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Poverty and health inequalities: Perceptions of social work students and nursing students

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Abstract

Aim: This study describes student perceptions on health inequalities and causes of poverty.

Background: As frontline providers, social workers and nurses are expected to engage with patients from socioeconomically diverse backgrounds.

Methods: In this cross-sectional study, a socio-demographic questionnaire, a questionnaire on health inequalities and the Perceived Causes of Poverty Scale were administered using a convenience sample of 155 students in social work and 266 students in nursing undergraduate programmes at a state university in Turkey. Mann–Whitney *U* test and Spearman correlation coefficient were used in the analysis of the data.

Findings: Social work students were more likely to attribute the cause of poverty to social injustice and a lack of opportunities, whereas nursing students had more fatalistic explanations or beliefs, maintaining that outcomes are pre-determined and therefore cannot be changed. In both groups, those who agreed that there were problems and deficiencies in health service provision and that there was ill-health among poor groups were more likely to associate poverty with social injustice and lack of opportunities. Those without a systemic understanding of poverty and health inequalities showed a tendency to hold more individualistic/fate-related perspectives.

Conclusion and implications for nursing and education policy: The nursing students, as compared to the social work students, tended to explain poverty more on the basis of individual responsibility and fatalism and were less likely to link poverty with health inequalities and to advocate for policies to end health inequalities. The students' perceptions on the causes of poverty affected their views on health inequalities. These findings suggest the need to develop curricula that equip nursing students with an understanding of poverty as a systemic cause of health inequality. Health inequality and poverty need to be positioned at the centre of training curricula by professional accreditation bodies. Interdisciplinary collaboration is recommended to foster advocacy skills in students. Furthermore, transformative changes are needed in nursing and social work education to prepare students to adequately address the Social Determinants of Health. Curricula should incorporate leadership and political activism within courses to facilitate structural change.

KEYWORDS
health inequalities, nursing education, nursing students, perceptions of causes of poverty, social work students

INTRODUCTION

Poverty is among the main factors driving health inequalities (Hitchcock et al., 2021; Øversveen, 2021). The pernicious effects of poverty and socioeconomic class on disparate health outcomes are emphasised in the United Nations (UN) Sustainable Development Goals (SDGs) (WHO, 2015). Health professionals play a critical role in realizing the SDGs related to health and poverty (Fairall & Bateman, 2017). Much of the work in this area includes advocacy for health equity. Professional bodies highlight their commitment to the elimination of health inequalities (Association of Public Health Nurses, 2015; International Council of Nurses, 2017; International Federation of Social Workers, 2012). The International Council of Nurses argues that nurses can contribute to eradicating health inequalities and poverty and point to the key roles that leadership and political activism have in making their voices heard (ICN, 2017).

The work directed at eliminating health inequalities requires a systemic perspective of the causes of poverty, a broader understanding of the root causes of inequalities in society and the development of social welfare programs for people living in poverty (Gama, 2016; Schneiderman & Olshansky, 2021). Perceptions on poverty and income inequalities likely affect the ways in which professional duties are performed, particularly when it comes to advocacy work (Newdick, 2017).

Thornton and Persaud (2018) stress that transformative changes need to be made in the education of future health professionals in order to address the Social Determinants of Health (SDoH). These changes to education must aim to ensure that students gain the necessary skills to advocate for the right to health for disadvantaged groups and to end health inequalities (Darcy-Mahoney et al., 2020; Lee & Willson, 2020; Young et al., 2018). In nursing education, when teaching about health inequalities and poverty, it is important to highlight the leadership and political activism roles of nurses (ICN, 2017), focusing specifically on increasing awareness regarding patient needs and on facilitating holistic change, rather than simply cognitive change, by looking at the interface between structural inequalities and beliefs and providing opportunities for interaction with disadvantaged groups (Alexander et al., 2020; Leunga et al., 2020; Mijangos et al., 2020; Reichlin et al., 2019).

