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Reconfiguring the concept and practice of 'health promotion' in nursing is needed to shift health inequalities

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Abstract

Health inequalities remain persistent and challenging. In some instances, health inequalities are growing within society with some communities disproportionately likely to die sooner and experience more ill health. At the core of addressing health inequalities is a need to focus on structural and political level determinants, rather than individual choices and lifestyles which are often a manifestation of broader economic and social issues. Health promotion is a key discipline in reversing health inequalities and it is laudable that the nursing curricula focuses substantially on promoting health. However this paper argues that without reconfiguration of training and practice, the nurse workforce will consistently fall short in meaningfully addressing health inequalities. A shift is needed in the training; conceptual understanding; and practical execution of health promotion by those within the nursing sector. The paper suggests some tangible ways forward to redefine the health-promoting potential of the nurse workforce.

This paper seeks to challenge current views about the role of the nurse workforce in tackling health inequalities, which remain stubborn and persistent both at a national and international level. The paper will argue that health promotion – a fundamental aspect of nurse education – is a key discipline in eradicating social injustices in health. However, current conceptualisations and ways of 'doing' health promotion by the nurse workforce fall short of making tangible impacts. Some practical suggestions to reconfigure the concept and practice of 'health promotion' in nursing is offered, including a move away from behaviour change approaches and lifestyle modifications toward focusing efforts on the broader social impacts on health.

It is well known that inequalities relate to differences in people's health as a result of a range of social or economic factors. Differences in people's health could relate to their life expectancy or their susceptibility to a particular condition (e.g. cancer or obesity) (Woodall and Cross, 2021). This article does not intend to rehearse the epidemiological data, but does seek to point out that health inequalities between groups continue to grow in the UK (Marmot et al., 2020). Moreover, commentators have argued that a shift is occurring whereby the long-held assumption that the next generation will live longer than the previous generation, may not always be the case:

> *"The UK has been seen as a world leader in identifying and addressing health inequalities but something dramatic is happening."* (Marmot et al., 2020: 5)

Inequalities relating to education, income and social status are having tangible impacts on people's health and circumstances. Health promoters, whose remit leans heavily on reducing inequalities, remain concerned by the current picture of widening health inequalities (Scriven et al., 2024).

One explanation for health inequalities is that due to material differences in people's lives, such as unemployment and/or poor living conditions, this can lead to chronic stress and impact negatively on health. This, for many, is the most plausible theory for health inequalities (Woodall and Cross, 2021). This raises wider questions about how to tackle health inequalities and who is best placed. Arguably, much of the action required must occur at structural levels rather than on an individual basis (through health coaching or health education, for example). Several international declarations have emphasised the structural factors influencing people's health – the Shanghai declaration on health promotion (WHO, 2016) strongly emphasised the role of structural forces on health outcomes over and above the role of individual decision-making and choice. Structural approaches, through legislation for example, can change behaviour on a greater magnitude. The seminal work of McKinlay (1979: 23) noted that this can be equal to several forms of individually targeted health intervention:

> *"It is probably true that one stroke of effective health legislation is equal to many separate health intervention endeavours and the cumulative efforts of innumerable health workers over long periods of time…greater changes will result from the continued politicization of illness, than from the modification of specific individual behaviours."*

In contemporary contexts, a recent example is also found with the move to smoke-free environments driven through policy-action. The Scottish prison Service, for instance, reduced the levels of second-hand smoke with effective policy design and implementation (Hunt et al., 2022). Other structural interventions open to address inequalities includes taxation to deter 'unhealthy' products from being purchased (Hawkins and McCambridge, 2020). Many jurisdictions across the USA as an example, implemented a soda tax to prevent the excessive purchase of sugary drinks and, indeed, saw reductions in consumption (Gostin, 2017). Some consider these macro-health promotion activities (policy intervention, like taxation on unhealthy products) as an apparatus of an overly authoritarian and preaching 'nanny state'. They argue that the state should let its citizens choose how they wish to lead their own life (Lupton, 1995). In this individualist perspective, the enterprise of health promotion is challenged, with the only acceptable policy being based on free availability of epidemiological information and total liberty of choice (Davison and Davey Smith, 1995).

Given the brief backdrop, this article turns to the question of how nurses can contribute to addressing health inequalities in their practice. This is because it is frequently purported that nurses are critical in promoting health (Kemppainen et al., 2013). One of the expectations of a nurse and nursing associate is to "promote health and prevent ill health to improve and maintain the mental, physical, behavioural health and well-being of people, families, carers and communities". Promoting health is a fundamental proficiency required by the Nursing and Midwifery Council (NMC) for future and registered nurses, midwives, and nurse associates, across all four fields of nursing practice (adult, children, learning disabilities and mental health). Health promotion is a professional practice standard as stipulated in the NMC's 'The Code' (Nursing and Midwifery Council, 2018a). Health promotion, therefore, is a significant element of nurse education.

