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REVIEW PAPER

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Health-promoting leadership: An integrative review and future research agenda

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Abstract

Aim: To provide a synthesis of the evidence of health-promoting leadership related to nursing by exploring definitions, core attributes and critical conditions.

Background: Increasing pressure in healthcare settings due to efficiency requirements, population ageing with complex illnesses and projected global shortage of nurses, is a potential threat to nurses' health and job satisfaction, and patient quality of care and safety. New ways of thinking about nursing leadership and evidence-based human resource management are required to improve nursing environments.

Design: Integrative literature review.

Data Sources: Eight databases were searched: Academic Search Premier, CINAHL, Emerald, ERIC, Web of Science, MEDLINE, Psychinfo and Science Direct. Included papers were published between 2000–2016.

Review methods: Of 339 papers, 13 were eligible for inclusion: eight qualitative and five quantitative. Studies were assessed for quality using standardized checklists. Framework-based synthesis was used, allowing for themes identified a priori to be specified as coding categories. This method also allows new themes to emerge de novo.

Results: Four themes were identified. There are multiple definitions of health-promoting leadership, along with description of the non-health-promoting leader. The health-promoting nurse leader engages in employees' health promotion, and takes responsibility for actions and maintains open communication, accommodating nurses' participation in change processes. Through competence development, the health-promoting organization builds capacity.

Conclusion: Health-promoting leadership may be a promising path to optimizing nursing outcomes through holistic thinking, which emphasizes the importance of context. Accumulated research is required to build a stronger line of international research, with attention to underlying mechanisms, limiting conditions and behaviours known to health-promoting leadership.

KEYWORDS

capacity building, healthcare settings, health promotion, health-promoting leadership, holistic, leadership, literature review, nurses, nursing outcomes

*Akerjordet and Furunes have shared first authorship on this article.

1 | INTRODUCTION

This integrative review focuses on health-promoting leadership (HPL) related to nursing, capturing the leadership dynamics of organizations more holistically. The significance of creating healthy work conditions to attract and retain nurses and to ensure quality of care and patient safety are of concern internationally. Today, there is an increasing pressure in healthcare settings due to efficiency requirements that are perceived to threaten nurses' health and job satisfaction, and patient quality of care and safety (Aiken, Sloane, Bruyneel, Van den Heede, & Sermeus, 2013; Brown, 2009; Shirey, 2006). New ways of thinking about nursing leadership and evidence-based human resource management are required to improve nurses' work environments (Aiken et al., 2013; Hutchinson & Jackson, 2013; Kirwan, Matthews, & Scott, 2013; Ma, Olds, & Dunton, 2015), thus necessitating the reframing of inquiries to bridge the domains of positive health and leadership (e.g. Macik-Frey, Quick, & Cooper, 2009; Nielsen & Daniels, 2012). Studies suggest that in Europe, more than 50% of all absence days are in some way linked to work-related stress, representing a huge cost in terms of both human distress and impaired economic performance (Skakon, Nielsen, Borg, & Guzman, 2010). An additional concern is the projected shortage of nurses globally, due to high turnover and an ageing population and nursing workforce (Buchan, Twigg, Dussault, Duffield, & Stone, 2015; Cummings et al., 2010). This concern is particularly palpable in regard to nurses' work environments and nurse resources (e.g. nurse–patient ratio) that are predictive of nurse job outcomes such as intention to leave and job satisfaction and patient outcomes such as adverse events and mortality rates (Aiken et al., 2013; Kutney-Lee, Wu, Sloane, & Aiken, 2013; Ma et al., 2015). In the wake of these challenges, the quality of nursing leadership is critical in creating a supportive and healthy environment to ensure workforce productivity (Clement-O' Brien, Polit, & Fitzpatrick, 2011; Kirwan et al., 2013; Laschinger, Wong, & Grau, 2013). A strong and more satisfied nursing workforce might lead to decreased organizational costs (Collini, Guidroz, & Perez, 2015; Feather, 2015) and higher quality of care and patient safety (Aiken et al., 2013; Van den Heede et al., 2013; You et al., 2013). These aspects reflect important outcomes of the Magnet® recognition program (Clement-O' Brien et al., 2011). These important concerns are a call to leadership, which includes rebuilding the nursing workforce and implementing new models of care to bring health and well-being into the organization (Cummings et al., 2010). Leaders who have the requisite agency to positively influence their staff and the organization's culture, climate and performance are more likely to succeed in future healthcare organizations (Collini et al., 2015; Hannah, Avolio, Luthans, & Harms, 2008; Stichler, 2009).

Although the role of leadership in the psychosocial work environment is well acknowledged, scarce knowledge exists on how leadership qualities and behaviours have an impact on work-related health (Brown, 2009; Dellve, Skagert, & Vilhelmsson, 2007; Laschinger, Finegan, & Wilk, 2009; McElligott, Siemers, Thomas, & Kohn, 2009).

Why is this review needed?

