something people can keep doing after it stops. However, we often notice that people stop if the intervention stops."

According to the GPs, it is important for the motivation of a patient, that lifestyle interventions are person-oriented and focused on the person specifically in order to make a sustainable behavioural change possible. Additionally, a lifestyle intervention has to have a considerable duration, so that patients can be guided through disappointments. According to most respondents, these elements within a lifestyle intervention will help the patient to retain motivation. The following quote describes this:

R2: "I believe that the difference between the group that keeps being motivated and the group that drops out eventually is due to the quality and the duration of the coaching. I believe that the GLI fits the right qualifications."

5.2.2 Knowledge of Lifestyle Coaching among GPs

Most of the GPs did not have enough knowledge to refer to lifestyle coaches. Although half of the GPs knew the content of the CLI, most of the respondents did not knew any lifestyle coach in their region. Almost all the GPs that did not know a lifestyle coach, were connected with a care group that decided not to contract lifestyle coaches. The following quote illustrates this:

R4: "My care group indicated that they decided not to contract lifestyle coaches, so I thought it was not possible to refer. Now, I know lifestyle coaches can be contracted individually by health insurers but I have no idea where I can find lifestyle coaches."

Additionally, half of the GPs indicated that they did not know what a lifestyle intervention contains and for whom a lifestyle intervention might be suitable. Those respondents indicated that their gap in knowledge might be due to their limited time. However, all those general practitioners indicated that they want to be

informed about their options to refer to lifestyle coaches, some GPs also preferred an introductory meeting with a lifestyle coach.

R4: "I want to know who they are and what they do. I want to meet them and see how they work."

5.2.3 The Responsibility of the GP

Some of the respondents felt that prevention by means of changing the lifestyle of patients, is not the responsibility of a general practitioner nor a care group, therefore, those general practices were not focused on lifestyle. Although, those GPs acknowledged that general practitioners have a role in signalling symptoms due to a bad lifestyle and, thereby, informing the patient about options to change lifestyle, they did not see interventions to change the lifestyle of patients as their responsibility. According to those respondents, lifestyle interventions should be the responsibility of the social domain, such as municipalities, and, therefore, referrals should not be done by general practitioners. They preferred a system by which there is no referral of the GP needed in order to start a lifestyle intervention. The following quote illustrates that perspective:

R3: "I believe that the CLI should be part of the social domain and not the responsibility of the first line of healthcare. We already have so many responsibilities."

Although those respondents indicated that the CLI should be part of the social domain, this perspective did not influence the intention of the general practitioners to refer, because they all emphasized that it is necessary to change the lifestyle of the Dutch population.

R2: "Although I believe that lifestyle intervention is the responsibility of the social domain, I believe that the intervention itself is a good initiative to tackle the increasing amount of overweight people. Therefore, our care group decided to start with the CLI."

5.2.4 Lifestyle Within the Organization

Within this research, three general practitioners were lifestyle-oriented and applied lifestyle in their general practices. This included, walking groups, close collaboration with dietitians and physiotherapists, stop smoking interventions and other interventions. All the respondents had POHs working in the general practices that were focused on lifestyle. All the GPs that worked in a lifestyle-oriented practice addressed changing lifestyle more in their consultation hours. Additionally, those general practitioners were less sceptical on the added value of lifestyle coaches, although the perspectives on the motivation of patient were mixed among those GPs.

R3: "I focus a lot on lifestyle in my consultation hours and consequently always address changing a patient's lifestyle if this is necessary."

5.2.5 Advantages of a Lifestyle Coach

Although most general practitioners felt sceptical about the motivation of patients to start and maintain behavioural change, most GPs indicated that a lifestyle coach that executes the CLI has several advantages. Different advantages of a lifestyle coach were named, whereby most general practitioners emphasized the duration of the CLI. According to the GPs, an intervention of two years might help the participant to handle disappointments, maintain motivation, and to achieve sustainable behavioural change. Especially, the mental guidance of the lifestyle coach was seen as valuable during the two year of the intervention. This is illustrated by the following quote:

R2: "I believe that the value of the CLI is the duration of the intervention that hopefully helps the participants to truly change their lifestyle."