Both nursing and social work professions are considered to be value-based professions, as they share the values of protecting human dignity, integrity, autonomy, altruism and social justice (APHN, 2015; Banks, 2006). As Soeffler and Rignaud (2020, p.284) note, poverty has been at the very core of the social work profession from its inception. The social work discipline has three main orientations to social problems: reflexive-therapeutic views, which focus on individual treatment on the one hand; socialist-collectivist views, where the aim is "cooperation and mutual support in society to give the most oppressed and disadvantaged people the ability to gain power over their lives" (Payne, 1997, p. 4), and individualist-reformist views, which "see social work as an aspect of welfare services for individuals" (Payne, 1997, p. 4). Therefore, at the micro-level, the social work profession aims at individual reform and treatment, while at the macro-level, it aims at social reform to end the underlying structural problems behind individual social conditions. Nurses play a key role in the advancement of social justice, as indicated by the ICN, who advocates that nurses can lead the transformation of health care by contributing to the elimination of health inequality and poverty (ICN, 2017). The nursing profession has the moral responsibility to investigate whether a particular health problem is related to underlying problematic social conditions. Exploring socially derived origins and determinants of poor health and tackling health inequality have been regarded as central to nursing's healing mission, purpose and goals (Russell, 2020; Tsimane & Downing, 2020). By comparing students from the nursing field and the social work field, two related, albeit distinct professional disciplines, we sought to better understand how disciplinary-specific perspectives influence views on poverty and health inequalities and look at the implications these perspectives have for future educational efforts. Moreover, by determining students' perceptions of the causes of poverty and their views on inequality in health, we will be better able to understand the steps that need to be taken to transform the nursing and social work profession, education and public policy.

Study aims

This study examines and compares the perceptions of poverty and health inequalities by social work and nursing students attending a Turkish state university. It addresses the following research questions: (1) Are there any differences in perceptions on the causes of poverty between social work and nursing students? (2) Are there any differences in their views on health inequalities experienced by people living in poverty? (3) What is the relationship between their perceptions on the causes of poverty and their views on health inequalities?

METHODS

Study design

This research is a cross-sectional quantitative study. The study report follows the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for cross-sectional studies.

Setting and participants

The study participants included third- and fourth-year nursing and social work undergraduate students from a state university in Turkey in the 2018 spring semester. The university's

student population is diverse in terms of socioeconomic background and geographical distribution. Approximately 76.4% ($n = 266$) of the third- and fourth-year nursing student population and 81.1% ($n = 155$) of the third- and fourth-year social work student population participated in this study; the final sample was comprised of 421 students.

The Bachelor of Science in Nursing (BSN) Programme in Turkey takes 4 years to complete. It aims to educate nurses as general practitioners of health, not as specialists. The first year focuses on the medical sciences and fundamentals of nursing, the second year is aimed at providing clinical knowledge and skills in medical and surgical nursing and the third and fourth years are centred on theoretical and practical courses on women's health, child health and public health (Bahçecik & Alpar, 2009).

The first two years of the Bachelor of Social Work (BSW) programme consist of courses in the social sciences (e.g., psychology, sociology, political science), as well as courses aimed at building basic knowledge about public administration, social services and disadvantaged groups. The second two years of the BA programme consist of courses on the theory and methods of social work, diverse client groups and the fields of social work (including a medical social work course), as well as field practice courses (Karataş & İl, 1999).

The sample for this study was determined based on convenience sampling. In order to ensure that the students had had sufficient exposure to essential study material (e.g., health-related issues, concepts and theory) and clinical/field practice encounters with disadvantaged people, only third- and fourth-year nursing and social work students were eligible to participate in the study.

Study instruments

Socio-demographic information

Socio-demographic variables included age, gender, parents' educational level, household size, estimated level of family income and rural/urban background.