- Focus on health-promoting leadership is of importance in healthcare settings to improve our knowledge of this phenomenon internationally and to improve organizational health so that nurses are attracted and retained as an essential resource.
- Research on health-promoting leadership indicates that this holistic view of health can optimize nursing outcomes such as work-related health, job satisfaction, quality of care and patient safety.
- Evidence-based recommendations on health-promoting leadership are absent, so there is need for a systematic review of the evidence.

What are the key findings?

- There are multiple definitions of health-promoting leadership.
- Meaningfulness, broad participation and competence development are core attributes of health-promoting leadership related to nursing requiring a relational-oriented leadership approach, Salutogenic presence and open communication.
- The health-promoting nurse leader engages in employees' health promotion, acts with courage, responsibility and a hands-on approach, moving beyond leadership styles and embracing a systemic, holistic view of leadership stressing the importance of context. In contrast, a non-health-promoting leader appears to be a destructive leader.

How should the findings be used to influence policy/practice/research/education?

- Increased educational and scientific attention to health-promoting leadership is important to build a stronger line of international research and to advance the field and ensure resilience in healthcare systems, enhancing recovery strategies instead of reducing stress.
- Future research is recommended to strengthen the scientific rigour, with more attention to underlying mechanisms, limiting conditions and behaviours known to health-promoting leadership internationally.

"Health-promoting leadership concerns creating a culture for health-promoting workplaces and values that inspire and motivate employees to participate in such a development" (Eriksson, 2011, p. 17). Since limited research exists in this research field, an integrative review approach was deemed appropriate (Whittemore & Knafl, 2005). This has the potential to make a meaningful contribution to advancing nursing leadership research beyond Europe to improve

nurses' health and patient outcomes based on scientific evidence (Sorensen, Iedema, & Severinsson, 2008; Whitehead, 2005). The review is part of an ongoing research project focusing on HPL to support resilience in healthcare systems, among others.

1.1 | Background

The value of health is underscored in current European Union initiatives (Horizon, 2020). To this end, leadership to advance agendas for change is a promising and frequently considered avenue (Wong, Cummings, & Ducharme, 2013). In recent decades, rapidly evolving healthcare systems have caused nursing to change in many ways. Continuous reorganization and downsizing of health care, together with growing patient demands and acuity of care, increased medical specialization and changing professional roles have led to increased workload and pressure for nurses (Cowden, Cummings, & Profetto-Mcgrath, 2011; Smith & Cusack, 2006; Sorensen et al., 2008). This detrimental trend is increasing the need to alleviate nurses' stress—something that can be done by promoting a positive work environment. Strong nursing leaders are thus required to undertake a significant health-promoting role (Mortier, Vlerick, & Clays, 2016; WHO, 2006a,b). Research shows that high levels of burnout among nurses are significantly related to lower levels of workplace empowerment, leading to negative health outcomes (e.g. depression and poor physical health) (Laschinger et al., 2013). Re-orienting healthcare services towards health promotion is one of the major public health promotion strategies proposed by the Ottawa Charter (Röthlin, 2013). In this regard, HPL appears to be a promising and critical part of the organizational capacity for health promotion (Eriksson, 2011). Although no consensus on this phenomenon appears to exist, the trend of HPL focuses on creating an organizational health culture and values for health-promoting workplaces that inspire and motivate employees to participate in such a development, considered as a shared responsibility (Eriksson, 2011). However, health promotion is viewed as a behaviour that is motivated by the desire to increase well-being and actualize human health potential, requiring a deconstruction of the medical paradigm in the public health field (Meresman et al., 2013; Pender, Murdaugh, & Parsons, 2006). This view on health represents research that strives to promote flourishing and fulfilment towards a better understanding of positive outcomes in healthcare settings, reflecting aspects of positive psychology and the salutogenic model of health, that is, the study of health and health determinants in the human context. Adopting this approach creates a sense of coherence (manageability, coherence and meaningfulness) and builds resilience (Antonovsky, 1996; Lindström & Eriksson, 2006; Snyder & Lopez, 2007; WHO, 2006a,b). Such leadership processes catalyse or facilitate organizational actions rather than command them, given the complexity of modern healthcare organizations and the impracticality of the controlling approach in such contexts (Marion & Uhl-Bien, 2001). This means that nursing leaders have a key role in developing new ways of working and innovating through use of knowledge and accumulation of learning related to health promotion (Chan, Tam, Lung, Wong, & Chau, 2013; Frenk et al., 2010). Against this background, this integrative review, therefore, contributes to the field of nursing leadership by investigating core attributes and critical conditions of HPL.

2 | THE REVIEW

2.1 | Aim

The aim of this integrative review was to describe, evaluate and synthesize previous studies on health-promoting leadership and propose a future research agenda.

The review questions addressed were:

RQ 1: How is health-promoting leadership defined?

RQ 2: What are the core attributes for health-promoting leadership related to nursing?

RQ 3: What are the critical conditions for health-promoting leadership related to nursing?

