

Invited Article

LOCATING HEALTH POLICY AND NURSING: TIME FOR A CLOSER RELATIONSHIP

Frances A. Hughes RN, MA, FCNA(NZ)
Chief Nurse Advisor, Ministry of Health, New Zealand (on leave)

Abstract

This paper is written in recognition that 100 years ago Grace Neill, first chief nurse in the world, brought about the first separate nursing legislation for nurses in the world and through that formalised the relationship of nurses and health policy in New Zealand.

For nurses in leadership positions it is sometimes difficult to understand why at times the profession can spend a great deal of energy on trying to influence a course of action and nothing happens, while at other times certain courses of action occur “in left field” and change happens quickly. Understanding policy processes allows nurses to make sense of their world and assists them to strategically align their energies to areas that will maximise opportunity and improve their services.

This paper outlines the role that policy and nursing have in a demanding and changing health care environment. As well it shows the basic tenets of policy and strategies for how nurses can increase their involvement.

Key Words: Health policy, nursing, policy process, policy communities

Introduction

On 12 September 2001 New Zealand celebrated the occasion that 100 years had elapsed since the passing of the Nurses Registration Act, by means of which New Zealand became the first country in the world to have separate legislation for the regulation of nursing. The introduction of the Act in 1901 can be attributed almost solely to the efforts of Grace Neill, the first Chief Nursing Advisor in New Zealand and the first Chief Nurse in the World. Following its adoption, Grace Neill administered all

provisions contained in the Nurses Registration Act (Neill, 1961).

This legislation represented the beginning of New Zealand nurses' formal involvement and relationship with the Government, and ultimately the contribution of nurses to health policy. A hundred years on it is timely that we reflect on the complexity of health policy process and the importance of the relationship between policy and nursing. Although a number of authors (Cohen et al., 1996; Cohen & Milone - Nuzzo, 2001; Gebbie, Wakefield, & Kerfoot, 2000))

have noted the need for nurses to increase their participation in influencing legislation that affects health care, nursing practice, and their patients, and many have provided prescriptive statements as to why policy activity is important and how it should be taught, relatively little has been written as to how these goals might be achieved.

It is interesting how often nurses are viewed as contributing to things “nursing” but not contributing to things “clinical or services”. Just as Grace Neill struggled 100 years ago for recognition of nursing, nurses now struggle to be invited to be present and participate at the table where decisions are being made in regard to nursing, health structures and systems, determinants, outcomes, and quality (Brown, 1996; Buerhaus, 1992; Martin, White & Hansen, 1989; Neill, 1965; Stimpson & Hanley, 1991). I hope in this paper through an amalgamation of thoughts from the literature and my own experience to provide some insight into what can be learnt from the present situation in terms of broadening nursing’s contribution to health care - particularly in the area of policy.

Changes in healthcare-locating nursing

The ongoing changes in health care affect the practice domains of nursing. These changes affect not only how policy is formulated and implemented but also the way nursing care is delivered. We, as a society, now have greater access to information and technologies that not only provide evidence for potential solutions but

have also created greater expectations from health consumers for “answers” to their health care problems.

We know through studies within the western world (Ministry of Health, 1999) that by the year 2020 among the top diseases/conditions that our populations and services will be facing are heart disease, cancers, road accidents, depressions, chronic respiratory and alcohol related conditions, osteo-arthritis, and dementia/degenerative conditions. All of these can be viewed as lifestyle related, thus early intervention, health promotion, health education and chronic management will be key to not only reducing the effects but also for effective management. Nurses will have a major role in prevention, early diagnosis and intervention, and work with consumers and allied health members to treat and manage these health care problems (Hughes, 2000).

Nurses and nursing have changed a great deal since the days of Grace Neill and her health policy work. Advances in knowledge, medical and nursing expertise have enabled a greater number of seriously ill patients to survive. The shortened length of hospital stay resulting from pressure on services means that more severely ill patients are being discharged sooner to nursing homes, rehabilitation facilities, or their own homes. Patients and their families may prefer care at home or in a hospice. Many are looking for a more humanistic approach to their healthcare (Lange & Cheek, 1997). Nurses have had to adapt to this shift in the types and levels of care

required, and the new systems and structures within the health services. It is becoming more and more evident through research that quality nursing care by trained, skilled nurses is required for the health care environment of this century because quality of care has a direct effect on patient and consumer health outcomes (Aiken, 1981; Aiken, Clarke & Sloan, 2000; Aiken et al., 2001).