Questionnaire on health inequalities among people living in poverty

The seventeen items on the questionnaire aim to determine the views of students on: (a) the right to healthcare for people living in poverty, (b) the health status of people living in poverty and (c) healthcare service availability and utilization among people living in poverty. Students rated their views on a 5-point Likert-type scale, which included the response choices of "Strongly Agree" (1 point), "Agree" (2 points), "Neutral" (3 points), "Disagree" (4 points) and "Strongly Disagree" (5 points).

Perceived causes of poverty scale- Turkish version (PCPS-TR)

The original version of the "Perceived Causes of Poverty Scale" was developed by Shek (2003) to measure explanations for the causes of poverty. The adaptation, reliability and validity study for the Turkish version of the scale was conducted by Içağasıoğlu Çoban et al. (2010). With the exclusion of one of the original items related to individual explanations, the scale was found to be reliable and valid for use in a Turkish context. The Cronbach's alpha coefficient calculated for the scores obtained from the four factors of the scale varied between 0.61 and 0.82 in the adapted version. The scale includes four factors and twelve questions, arranged on a 5-point Likert-type scale, with response options ranging from "Strongly Agree" (5 points) to "Strongly Disagree" (1 point). Factor one comprises statements on personal problems as reasons for poverty (Items 1, 2, 3); factor two comprises of statements on exploitation in society (Items 4, 5 and 6); factor three comprises of statements that are associated with individuals' lack of opportunities (Items 7, 8, 11 and 12); and factor four comprises of statements that link poverty with fate (Items 9 and 10) (Polat-Uluocak et al., 2010). Higher scores obtained from each factor indicate higher agreement with the relevant statements constituting that factor.

Data collection

The data collected for this study were gathered at the end of the spring semester in June of the 2017–2018 academic year using self-report questionnaires, which were administered face-to-face in a single session by two of the authors. Prior to collecting the data, permission of the course instructors was obtained, and the purpose of the study was explained to the students, after which written consent was obtained from those who wished to participate. Participants were informed that participation was voluntary, and that they could withdraw from the study at any time, without any consequences. Two of the authors distributed the questionnaires, and it took about 20–30 min for the students to complete them.

Ethical considerations

The study was approved by the Ethics Committee at Ankara University, Turkey (approval date: 7 June 2018; approval number: 38119), and written informed consent was obtained from the students prior to their participation in the study. All data were kept confidential, and an identification number was used in place of the participants' names to link their data with the questionnaires and thus secure their anonymity. Institutional research approval was obtained from the Faculty. Written permission was obtained from the Perceived Causes of Poverty Scale-Turkish Version.

TABLE 1 Comparison of students regarding factor scores of PCPS

Scores of Subdimensions	Programmes				
	Social work ($n = 155$)		Nursing ($n = 266$)		
	Median (interquartile range)	Mean ± SD	Median (interquartile range)	Mean ± SD	*p*-Value
Personal problems	6.0 (2.3)	6.7 ± 2.15	6.0 (3.0)	6.5 ± 2.35	0.436
Exploitation/injustice	12.0 (4.0)	11.4 ± 2.68	11.0 (4.0)	10.3 ± 2.87	*0.001**
Lack of opportunities	15.0 (2.3)	14.8 ± 2.78	15.0 (4.0)	13.8 ± 3.25	*0.005**
Fate	4.0 (3.0)	4.6 ± 1.88	5.0 (2.0)	5.2 ± 1.94	*0.003**

*Statistically significant.

Data analysis

All statistical analyses were performed using SPSS for Windows version 11.5 (SPSS Inc., Chicago, IL, USA). The Kolmogorov-Smirnov test was used to assess the assumption of normality. Descriptive statistics were calculated as median (interquartile range) and mean ± standard deviation for continuous variables that did not have normal distribution or ordinal variables, and as number of individuals (n) and percentages (%) for nominal variables. Differences between the nursing and social work students in their views on causes of poverty and health inequalities (*Research questions 1 and 2*) were tested using the Mann–Whitney *U*-test. The scores obtained from the subdimensions of the "Perceived Causes of Poverty Scale" (personal problems, exploitation/injustice, lack of opportunities and fate) and from the questions on "Poverty and Health Inequality" (*Research question 3*) were analysed using the Spearman Correlation Coefficient. This coefficient was also used to analyse the scores obtained on the total "Perceived Causes of Poverty Scale," as well as some of the socio-demographic variables (family income level, rural/urban background). A two-sided p-value < 0.05 was considered as statistically significant.