2.2 | Design

An integrative review of peer-reviewed literature was undertaken to summarize and synthesize accumulated evidence to generate new, integrated knowledge on HPL (Whittemore & Knafl, 2005). The reason for applying this approach was that relatively little research exists in this area, but the phenomenon is considered to be of significance for future nursing leadership internationally. Researchers have successfully adapted this method to integrate research, as it allows diverse primary sources and multiple perspectives to be combined to gain an in-depth understanding of a complex phenomenon. This review was conducted in a systematic manner that applied detailed, rigorous and explicit strategies to identifying research questions, searches, developing inclusion and exclusion criteria, appraising and synthesizing data and presenting results (Lin, Myall, & Jarrett, 2017, p. 2866).

2.3 | Search methods

Prior to formal development of a search strategy, broadly scoped searches were completed (see Table S1). The initial search for "health promotion" retrieved more than 380,000 hits, meaning there was a need to developing a review protocol with a search strategy to ensure all relevant terms were used and bias was minimized (Table S1). To increase the potential to identify accurate results emerging from appropriate databases, a systematic and well-defined literature search strategy was developed. The reporting of the review was informed by the ENTREQ framework (Table S2). Although the initial interest focused on HPL in nursing, further scoping searches indicated that studies on HPL were not limited to nursing and health journals. Consequently, to include all relevant studies on the phenomenon and to obtain aspects significant for nursing, the final search could not be limited to particular professions, populations or fields. The following eight databases were used: Academic Search Premier, CINAHL, Emerald, ERIC, Web of Science, MEDLINE,

Psychinfo and Science Direct. For each database, seven searches were performed, with the search terms "health promoting leadership," "health promoting," "health promotion," "salutogenic," "workplace health," "workplace empowerment" and "organi*ation* health," in combination with (AND) leadership AND nursing. Based on the aim of the research and previous experience with review papers, inclusion and exclusion criteria were developed prior to commencing the search (Table 1) and the scope narrowed over time (see PRISMA Flow chart, Figure 1). Papers were included if they were published between January 2000 and December 2016, peer-reviewed and reported primary data from work-life settings.

2.4 | Search outcomes

Figure 1 details and describes the identification and selection process from 442 papers to an outcome of 13 papers using the PRISMA flow chart (Moher, Liberati, Tetzlaff, & Altman, 2009). After removal of duplicates, the titles and abstracts of all identified papers were initially screened against the inclusion and exclusion criteria (Table 1) by two independent reviewers (KA, TF), who discussed the results of the initial screening process to achieve consensus. Finally, references in the articles that were initially included were scanned manually for additional studies that might have been missed by the database searches. Studies appearing to be potentially relevant ($N = 49$) were read in full and 36 were excluded. Thirteen papers were deemed eligible and included in the integrative review. The final sample of papers includes empirical studies, with focus on the phenomenon of HPL.

2.5 | Quality appraisal

A golden standard for appraising quality in reviews is lacking, the appraisal thus being considered a complex process (Whittemore & Knafl, 2005). Nevertheless, each included study was critically appraised for methodological soundness using the Critical Appraisal Skills Programme (CASP) (Singh, 2013). The CASP tool was used to evaluate qualitative studies, but as there is no CASP tool for evaluating questionnaire surveys, we used Lines, Hutton and Grant's adapted version of CASP (Lines, Hutton, & Grant, 2017). Checklists were used to aid critical considerations of the evidence but scores are not provided since the approaches are not treated equally, making the scores meaningless (e.g. Lin et al., 2017). Two researchers (KA, TF) independently assessed the studies and discussed and resolved any uncertainty.

Methodological rigour was moderate to high so no studies were excluded on the basis of inadequate scientific quality (Table S3). There were typically two criteria not adequately described in the qualitative papers: (1) the role of the researcher (e.g. few papers discussed the researcher's characteristics and reflexivity); and (2) ethical issues (e.g. documentation only concerned informed consent and contained no ethical reflections). Furthermore, conflict of interest or funding of research was not clearly stated. Few papers informed about start and stop date for data collection. For sampling strategy, some papers also had weak explanations for how and why participants were selected and how they reached the final sample. Finally, several authors failed to integrate their research with prior work, state the contribution and discuss implications of their research.

Across quantitative papers, there was limited awareness about the importance of minimizing selection bias. Study participants were not well described; many used convenience sampling, had low response rates, or failed to report response rates. In addition, there were few reflections regarding missing data, no discussion of non-respondents and deficient descriptions of statistical methods used. Concerning measurement bias, there was little use of established scales, as researchers aimed to establish new ways of measuring HPL. Furthermore, no studies used multilevel designs; only two studies had a longitudinal design (Dellve et al., 2007; Franke, Felfe, & Pundt, 2014) and the remaining were cross-sectional surveys. Across studies, there is little generation of accumulated knowledge. Another weakness is papers (i.e. Jiménez, Winkler, & Dunkl, 2016; Larsson, Stier, Åkerlind, & Sandmark, 2015) just reporting parts of larger studies rather than informing about the full picture.

