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Health awareness and lifestyle toward healthcare-seeking behavior among students in Universitas Advent Indonesia

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Abstract: **Objective:** Healthcare-seeking behavior (HSB) would affect the prevalence of morbidity and mortality. There are various factors that affect one's HSB. This study aimed to determine if health awareness and lifestyle might relate to HSB.
Methods: A cross-sectional study was applied by using three questionnaires to determine participants' health awareness, lifestyle, and HSB. This study took place in Universitas Advent Indonesia and the students were recruited to be participants.
Results: There were 39 participants joined in this study. Most of the participants were females, third-year students, and from Accounting major. Almost all participants were aware of their low risk of health issues, had a fine lifestyle, and had moderate HSB.
Conclusions: One's urge to seek health care facilities was not related to their health awareness and lifestyle. There was no further study to contradict with this finding at this moment.

Keywords: health awareness • healthcare-seeking behavior • healthcare service utilization • lifestyle • public health

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1. Introduction

Healthcare-seeking Behavior (HSB), which can also be termed as illness behavior or sick-term behavior, is any action or inaction by individuals who consider themselves having a health problem to seek appropriate remedy.[1] HSB includes health-seeking behavior, the action of individuals to conduct health screening to detect any minor symptoms to get treatment immediately in case there is something needed to be cured.[2] It will affect health care utilization involving in health care policies and planning for prevention, early diagnosis, and management of health conditions, which will impact to reduction of health care costs, disability, and death from diseases.[3] Furthermore, HSB is also contributing to providing data about emerging diseases in certain areas, which can be public-health threat[4] as prevention for the diseases become epidemic or even pandemic.

Numerous factors can affect individuals' HSB. Living area, educational level, Internet usage to look for information about disease, perception of own health status, and alternative medicine usage can be some factors that can affect HSB.[5] These are just some of them and there are still many other factors mentioned by various researchers. Factors that become barriers that cause delays in seeking care of individuals are

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associated with remarkable morbidity and mortality.[6] It is more obvious that poor HSB will cause more health problems to individuals or even to society.

As the fourth most populous country in the world, Indonesia has more than 260 million inhabitants[7] with countless diversities. Upon various backgrounds of people, Indonesia also has various levels of HSB. In some areas, poor HSB is related to a poor understanding of the disease process about educational level, socio-economic status, occupation, and distance to nearest health facilities.[8] This problem is a barrier for Indonesia to achieve the third Sustainable Development Goal (SDG)—good health and well-being.

HSB impacts the health level of an area or country. Curiosity emerges to find more significant factors to improve HSB. Health status awareness and lifestyle are suspected to have a role in influencing HSB. Therefore, this research aimed to find the correlation of health status awareness and lifestyle toward HSB.

2. Methods

2.1. Study design

A cross-sectional design was applied in this study, which displayed a quantitative description of health status awareness, lifestyle, and HSB of the population's representative without any experiment. The primary purpose of this study was to figure out whether health status awareness and lifestyle would affect HSB.

2.2. Setting and samples

This study was conducted at the private Adventist University located in West Java, Indonesia. Six faculties were available at this university: (1) nursing faculty, (2) economy faculty, (3) theology faculty, (4) mathematics and science faculty, (5) education faculty, and (6) information technology faculty. To avoid bias, nursing faculty was excluded from this study. The participants were male or female aged 19–27 years of age to have the same knowledge/perception and could be independent to join the study as they were already in the early adulthood phase. The exclusion criteria were students from the nursing faculty and aged <19 years old or >27 years old.

2.3. Data collection

The main tool in quantitative research is a questionnaire and this study utilized three questionnaires. The first questionnaire was Family History Screening,[9] developed and validated by Emery et al., to determine the awareness of participants about their health based on family history. There were 15 questions in this questionnaire—13 questions were related to family history and 2 questions related to ethnicity. According to their answer, participants were categorized into *Not Aware*, *Aware of Low Health-Risk*, and *Aware of High Health-Risk*.

The second questionnaire was the Healthy Lifestyle Screening Tool,[10] developed and validated by Kim and Kang, to determine how healthy the lifestyle of the participants were. There were 9 domains with a total of 36 questions related to sunlight, water, air, rest, exercise, nutrition, temperament, trust, and general condition. The responses were using a Likert Scale from 1 to 5, representing "Strongly Disagree," "Disagree," "Neutral," "Agree," and "Strongly Agree." The score range of the responses was 36–180 and categorized as *Poor Lifestyle*, *Moderate Lifestyle*, and *Fine Lifestyle*.

The third questionnaire was the Healthcare-Seeking Behaviour Questionnaire,[11] developed and validated by Davidson and Schattner, to determine the degree of HSB from participants. This questionnaire consisted of 11 questions and also used a Likert Scale from 1 to 5. The categories of this variable were *Poor Attitude*, *Moderate Attitude*, and *Fine Attitude*. All the questionnaires were created in a Google Form and were shared in university's WhatsApp and Telegram groups. Informed consent was available on the first page of Google Form and participants could start to fill the form after giving their consent.