In the past health structures in New Zealand were separated, we now have District Health Board structures that allow greater integration and more flexibility between services. Links to primary health care have been strengthened, and services are better co-ordinated to work regionally. The timing is right for nursing to show leadership and direction in models of care and delivery.

In order to ensure that New Zealand healthcare consumers have access to the best skilled nurses, nurses are now prepared at degree level, with many continuing on to study at masters and doctoral level. This growth in the professional development of nurses is driven by both changes within the healthcare services, higher consumer expectations, and nurses' own increasing awareness that education underpins excellence in practice. It is not, as some critics suggest, a move away from the bedside to join an elite (Hughes, 2000).

In New Zealand there are approximately 33,000 nurses actively practising in the workforce at a ratio of 845 per 100,000 population. Registered nurses make up 70 percent

of the health and disability workforce at a cost of nearly 1 billion dollars per year (Ministry of Health, 2001). Consequently nurses are a major stakeholder in health in terms of both numbers and costs. They will be instrumental in assisting to deliver on the key Government objectives contained in the New Zealand Health Strategy and the New Zealand Disability Strategy.

To meet the challenges of today's healthcare environment, nursing influence is required, not only in the clinical and management areas of healthcare, but also in health policy. As a stakeholder group nurses need to be more widely viewed as agenda setters of health policy (Kingdon, 1995). Nurses generate many great ideas but sadly, as with the good ideas of many hundreds of others these don't automatically turn into action. Mostly this is because the necessary political sophistication with regard to policy development and political processes has not yet been developed (Cohen et al., 1996; Cohen & Milone-Nuzzo, 2001; Lindblom, 1987).

The nature of policy

Policy encompasses the authoritative guidelines that direct human behaviour toward specific goals, in either the private or public sector. It includes the broad range of activities through which authority figures make decisions directed toward a goal and levy sanctions that affect the conduct of affairs (Kalisch & Kalisch, 1992; Lindblom, 1987). Policy has been defined as a "course or principle of action adopted or proposed by a government, party business or

individual” (Concise Oxford Dictionary, 1998). It can also be considered to be a set of processes, for which many different models exist, sequential, linear and circular. In general the processes can be categorised as a sequence of problem identification, policy formulation, policy adoption, policy implementation, and policy evaluation (Kingdon, 1995; Lindblom, 1987; Weissert & Weissert, 1996; Wieczorek, 1995).

Policy formulation involves the setting of the agenda, and the specification of alternatives from which a choice is to be made. Policy adoption involves an authoritative choice among those specified alternatives, as in a legislative vote or government decision (Hancock, 1999; Kingdon, 1995; Wieczorek, 1995). Policy analysis on the other hand is the systematic study of the content and anticipated or actual standing or proposed policies. What needs to be appreciated is that policy may involve a “web” of decisions rather than a single decision. Policy also changes over time, the study of non-decisions and inactions is just as important as decisions and actions. All areas are key to one another and the policy community of which nursing is a part has roles in all these stages. Policy either works or fails depending on how successful these steps are and the depth of analysis that surrounds them.

Kingdon (1995) has another approach to looking at policy. He describes policy in terms of streams of which there are three problems, policy and political.

1. Problem stream deals with the complexities in getting

policymakers to focus on one problem out of many facing the health sector

2. Policy stream addresses policy goals, ideas from officials and interest groups
3. Political stream includes factors in the political environment that influence the policy agenda - economic recession, disasters, pivotal elections etc. These conditions allow items to rise higher up the national health agenda.

Streams coming together at critical times. A problem is recognised, a solution is available, the political climate makes the time right for change, and the constraints do not prohibit action. People who are willing to invest time and energy into pushing proposals and problems are key to helping policy streams merge; they prompt important people to pay attention to problems and thereby help link solutions to problems (Kingdon, 1995. p.20).

Kingdon’s (1995) streams are based on Cohen, March and Olsen’s (1972) “garbage can model”, which describes the policy process as a series of options floating around seeking a problem. The coming together of problem, policies and politics is referred to as “policy primeval soup”.

Policy involvement can occur at many different levels, from individual actions, professional organisations, research, education and dedicated positions (Gebbie et al., 2000).