2.6 | Data extraction

All included papers were uploaded in NVivo11 software and data were extracted to a standardized form presented in Tables (2 & S4).

TABLE 1 Literature inclusion and exclusion criteria

Inclusion	Exclusion
Empirical studies focusing on the phenomenon health-promoting leadership	Review articles
Peer-review articles published in English, Swedish or Norwegian	Book reviews
Studies with qualitative and quantitative design	Official reports
Studies in a work-life setting	Conceptual papers
Articles published in the period January 2000–December 2016	Conference proceedings
	Editorials and Dissertations
	Articles published before Jan. 2000
	Secondary analyses
	Empirical papers with student samples
	Empirical papers focusing on nursing school and educational issues
	Empirical papers with only patient-related outcomes
	Empirical articles focusing on empowerment, with implications for health promotion

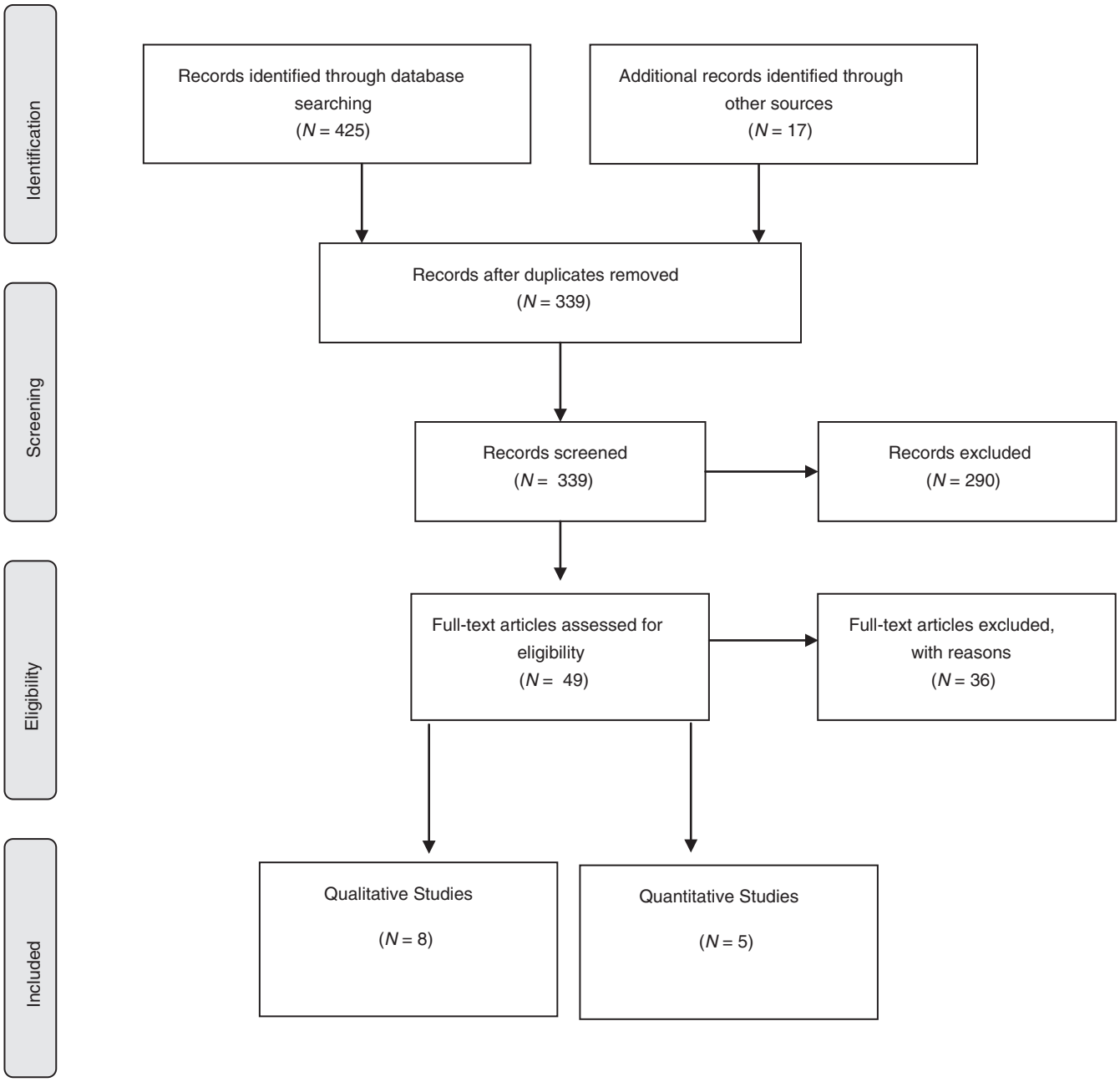

FIGURE 1 PRISMA flowchart of the integrative review process (Moher et al., 2009)

TF was responsible for data extraction that was further discussed with the co-authors.