Additionally, some general practitioners named the group sessions as a valuable aspect of the intervention, as they have experienced that a group intervention helps patients to feel support and to maintain their motivation. According to the GPs, it might be especially valuable for the commitment of the participants to continue sports initiatives. The added value of group sessions is described in the following quote:

R1: "Group sessions might really make a difference because it connects the participants and provides support. I have experienced the group element in my general practices, especially during walking sessions if it is cold and people do not want to go. Most of the times they come anyway because they agreed to do it together."

According to the GPs, another positive aspect of a lifestyle coach is the connection with the social domain. Some GPs emphasized that the increasing overweight Dutch population is not only a health problem but also includes a social component that needs attention. Elements, such as stress and loneliness, where named as underlying components that might lead to an unhealthy lifestyle. Additionally, one general practitioner indicated that there is a need to improve the interaction between the social domain and the first line of healthcare, and he emphasized the potential added value of a lifestyle coach as the connector between these two. This is illustrated by the following quote:

R3: "I believe that being overweight is a bigger problem than just a health issue and that it is more the responsibility of the social domain. I believe that a lifestyle coach can connect the social domain with the first line of healthcare in order to improve the collaboration."

Last, some GPs emphasized that a lifestyle intervention focuses on all the elements of lifestyle, which helps the participant to change underlying causes, such as stress and sleep. Therefore, according to some GPs, this holistic approach might lead to a more sustainable behavioural change. Additionally, some GPs emphasized that the multidisciplinary approach unburdens general practitioners. Those GPs indicated that they currently do not have the time to discuss all those components, although they feel that there is a need to discuss this by the patients. The following quote illustrates the holistic approach:

R4: "As a GP, I can't change the lifestyle of a patient by myself. Currently, patients are treated by medication and I believe there is so much to gain in changing lifestyle. Therefore, I believe that the multidisciplinary approach within behavioural change will be the future."

5.2.6 Sceptical Notes of a Lifestyle Coach

In general, the general practitioners indicated that there were no disadvantages of a lifestyle intervention provided by a lifestyle coach. However, two elements made some GPs sceptical about the effect of a lifestyle coach on the Dutch overweight population. First, some GPs described that most patients are not willing to change lifestyle, therefore, a lifestyle intervention will not work. According to those GPs, there are few people that are intrinsically motivated to retain a healthy lifestyle, because, in general, people are intrinsically lazy and therefore not willing to change their lifestyle, Therefore, half of the GPs emphasized the role of the government to make unhealthy choices less favourable and to encourage healthy choices. According to those GPs, only this will affect the motivation of patients and might help lifestyle interventions to be effective. This perspective is described below:

R2: "Politics have the intervene, because, currently, nothing changes. I really think that we should implement sugar taxes."

Second, some GPs indicated that they felt reserved about lifestyle interventions, because, in the past, they experienced more lifestyle initiatives that eventually stopped, due to financial cuts by authorities. Subsequently, Although GPs acknowledged the added value of prevention within healthcare, they indicated that they fear that the CLI will be an endless construction. Consequently, the GPs expressed their hope that the CLI will remain subsidized for a considered time. This is illustrated by the following quote:

R6: "As GP, I want the guarantee that the GLI will stay for 20-30 years. Most people will not start the GLI if it is not subsidized."

6 Discussion

The objective of this research was to contribute to the implementation of the profession of a lifestyle coach by providing a clear insight into the barriers and facilitators of care groups and general practitioners (GPs) to cooperate with lifestyle coaches. This chapter will elaborate on the key findings of the research, the comparison of the results with other studies and additionally discusses the strengths and limitations.

6.1 Key Findings

In general, both the care groups and the GPs held a positive attitude towards lifestyle intervention executed by lifestyle coaches. Additionally, most care groups and GPs had the intention to cooperate with lifestyle coaches, but experienced barriers due to their perceived behavioural control. First, this paragraph is focused on the key finding of the barriers and facilitators of care group, where after the key finding of the GPs is presented.

6.1.1 Key Findings of Care Groups

The results from this research derived from seven care groups, by which five contracted lifestyle coaches and one care group had the intention to contract lifestyle coaches in the future. The results are consistent with the Theory of Planned Behaviour (TPB), that states that attitudes, social norms and control beliefs are predictors for initiating behaviour (Azjer, 1991). In general, the care groups' contracting behaviour seemed mostly related to their attitudes and perceived subjective norms. However, non-contracted care groups emphasized that they experienced too many barriers in their perceived behavioural control, and additionally, the contracted care groups indicated that they might not contract lifestyle coaches in the future, due to those perceived behavioural controls. Therefore, these findings raise intriguing questions regarding the future implications of Combined Lifestyle Intervention (CLI), if those barrier beliefs remain.