FINDINGS

The median age (interquartile range) was 22 (2.0) for the social-work students and 22 (1.0) for the nursing students ($p = 0.039$). There was no difference in gender distributions between the social work and nursing students ($p = 0.404$). Parents' educational levels (of both mother and father) were higher in the cohort of social work students than those in the cohort of nursing students (p-values < 0.001 and 0.002, respectively). The nursing students also had a lower level of family income ($p = 0.002$) than that of the social work students. Among the cohort of social work students, four (2.6%) students had a single parent and/or stepfamily, while among the cohort of nursing students, one (0.4%) student had a single parent and/or stepfamily ($p = 0.035$). Seven (4.5%) of the social work students and 48 (18.0%) of the nursing students had a rural background ($p < 0.001$).

Table 1 presents the results of the first research question regarding the differences in Perceived Causes of Poverty Scale (PCPS) between the social work students and the nursing students.

There was no difference between the two student cohorts regarding the "Personal Problems" scores. The nursing and social work cohorts, however, differed on measures related to "Exploitation/Injustice", "Lack of Opportunities" and "Fate", with the social work students having a higher "Exploitation/Injustice" score and a higher "Lack of Opportunities" score, and the nursing students having a higher "Fate" score.

We further analysed which socio-demographic variables were related with this finding. When the social work and nursing students were examined separately, there were no correlations between the scores on "Exploitation/Injustice", "Lack of Opportunities" and "Fate" *and* "family income level" and "urban/rural background" (all p-values > 0.05).

Table 2 presents the results of the second research question regarding the differences in the views of the students on health inequalities experienced by people living in poverty.

Nursing students were more likely than social work students to agree with the following statements: "People living in poverty need health services more than other groups in the society"; "Privacy of medical records of people living in poverty are given less importance"; "People living in poverty are an economic burden on health services"; "People living in poverty are more prone to infectious diseases" and "People living in poverty are more at risk for mental illnesses" (all p-values are < 0.05).

On the other hand, social work students were more likely than nursing students to agree with the following statement: "People living in poverty use health services more than other groups in society" ($p < 0.05$).

Table 3 presents the results of the third research question on the relationship between PCPS and views on health inequalities.

A negative correlation between the PCPS factor in Table 3 and its related item on health inequalities in the left column indicates that students who explained poverty with that specific PCPS factor agreed more strongly with the corresponding health inequalities item. Students who explained poverty with personal problems/fate agreed more with statements that

TABLE 2 Comparison of social work and nursing students' views regarding health inequalities among poor groups