2.7 | Data synthesis

An adapted framework-based synthesis was used (Dixon-Woods, 2011), allowing for themes identified a priori to be specified as coding categories. This method also allows new themes to emerge de novo by inductive analysis. This enables questions or issues identified in advance to be explicitly and systematically considered in the analysis, while also facilitating enough flexibility to detect and characterize issues that emerge from the data. More specifically, the findings in this systematic review are synthesized and presented in a narrative form in a three-step approach. First, data were summarized by using the review questions deductively, as coding categories. This step involved assembling extracted data across studies by three a priori subgroups—namely definitions of HPL, core attributes and critical conditions for HPL (as the dependent variable in this study) related to nursing. The quantitative outcomes are reported on a study by study basis in Table S4. Second, we undertook a synthesis of the qualitative studies and descriptively summarized data from the quantitative results of included papers and all collected data through surveys. Conclusions were drawn by synthesizing the described patterns and relationships and verified by primary source data. Interestingly, through the

TABLE 2 Studies included in the review

Author(s) (year)	Design	Country and setting	Participants	Data collection method
Dellve et al. (2007)	Quantitative, longitudinal	Sweden, municipality workers, including health care	*N* = 3,275 municipal workers in elder care, social work, schools and admin jobs	Questionnaire, 3-year register data on sick leave
Dunkl et al. (2015)	Quantitative, cross-sectional	Slovenia, cross-sectorial	*N* = 212 employees	Questionnaire, online
Eriksson et al. (2008)	Case study	Sweden, industrial company	*N* = 6 (CEO and 5 employees)	Interviews, observation and document analysis
Eriksson et al. (2010)	Holistic case study	Sweden, municipality, including health	*N* = 15, managers in nursing homes, social service and schools	Semi-structured interviews and questionnaire
Eriksson et al. (2011)	Phenomenographic	Sweden, in eight municipalities	*N* = 20, managers in nursing homes, social service and schools and HR professionals	Semi-structured interviews
Eriksson et al. (2012)	Holistic case study	Sweden, municipality	*N* = NA	Interviews, observation and document analysis
Franke et al. (2014)	Quantitative, cross-sectional and longitudinal	Germany, service sector, health care, education	*N* = 535 employees *N* = 383 employees	Two questionnaires
Grönlund & Stenbock-Hult, 2014)	Qualitative	Finland, nursing	*N* = 17 nursing staff	Three focus group interviews
Gurt et al. (2011)	Quantitative, cross-sectional	Germany, public sector	*N* = 1,027 employees in tax administration	Questionnaire, online
Jiménez et al. (2016)	Quantitative, cross-sectional	Austria	*N* = 299 leaders, in commerce, consulting, crafts and education	Questionnaire
Larsson et al. (2015)	Case study	Sweden, municipality	*N* = 11 managers	Interviews
Nilsson et al. (2005)	Qualitative	Sweden, hospital care units	*N* = 17 nurse managers	Thematic open-ended interviews
Skarholt et al. (2016)	Qualitative, comparative	Norway, four industries: health care, oil & gas, construction, cleaning	*N* = 65 leaders and employees	Semi-structured interviews

synthesis, evidence of non-HPL emerged de novo. Consensus among researchers was reached for the final synthesis.

3 | RESULTS

3.1 | Characteristics of the studies

Thirteen empirical papers describing 13 different studies met the inclusion criteria and are presented in evidence Tables (2 & S4). Eight studies reported using qualitative methods and five used quantitative methods. All the studies were conducted in Europe, with seven samples from Sweden (Dellve et al., 2007; Eriksson, Axelsson, & Axelsson, 2011; Eriksson, Axelsson, & Bihari Axelsson, 2010; Eriksson, Bihari Axelsson, & Axelsson, 2012; Eriksson, Jansson, Haglund, & Axelsson, 2008; Larsson et al., 2015; Nilsson, Hertting, Petterson, & Theorell, 2005). The studies are across occupations, whereof six included samples from the field of nursing or health professionals (Dellve et al., 2007; Eriksson et al., 2010; Franke et al., 2014; Grönlund & Stenbock-Hult, 2014; Nilsson et al., 2005; Skarholt, Blix, Sandsund, & Andersen, 2016). Half of the papers were published in the last 5 years. Some papers study HPL from the employees' points of view (e.g. Dunkl, Jiménez, Šarotar Žižek, Milfelner, & Kallus, 2015; Grönlund & Stenbock-Hult, 2014), while other papers study HPL from the employers' points of view (e.g. Jiménez et al., 2016; Larsson et al., 2015).

The papers describe HPL in one (Grönlund & Stenbock-Hult, 2014) or more contexts (e.g. Eriksson et al., 2010, 2011; Larsson et al., 2015; Skarholt et al., 2016) or develop a tool to measure HPL (Dunkl et al., 2015; Franke et al., 2014; Gurt, Schwennen, & Elke, 2011; Jiménez et al., 2016). Apart from research by Jiménez et al. (2016) and Dunkl et al. (2015), there are few attempts to build accumulated knowledge. Due to the heterogeneity of the studies, the synthesis is a narrative summary based on previous extraction of primary data (Tables 2 & S4). The four identified themes are presented below.