An initial objective of this study was to identify the perceived behavioural control of care groups with respect to their contracting behaviour. It is interesting to note that all respondents emphasized that they experienced barriers in their perceived behavioural control, namely the no-follow policy, the deviant payment system, and the current maximum NzA tariffs without organizational recognition. These findings are consistent with that of *Johannesma & Van Hoof* (2019), who stated that care groups experience difficulties in the different policies of health insurance companies and in financial insecurities. Additionally, the findings are also reported by *Van Rossum & Van Plas (2019)*, that wrote to the secretary of the state that NzA does not recognize the organizational cost and health insurance companies offer prices beneath the NzA tariff. These results confirm the association between a care group's perceived behavioural control and their intention to contract lifestyle coaches (Azjer, 1991). These findings have noted the importance of the possibility to change policies regarding CLIs, in order to successfully implement lifestyle coaches within the current healthcare system.

Another important finding was that knowledge is an important control belief that positively influenced the contracting behaviour of the care groups, and additionally, some care groups emphasized that several ambiguities around the CLI were closely related to their decision not to contract lifestyle coaches. This finding is consistent with that of RIVM (2019), which described that care groups need clear information about preconditions, tariffs that are provided by health insurance companies and mandatory result indicators. Therefore, there is a need for one up-to-date transparent platform for health organizations that would like to contract CLI.

This study sought to determine the general attitudes of the Dutch care groups with respect to their contracting behaviour. The current study found that all the contracted care groups held a positive attitude towards lifestyle interventions executed by lifestyle coaches. According to those care groups, valuable elements of the lifestyle intervention were; the holistic approach, the included group sessions, the duration

and quality of the intervention, and the person-oriented approach. In contrast, named disadvantages were the minimal effects in weight reduction, the openness of the intervention and the shortages of lifestyle coaches in some regions. However, respondents indicated that they did not experienced those disadvantages problematic. Subsequently, the indicated disadvantages did not affect the overall general attitude of the respondents. Additionally, the perceived attitudes of the respondents were closely related to the intention of the care groups and, thus, their contracting behaviour. To the best of our knowledge, this is the first study that examined the attitudes of Dutch care groups on the profession of lifestyle coaches. Interestingly, although care groups are organizations for primary healthcare providers and therefore one might assume that attitudes of care groups and GPs would not differ, our findings suggest that, in general, care groups held a more positive attitude towards lifestyle interventions compared to GPs. Indeed, comparison of the findings with those of other studies suggests that the general attitude of GPs is more varied than the relatively positive attitudes of care groups (Hébert, et al., 2012). A possible explanation for this might be that, in general, care groups are more focused on chronical care and, therefore, lifestyle is perceived as more important among care groups.

One of the research questions in this study was to identify the perceived subjective norms of care groups with respect to contracting lifestyle coaches. The results of this study show that the perceived subjective norms of the respondents were highly related to the intention of a care group to contract lifestyle coaches. Subsequently, all the respondents that indicated that lifestyle was seen as important within the organization, were contracted with lifestyle coaches or had the intention. Additionally, the care group that indicated that prevention, and thus lifestyle, might be more the responsibility of the social domain, was still hesitating if they had the intention to contract lifestyle coaches in the future. Although the perceived subjective norms within the organization influenced the intention of the care groups, the relation between the perceived subjective norms towards their GPs and the organizational intention was not always clear. Some care groups indicated the need of the GPs to cooperate with lifestyle coaches, and therefore, decided to contract lifestyle coaches. However, the perspectives among GPs towards lifestyle coaches varied among care groups and therefore, this research provides no evidence with respect to the perceived subjective norms towards the GPs and the intention of care groups to contract lifestyle coaches. To the best of our knowledge, this is the first study that examined the perceived subjective norms of the Dutch care groups.

It was hypothesized that, in general, Dutch care groups decided not to contract lifestyle coaches due to insufficient budgeting of the Dutch government for 2019. However, the findings of the current study do not support this hypothesis. According to these data, we can infer that care groups experienced barrier beliefs in their perceived behavioural control. It can, therefore, be assumed that there is a strong need to (i) increase the rates of lifestyle coaches, with organizational recognition of the NzA; (ii) have a free payment system that is applicable within the current systems of care groups; (iii) health insurance companies that follow each other's contracts.

