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Guest Editorial

Are nurses fit for their public health role?

Each year chronic diseases cause more than 36 million deaths globally which accounts for 63% of all mortality (UN, 2012a). More than 80% of these deaths are caused by four diseases, namely, cardiovascular diseases, cancers, diabetes and chronic respiratory diseases with exposure to risk factors such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol accumulating over the life course and increasing the risk of morbidity and mortality to these diseases (WHO, 2008a). Perversely as the population ages (UN, 2012b), chronic diseases cause a growing proportion of all morbidity and mortality as these diseases increase with age. Thus, future population growth and population ageing will increase the global health care burden even with treatment advances unless the exposure to risk factors is addressed.

While major gains in life expectancy are a cause for celebration, they also present a challenge to health systems and nurses. Chronological age is an imprecise indicator of functional capacity, that is, independence and an active life, indeed there are significant variations in the health status, levels of independence and participation across older people of the same age (WHO, 2002). Ideally everyone should remain independent and active for as long as possible, however, older people are not a homogenous group with individual diversity increasing with age due to both genetics and exposure to risk factors. Further, a long life is not necessarily a happy life unless there is quality of life associated with life extension (WHO, 2002). An important challenge is therefore how nurses can help everyone achieve a healthier old age – it is not a luxury but a necessity because the costs of health and social care cannot be allowed to bankrupt national budgets.

Obesity is a major risk facing many countries reflecting changes in eating habits and physical activity levels (WHO, 2008b). It is not only underpins the rising levels of diabetes but is also the second largest cause of cancer after smoking (Pi-Sunyer, 2009). Obese individuals live on average 9 years less than their normal weight peers and after years of consistent improvements in life expectancy it may be the case that parents will outlive their obese children (NAO, 2001). Physical activity in all age groups is critically important in the prevention of disease, maintenance of independence and improved quality of life which is echoed in the WHO (2010) recommendations regarding physical activity including for those aged 65 years and older. However, while there are considerable international efforts to promote physical activity levels within child, youth and adult populations, the physical activity levels of older people attract considerably less attention despite being a key component of chronic disease prevention and healthy ageing with little known about current activity levels except that older age groups are less likely than the reference group to be regularly active and women are generally less likely than men to engage in regular physical activity (Sun et al., 2013).

Nurses need to change the discourse of clinical practice so that public health and promoting health are central to practice rather than an occasional adjunct. The gains to individuals, society and national budgets will be immense and far exceed the effects of good hospital care because a recalibration of nursing clinical practice has the potential to achieve: fewer premature deaths during the highly productive stages of life thereby reducing the impact of morbidity and mortality upon Gross National Products (WHO, 2006); fewer disabilities and loss of functional ability associated with diseases of old age (WHO, 2002); more people participating actively as they age in all aspects of society including paid and unpaid roles and in their families and in social, political and cultural life (WHO, 2002); and more people experiencing a high quality life as they age (WHO, 2002). This will be the most effective way of achieving lower costs related to healthcare because it will minimise the need for medical treatments and hospital stays and social care to meet dependency needs.

These health trends highlight that the primary mission of nurses should be to enable people to take control of and improve their health albeit that they may only encounter patients when they are sick in hospital receiving medical treatment. Patients are at their most receptive when they are receiving healthcare and we need to maximise the potential of these contacts to enable patients to minimise hospital use and avoid ill health or further health deterioration (McDermott and While, 2013). Primary prevention offered by nurses includes: advising regarding

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healthy eating, physical activity levels, avoidance of tobacco and substance abuse. While secondary prevention activities could include: screening by asking about smoking, alcohol/substance use, BMI assessment and advising appropriately perhaps using a widely established framework such as the 5 As behavioural counselling framework (Glasgow et al., 2006) which comprises five components – assess, advise, agree, assist, and arrange. Tertiary prevention is probably embedded to varying degrees within much nursing work since it includes the appropriate clinical management with interventions to minimise complications to reduce the risk of disabilities and health deterioration (Forbes and While, 2008) but it should also include the promotion and delivery of prophylactic interventions such as the influenza vaccination to vulnerable groups. Indeed, it could be argued that it is the duty of a Registered Nurse to be vaccinated against influenza not only because it prevents the nurse from being a vector of influenza to vulnerable patients but also reduces the likelihood of absence from work due to influenza which is the moral duty of any employee.