3.1.1 | Theme 1: Definition of health-promoting leadership

The first outcome category concerns the variation of definitions of HPL used across the included papers. Although the term HPL includes the word "promoting" [lat. promotus = move forward,

advance], indicating that health should advance, definitions vary from focusing on maintaining employees' current health to definitions of HPL as a means to increase employees' health at work. Thus, there are multiple definitions of HPL, including an element of health awareness.

Five of the qualitative papers define HPL as the interaction between leadership and work environment, focusing on building a culture that promotes a healthy work environment (Eriksson et al., 2008, 2010, 2011; Grönlund & Stenbock-Hult, 2014; Nilsson et al., 2005). All quantitative papers, except Franke et al. (2014), have a narrower view of HPL as a workplace or organizational strategy to promote workplace health (Dellve et al., 2007; Dunkl et al., 2015; Jiménez et al., 2016). These narrow definitions have an instrumental view of HPL as a means to a certain outcome. Franke et al. (2014) have a more holistic view, capturing both leaders' health orientation towards employees (i.e. health awareness and value of health) and employees' care for their own health (i.e. health risks at work and health behaviour).

Only one qualitative (Skarholt et al., 2016) and one quantitative study (Gurt et al., 2011) define HPL as a leadership style, that is democratic, supportive, motivating (Skarholt et al., 2016), responsible, direct and considerate (Gurt et al., 2011) and where the leader is engaged in employees' health. Gurt et al. (2011) distinguish health-specific leadership as an approach where the leader takes responsibility for employee health, communicates about health-related topics, sets the agenda for workplace health promotion and motivates employees to participate in it. By actively including the employees and the context while focusing on health, Gurt et al. (2011) differentiate HPL from general sound leadership.

3.1.2 | Theme 2: The non-health-promoting leader

The second outcome category emerged de novo through the qualitative study by Grönlund and Stenbock-Hult (2014), which is rich in details and informative through contrasting. The non-health-promoting leader shows lack of morality and understanding of employee interactions by being unreliable, having the wrong focus and giving unequal treatment, or forgetting to support and acknowledge employees. Furthermore, there is lack of communication, that is, feedback and follow-up. These leaders hide behind their title and cowardice. The nurses described it as frustrating if leaders did not have the fortitude to develop themselves and their leadership qualities. Such managers are stuck in old patterns and routines, avoid creativity, have no interest in self-development and thus end up with result-oriented thinking rather than managing human resources.

3.1.3 | Theme 3: Core attributes of health-promoting leadership related to nursing

The third outcome category captures core attributes of HPL; both organizational and individual leader characteristics. The qualitative studies by Eriksson et al. (2008) and Grönlund and Stenbock-Hult (2014) found that in a health-promoting work environment, the work should be meaningful to the employees. Additional attributes found in qualitative studies are broad participation among employees and leaders (Eriksson et al., 2010; Grönlund & Stenbock-Hult, 2014; Larsson et al., 2015; Nilsson et al., 2005) and a focus on employees' competence development (Grönlund & Stenbock-Hult, 2014; Skarholt et al., 2016). Individual skills development as a core attribute of a health-promoting workplace seems particularly important for health personnel (i.e. nurses and auxiliary nurses) (Grönlund & Stenbock-Hult, 2014; Skarholt et al., 2016).

Being supportive and motivating (Eriksson et al., 2011; Grönlund & Stenbock-Hult, 2014; Skarholt et al., 2016) are core attributes, but in isolation, not enough. Qualitative studies further show that the health-promoting leader is responsible (Eriksson et al., 2008, 2011; Grönlund & Stenbock-Hult, 2014) and courageous through making decisions and giving feedback and recognition, for example, through performance appraisals (Grönlund & Stenbock-Hult, 2014; Nilsson et al., 2005). To listen and see employees' physical and mental health, the health-promoting leader must be attentive and spend time with employees (Grönlund & Stenbock-Hult, 2014). Among health personnel, being attentive seems aligned with being hands-on (Skarholt et al., 2016). Furthermore, it is anticipated that leaders in the health sector are ethical, fair and professional (Grönlund & Stenbock-Hult, 2014), caring and genuinely interested in their employees (Grönlund & Stenbock-Hult, 2014) so that they can build trust (Nilsson et al., 2005) and empower them (Skarholt et al., 2016). Only one of the quantitative papers examined healthcare workers. Four out of five studies aimed to develop scales for measuring related terms, such as health-specific leadership (Gurt et al., 2011), health-oriented leadership (HoL), including leaders' StaffCare and SelfCare (Franke et al., 2014) and HPL conditions (HPLC) (Jiménez et al., 2016). The developed measures are compared with existing concepts so that health-specific leadership is found to be something beyond general sound leadership ($r = .68$**) (Gurt et al., 2011), while HoL is something beyond transformational leadership (Franke et al., 2014), with strong correlations between StaffCare and transformational leadership (three scales, $r = .59$–$.65$***) and weak correlations between SelfCare and transformational leadership (three scales, $r = .06^{ns}$–$.19$, $p < .001$). Dunkl et al. (2015) used HPLC presented in Jiménez et al. (2016) and found that HPLC dimensions show moderate positive correlations with transformational leadership scales ($r = .27$–$.42$, $p < .01$). Jiménez et al. (2016), partly build on Franke et al.'s (2014), showing that HPLC (seven scales) correlates moderate to strong with HoL (four scales) ($r = .32$**–$.65$**). Jiménez et al. (2016) claim that while HoL measures leadership style, HPLC also embraces the interaction between individuals and the organization (Jiménez et al., 2016). Similar to qualitative studies, Gurt et al. (2011) stress that health-oriented leaders feel responsible for influencing employee health. Being responsible thus means setting the agenda for health promotion in the workplace (Gurt et al., 2011).