Recommendations

These findings have indicated the importance of the essential need for care groups to change policies regarding combined lifestyle interventions, in order to successfully implement lifestyle coaches within the current healthcare system. Consequently, these findings do support strong recommendations to the Dutch Ministry of Health to discuss alternative options for the current payment system; the low working rates without recognition of organizational handling; and tackling the no-follow policy. Unless the government adopt those changes, a successful implementation of the CLI, will not be attained.

Moreover, more effort should be done to create a transparent up-to-date platform for care groups to obtain clear information on the content and contract requirements of the GLI. This information will give care groups the resources to contract lifestyle coaches and therefore, more care groups will be motivated to start executing the GLI.

Future research
These findings, while preliminary, suggest that care groups are motivated to contract lifestyle coaches that executes combined lifestyle interventions. To develop a full picture of the general motivation and added value of care groups to contract lifestyle coaches, additional quantitative studies will be needed, such as national surveys. Because, our findings suggest that lifestyle coaches experience multiple advantages when contracted by care groups, the motivation of care groups is an important issue for future research, in order to develop possible strategies that successfully connect lifestyle coaches with local care groups.

6.1.2 Key Findings of General Practitioners

The findings of this study derived from six general practitioners (GPs), by which two have referred patients to lifestyle coaches. All six general practitioners had the intention to refer patients to a CLI, although two indicated that they only have the intention to refer if patients explicitly ask about a lifestyle intervention. Within this research, only two general practitioners indicated that they have referred patients to lifestyle coaches. These findings are contrary to our hypothesis, stating that GPs are, in general, not motivated to refer patients to lifestyle interventions. According to our findings, most GPs were motivated to refer patients but felt barrier beliefs in their perceived behavioural control.

As expected, the results support the TPB, that describes that attitudes, social norms and control beliefs are strong predictors for initiating behaviour (Azjer, 1991). However, the findings of the current study show that the perceived responsibility of a GP is an additional predictor for their referring behaviour. According to some GPs, prevention, and thus lifestyle is the responsibility of the social domain and therefore the motivation to refer patients is lower. Indeed, prior studies have noted the limitations of TPB, because initiating behaviour often have a moral component that is not included in the TPB and must be taken into account for an adequate analysis of this type of behaviour (López-Mosquera, et al., 2014). Continuing in this line of study, various studies have shown that social responsibility often the determine intentions and behaviour and consequently, have expended the TPB with the inclusion of social obligations (Tonglet & Bates, 2004).

The present study was designed to determine what the general perceived behavioural control, patient indicators, and attitudes were among GPs with respect to their referral behaviour. The most obvious finding to emerge from the analysis is that the motivation of the patients was strongly related to their referral behaviour and influenced a GP's perceived behavioural control and its' attitudes. Subsequently, a patient's lack of motivation was seen as a contraindicator (e.g. patient indicator) for referral, because all the respondents agreed that the motivation of a patient is essential in order to start and successfully maintain a sustainable behavioural change. Additionally, according to some GPs, patients often lack this commitment. This finding was also reported by *Kim et al.,* (2015), that stated that predominant factors influencing GPs' referral were their perception of how motivated patients were in relation to their health. Surprisingly, the perception of the degree of patients' motivation varied among GPs. A possible explanation for this might be that motivation to change lifestyle is partly attributed to geographical factors. Another possible explanation might be that most GPs do not consider referral, because they assume that a patient lacks motivation without explicitly ask the patient about its' commitment (Bouma, 2018). However, this is in contrast with the results derived from one respondent that emphasized she always tries to refer, regardless of a patients' motivation, but that patients often indicate that they are not willing to participate.

Additionally, the perceived behavioural control of the GPs was strongly related to their lack of knowledge on the content of the lifestyle interventions and, additionally, the lack of awareness of the lifestyle coaches in the region. This also accords with earlier observations, which showed that many GPs cited lack of knowledge as a barrier to their referral behaviour (Hébert, et al., 2012). These findings have noted the importance of

the national promotion for lifestyle interventions and, additionally, the importance for lifestyle coaches to make themselves known within their local social chart.