Items	Programme				
	Social Work ($n = 155$)		Nursing ($n = 266$)		
	median (interquartile range)	Mean ± SD	median (interquartile range)	Mean ± SD	*p*-value
People living in poverty need health services more than other groups in society.	2.0 (1.0)	2.0 ± 0.84	2.0 (1.0)	1.8 ± 0.68	*0.028**
People living in poverty use health services more than other groups in society.	3.0 (2.0)	2.9 ± 0.94	3.0 (1.0)	3.3 ± 1.08	*<0.001**
People living in poverty are an economic burden on health services	3.0 (1.0)	3.3 ± 1.09	3.0 (2.0)	3.0 ± 1.19	*0.018**
There must be measures developed for people living in poverty to facilitate their utilization of health services.	2.0 (1.0)	1.7 ± 0.72	2.0 (1.0)	1.8 ± 0.72	0.563
People living in poverty are more prone to infectious diseases.	2.0 (1.0)	2.2 ± 0.94	2.0 (1.0)	1.8 ± 0.83	*<0.001**
People living in poverty are more vulnerable to mental health issues	2.0 (1.0)	2.6 ± 1.06	2.0 (2.0)	2.1 ± 0.90	*<0.001**
People living in poverty are not able to receive municipal services (utilities, clean water, wastewater treatment etc.) that would guarantee better health status.	2.0 (0.0)	2.1 ± 0.83	2.0 (2.0)	2.1 ± 0.88	0.872
People living in poverty experience discrimination in access to health services.	2.0 (1.0)	2.3 ± 0.81	2.0 (1.0)	2.2 ± 0.94	0.144
People living in poverty have easy access to health care institutions in the regions they reside.	3.0 (2.0)	3.1 ± 0.97	3.0 (1.0)	3.2 ± 1.01	0.099
People living in poverty have easy access to clean water, sanitation, and decontamination services that would improve their health.	3.0 (1.0)	3.4 ± 0.96	4.0 (1.0)	3.3 ± 0.98	0.488
People living in poverty should be prioritised to receive assistance from the general budget in order to finance their healthcare expenditures.	2.0 (1.0)	2.2 ± 0.81	2.0 (0.0)	2.1 ± 0.80	0.098
The Premium-based health service delivery system creates a disadvantage for people living in poverty.	2.0 (1.0)	2.2 ± 0.81	2.0 (1.0)	2.3 ± 0.88	0.545
People living in poverty have difficulties accessing reliable, sufficient medical information.	2.0 (0.0)	2.0 ± 0.73	2.0 (0.0)	2.1 ± 0.80	0.451
The privacy of medical records of people living in poverty are given less importance	3.0 (2.0)	3.1 ± 1.11	3.0 (2.0)	2.8 ± 1.06	*0.028**
The medical ethics applied in healthcare provision for people living in poverty are given less emphasis.	3.0 (2.0)	2.9 ± 1.06	3.0 (1.0)	2.8 ± 1.02	0.109
Healthcare professionals provide services appropriate to the cultural backgrounds of people living in poverty.	3.0 (2.0)	3.0 ± 0.95	3.0 (2.0)	2.9 ± 0.96	0.291
The health services used by people living in poverty are scientifically and medically of sound quality.	3.0 (2.0)	3.0 ± 0.99	3.0 (2.0)	3.1 ± 0.94	0.779

*Statistically significant.

TABLE 3 Relationship between the views on health inequalities among poor groups and PCPS factor scores

