LEADERSHIP & NURSING
CONTEMPORARY PERSPECTIVES

2ND EDITION

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FOREWORD

It is an honour to write the foreword of the second edition of *Leadership and Nursing: Contemporary Perspectives*, edited by John Daly, Sandra Speedy and Debra Jackson. Leadership is probably one of the themes most written about across many spheres of human endeavour; for example, in the literature on the professions, politics, the military, to name a few—not surprisingly it has also received considerable attention in nursing. Leadership influences all spheres of nursing—practice, teaching, research and professional development. We can therefore identify with the interest in leadership. With reference to practice, evidence indicates that good leaders have a positive influence on the work environment. As John C. Maxwell stated eloquently, ‘a leader is one who knows the way, goes the way, and shows the way’. In knowing, going and showing the way, it is thus timely that the authors unpack the concept and challenges of leadership in relation to the practice in Chapter 1. The authors give due recognition to the position of practice, and continue to focus on important aspects related to practice in, for example, Chapter 4: Leadership, ethics and the nursing work environments, Chapter 9: Leading contemporary approaches to nursing practice, Chapter 10: Governance of nursing practice: Steps for the quality and safety of healthcare and Chapter 12: Leadership and its influence on patient outcomes.

Long gone are the days that research is conducted for the sake of research. Nursing research is focused at improving the practice of nursing, to ensure quality patient care, to improve patient outcomes and, therefore, nursing decisions based on evidence are critical. Throughout the book it is evident that the authors support these aspects. In Chapter 7 the authors articulate the overlap between leadership, research and practice coherently and describe leading research to enhance nursing practice.

Wendell L. Wilkie stated that ‘education is the mother of leadership’ and Nelson Mandela echoes that ‘education is the most powerful weapon which you can use to change the world’. Nursing professionals realise the importance of education, yet we are increasingly aware of the changing landscape of education. This century asks for transformation of education of healthcare professionals to strengthen health systems. The authors give due attention to interprofessional education practice and leading nursing in the Academy in Chapters 16 and 18, respectively, and highlight the challenges faced by leaders.

Leaders and managers are aware of the concepts of ‘empowerment’, ‘change management’, ‘identity’ and ‘legacy management’. The description of these concepts in various chapters provides useful explanations and simplifies the complexities of how these concepts are related to leadership. Bill Gates so rightly states that ‘as we look ahead into the next century, leaders will be those who empower others’—an element that is embraced throughout the book. Of particular note is the structure of the chapters: each starts with learning objectives and keywords, and concludes with reflective exercises as well as a recommended list for reading.
I believe that this edition of *Leadership and Nursing: Contemporary Perspectives* is a timely revision and addresses all of the important aspects of leadership and the related concepts of equal importance. This book is a resource for the leaders and managers in various contexts and will be useful across the career span. The book is inspiring and provides valuable information that is not freely available in the literature. It makes an important contribution to leadership and nursing, and will be a resource as we continuously renew ourselves through personal and professional development. I strongly recommend this book as a most valuable resource.

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PREFACE

This second edition, of what was a timely book first published in 2004 to fill a vital need in the nursing profession and in nursing practice, has been radically revised and improved. It represents a diverse range of scholarly voices who interrogate the current condition of nursing leadership as practised in a diverse range of settings, and indicates the challenges that nurse leaders face in ethically fulfilling their various leadership roles, both now and in the future. It points to a future for nursing that is dependent on skilled and informed leadership from within its ranks, whether this be formal or informal leadership. The book rests on the premise that leadership is the responsibility of health professionals in all settings. It is not just for the person authorised to hold a position of leadership within the organisation. Equally, we believe that effective leadership is not possible until one has an understanding of self, what motivates others and what systems can facilitate or frustrate leaders. A major feature of this edition is the inclusion of carefully selected global nurse leaders whose expertise will be apparent to readers.

A number of individuals provided vital assistance and support during the preparation of this book. First and foremost, gratitude must go to our families and loved ones for their patience, tolerance and sacrifice of lost time with us. Our sincere thanks go to Libby Houston, Tamsin Curtis, Vicky Spichopoulos and Karthikeyan Murthy of Elsevier for seeing us through the project and providing support along the way, and especially to Jo Crichton for her diligent editorial work.