This study set out with the aim of assessing the general attitudes of GPs with respect to lifestyle coaches. The results of this study showed that, in general, GPs held a positive attitude towards lifestyle interventions and the CLI, although the attitudes varied among GPs. Positive elements that were named are the duration of the intervention; the person-oriented and multidisciplinary approach, and the inclusion group sessions. According to GPs, the most important disadvantages of CLI were that it might not be effective due to the lack of a participant's motivation, and additionally, the perceived endless construction of subsidizing the CLI. Interestingly, contrasting opinions emerged on the perceived effectiveness of combined lifestyle interventions, which consequently has led to variation in GPs' attitudes. These results match those of observed studies, that found that the perceived effectiveness of lifestyle interventions among GPs varied (Hébert, et al., 2012). For a better referral in practice, there is a need for an up-to-date transparent platform on the effectiveness of the CLI that is accessible for general practitioners.

One of the research questions of this study was to identify the perceived subjective norms of the GPs. The results of this study show that, in general, the three GPs that worked in a lifestyle-oriented general practice, were more motivated to refer patients to lifestyle coaches. Additionally, two general practitioners that were not especially focused on lifestyle within their general practice, indicated only to consider referral if a patient explicitly asks to be referred. These results reflect those of *Bouma* (2018), that stated that a GP's refer behaviour seemed significantly related to their perceived subjective norms. According to Bartholomew, et al (1998), socialization often occurs through institutions, such as universities. Therefore, strategies have to be developed to shift social norms, for example by incorporating lifestyle interventions within the curriculum of medical schools.

One unanticipated finding was that some GPs indicated the increased awareness among their patients to change lifestyle behaviour, due to promotion through social media. Indeed, behavioural journalism uses stories of mass media role models and communities, and advise from experts to increase the adoption of a certain desirable behaviour (Bartholomew, et al., 1998). Therefore, in order to perceive more awareness and social support among patients, more attention should be given to change lifestyle behaviour, through social media platforms.

Recommendations

These findings suggest several courses of actions for the Ministry of Health, lifestyle coaches, institutions, and social media. A recommendation for the Ministry of Health is that there is a definite need for an up-to-date platform that is accessible for GPs, on the obtained results of combined lifestyle interventions. This will provide insights for GPs on the effectiveness of CLI, that consequently, will improve their motivation to refer. Additionally, strategies should be developed to strengthen the local networks of lifestyle coaches and primary healthcare providers. Additionally, a practical implication for lifestyle coaches is that if they start with executing combined lifestyle interventions, the key priority should be to establish a sustainable network of local general practitioners. GPs indicated that this is an essential need for them to refer patients to lifestyle interventions.

Moreover, our findings suggest that health promotion is needed to improve awareness of the importance of adopting a healthy lifestyle among the Dutch population. Consequently, informational documentaries that include lifestyle promotion will shift the general social norms that might lead to a more sustainable behavioural change. In addition to the awareness among the Dutch population, greater efforts on medical universities are needed to incorporate lifestyle interventions in the current curriculum. This might improve the subjective norms of general practitioners to refer to lifestyle interventions.

Future research

Further research needs to be done to investigate the effectiveness of the implementation of lifestyle coaches in the field of the primary healthcare setting, compared to the effectiveness of implementation in the field of the social domain. Some GPs have emphasized that prevention should be the role of the social domain, therefore, they perceived that lifestyle coaches should be implemented there. Further research could assess the different implementation positions for lifestyle interventions, such as care groups, municipalities or the 'GGD', in order to investigate provide insights into the future position of lifestyle coaches.

6.2 Strengths and Limitations

This study had some relevant limitations. First, one source of weakness in this study was the relatively limited sample size of care groups and general practitioners. This limitation might affect the validity of this research. Although the current study is based on a small sample of participants, within the research of care groups the concept of data saturation is used, which is the point that no new information or themes are observed in the data of additional respondents (Boddy, 2016). This strategy is seen as a widely used justification for the use of a particular sample size. The limited sample size of the GPs is attributed to that most GPs experienced lack of time, therefore, they indicated that they were unable to participate. Notwithstanding the relatively limited sample size of GPs, our findings are consistent with those of other studies that investigate the motivation of GPs to refer to lifestyle interventions. This suggests that the validity of this study remained intact.

Additionally, the different barriers and facilitators of care groups are investigated by applying the Theory of Planned Behaviour. The limitation of this study is that this theory describes the elements that influence initiating individualistic behaviour. To the best of our knowledge, no research has been done to justify the application of TPB on organizational behaviours, such as contracting lifestyle coaches. Therefore, the reliability of this study might be uncertain. Despite its exploratory nature by applying TPB to the contracting behaviour of care groups, the reliability was protected by the summaries that were sent to the respondents, in order to check the interpretations of the interviewer.