	Correlation coefficients (*p*-value)			
Items	**Personal problems**	**Exploitation/ Injustice**	**Lack of opportunities**	**Fate**
People living in poverty need health services more than other groups in society.	0.029 (0.560)	*−0.105 (0.037)**	*−0.164 (0.001)**	−0.071 (0.158)
People living in poverty use health services more than other groups in society.	*−0.136 (0.007)**	0.067 (0.181)	0.024 (0.630)	0.006 (0.909)
People living in poverty are an economic burden on health services	*−0.145 (0.005)**	*0.100 (0.051)**	0.002 (0.971)	*−0.126 (0.014)**
There must be measures developed for people living in poverty to facilitate their utilization of health services.	*0.203 (<0.001)**	*−0.266 (<0.001)**	*−0.275 (<0.001)**	0.048 (0.351)
People living in poverty are more prone to infectious diseases.	0.061 (0.232)	*−0.128 (0.012)**	*−0.199 (<0.001)**	0.042 (0.412)
People living in poverty are more vulnerable to mental health issues	0.048 (0.349)	*−0.112 (0.027)**	*−0.128 (0.012)**	−0.064 (0.206)
People living in poverty are not able to receive municipal services (utilities, clean water, wastewater treatment etc.) that would guarantee better health status.	0.034 (0.505)	*−0.211 (<0.001)**	*−0.252 (<0.001)**	−0.040 (0.434)
People living in poverty experience discrimination in access to health services.	0.042 (0.403)	*−0.239 (<0.001)**	*−0.258 (<0.001)**	−0.088 (0.082)
People living in poverty have easy access to healthcare institutions in the regions they reside.	*−0.191 (<0.001)**	*0.198 (<0.001)**	*0.153 (0.002)**	−0.022 (0.667)
People living in poverty have easy access to clean water, sanitation, and decontamination services that would improve their health.	−0.005 (0.929)	*0.194 (<0.001)**	*0.141 (0.005)**	*−0.111 (0.027)**
People living in poverty should be prioritised to receive assistance from the general budget in order to finance their health care expenditures.	*0.155 (0.002)**	*−0.129 (0.010)**	*−0.194 (<0.001)**	0.036 (0.479)
The Premium-based health service delivery system creates a disadvantage for people living in poverty.	0.056 (0.273)	*−0.187 (<0.001)**	*−0.187 (<0.001)**	0.058 (0.254)
People living in poverty have difficulties accessing reliable, sufficient medical information.	0.087 (0.086)	*−0.192 (<0.001)**	*−0.229 (<0.001)**	0.056 (0.264)
The privacy of medical records of people living in poverty are given less importance	−0.090 (0.075)	−0.056 (0.268)	−0.090 (0.072)	*−0.145 (0.004)**
The medical ethics applied in the provision of healthcare to people living in poverty are given less emphasis.	−0.038 (0.446)	*−0.144 (0.004)**	*−0.129 (0.010)**	−0.084 (0.096)
Healthcare professionals provide services appropriate to the cultural backgrounds of people living in poverty.	−0.006 (0.907)	*0.139 (0.005)**	*0.100 (0.045)**	*−0.114 (0.023)**
The health services used by the people living in poverty are scientifically and medically of sound quality.	*−0.140 (0.005)**	*0.264 (<0.001)**	*0.130 (0.010)**	*−0.112 (0.026)**

*Statistically significant.

regard people living in poverty as a burden (i.e., "People living in poverty use health services more than other groups in society," "People living in poverty are an economic burden on health services") and that people living in poverty are not at any disadvantage in terms of health service utilization and service quality (i.e., "People living in poverty can easily access health care institutions in the regions they reside," "Health services used by people living in poverty are scientifically and medically of sound quality"). They disagreed with the statements that mention a need for welfare measures (i.e., "There must be measures taken for people living in poverty to facilitate their utilization of health services," "People living in poverty should be prioritised to receive assistance from the general budget in order to finance their health-care expenditures").

On the other hand, students who explained poverty with social injustice/lack of opportunities agreed more with the items that point towards the disadvantages that people living in poverty have in terms of health status, health service utilization and quality of services received.

DISCUSSION

Social work students' views on health inequalities and the causes of poverty showed statistically significant differences on certain items when compared to those of the nursing students. However, most of the differences were not pronounced.

The first research question addressed the perceptions the two student groups had on causes of poverty. There were significant differences in the PCPS scores between the social work and nursing students on the factors of exploitation/injustice, lack of opportunities and fate. Social work students had higher scores on the exploitation /injustice and the lack of opportunities factors, while nursing students had higher scores on the fate factor. In other words, social work students attributed injustice and lack of opportunities to the causes of poverty, whereas nursing students attributed fate to the causes of poverty. Social work education might be a contributor to the difference in social work students' values. In another study conducted with social work students in Turkey, it was shown that the students placed high value on the concept of universalism, which is related to social justice, equality and welfare (Acar et al., 2016). Viewing poverty within the framework of exploitation, injustice and lack of opportunities reflects the value base of social work.