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LEARNING OBJECTIVES

At the completion of this chapter, the reader will be able to:

▲ describe attributes and characteristics of policy;
▲ explain the concept of the policy cycle;
▲ delineate the stages of the policy cycle and key challenges in successful policy implementation;
▲ understand the critical role of policy in governance in healthcare at local, national and global levels;
▲ appreciate the power of policy as a tool to enhance nursing’s contribution to health system leadership in a multidisciplinary healthcare team context;
▲ understand the role of leaders in influencing, developing, implementing and evaluating health policy.
INTRODUCTION

As discussed in other chapters in this book, numerous international health leadership organisations such as the Institute of Medicine (IOM) in the USA (IOM, 2011) and the World Health Organization (2011, 2013a, 2013b) and others are calling for nursing to more fully exploit its potential for leading change in healthcare systems in partnership with other members of the healthcare team. The World Health Assembly has passed resolutions in the recent past and directed strategy to some extent in efforts to strengthen nursing and midwifery internationally (WHO, 2013a).

Nurses are currently under-represented in senior executive ranks in health service leadership organisations including at higher government level. Historically, the reasons for this are many and varied. Undoubtedly gender politics and traditional professional hierarchies in health education and healthcare have exerted a major impact (see Chapter 4 for more discussion on gender and politics). The profession could also shoulder some responsibility for that situation, as author Suzanne Gordon (2010) has observed, ‘nurses tend to emphasize virtue rather than knowledge’. She also calls for nursing to become more assertive and ‘activist’.

An active role in system reform is vital if the profession of nursing is to maximise its contribution to healthcare enhancement. The demands on health systems are increasing exponentially. Shifts in demography (as many developed countries like Australia and Japan age rapidly, while other, developing countries, increase their demand for better child and maternal care), illness profiles (including a global increase in non-communicable diseases), workforce ageing and shortages, and the persistence of medical errors, mean that both public and private healthcare providers are seeking better ways to become more effective, efficient, appropriate, equitable and, most of all, viable. Nursing has the potential to play a very significant leadership role along with other health professionals in responding to these challenges.

Increases in patient and system complexity, resource and quality and safety issues have also led to a more systems view in many health system contexts (Schyve, 2009). Indeed, Schyve (2009, p. 1) suggests that ‘Rather than thinking of the healthcare organization as a conglomerate of units, think of it as a “system”—a combination of processes, people, and other resources that, working together, achieve an end’. It is here that nurses are finally being recognised as key collaborators in the 'working together process' which involves at its core, theorising ways of achieving future system changes (from bedside to boardroom argues the IOM (2011)) in order to ensure that equitable, sustainable quality healthcare is to be able to be achieved and sustained.

Policy therefore needs to be part of the professional lexicon for all nurses. Purposeful efforts at capacity building to achieve greater levels of knowledge and skill in policy development, implementation and evaluation, among nurses at all levels will be crucial if nursing is to expand its potential to contribute to effective transformation endeavours in healthcare.

WHAT ARE THE ATTRIBUTES AND CHARACTERISTICS OF POLICY?

There have been numerous calls in the international literature for nursing to engage and more fully participate in health policy development and implementation (Gordon, 2010; Hinshaw & Grady, 2011; Mason, Leavitt, & Chaffee, 2014). But what is policy and how does it relate to the work of nurses in general and nursing leadership in particular?

Policy as a concept can mean many things and there is no clear agreement in the literature on a simple or all-encompassing definition (Althaus, Bridgman, & Davis, 2013). The concept is in widespread use in many sectors and institutions in society, particularly in politics and organisational theory. This points to an almost implicit assumption on the part of those who use the term freely, that all who are exposed to it will understand its meaning and implications. Althaus et al. (2013) position policy...
as a concept, and assert that a ‘multitude of meanings is inevitable, since policy is a shorthand description for everything from an analysis of past decisions to the imposition of current political thinking’ (p. 6).

The political nature of policies is closely related to their focus. Anderson (2014) talks about public policies as addressing, by their very nature, a problem or a matter of public concern. For Dye (1995) public policy is defined much more simply. Created by governments, policies are, in practice, whatever they choose to do or not do and the difference it makes. At an even simpler level we can understand policies as those directives or guidelines by which the actions of governments, systems, organisations, teams or individuals are facilitated or constrained.

What is clear, and what we will discuss in the next section, is that policy is value-laden, political, often contested, most often in a collective sense (Althaus et al., 2013; Brownson, Chriqui, & Stamatakis, 2009). Policy, according to Colebatch (2009), is a way of creating and maintaining order and predictability, of establishing and mobilising goals within complex circumstances, through the creation and development of linkages. It is also, at the same time, about creating stability and managing change. In this sense policy is less about the decision-making process and more about a process of ongoing societal [and in our case, professional] negotiation (Colebatch, 2009).