Understanding policy

To be a player in the game of policy nurses as a profession must not only accept policy as having a legitimate place in graduate education but also be seen as actively engaged with policy. So far nurses have been slow to participate in health related political decision-making processes (Wieczorek, 1985). Although some research has been conducted focusing on health policy content in nursing education programmes (Androeli, Musser & Otto, 1987; Cohn, & Milone-Nuzzo, 2001) and the identification of specific political competencies for specialty practice (Misener et al., 1997), this has not gone far enough. Some critics argue that in order to make good this gap policy components need to be made mandatory in post graduate study for nurses. Generally the profession has not shown eagerness to become involved in policy. The reason for this I suggest could be that either nurses do not understand policy or are not educated effectively with regard to health care policy. There is a challenge here for New Zealand nursing schools.

Despite the size of the profession, nurses' political influence as health professionals is acknowledged primarily only in a time of crisis. These 'crisis' situations often pertain to either pay issues or nurse shortages, and these events tend to be the only times that nursing issues reach the public policy agenda. A glance at any daily newspaper in the country at present will confirm this view (Ferguson, 1985; Rafferty, 1992). Nurses' perception of themselves as

non-influential stakeholders in health also explains numbers not equating to influence. Buerhaus (1992) suggests nurses often miss the opportunities to participate or when they do contribute they are unable to maximise the chance.

Antrobus and Kitson (1999) suggest that efforts to change the view of nurses as active contributors to a nation's health are currently limited by a number of factors:

The majority of nurses traditionally work as direct caregivers within clinical practice. Because of this, the populist view of nursing, reinforced by media images, is that nurses are solely concerned with operational issues related to care delivery. Confined to care delivery, the nurse is viewed, in scientific management terms, as analogous to a factory worker on the shop floor. The factory does not need input from the shop floor worker at the level of strategy. Rather, the factory worker is informed of strategic decisions related to factory business and is managed accordingly (Hewson, 1999, p.1376).

This begs the question whether nursing is really viewed as part of the health policy community. In New Zealand we have had a clear indication from the Government and the Ministry of Health that nurses are viewed as a key stakeholder in the policy community. This is evident in the formation of the Memorandum of

Understanding (MOU) with all professional nursing organisations who sought involvement. The Ministry of Health recognised the importance of building on its formal individual processes with nursing groups and through the MOU process ensures early involvement with the nursing sector when problem identification and policy formation is occurring. Weissert and Weissert (1996, p.279) reinforce this view.

When this community is integrated and in agreement on the nature of the problem and its optimal solution, it can play an important part in policy development [and implementation]. If it is fragmented or multiple groups claim policy community standing, the nursing community's influence is diminished and the likelihood of successful comprehensive policies is lessened..

Nurses can influence policy on many fronts. It can be by means of the advocacy role that they undertake for clients through to a planned business case for new beds and resources. Every day nurses in various positions undertake these kinds of activities, but would not necessarily view this as contributing to policy. Yet it is ultimately the vignettes of nursing practice that bring the reality to policy. But nurses in clinical practice are not the only contributors, nurse researchers, nursing in management, policy, political positions can and do influence the policy processes. Gebbie, Wakefield and Kerfoot (2000, p.309) write about a "passion for care"

that drove nurses beyond clinical practice to reach out to policy and decision-makers, and eventually to seek policy positions.

Gebbie et al. (2000, pp.309-310) through their research describe examples of what nurses bring to policy: the "application of clinical observation skills" to policy work as emanating from nurses' extensive study of interpersonal communications; nursing practice requires that quantitative information must be accumulated and used accurately and often very rapidly; the "importance of a perspective on real lives of people's experiences" that moves beyond balance sheets; "mastery of many people skills"; the "ability to juggle" competing demands; communicating with and mobilising difference groups; effective problem-solving processes; ability to deal with wide range of issues, problems and criticism. Ultimately it is often the combination of these skills by a nurse prepared at graduate level that shows the unique difference nursing can make compared to other disciplines.

How nurses can respond to the challenge

Policy is about problems and options for their solution. Nursing is about assessment of problems and gathering of evidence and decisions regarding options of care. Unfortunately somehow throughout their socialisation and enculturation nurses are not "thinking or doing policy". To encourage more nurses to develop their practice in terms of influencing policy there needs to be a multifaceted approach. Nurses need

to educate themselves on policy processes and government mechanisms so they can ensure that the problems and proposals which exist are introduced into one of the policy streams and put into the “soup”, thereby opening up new opportunities for policy change. Nursing groups need to be alert keeping an ear to the ground, have mechanisms that can scan and interpret the horizon, build up contacts in key agencies, network with each other so as to be clear about direction and statements, and exercise patience in waiting for that “window of opportunity” to open. Then they must be ready to put strategies forward.