The current evidence suggests that core attributes both include characteristics of the work environment (i.e. focusing on participation, meaningful work, skills development) and the individual leader characteristics (i.e. being caring, supportive, courageous, responsible, attentive and ethical).

3.1.4 | Theme 4: Critical conditions for health-promoting leadership related to nursing

The fourth outcome category comprises critical conditions for HPL to be successful. The synthesis indicates that while core attributes of HPL could be found across studies and settings, critical conditions seem contextual. Accordingly, the focus here is on critical conditions for health organizations and nursing, in particular. The qualitative studies suggest that the attentive nurse leader provides social support (Eriksson et al., 2008; Nilsson et al., 2005; Skarholt et al., 2016) and is able to develop a positive organizational culture.

The qualitative studies stress the critical importance that the nurse leader believes employees are looking for meaningfulness (Eriksson et al., 2008) and comprehensiveness (Eriksson et al., 2010) and consequently gives them opportunity for personal development, empowerment and responsibility (Eriksson et al., 2008, 2011; Nilsson et al., 2005). For health personnel, having time for reflection also seems imperative (Eriksson et al., 2008). Many of the studies survey middle managers and comment on how they fail because of inadequate health work conditions. Thus, for middle managers to succeed with HPL, they also need support (Eriksson et al., 2010, 2012; Larsson et al., 2015) and counselling (Grönlund & Stenbock-Hult, 2014) to make the change that top managers expect to see. It seems imperative for the success of HPL that it is part of a holistic programme with a systemic approach and not a pilot project or a project organization. This entails integration of new and existing organizational strategies and procedures (Eriksson et al., 2010, 2012; Grönlund & Stenbock-Hult, 2014; Larsson et al., 2015; Skarholt et al., 2016), paving the way for broad participation (Eriksson et al., 2010; Skarholt et al., 2016).

To succeed with creating a health-promoting workplace, it would appear crucial that the leader sees employees' needs for recognition (Dellve et al., 2007; Franke et al., 2014; Jiménez et al., 2016) and is aware of the importance of health and communicates goals openly by providing enough information for employees to be involved in the process of making a health-promoting workplace (Dellve et al., 2007; Gurt et al., 2011). This is a way of making employees' work manageable and enhancing recovery strategies instead of reducing stress (Dunkl et al., 2015).

Franke et al.'s (2014) longitudinal study shows that employees who perceive their leader to be caring have better health (r = .24–.29, $p < .001$), less irritation ($r = -.21$ to $-.24$, $p < .001$), health complaints ($r = -.20$ to $-.23$, $p < .001$) and work–family conflicts ($r = -.23$ to $-.30$, $p < .001$) 4 months later. The findings contribute to a more comprehensive picture of ways leaders can promote employees' health by (1) engaging in employee health and (2) fostering employee self-care. Dellve et al.'s (2007) longitudinal study shows that successful leaders view the organization rather than individual workers as responsible for the high rate of sick leave. The study indicated that leaders' use of respect, recognition and rewards was positively associated with work attendance at follow-up. Leadership, work-health promotion strategies and leaders' attitudes towards employee work-related health, appear to have importance for implementation processes and affecting employee work attendance. Multi-focused projects that aimed to increase employees' awareness of their health were successful, whereas projects with a single focus (e.g. strengthening individual, professional or organizational resources) were negatively related to work attendance and should thus be avoided. Apart from the longitudinal studies (Dellve et al., 2007; Franke et al., 2014), few conclusions can be drawn about the effect of HPL. Implicitly, this is not possible due to different conceptualizations of HPL and health (e.g. physical, emotional and psychosocial).

The current evidence suggests that it is critical that nurse leaders recognize nurses' need for a meaningful job where they can develop. To succeed with building organizational capacity through HPL, initiatives have to be part of a holistic programme with a systemic approach, where middle managers also are supported. Longitudinal studies show that leaders' health awareness has positive outcomes for employee health.