Policy attributes

The attributes of policies can be as difficult to pin down as their definition (and, of course, for the same reason). At a very basic level, policies can be either formal (such as policies enacted as laws or regulations) or informal (policies which operate as guidelines). Policies can vary in where and how they are generated, their focus, their type, their direction and their outcomes. We will discuss each briefly in turn.

Policies are generated from a variety of institutions. This is particularly true of policies in the health sector. Health policies are made, implemented and monitored at international (i.e. World Health Organization), national, state and local government levels, as well as by systems, organisations, services, teams and units.

Policies have a variety of foci. They can address: the production (creation, management), distribution and consumption of resources; identity issues (including national and professional identities); and in reflexive mode, how policies themselves are made and who is involved in the process (that is, policies on policy making, such as the inclusion of patients on local health district boards) (Fenna, 2004).

Policies also differ in type. Policies can be distributive, redistributive, constituent, regulatory (Lowi, 1972) or symbolic (Edelman, 1964). Distributive policies (sometimes also known as material policies) shape the way in which resources are allocated across a country, system or organisation. They can determine, for example, what proportion of the national budget is spent on health services, or what amount of a hospital budget goes to paediatrics compared with surgery.

Redistributive policies are a mechanism by which resources are shared across different groups. One example is the Pharmaceutical Benefits Scheme in Australia, which subsidises some medications for some groups. Constituent policies are understood by some to be those policies which direct actions (such as the legislation) required to ensure redistribution occurs, but by others are considered to be about the non-material aspects of redistribution, such as governance.

Regulatory (or self-regulatory as in the case of professional bodies) policies determine what is considered acceptable behaviour by individuals or groups. A good
example of regulatory policies are those which are issued by Colleges of Nursing and/or Midwifery, and which direct expectations of length and type of training, as well as appropriate types of professional, ethical behaviour.

One final category, symbolic policies, are those which have no material resources attached, and which either can have symbolic power or which can be used to shift the focus away from a fully resourced policy. A good example of the former is that the shift to person-centred care does not necessarily affect the type or amount of funding a service or unit receives (although it can) but as a policy it has shaped the behaviour of both clients and clinicians (Epstein, Fiscella, Lesser, & Stange, 2010). An example of the latter is any policy which ‘... permit[s] elected leaders to show great concern but relieve them of the need to allocate resources’ (Schneider & Ingram, 1993, p. 338).

Policies, Palmer and Short (2010) argue, can have different directions. They can be about intentions or objectives—that is, they can be about directing future action (such as the focus of nursing education) or they can be directed at remedying something that has occurred in the past (such as the establishment of the Australian Dust Diseases Board to pay compensation to people exposed to asbestos).

These two examples—nursing education and compensation for an acquired illness—speak to some of the other characteristics of policies. Policies can be substantive; that is, they can address a whole issue or area (for example, higher education). But they can also be procedural; that is, a way of establishing what actions need to be taken, by which individuals, and according to what rules. Hand hygiene policies are also a good example of the latter.

Finally, and equally importantly, policies can have two basic outcomes. These are intended and unintended. One of the key elements of good policy making is the ability to not only plan for intended outcomes but also to assess as many potential unintended outcomes as possible.

THE POLICY CYCLE: HOW IS POLICY MADE?

For Colebatch (2009), policy is an organisational construct that has three dimensions, vertical, horizontal and scene setting. The vertical dimension is where the dominant account of policy is the ‘authorised choice’, in other words the authority of governments to make policy that they believe will solve problems in an autonomous, goal-oriented and purposive way. The horizontal includes the pattern of structured interaction amongst participants or stakeholders, each with a different understanding of ‘the’ problem, with conflicting, overlapping, negotiated and compromised interactions rather than the ‘decision and order’ that seems to operate vertically. Finally, there is the scene-setting dimension, which refers to shared values, ideals and understandings within a policy-making milieu (Colebatch, 2009). But what does this mean in practice? As Colebatch (2009) states:

*These dimensions are not alternatives: rather, each tends to assume the others. ... Policy practitioners use both accounts: they recognize the need to try and ensure that the relevant interests have been involved in framing the policy outcome (horizontal) before it is presented for official approval (vertical). In their more reflective moments, they are likely to recognize also that there is another dimension, where their contribution is less direct: the sphere of shared understandings and values within which the negotiation and the decision making take place ... the scene-setting dimension (p. 36).*

The scene-setting dimension also speaks to the other elements of policy making. The process, as we will discuss in the next section, is well understood and
documented. But the process does not take place in a vacuum. At the beginning of this chapter we offered several definitions that spoke about policy address problems. But how does something become a social or a health problem? Factors such as politics and the relative power of stakeholders make all the difference and can influence something to be recognised as a problem or concern that needs addressing in/ by policy.