Çelik et al. (2014) observed a widespread belief in fate among nurses (96.2%), and this was found to be related with traditional values. Therefore, nursing students' higher fate scores could be a general reflection of the strong traditional/conservative values in Turkey (Çarkoğlu & Kalaycıoğlu, 2009). As social justice and advocacy have been shown to be learned behaviour (Hellman et al., 2018), other researchers have emphasised that nursing programs should address the issues of social justice, poverty and disadvantaged groups at the beginning of learning experiences so that students can have the opportunity to later apply this knowledge throughout their clinical experiences (Phillips et al., 2020; Turk & Colbert, 2018). The curricula on health inequalities should also include a sufficient number of components aimed at increasing the awareness of students about rights-based perspectives and structural inequalities, as this would contribute to the development of a structural view of poverty rather than a fatalistic perspective (Phillips et al., 2020; Woolsey & Narruhn, 2018). As Reichlin et al. (2019) emphasised, the nursing profession has to move beyond the "individual nurse-patient dyad" and adopt a socially grounded approach.

The second research question addressed the differences in views on health inequalities. Although there was no significant difference between nursing and social work students on this issue, more of the nursing students than the social work students viewed people living in poverty as being disadvantaged. There are two possible reasons for this. First, the fact that nursing students come into contact with people living in poverty during their public health course could mean that they have greater awareness about whether people in poverty are disadvantaged or not. Second, the nursing students in the study group came from a more disadvantaged socioeconomic background than that of the social work students. Knesebeck et al. (2018), in their study, reported that there was a relationship between individual socioeconomic status and the perception that poverty is a determinant of health. For our study sample, the higher awareness of poverty as a determinant of health among the nursing students may be related to their lower family income, as compared to that of the social work students. This finding can also be related to the holistic care perspective taught in nursing education, which is emphasised from the very beginning of the programme.

Differences between the two study groups in terms of their perspectives on responses to health inequalities at the political level were not statistically significant. Both groups agreed with statements related to the state's responsibility for eliminating health inequalities, the structural regulations that should be implemented and the disadvantage that poor people experience in health services. However, the nursing students were more likely than the social work students to see people living in poverty as an economic burden on health services. The nursing students' fatalistic explanations for poverty could explain why they tended to underscore the economic burden that people living in poverty caused rather than affirming the responsibility that policymakers had to end poverty. Moreover, it could be argued that the concept of social justice is insufficiently taught in undergraduate nursing education (Habibzadeh et al., 2021). The inclusion of the social determinants of health in accreditation standards for nursing programs should be considered, as Mahoney et al. (2020) emphasised in their study.

Social work students agreed more than nursing students that people living in poverty use health services at a higher rate than that of other groups in society. This may be due to social work students' field placements in hospitals, where they usually are responsible for working with disadvantaged patients who are not able to pay their hospital bills (Özbesler & İçağasıoğlu Çoban, 2010). This intense contact at hospitals

with people living in poverty might lead students to not perceive the disadvantage in terms of utilization of health services. On the other hand, while nursing students view poverty as a disadvantage in terms of utilization of health services, their belief that poverty is caused by individual/fate factors make them less likely to engage in political action to end social injustices. Therefore it is necessary to include teaching methods that serve to improve innovative skills and critical reflection (Tsimane & Downing, 2020) and provide educational strategies, that is, poverty simulation with affective learning approaches and role-playing to enable students to gain a holistic perspective on poverty, engage more critically in social issues and liberate them from the prevailing medical paradigm (Meaux et al., 2019; Northrup et al., 2020; Smith-Carrier et al., 2019).

Analysis of the third research question on the relationship between PCPS and views on health inequalities revealed that the students who perceived poverty as a personal problem/fate believed that there was no problem related to health service utilization and quality of services received by people living in poverty. However, the students who attributed poverty to social injustice/lack of opportunities agreed with statements highlighting the disadvantages that people living in poverty experience regarding health service utilization, health service quality and health status. They also agreed that there is a need for measures aimed at protecting their rights to receive better services and to achieve better health. Nursing curricula should include more emphasis on health utilization and quality health care for vulnerable communities (Jay & Priya, 2018). To promote a structural view, it is important for nursing students to be aware of the community resources available for providing comprehensive nursing care for clients (Phillips et al., 2020). Furthermore, relationship building and interaction with people living in poverty (Alexander et al., 2020) are important steps for developing this structural view.