Undergraduate and graduate nurses need exposure to mentoring and policy-making and the power of sound influential nursing leadership to understand ways to improve how the organisation and financing of care is shaped. At the same time policymakers need exposure to the perspectives on health and illness that nurses’ acquire in their daily work (Gebbie et al., 2000, p.314).

Nurse authors need to think about policymakers being part of their audience and include a discussion of policy ramifications. Although not every nurse needs to be a policy analyst, making these linkages can help shape policy that ultimately changes practice. Policymakers need research that they can clearly understand and from which they can draw conclusions (Hewison, 1999). Importantly, to foster this interchange

individual fellowships and scholarships in health policy need to be considered.

Hospital and health services need to take steps to ensure nurses are actively encouraged to be involved at all levels of decision making and policy planning. Consistent with this aim the Ministry of Health in New Zealand has, for the first time, included nursing requirements in its Funding Agreement with District Health Boards. It is mechanisms such as this which provide the platform for the nursing profession to become directly involved in decision-making at all levels.

Some would argue strongly that nursing does not qualify as a graduate profession if nurses are not competent in applying policy or understanding its relevance. I would go further and state that with regard to the nurse practitioner development and nurse practitioners becoming the “flagship” for nursing in New Zealand, unless advanced practice contributes to health care policy it cannot be seen as advanced practice (Cohen et al., 1996; Cohen & Milone-Nuzzo, 2001; Hughes, 2001). Policy is a legitimate component of nursing practice. It cannot be left only to those in policy related positions to undertake all that needs to occur. All areas of nursing can contribute. Contributions can be at an individual or a group level, and all nurses should see themselves as contributing in some way. Consumers need nursing involvement in health policy to make health care delivery effective for them.

Conclusion

If nurses are to play a strong and constructive role in health policy and service development they need to look beyond their clinical expertise and perceive themselves as contributing in a broader strategic manner to health care. At the same time there is a need for the policy and political community to view nurses' potential contribution as being wider than operational issues.

Nurses also need to recognise and acknowledge that policy is also part of nursing. When one discusses, not only within but also outside of the profession, the role of the nurse or the contribution nurses make to health care in New Zealand, an array of comments are heard. These range from descriptions of the most basic

physical cares to highly technical procedures, and include references to advice, information, emotional support (and the style in which these are given), through to personal comments on how nurses "were there for me", to how they are the backbone and "salt of the earth". References to "health policy" do not appear as a component of any of the usual answers to the question "what is nursing?" Yet nursing is far more than what is covered by the foregoing descriptions, and through its ability to inform and influence policy can help this country to tackle the most difficult health problems. A more policy orientated nursing workforce will assist the society it serves to become more politically informed and facilitate more active democracy (Lindblom, 1987).

Frances Hughes is a Doctoral Student at University of Technology, Sydney Australia. She is currently a Senior Fellow, (2001-02) Harkness Fellowship in Health Care Policy at the Center for Health Outcomes and Health Policy at University of Pennsylvania, 420 Guardian Drive, Philadelphia. 19104. PA.

I would like to thank the support of the Commonwealth Fund of New York City - Board, Directors, and Staff.

Editors Note:

This article is partly based on a lecture given by Frances Hughes as part of the Grace Neill Memorial Lecture Series put on by the Graduate School of Nursing & Midwifery, Victoria University of Wellington. A book of this series is currently in press.

References

Aiken, L. (Ed.). (1981). *Health policy and nursing practice*. New York: American Academy of Nursing, McGraw-Hill.

Aiken, L. H., Clarke, S. P., & Sloan, D. M. (2000). Hospital restructuring: does it adversely affect care and outcomes? *Journal of Nursing Administration*, 3(10), 457-465.