The political will of governments to create and enact adequate resource policies is shaped by any number of stakeholders. These can include (amongst others) the public (as in the case with increased gun control), professionals (e.g. health professionals’ concern about obesity), researchers (e.g. providing the evidence around smoking) and/or lobby groups (e.g. the fast food industry and support or voluntary groups including those for specific diseases and conditions such as breast cancer).

The relative power of these stakeholders shapes what is on the agenda and what is left off. One of the most important aspects of policy making that needs to be considered is that the lack of a formal policy can itself operate as a policy. Not banning fast food advertising at peak TV watching times for children is effectively a policy that acts to allow children to see such advertisements.

It is important to remember Colebatch’s (2009) dimensions as we consider the policy cycle model. The problem with any model or linear (or in this case circular, but with the same limitations) representation is that they tend to present an idealised version of the process.

The policy model represents an idealised process. However, in reality the process is more fluid, more complex and less predictable (Althaus et al., 2013). While reality of the policy process is much closer to Durkheim’s notion of the profane (that is, the mundane, the messy and the everyday) than to the ‘sacred’ model (Durkheim, 1915), the policy cycle does provide us with a basic guide and some useful stepping stones for the process.

The policy cycle

The terms policy process and policy cycle are used in the literature and they appear to be interchangeable. The process is complex and a range of factors, if not anticipated and managed well, may result in policy failure. Policy development is best approached in a systematic way. The policy process or cycle model is composed of a number of stages that need to be considered to optimise chances of a successful outcome. Althaus et al. (2013) assert that ‘good policy should include the basic elements of the cycle. That is, a policy process that does not include everything from problem identification to implementation to evaluation has less chance of success. This will not hold true for every example—some policy issues are so simple that investment in process is redundant. But on balance, and across cumulated experience of policy making, a more thorough policy process is less likely to produce an obvious policy mistake. A policy cycle assists systematic thinking, even if many different types of policy cycle are conceivable’ (p. 34).

The policy cycle process

What has come to be known generally as the policy process, or the policy cycle, is more precisely understood at the technical or institutional or rationalist choice model of policy making (Althaus et al., 2013). This model involves a series of steps that are seen to flow logically from one another. The difference between the linear model and the cycle is simply that in cyclical models once the policy is implemented and
evaluated, the policy makers go back to the start and reconsider what emerging (in both the political and practical sense) problems may require additional policy.

The rational aspect of this model makes it very attractive to policy makers who are interested in evidence-informed decision or policy making. As in evidence-based clinical practice, evidence-based decision making is centred on the justification of decisions based on the best research evidence. In the shift from an individual-clinical to a population-policy level, the decision-making context becomes more uncertain, variable and complex (Dobrow, Goel, & Upshur, 2004, p. 207). Evidence-based (or evidence-informed decision making) is one attempt to address this uncertainty (Oxman, Lavis, Lewin, & Fretheim, 2009).

There are alternatives to this type of policy-making model. These speak to a less linear and vertical model, incorporating (or at the very least recognising) more of the horizontal negotiation and scene-setting or contextual processes. Some alternatives (there are others) to the rationalist model of policy making include the:

▲ Incrementalist or ‘muddling through’ model which argues that it is actually small shifts in what a government or organisation does that create policy and that policy making is essentially a process of such bodies making comparisons between their existing policies and any potential alternatives (Lindblom, 1959).

▲ Garbage can or multiple streams model. This model recognises the primacy of the elements we discussed in the last section. Proponents of this model say that at any one time there are three independent streams flowing into a policy-making environment—the problems themselves, politics and policy processes (or solutions). Policies are made when the politics of the day allow the policy maker to match the problem and the solution (Cohen, March, & Olsen, 1972; Kingdon, 2010).