Despite influenza vaccination being the primary method of preventing influenza and its complications, the uptake of the seasonal influenza vaccination by healthcare professionals is relatively low with nurses more reluctant than other healthcare professionals to be vaccinated (Zhang et al., 2010). An analysis of both vaccinated and unvaccinated nurses' behaviours suggests that nurses' seasonal influenza vaccination behaviours are complex with two predictors influencing their decision making (Zhang et al., 2012a). Thus, those with higher knowledge scores and risk perceptions were significantly more likely to be vaccinated with those working in primary care having significantly higher knowledge and being more likely to be vaccinated (Zhang et al., 2011). Further, this study revealed that the personal uptake of vaccination by nurses was significantly related to vaccination promotion to patients (Zhang et al., 2012a). Similarly H1N1 vaccination uptake was also associated with risk perception, knowledge, clinical speciality (primary care) and recommendation to patients (Zhang et al., 2012b).

A more sensitive personal behaviour relates to the body size of healthcare professionals as global health systems attempt to manage the obesity epidemic. Two systematic reviews (Zhu et al., 2011a,b) provide evidence of a relationship between personal weight status and attitudes towards professional weight management practices. A review of nine studies (Zhu et al., 2011a) reported that normal weight healthcare professionals including nurses were likely to be more confident in their weight management practices, perceive fewer barriers to weight management, have higher self-efficacy relating to weight management practices and more positive outcome expectations than their overweight or obese peers while the second review (Zhu et al., 2011b) of 12 cross-sectional studies revealed that normal weight nurses and doctors were more likely than overweight nurses and doctors to offer general advice relating to weight loss to overweight and obese patients with accompanying differences in related knowledge and self-efficacy levels. Further a single site study (Zhu et al., 2013a) has found that 20% of student and qualified nurses underestimated their BMI weight status with the misperception being associated with personal overweight/obese BMI status. Zhu et al. also reported a significant association between ethnicity and family history of obesity related co-morbidities and the misperception of personal weight status which may have implications for professional practice in terms of identifying patients in need of an assessment and weight management advice and support. An analysis of weight management practices using a structural equation model (Zhu et al., 2013b) confirmed the importance of psychosocial factors for explaining weight management practices of the sample nurses and in particular the direct and positive influence of self-efficacy upon their weight management practices. While further research is clearly indicated, the evidence to date is concerning not only because it suggests that there may be a relationship between personal weight status and less than optimal professional weight management practices but also the irrefutable evidence that obesity increases morbidity and mortality (Pi-Sunyer, 2009) means that the high prevalence of obesity among nurses and midwives (Bogassian et al., 2012) will add to the global health burden.

The measurement of physical activity behaviour is challenging and there is little robust evidence relating to the physical activity behaviours of healthcare professionals. This may explain why a systematic review (Fei et al., 2013) exploring the relationship between personal physical activity behaviour and physical activity health promotion found only 13 relevant studies over a 13 year period. Nonetheless, the majority of those studies found a relationship between personal physical activity levels and physical activity-promoting practices with healthcare professionals with positive attitudes towards physical activity being more likely to promote physical activity and an ongoing study suggests that there is a relationship between attitudes and physical activity-promoting practices. Only six studies (Bakhshi and While, 2014) between 2007 and 2013 have explored the relationship between personal alcohol-related behaviour and alcohol-related health promotion activities/attitudes of healthcare professionals including nurses with two reporting positive associations between health professionals' alcohol-related health promotion activities and their personal attitudes towards alcohol and a further two reporting positive associations with personal alcohol use. This lack of research is surprising given the evidence of harmful drinking among healthcare professionals (Baldisseri, 2007) and nurses and midwives (Schluter et al., 2012).

Historically smoking prevalence among nurses has been as high as the general population (Adriannse et al., 1991) and more recent studies (Fathallaha et al., 2012; Mujika et al., 2014) suggest that smoking prevalence among nurses remains a cause for concern. In a recently completed systematic review of 14 studies of doctors (Duaso et al., unpublished) current smokers were found to have a 17% increased risk of not advising their patients to quit compared to non-smokers. However, the effect disappeared amongst doctors for whom smoking cessation was highly relevant to their practice which suggests that the smoking status of doctors may have an impact on their