Health Belief Model

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**Introduction**

The purpose of this paper is to present a summary of the Health Belief Model. The first section of this paper will present a brief explanation of the origins and background of this model. The next section will provide the key concepts of the model. The following section will discuss the application of the model within the scholarly literature, and to the Community Wellness Project. The final section of the paper will present some of the limitations and strengths of the model. There will also be a references section at the end of the paper.

**Origins/Background of the Health Belief Model**

This section will trace the origin and development of the Health Belief Model. The Health Belief Model was developed in the 1950s by social psychologists in the United States Public Health Service to explain the failure of people to participate in programs to prevent and detect disease (Hochbaum, 1958; Rosenstock, 1960, 1974). The model was later extended to study people’s responses to symptoms (Kirscht, 1974) and their behaviors in response to a diagnosed illness, particularly adherence to medical regimens (Becker, 1974).

**Key Concepts of the Health Belief Model**

This section will list and explain each of the key concepts covered within the Health Belief Model. The Health Belief Model contains several primary concepts that predict why people will take action to prevent, to screen for, or to control illness conditions. These include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. If individuals regard themselves as susceptible to a condition, believe that condition would have serious consequences, believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition, and believe the benefits of taking action outweigh the barriers to action, they are likely to take action
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that they believe will reduce their risks. In the case of medically established illness (rather than risk reduction), the dimension has been reformulated to include acceptance of the diagnosis, personal estimates of susceptibility to consequences of the illness, and susceptibility to illness in general (Champion & Skinner, 2008).

Champion and Skinner (2008) present the key constructs of the Health Belief Model as follows:

*Perceived susceptibility* refers to beliefs about the likelihood of getting a disease or condition. *Perceived severity* refers to feelings about the seriousness of contracting an illness or of leaving it untreated including evaluations of medical and clinical consequences, and social consequences. The combination of susceptibility and severity are labeled as perceived threat. Individuals exhibiting beliefs in perceived threat are not expected to accept any recommended health action unless they also perceive the action as beneficial by reducing the threat (*perceived benefits*). The potential negative aspects of a particular health action (*perceived barriers*) act as impediments to undertaking recommended behaviors. An analysis occurs wherein individuals weigh the action’s benefits with perceived barriers. Susceptibility and severity plus perceived benefits minus perceived barriers provide a preferred path of action (Rosenstock, 1974). Hochbaum (1958) thought that readiness to take action could only be potentiated by other factors, particularly by cues to instigate action. Although the concept of cues as triggering mechanisms is appealing, *cues to action* are difficult to study in explanatory surveys. *Self-efficacy* is defined as the conviction that one can successfully execute the behavior required to produce the outcomes (Bandura, 1977). Bandura
distinguished self-efficacy expectations from outcome expectations, defined as a person’s estimate that a given behavior will lead to certain outcomes. Outcome expectations are similar to but distinct from the Health Belief Model concept of perceived benefits. Rosenstock, Strecher, and Becker (1988) suggested that self-efficacy be added to the Health Belief Model as a separate construct. Self-efficacy was never incorporated into early formulations of the Health Belief Model. The original model was developed in the context of preventative health actions that were not perceived to involve complex behaviors. Self-efficacy is important in initiation and maintenance of behavioral change (Bandura, 1997; pp. 47 – 50).

For behavior change to succeed, people must feel threatened by their current behavioral patterns (perceived susceptibility and severity) and believe that change of a specific kind will result in a valued outcome at an acceptable cost (perceived benefit). They also must feel themselves competent to overcome perceived barriers to take action. Diverse demographic, sociopsychological, and structural variables also influence perceptions and thereby influence health-related behavior as well (Champion & Skinner, 2008).

A review of studies of the Health Belief Model conducted between 1974 and 1984 combined new results with earlier findings to permit an overall assessment of the model’s performance (Becker, 1974; Janz & Becker, 1984). Perceived barriers were the most powerful single predictor across all studies and behaviors. Although perceived susceptibility and perceived benefits were important overall, perceived susceptibility was a stronger predictor of preventive health behavior than sick-role behavior. The reverse was true for perceived benefits. Overall, perceived severity was the least powerful predictor; however, this was strongly related to sick-role behavior (Champion & Skinner, 2008).
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Application in the Scholarly Literature and to the Community Wellness Project