▲ Advocacy coalition framework (Sabatier, 1988). In this model of policy making, coalitions form around specific policy issues. These can include policy makers and analysts, researchers and academics, the public and the media. Policy or policy change happens when a particular coalition (e.g. the anti-smoking lobby) rises to power above other coalitions (e.g. tobacco companies, tobacco growers) and is able to set the policy agenda.

▲ Punctuated equilibrium framework (Baumgartner & Jones, 1993) argues that policy making is essentially about long periods of small incremental changes (as above) followed by short periods of major policy change.

### THE STAGES OF THE POLICY CYCLE AND KEY CHALLENGES IN SUCCESSFUL POLICY IMPLEMENTATION

The policy process essentially involves several key steps. These are presented in Table 14.1.

The attractiveness of this approach to policy making is clear. It is logical, ‘doable’ and seemingly consistent with the principles of evidence-based practice. Many of the shortfalls have been identified in the explanation of the steps. It is clear, for example, that good evidence is needed to support the case for a policy intervention (as opposed to any other mechanism for change) for a specific problem (as opposed to multiple other issues), utilising a specific policy (the actual policy intervention chosen).
Table 14.1 Steps and explanation of the policy process

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify and define the problem</td>
<td>What is deemed a problem? By whom? How do problems come to the attention of policy makers? How can they be defined? What alternative conceptualisations and perspectives need to be taken into account? How will you get agreement from key stakeholders on what the problem is and how it should be addressed? (Hint: engage them at this point.)</td>
</tr>
<tr>
<td>a. Establish your goals and objectives</td>
<td>Who is involved in the process of setting goals and objectives? How do you know your goals and objectives are achievable? How broad or specific do your goals need to be?</td>
</tr>
<tr>
<td>2. Identify the evidence</td>
<td>What are your sources of evidence? What will you do if there is little or no evidence?</td>
</tr>
<tr>
<td>a. What are the known causes of the problem?</td>
<td>What evidence do you have about the causes of the problem itself, and from which sources? How will you ensure that the voices of the vulnerable are included?</td>
</tr>
<tr>
<td>b. What evidence is there for the impact of previous policies, strategies or interventions?</td>
<td>What has been shown to work? To not work? By whom? When? Which scene-setting or contextual factors do you think might have impinged on the impact of previous attempts to address this problem?</td>
</tr>
<tr>
<td>c. Why do you think a policy is appropriate?</td>
<td>What alternatives or adjuncts to policy can you employ?</td>
</tr>
<tr>
<td>3. Identify your options</td>
<td>What do you think you will do as a result of your policy? What features of the community, system or organisation (scene setting) do you need to take into account?</td>
</tr>
<tr>
<td>a. What evidence do you have for the appropriateness, effectiveness and impact of your chosen options?</td>
<td>How do you know that your options are sound and are the right response to the problem and its causes?</td>
</tr>
<tr>
<td>4. Select the evaluation criterion</td>
<td>How will you know if the policy has met your objectives? How will you know what outcomes (expected and unexpected) and impact (desirable and undesirable, and for whom) it has had? Who needs to be involved in the evaluation? What baseline data do you need to collect before you commence the implementation?</td>
</tr>
<tr>
<td>5. Determine known (desirable) outcomes and potential unknown outcomes (both desirable and undesirable)</td>
<td>What are your expected outcomes, and what are your potential outcomes (good and bad)? What types of scenarios can you construct and test before implementation?</td>
</tr>
<tr>
<td>6. Evaluate the options</td>
<td>How feasible and implementable are your options? How do you know? Who do you need to consult? How will you hear the voices of the vulnerable?</td>
</tr>
</tbody>
</table>
### Table 14.1 cont

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| a. What are the costs (resources, politics, power, etc.)?           | What will it take to implement your policy?  
|                                                                     | Who will you need to engage in the negotiation process?  
|                                                                     | What politics and power relations will you need to consider, or to bring onside? How will you do this?  
|                                                                     | What alternatives will you have if your policy cannot be fully implemented?                                                                                                                                                                                                      |
| b. Decide on your best option                                      | Based on a) above, what is your best option (intervention) in addressing the problem?                                                                                                                                                                                                                                                  |
| c. Find support                                                    | How will you gain the support you need?  
|                                                                     | Who do you need to include in the implementation process?  
|                                                                     | Who do you need to lobby?                                                                                                                                                                                                                                                                                                                 |
| 7. Implement your chosen option                                    | How will you implement your option(s)? How will you convert your goals and objectives into a specific plan?  
|                                                                     | Who will you engage in the implementation process?  
|                                                                     | How long will this take?                                                                                                                                                                                                                                                                                                                    |
| 8. Evaluate                                                        | According to the criteria established in step 4: How will you disseminate the findings? How will you ensure the continued employment of any successful options? How will you address any negative outcomes?                                                                                                                                                  |
| 9. Identify and define the problem                                 | Given what you know now, what is the next problem you need to address?                                                                                                                                                                                                                                                                    |