2.4. Data analysis

All the data from Google Form were created into an Excel sheet. Participants' score for each variable was calculated and coded into their degrees. Health awareness and lifestyle were considered independent variables, whereas HSB was the dependent variable. The correlation between these variables was analyzed using IBM Statistical Package for the Social Sciences (SPSS) 27.0 (IBM Corporation, Armonk, NY, United States) using Spearman's rho since the data were not normally distributed. There would be a correlation if the significance score of $\alpha \leq 0.05$.

2.5. Ethical considerations

The study was approved by Ethic Committees of Universitas Advent Indonesia. Participants were provided about the purpose of this study through informed consent. All the data will be kept confidential with a specific code for each participant. There was no coercion to participate in this study, which gave participants full freedom to refuse or withdraw from this study at any time.

3. Results

Participants' demographic data are presented in Table 1. Most of the participants were females with ages ranging from 18 years old to 20 years old. The biggest sample was in third-year degree and from Accounting major of Economy faculty.

As a result of answers received from the questionnaire, most of the participants were aware of low health risk (92.3%), had a good lifestyle (76.9%), and had moderate HSB (46.2%). The complete data along with the score classification were presented in Table 2.

Classification	N	%
Gender		
Female	23	0.590
Male	16	0.410
Age (years old)		
18–20	22	0.564
21–23	15	0.385
24–27	2	0.051
Major		
Accounting	28	0.718
Management	5	0.128
Information System	2	0.051
Information Technology	3	0.077
Education	1	0.026
Grade		
First-year	6	0.154
Second-year	5	0.128
Third-year	22	0.564
Fourth-year	6	0.154

Table 1. Demographic data.

Classification	N	%
Health awareness		
Not aware	3	0.077
Aware of low health-risk	36	0.923
Aware of high health-risk	0	0
Lifestyle		
Fine lifestyle (score >120)	30	0.769
Moderate lifestyle (score 81–120)	9	0.231
Poor lifestyle (score 36–80)	0	0
HSB		
Fine ehavior (score >35)	5	0.128
Moderate ehavior (score 26–35)	18	0.462
Poor ehavior (score 11–25)	16	0.410

Note: HSB, healthcare-seeking behavior.

Table 2. Health awareness, lifestyle, and HSBehavior of participants.

Variables	HSB
Health awareness	
Correlation	0.103
Sig. (2-tailed)	0.532
N	39
Lifestyle	
Correlation	−0.059
Sig. (2-tailed)	0.720
N	39

Note: HSB, healthcare-seeking behavior.

Table 3. Correlation between variables.

Finally, the correlation of health awareness and lifestyle toward HSB was analyzed using Spearman's rho. There was no correlation between variables since all the significance coefficients is $\alpha > 0.05$ (Table 3).

4. Discussion

This study aimed to find the new factors that might influence one's HSB. Nonetheless, this study did not find a correlation between one's health awareness to their HSB. Health awareness in this study was defined as one's awareness of their risk in getting sick because of disease in family history. Other studies found a correlation between one's perception of their health status and behavior of seeking healthcare facilities.[12–15] However, perception of their health status at the present moment while they had health issues was different compared with only knowing their family history disease. The knowledge of family history disease did not affect one's behavior to seek help in health care facilities.

Moving to another variable, lifestyle also did not correlate with HSB in this study. It was contradicted with study by Sultana et al.,[16] which found an association between lifestyle and HSB, yet the correlation was not explained in their study. Another study to explore the lifestyle and health care service utilization of Nepali migrants in India found that they had poor lifestyle and poor health care service utilization.[17] It might seem contradicted with this study, but their poor access to health care was due to poverty and discrimination which were similar barriers found in the study conducted in Austria.[18] There was no study concluded that lifestyle could affect one's HSB, but one study proposed healthy lifestyle promotion might improve health care utilization.[19]

As stated earlier, we hypothesized that health awareness and lifestyle might have a correlation to HSB. It was suspected that type 1 error was applied

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as the outcome of this study as both independent variables turned out to not have any correlation with the dependent variable. This might happen because the utilization of incorrect tool or little sample size. Future researchers could conduct a deeper study in this field by using different questionnaires or gathering more samples. Or, qualitative study could be implemented to cultivate one's perspective and behavior. In the meantime, we believed that the result was precise since there was no further study contradicting it yet.

5. Conclusions

Health awareness of one's risk of acquiring disease in family history was not relevant to their HSB. Lifestyle also did not have an association to increase or decrease one's HSB. Health awareness and lifestyle were irrelevant compared with their perception of their health status in the moment which would create the urgency or not to visit healthcare facilities.

Acknowledgment

Ethical Approval

The study was approved by Ethic Committees from Universitas Advent Indonesia.

Conflicts of Interest

All contributing authors declare no conflicts of interest.

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