This section will look at how the key concepts of the Health Belief Model have been applied in the scholarly literature and to the Community Wellness Project including the Focus Group and follow-up Presentation. According to Rosenstock (1966), the original goal of the model was to focus the efforts to improve public health by understanding why people failed to adopt a preventative health measure. The model’s ability to explain and predict a variety of behaviors associated with positive health outcomes has been successfully replicated (Janz & Becker, 1984). The model has also been used to develop many successful health communication interventions by targeting messages at the Health Belief Model constructs to change health behaviors (Sohl & Moyer, 2007). The individual constructs of the model, however, have varied in their ability to predict health behaviors (Harrison, Mullen, & Green, 1992). Rosenstock (1966) argued that in order for relationships between behavior and the Health Belief Model constructs to have any meaning, the subjects’ perceptions of these constructs have not changed since they first adopted the behavior. Cognitive dissonance would predict that perceptions of the constructs would change after adopting a prevention behavior since once one adopts a behavior, one is likely to change one’s belief to be consistent with that behavior. This would predict a strong relationship between the constructs and the behavioral change. Janz and Becker (1984) argued the opposite pattern of results could occur suggesting that after one has adopted a prevention behavior, one should perceive oneself as less susceptible to the negative health outcome causing a negative relationship between the constructs and the behavior change (Carpenter, 2010).

Research has identified perceived barriers as a significant predictor of behavior (Carpenter, 2010; Janz & Becker, 1984). Practitioners should focus their efforts on identifying and countering perceived barriers. Yet data also suggest that perceived barriers are engaged only
Health Belief Model for individuals with low to moderate self-efficacy. This suggests that self-efficacy could be low because individuals perceived insurmountable barriers to action. Targeting barriers to action may then increase self-efficacy. Where self-efficacy is high, practitioners may find it beneficial to target perceived threat. Threat is more effective for high self-efficacy populations. Perceived benefits may be a lower priority or best targeted at a later stage. For example, once self-efficacy and threat are high and perceived barriers are low, then the influence of perceived benefits could manifest to influence behavior (Jones et al., 2015).

The Health Belief Model is a behavioral change model that can be used to assess and treat overweight and obese patients, stressing the importance of addressing the psychological co-morbidities that can affect long-term success. If the patient’s health beliefs do not support the management of overweight and obesity, they are less likely to achieve and maintain weight loss (Daddario, 2007). Just as the Health Belief Model can be used for overweight and obese patients, it can also be used to assess nutritional behavioral change of seniors. The Community Wellness Project will be conducted at the Keene Senior Center with Keene residents over the age of 50 concerning nutrition among seniors. The Health Belief Model constructs can be utilized to assess change in eating for nutritional health. Perceived susceptibility is the perception of becoming sick if not eating healthy food. Perceived severity is the perception of the consequences of that illness. Perceived benefit is the perception of obtaining optimum health with proper nutrition. Perceived barriers are the impediments to undertaking healthy eating, such as cost, time, and planning. The Keene Senior Center provides Garden Fresh Friday supplying a well-balanced lunch with nutrition education by a Keene State College nutrition intern. This can be an external cue to action. Self-efficacy is their belief that they can obtain optimal health by eating nutritious food daily. The answers to the questions from the Focus Group can reveal how ready the seniors
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are to change their eating habits. The presentation will address their readiness, their beliefs and perceptions, and enhance their self-efficacy in order for them to take action in eating healthy, nutritious meals every day.

**Conclusion**

Williams, Grow, Freedman, Ryan, and Deci (1996) identified the Health Belief Model as the motivational approach most frequently applied in health care settings. The primary motivation to change is the level of perceived threat or risk of a specific condition, and the primary resource for change is self-efficacy or confidence. The person with a greater level of confidence will more likely engage in a specific behavior to improve health. This process occurs in several steps. Certain cues would stimulate the person’s threat of the disease by influencing perceived seriousness, susceptibility, or both. With more powerful cues, those with more personal relevance, or the accumulation of cues, the person is stimulated to take action. The person’s action results from perceived benefits, perceived barriers that could be overcome, costs that could be avoided, and the person’s confidence in his or her ability to perform the new behavior. Individuals select from the alternative behaviors to minimize the perceived threat. Research focuses on performing or not performing a specific behavior. Little research has been completed related to cues to action. Internal cues, such as feeling better physically or mentally after taking an action, were rated as the most likely to prompt action. However, people may not accurately rate the importance of a cue to change (Daddario, 2007).

Despite a large body of research supporting the influence of the Health Belief Model constructs on health behavior, ambiguity still exists concerning which constructs are most important and how the constructs interact within the model. Exploring construct ordering within
the Health Belief Model will advance theory and practice by improving evaluation, identifying relative importance of the constructs, and suggesting new postulates for behavior change (Jones et al., 2015).

References


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