Although we are not able to generalize our results, based on the qualitative characteristics of this research, our study has provided a deeper insight into the implementation of lifestyle interventions in the Dutch healthcare system. The strength of this research is the exploratory nature of the barriers and facilitators of care groups to contract lifestyle coaches. To the best of our knowledge, this is the first research that has been done to investigate the perception of care groups.

7 Conclusion

This purpose of the current study was to determine the different barriers and facilitators of general practitioners (GPs) and Dutch care groups to cooperate with the profession of lifestyle coaches. This research has shown that, in general, the intention to cooperate with lifestyle coaches within the primary healthcare setting is high. Dutch care groups and GPs held positive attitudes towards lifestyle interventions and experienced positive subjective norms. However, both groups experienced barriers in their perceived behavioural control, due to mostly policies constructions.

The current challenge of the implementation of the profession of lifestyle coaches is that all different entities have to find mutual agreements on the long term objectives of the implementation, namely, reducing the national healthcare costs and a healthier Dutch population. Only if all the relevant stakeholders of the CLI collaborate and communicate intensively, we are able to make the first prevention intervention within the basic healthcare insurance a success. Additionally, the current variation of the short-term interest between different entities might consequently lead to too much uncertainties that can affect the contracting and referring behaviour of GPs and care groups in the future.

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Appendix 1: Interview Design General Practitioners (NL)

Interview Design voor de Academie voor Leefstijl en Gezondheid

Meenemen:

- Informele kleren
- Papier
- Pen
- Recorder
- Informed consent
- Bedankje (gezonde snack of bloemetje)
- **Print interview guide!**

Interview gids Dit is een lijst van vragen en onderwerpen die tijdens het interview behandeld dient te worden in deze volgorde. Volg deze gids voor betrouwbare kwalitatieve data die met elkaar vergeleken kan worden.

- Het interview is semigestructureerd met open vragen: de onderwerpen dienen behandeld te worden maar er moet ruimte voor de deelnemer te zijn om in te gaan op zijn of haar antwoorden. Dit zorgt voor diepgaande inzichten van de perspectief van de deelnemers
- De vragen gaan in op de theorie van Azjen: The Theory of Planned Behaviour

Belangrijk voor de interviewer, voor het interview

- Wees professioneel maar niet te formeel
- Kleed je geschikt voor de situatie
- Denk aan het gebruik van probes, deze staan opgesomd aan het einde van de pagina
- Denk aan de ethische aspecten:
    - Breng de deelnemer in geen enkele situatie schade toe
    - Het interview is vertrouwelijk
    - Heb respect voor de deelnemer

Introductie

Introduceer jezelf en je onderzoek

- Naam en achtergrond
- Achtergrond van de Academie voor Leefstijl en Gezondheid

- Doel van het onderzoek: efficiëntere samenwerking tussen huisarts en leefstijl coaches.
- Binnen in dit interview wil ik me graag specifiek focussen op de behoeftes van de huisartsen voor een efficiënte samenwerking.
- Aan de hand van de resultaten wil ik graag nieuwe inzichten opdoen over de barrières en facilitators van huisartsen om door te verwijzen naar Leefstijlcoaches. Ik ga hier vervolgens aanbevelingen over schrijven.
- Er is absoluut geen goed of fout antwoord, ik ben echt benieuwd naar uw kijk hierop
- Uw antwoorden worden getranscribeerd en gecodeerd.
- U kunt zich te allen tijde terugtrekken uit het onderzoek.
- Ik zou graag opnames een notities willen maken voor de kwaliteit van het onderzoek

Vragen:

- Hoe oud bent u?
- Hoelang bent u al werkzaam als huisarts?
- Wat motiveert u om werkzaam te zijn als huisarts?
- Hoeveel uur werkt u gemiddeld in de week?
- In wat voor een praktijk bent u werkzaam?

  → solopraktijk → deelpraktijk →gezondheidscentrum
- Hoe belangrijk is leefstijl in uw eigen leven?