Analysis has, however, highlighted some role confusion for nursing professionals and difficulties in establishing the boundaries of their role (Whitehead, 2010). Clearly the role of a nurse in a patient-centred consultation offers a myriad of opportunity to engage constructively around health education, but research has demonstrated that the ability for nurses to influence policy or tackle structural matters that influence health inequalities is relatively rare, with school nursing being one exception where influence has been made by nurse professionals at policy levels (Iriarte-Roteta et al., 2020). Some have been vehemently critical of the nursing profession, by claiming their

reluctance to engage in shaping policy and political decision-making around the determinants of health (Fyffe, 2009). Addressing lifestyle issues has often been seen as a synonym in nursing for 'doing health promotion' (Irvine, 2007), but commentators have questioned the futility of focussing on 'lifestyle' when many behaviours are manifestations of far wider social and structural problems (Green et al., 2019). Some have queried whether the conceptual basis by which nursing professionals consider and practice health promotion is fundamentally limited in scope (Iriarte-Roteta et al., 2020). The adherence to a medical model, by which many nurses subscribe to, can be ideologically at-odds with holistic views of health promotion (Woodall and Freeman, 2020).

The education and training of nurses, particularly through university-level nursing curricula, has been identified as one way of enabling nurses to work more effectively in health promotion and in addressing health inequalities (Iriarte-Roteta et al., 2020, Institute for Apprenticeships & Technical Education, 2023). Promoting health and preventing ill health are the focus of Platform 2 of the NMC's standards of proficiency for registered nurses and nurse associates (Nursing and Midwifery Council, 2018b, Nursing and Midwifery Council, 2018c) and public health, health promotion and health protection are the focus of Domain 3A of the NMC's standards of proficiency for registered midwives (Nursing and Midwifery Council, 2019). All three documents state that nurses, midwives, and nursing associates should demonstrate an understanding of health inequalities and the wider determinants of health. Yet, working at structural and population-levels is not the raison d'être of most of the nurse workforce (Mabhala, 2015).

Despite the identification of improving global training and education for nurses to address health inequalities through health promotion practice (Rosa et al., 2021), there exists a wide variation of health promotion curriculum content and structure in the United Kingdom and internationally (Mooney et al., 2011). This variation in content potentially relates to a lack of clarity of what health promotion practice entails for these health professionals (Iriarte-Roteta et al., 2020). The development of Health Promotion Practice (HPP) competency frameworks has evolved since the Ottawa Charter (WHO, 1986) which introduced core principles and approaches to HPP, and can be useful for offering a consensus for the skills, knowledge, training, and ideals necessary for HPP for nurses (Battel-Kirk et al., 2009, Shilton, 2009). These include the Galway Consensus (Barry et al., 2009), most suited to those considered 'specialist health promoters' whose work almost exclusively adopts HPP activity (Battel-Kirk et al., 2009), and the UK Public Health Skills and Knowledge Framework (Public Health England, 2016), most likely to be adopted by those working within the healthcare workforce. However, competency frameworks can be restrictive and task oriented (Cross et al., 2021) and as health-promoting activities are diverse and forever evolving, competencies could restrict practitioner's abilities for reflection, which is essential for critical practice (Naidoo and Wills, 2016). What is fundamental in nursing education is nurturing an interest in the determinants that influence health, wellbeing and happiness, including the personal, economic, environmental, social and structural factors that shape health choices for people and communities. Yet, nurse educators working in training new practitioners may be inclined to replicate their own understanding of health promotion, which as alluded to already may be limited to lifestyle modifications.

Theoretically, there are considerable gains to be made in addressing health inequalities utilising the nurse workforce, especially if action relating to the social determinants of health are integrated as part of care planning and co-ordinated with, for example, local government and third sector providers in communities. Shifts in current practice though are required and significant barriers exist from making this a reality. The barriers are complex and multifaceted and broadly fall into six areas. First, good quality health promotion can be demanding and the lack of time and resources often coupled with inadequate training further hampers nurses' health promotion roles. Second, and a

point already alluded to, the dominance of medical model in health and social care using top-down approaches can be antithetical to health promotion values which privilege empowerment. Third, health promotion in nursing is synonymous with lifestyle approaches – health promotion is far more than this and requires socio-political action. Fourth, nursing roles are seen as caring for and treating those who are unwell, with less status given to health promotion or well-being in training or practice settings. Fifth, health promotion is a complex and specialist area which is too readily diluted in nurse education to a 'basic' overview relating to behaviour change techniques or disease prevention. Finally, organisational culture with respect to health promotion is variable in healthcare settings and can either support or discourage nurses from implementing it.

In conclusion, health inequalities are a mammoth challenge that require a concerted effort to reverse current trends and epidemiological evidence. This paper sought to re-ignite debate on the nurse workforce in addressing health inequalities, but has suggested some significant challenges in the way health promotion – a key discipline in addressing injustices in health – is conceptualised and practiced. The paper makes a case for re-configuring the role of nurses in health promotion, arguing that a move away from individually-centred lifestyle modification and behaviour change approaches with patients would be beneficial. Instead a more radical view would be for the nurse workforce to advocate and act upon the social and political determinants of health. A starting point, would be to see training and educational content related to the social determinants of health, health equity, person-centred care and co-production embedded in the training for all nursing specialties and adapted for all scopes of practice.

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