During nursing and social work education, interprofessional simulation can also be employed to teach about health service utilization and quality of services received by people living in poverty. The Association of Public Health Nurses (APHN, 2015) and Council on Social Work Education (CSWE, 2016) strongly encourage that during undergraduate education, interprofessional teams be created to facilitate the learning process.

LIMITATIONS

There are some limitations to this study. Although educational programmes in social work and nursing are similar in other universities, convenience sampling limits the generalizability of the results to the national population. Furthermore, the findings should be interpreted in light of Turkey's own socioeconomic context, considering that despite being an upper middle-income country (World Bank, 2021), Turkey has a lower employment rate than the OECD average and higher inequalities than most of the developed countries (OECD, 2021). Therefore, although poverty is a relevant issue in other countries as regards this study topic, these aforementioned facts should be considered when making comparisons.

The use of a cross-sectional design makes it difficult to determine the detailed effect of curriculum design on student perceptions. Future research should therefore focus on investigating the effect of curriculum design by obtaining baseline data through the administration of a survey at the beginning and at the end of the academic year.

CONCLUSION

In this study, nursing students, compared to social work students, tended to explain poverty more with individual/fatalistic explanations and were less likely to link poverty with health inequalities and to take action to promote policies that end health inequalities.

Perceptions on the causes of poverty affected the students' views on health inequalities. Awareness of the social injustice behind the problem of poverty contributed to awareness about the disadvantages that people living in poverty experience, such as difficulties in health service utilization, poor quality of services and poor health. Moreover, a structural understanding of poverty contributed to recognition of the responsibility that the state and policy makers had in addressing health inequalities and of the responsibility professions had to take policy actions and engage in direct work with disadvantaged groups.

IMPLICATIONS FOR NURSING AND EDUCATION POLICY

The findings from this study can serve as a guideline for both nursing and social work educators in fostering a social justice perspective in their students to enable them to work effectively in situations involving poverty and health inequalities.

The results from this study conducted in Turkey highlight the importance of social justice ideals to both nursing and social work professionals. Some of the options available for advancing students' understanding of the social determinants of health include the development of curriculum content on the structural causes of poverty and on other bio-psychosocial issues, transformative changes in nursing education to prepare nurses to adequately address SDoH, and the incorporation of interventions within nursing curricula to achieve structural change.

Educators should be ready and willing to change traditional teaching practices and strategies to ones that will facilitate transformative change. Social determinants of health should be addressed in the earlier years of nursing education. When teaching about health inequalities, it is crucial to address the underlying paradigm of the structural causes of poverty and other social problems. Interdisciplinary contributions in nursing and social work education would be valuable in terms of providing a holistic perspective on poverty for students of both programmes. Including more social work lecturers in

nursing programmes and vice versa, more nursing lectures in social work programmes, would be beneficial.

Our study findings are relevant for leaders and directors of educational accreditation bodies. We recommend continuing, steadfast attention to issues of social justice in health and healthcare for groups challenged by socioeconomic and other systemic forms of disadvantage. Nursing courses and practice placements should include more of a focus on knowledge and skill-building in social advocacy, legislative lobbying and coalition building. Optimally, this learning content would be designated as core competencies for theprofession.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

Study design: Gonca Polat and Basak Demirtas. *Data collection*: Basak Demirtas and Gonca Polat. *Data analysis*: Funda Seher Özalp Ateş.

Study supervision: Basak Demirtas, Gonca Polat and Lana Sue Ka'opua. *Manuscript writing*: Gonca Polat and Basak Demirtas. *Critical revisions for important intellectual content*: Basak Demirtas, Gonca Polat and Lana Sue Ka'opua.

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