- Aiken, L. H., Clarke, S. P., Sloan, D. M., Sochalski, J. A., Busse, R., Clarke, H., Giovannetti, P., Hunt J., Rafferty, A., & Shamian, J. (2001) Nurses' report on hospital care in five countries. *Health Affairs*, 220(3), 43-53.
- Andreoli, K., Musser, L. A., & Otto, D. A. (1987) Health policy in nursing curriculum. *Journal of Nursing Education*, 26(6), 239-243.
- Antrobus, S., & Kitson, A. (1999). Nursing leadership: influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing*, 29(3), 746-753.
- Brown, S. G. (1996). Incorporating political socialization theory into baccalaureate nursing education. *Nursing Outlook*, 44(1), 20-23.
- Buerhaus, P. I. (1992). Teaching health care public policy. *Nursing and Health Care*, 3(6), 304-309.
- Cohen, S., Mason, D., Kovner, C., Leavitt, J., Pulcini, J., & Sochalski, J. (1996). Stages of nursing's political development: Where we've been and where we ought to go. *Nursing Outlook*, 22(6), 259-266.
- Cohen, M., March, J., & Olsen, J. (1972). A garbage can model of organizational choice. *Administrative Science Quarterly*, 17, 1-25.
- Cohen, S. S., & Milone-Nuzzo, P. (2001). *Learning. Advances in Nursing Science*, 23(3) 28-40.
- Concise Oxford Dictionary. (1998) Oxford University Press: London.
- Ferguson V. (1985). Overview of the concepts of power, politics and policy in nursing. In R. R. Wicczorek (Ed.). *Power Politics and Policy in Nursing*. (pp. 5-21). New York: Springer Publishing Company.
- Gebbie, K. M., Wakefield, M., & Kerfoot, K. (2000). Nursing and health policy. *Journal of Nursing Scholarship*, 32(3), 307-315.
- Hancock, L. (1999). Policy, power and interests. In *Health policy in the market state*. (pp.19-47). St Leonards: Allen & Unwin.
- Hewison, A. (1999). The new public management and the new nursing: related by rhetoric? Some reflections on the policy process and nursing. *Journal of Advanced Nursing*, 29(6), 1377-1384.
- Hughes, F. A. (2000). Health policy - locating New Zealand and nursing. Unpublished dissertation portfolio, University of Technology, Sydney, Australia.

- Kalisch, B., & Kalisch, P. (1982). *The politics of nursing*. Philadelphia: J. B. Lippincott.
- Kingdon, J. W. (1995). *Agendas, alternatives and public policies*. New York: Harper Collins College Publishers.
- Lange, A., & Cheek, J. (1997). Health policy and the nursing profession: a deafening silence. *International Journal of Nursing Practice*, 3(1), 2-9.
- Lindblom, C. E. (1987). *The policy making process*. Yale: Prentice-Hall
- Martin, E. J., White, J. E., & Hansen, M. M. (1989). Preparing students to shape health policy. *Nursing Outlook*, 37(2), 89-93.
- Ministry of Health. (1998). Releasing the potential of nursing: *Report of the Ministerial Taskforce on Nursing*. Wellington: Author.
- Ministry of Health. (1999). *Our Health Our Future - Hauora Pakari - Koiora Roa: The health of New Zealanders*. Wellington: Author.
- Ministry of Health. (2001). *Nursing workforce statistics*. Wellington: Author.
- Misener, T. R., Alexander, J. W., Blaha, A. J., Clarke, P. N., Cover, C. M., Felton, G.M., Fuller, S. G., Herman, J., Rodes, M. M., & Sharp, H. F. (1997). National Delphi study to determine competencies for nursing leadership in public health. *Image: Journal of Nursing Scholarship*, 29, 47-51.
- Neill, J. O. C. (1961). *Grace Neill: The Story of a Noble Woman*. Christchurch, New Zealand: N.M. Peryer Ltd.
- Polit, D. F., & Hungler, B. (1991). *Nursing research: Principles and methods* (4th ed). Philadelphia: Lippincott.
- Rafferty A. M. (1992). Nursing policy and nationalization of nursing: The representation of crisis and the crisis of representation. In J. Robinson., A. Gray, & R. Elkan. (Eds.). *Policy issues in nursing*.(pp. 68-83). Buckingham: Open University Press.
- Stimpson, M., & Hanley, B. (1991). Nurse policy analyst. *Nursing and Health Care* 12 (1), 10-15.
- Weissert, C., & Weissert, W. (1996). Health care policy and problem definition. *Governing health: The politics of health policy* (pp 225-256). Baltimore: John Hopkins University Press.
- Wieczorek, R., (Ed.). (1995). *Power, Politics and Policy in Nursing*, New York, Springer Publishing Company.