4 | DISCUSSION

This systematic review revealed that while multiple definitions of HPL exist, it appears to be a promising path and critical part of organizational capacity for health promotion. This is particularly true when using a more holistic and long-term, systemic approach, shifting the focus from health threats to health resources (e.g. work engagement, job satisfaction) and paving the way for broad participation. Health-promoting leadership appears in this regard to go beyond leadership styles by raising leaders' health awareness and awareness of influencing contextual factors, which is often overlooked in leadership research (Jiménez et al., 2016; Skakon et al., 2010). Beyond good leadership practices, health-promoting leaders maintain a specific focus on health by taking responsibility for their own health and that of the employees. The HPL leaders also communicate about health-related topics, set the agenda for workplace health promotion contextually and motivate employees to participate. The focus should be on enhancing recovery strategies instead of reducing stress (Dunkl et al., 2015; Gurt et al., 2011).

In this regard, Salutogenic presence, open communication and more relationship-oriented leadership styles seem to be of significance for work-related health and work attendance (Laschinger et al., 2013; Vinje & Ausland, 2013). This is closely linked to health-promoting leaders' caring attitude, courage and ability to take responsibility, which are ontologically associated with fair and authentic leadership (e.g. Perko, Kinnunen, Tolvanen, & Feldt, 2016; Wong & Laschinger, 2012). To have courage, middle managers need support and decision latitude from their superiors, enabling them to take responsibility and action. Clarity about self and their role, and authenticity through action are also required (Avolio, Walumbwa, & Weber, 2009). One of the most striking findings, however, is that the non-health-promoting leader behaves deceitfully, with no concern for the employees. This instrumental approach to human resources management is viewed as a destructive leadership style

leading to detrimental costs, which is under-researched in nursing (e.g. Hutchinson & Jackson, 2013; Perko et al., 2016).

Nevertheless, successful health-promoting leaders view the organization and not the individual worker as responsible for unhealthy conditions (Dellve et al., 2007; Dunkl et al., 2015; Jiménez et al., 2016). To succeed in creating a health-promoting workplace, it seems pivotal that the leader is authentic, professional, competent and mindful of the potential benefits of focusing on employees' health, professional development and contextual factors to ensure effective services, but not necessarily cost effectiveness (e.g. New Public Management Philosophies) (e.g. Laschinger et al., 2013; Orvik & Axelsson, 2012). The emotional intelligence (EI) capabilities of the nursing leader and time for reflection may, therefore, be critical to HPL to foster positive psychological resources such as trust and meaningfulness and a healthy work environment for nurses (Akerjordet, 2009; Carragher & Gormley, 2016). This is particularly true when nursing leaders integrate moral and ethical principles into the deployment of EI enhancing compassion (Akerjordet & Severinsson, 2010).

4.1 | Future research agenda

So far, research related to HPL has been conducted exclusively in Europe and primarily in Sweden. The study, therefore, opens several avenues for future research to get a substantial understanding of this complex phenomenon internationally. First, it captures important nuances and paradoxical relationships. Future research should include more qualitative studies to expand our conceptual understanding of HPL in nursing and to generate relevant hypothesis. Second, study design should include comparisons across robust samples and settings internationally. Third, to strengthen the validity of previous research and to extend our knowledge, multilevel and longitudinal studies are required to see how dynamics fluctuate over time and the extent of their impact on organizational members' health, including short- and long-term effects of HPL. Finally, the impact of the leaders' power and employees' vulnerability is an important aspect in leadership. Investigating HPL at different hierarchical levels and in different organizations and cultures is thus required.

4.2 | Strengths and limitations

Although the quality of the included studies was relatively high, the generalizability of the quantitative studies was limited. The study designs and lack of accumulated knowledge may thus lead to bias in the synthesis. Despite doing a comprehensive search of available empirical studies with assistance from a specialized Librarian, the inclusion of grey literature may have contributed differently. The results of this review should, therefore, be treated with caution until more robust, discriminant, predictive and incrementally valid evidence is provided. The authors' demonstrated transparency, use of well-known criteria and resulting consensus are considered a strength. This review represents the researchers' reading of the studies in question; other authors with divergent interests may have arrived at a different conclusion. Furthermore, sources generated through the use of other keywords, databases and search strategies might have contributed differently. We nevertheless believe that this synthesis contributes to an extended understanding of HPL as showing promising trends internationally.

5 | CONCLUSION

This integrative review aimed to describe, evaluate and synthesize previous studies on HPL and propose a future research agenda. Health-promoting leadership is value-based and shows a promising path to optimizing nursing (e.g. attracting and retaining nurses) and patient outcomes (e.g. quality of care and patient safety) moving beyond good leadership behaviour and bridging the domains of positive health and leadership. This reflects a more systemic, holistic view of leadership contributing to a more comprehensive picture of ways leaders can promote employees' health. Contextual effects of positive supervisor relationships and a healthy work environment are crucial in clinical nursing practice. The nurse leaders' health awareness and EI is, therefore, of significance to HPL to create a culture for health promotion. However, accumulated research is required to build a stronger line of international research on HPL related to nursing. This has the potential to make a meaningful contribution to advancing nursing leadership, enhancing resilience in healthcare systems internationally.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [http://www.icmje.org/recommendations/]):

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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