Concept	Vragen
Kennis	• Zou u voor mijn beeld kunnen omschrijven wat het vak leefstijlcoach inhoudt? • Hoe ervaart u de volledigheid van uw kennis over het vak van een leefstijlcoach? • Hoe vaak staat u momenteel in contact met Leefstijlcoaches?
Patiënt indicatoren	• Wat zijn de indicaties van een patiënt om een geschikte te zijn voor een leefstijlinterventie?
Intentie	• Hoe vaak treft u deze patiënten in uw praktijk? • Hoe vaak overweegt u om deze patiënten door te verwijzen naar een leefstijlcoach? • Hoe vaak heeft u in de afgelopen 3 maanden doorverwezen naar leefstijlinterventies? * *Als er een discrepantie is tussen hoe vaak patiënten geschikt zijn en hoe vaak de huisarts overweeg → vraag waarom dit zo is!*
Perspectief (Instrumentele overtuigingen)	• Wat verwacht u dat gebeurt met een patiënt als u doorverwijst naar een leefstijlcoach? • Wat is naar uw idee de voordelen van doorverwijzen naar een leefstijlcoach? • Wat is naar uw idee de nadelen van doorverwijzen naar een leefstijlcoach?
Perspectief (Affectieve overtuigingen)	• Hoe staat u tegenover het doorverwijzen naar een leefstijlcoach?
Subjectieve normen van huisartsen	• Heeft u het met uw collega's weleens over het werk van leefstijl coaches? • Wat vinden collega's van het verwijzen naar Leefstijlcoaches? • Hoe wordt er over verwijzen naar Leefstijlcoaches gesproken in uw directe omgeving?

	● Hoe hebben de overtuigingen van je directe omgeving invloed in uw overweging om door te verwijzen naar Leefstijlcoaches?
Waargenomen gedragscontrole	● Wat heeft u nodig in het doorverwijzen naar Leefstijlcoaches? ● In hoeverre ervaart u momenteel dat u in staat bent om door te verwijzen? ● Wat zijn uw obstakels in het doorverwijzen naar Leefstijlcoaches? ● Hoe hebben uw obstakels invloed in uw overweging om door te verwijzen naar Leefstijlcoaches?

Afsluiting

- Samenvatting van de bevindingen, check dit bij de huisarts.
- Is er iets wat je nog zou willen toevoegen of wat niet genoemd is?
- Zijn er vragen of opmerkingen?
- Leg uit wat er hierna gebeurt, maak een afspraak over contact in het vervolg - geef contactgegevens voor als de huisarts nog vragen heeft op een later moment, een samenvatting zal worden gestuurd om zeker te weten dat alles goed begrepen is.
- Aan het einde zullen we een samenvatting maken, deze kunnen we naar u sturen zodat u terug kunt lezen wat er is gezegd en zo nodig nog dingen aanpassen. (Ook de optie om te bellen en het erover te hebben!)
- Informeer over hoe lang de data opgeslagen zou zijn en wie hier toegang tot heeft.
- Bedank de huisarts en geef het bedankje

· **Proces:**

Detail-georiënteerd (waar, wanneer, hoe)
Stille prove
Echo prove (herhaling, vraag om door te gaan)
Neutrale prove (uh huh, ik begrijp het)
Uitwerken van een vraag (vertel me meer, waarom precies…)
Lange vragen prove (de vraag om een gedetailleerder antwoord te geven)

Appendix 2: Interview Design Care Groups (NL)

Interview Design voor de Academie voor Leefstijl en Gezondheid

Meenemen:

- Informele kleren
- Papier
- Pen
- Recorder
- Informed consent
- Bedankje (gezonde snack of bloemetje)
- **Print interview guide!**

Interview gids Dit is een lijst van vragen en onderwerpen die tijdens het interview behandeld dient te worden in deze volgorde. Volg deze gids voor betrouwbare kwalitatieve data die met elkaar vergeleken kan worden.

- Het interview is semigestructureerd met open vragen: de onderwerpen dienen behandeld te worden maar er moet ruimte voor de deelnemer te zijn om in te gaan op zijn of haar antwoorden. Dit zorgt voor diepgaande inzichten van de perspectief van de deelnemers
- De vragen gaan in op de theorie van Azjen: The Theory of Planned Behaviour

Belangrijk voor de interviewer, voor het interview

- Wees professioneel maar niet te formeel
- Kleed je geschikt voor de situatie
- Denk aan het gebruik van probes, deze staan opgesomd aan het einde van de pagina
- Denk aan de ethische aspecten:
    - Breng de deelnemer in geen enkele situatie schade toe
    - Het interview is vertrouwelijk
    - Heb respect voor de deelnemer

Introductie

Introduceer jezelf en je onderzoek

- Naam en achtergrond

- Achtergrond van de Academie voor Leefstijl en Gezondheid
- Doel van het onderzoek: efficiëntere samenwerking tussen zorggroepen en leefstijl coaches.
- Binnen in dit interview wil ik me graag specifiek focussen op de behoeftes van de zorggroepen voor een efficiënte samenwerking.
- Aan de hand van de resultaten wil ik graag nieuwe inzichten opdoen over de barrières en facilitators van zorggroepen om Leefstijlcoaches te contracteren. Ik ga hier vervolgens aanbevelingen over schrijven.
- Er is absoluut geen goed of fout antwoord, ik ben echt benieuwd naar uw kijk hierop
- Uw antwoorden worden getranscribeerd en gecodeerd.
- U kunt zich te allen tijde terugtrekken uit het onderzoek.
- Ik zou graag opnames een notities willen maken voor de kwaliteit van het onderzoek

Vragen:

- Wie bent u?
- Wat is uw achtergrond?
- Wat is uw functie binnen uw zorggroep?
- Wat zijn de expertises van deze zorggroep?
- Heeft u zorggroep momenteel contracten met Leefstijlcoaches?

**Zo nee, vraag waarom niet*

Concept	Vragen
Kennis	• Zou u voor mijn beeld kunnen omschrijven wat het vak leefstijlcoach inhoudt? • Hoe ervaart u de volledigheid van uw kennis over het vak van een leefstijlcoach? • Hoe vaak staat u momenteel in contact met Leefstijlcoaches?
Intentie	• In hoeverre bent u gemotiveerd om Leefstijlcoaches te contracteren?
Perspectief (Instrumentele)	• Wat verwacht u dat gebeurt voor uw organisatie als uw zorgroep een leefstijlcoach contracteert? • Wat is naar uw idee de voordelen van het contracteren van een leefstijlcoach? • Wat is naar uw idee de nadelen van het contracteren van een leefstijlcoach?
Perspectief (affectieve)	• Hoe staat u tegenover het contracteren van uw zorggroep met een leefstijlcoach?
Subjectieve normen	• Heeft u het met uw collega's weleens over het werk van leefstijl coaches? • Wat vinden collega's van het contracteren van Leefstijlcoaches? • Hoe wordt er over contracteren over Leefstijlcoaches gesproken in uw directe omgeving? • Hoe hebben de overtuigingen van je directe omgeving invloed in uw overweging om door te verwijzen naar Leefstijlcoaches? In hoeverre zijn uw collega's binnen de zorggroep bekend met Leefstijlcoaches?
Waargenomen gedragscontrole	• Wat heeft u nodig om uw zorggroep te contracteren met Leefstijlcoaches? • In hoeverre ervaart u momenteel dat u in staat bent om contracten met Leefstijlcoaches af te sluiten? • Wat zijn uw obstakels in het contracteren van Leefstijlcoaches?

	• Hoe hebben uw obstakels invloed in uw overweging Leefstijlcoaches te contracteren?

Afsluiting

- Samenvatting van de bevindingen, check dit bij de deelnemer?
- Is er iets wat je nog zou willen toevoegen of wat niet genoemd is?
- Zijn er vragen of opmerkingen?
- Leg uit wat er hierna gebeurt, maak een afspraak over contact in het vervolg - geef contactgegevens voor als de huisarts nog vragen heeft op een later moment, een samenvatting zal worden gestuurd om zeker te weten dat alles goed begrepen is.
- Aan het einde zullen we een samenvatting maken, deze kunnen we naar u sturen zodat u terug kunt lezen wat er is gezegd en zo nodig nog dingen aanpassen. (Ook de optie om te bellen en het erover te hebben!)
- Informeer over hoe lang de data opgeslagen zou zijn en wie hier toegang tot heeft.
- Bedank de deelnemer en geef het bedankje

· **Probes:**

Detail-georiënteerd (waar, wanneer, hoe)
Stille prove
Echo probe (herhaling, vraag om door te gaan)
Neutrale probe (uh huh, ik begrijp het)
Uitwerken van een vraag (vertel me meer, waarom precies…)
Lange vragen probe (de vraag om een gedetailleerder antwoord te geven)

Appendix 3: Successful Meeting with the Secretary of the State of Public Health