Hoy and Miskel (2013), writing about educational administration, identify some potential traps in evidence gathering and decision making that can also beset the making and implementation of healthcare policies. These include the:

▲ An **Anchoring Trap**: Giving disproportional weight to initial information.

▲ **Comfort Trap**: A bias towards alternatives that support the status quo.

▲ **Recognition Trap**: Tendency to place a higher value on that which is familiar.

▲ **Representative Trap**: Tendency to see others as representative of the typical stereotype.

▲ **Sunk-Cost Trap**: Tendency to make decisions that justify previous decisions that are not working.

▲ **Framing Trap**: Framing of the problem impacts the eventual solution.

▲ **Prudence Trap**: Tendency to be overcautious when faced with high-stakes decisions.

▲ **Memory Trap**: Tendency to base predictions on memory of past events, which are often very influenced by both recent and dramatic events.

Implementation is critical to success in policy outcomes, including achievement of a policy’s objectives. Sabatier (2007) (of the advocacy coalition model) gives some insights into why policies are difficult to develop and to implement. He argues that:

▲ For any one policy there are hundreds of actors (stakeholders and other) from different agencies, organisations, levels of government, interest groups,
academics, legislators and media representatives who are or could be involved in the development and implementation process.

▲ Policy cycles can typically take a decade (and up to 40 years) from the time when a problem is identified through the period when there is enough evidence on its cause and consequences, to when the actual impact of the implemented policy can be assessed.

▲ There is rarely only one policy at work. Whatever the issue, there are often a number of different programs, players and policies all interacting (and at times competing) with each other.

▲ Policy is developed and played out in different arenas. The debates, which shape and direct policies, can take place in Ministries of Health, but they are also shaped by public inquiries, political debates influencing the development of government regulations and interventions and judicial processes.

▲ The policy process can involve deeply held social or religious values (such as those surrounding terminations and euthanasia) and financial interests (including industry).

Policy is being made constantly. Like communication, even when you think you or others are not making policy, you are. Because of the complexity of most policy processes, and the speed at which they can be required by governments, systems and services (as opposed to the speed at which the problem can gestate), nurses need to be more than actively involved, as noted by Gordon (2010) at the beginning of this chapter. They need to take the lead. In the next section we address just that question.

NURSING AND HEALTH POLICY

In healthcare, policy is associated with change and as has been argued in Chapter 4, imposed change is acknowledged as a contributor to some of the work-based adversity issues facing nursing, including retention, burnout and job dissatisfaction (Kowalski et al., 2010). One way that nurses can act against imposed change, and ensure that nursing concerns and interests are considered in the change process, is for nursing to actively contribute to policy change and policy development.

In an earlier chapter of this book we highlight the importance of nurses being politically aware and being able to operate at the level of the political (see Chapter 4). This political insight and confidence is essential if nurses are to contribute to policy development and health reform. It may be that the role of nurses in relation to policy is seen as simply being one of implementing policy. But we argue that nurses are key to health reform, and so have a much more holistic role to play in relation to policy—nurses have roles in all aspects of policy development and implementation—right from recognition of a need for policy (or policy reform), through to contributing to its development and implementation. Further, it is crucial that nurses engage in policy development and implementation beyond the local level and contribute at the regional, national and international levels.

When considering the types of policies discussed earlier—distributive, redistributive, constituent, regulatory and symbolic policies—it is important to consider where nursing involvement might be centred currently, and where there is a need to increase or enhance the nursing contribution.

Nursing leaders in particular have a role to play here—not only a role in contributing to the development of policy themselves, but in two other important areas: 1.) advocating for nursing involvement and inclusion in all levels and types of policy
development forums; and 2.) facilitating nurses to develop the skills and confidence needed to participate in policy development and reform.

**CONCLUSION**

Policy is a crucial and often powerful instrument in governance of healthcare. Choices made in crafting policy for health can have profound implications for healthcare structure, process, resourcing and delivery. Leaders in nursing are well positioned to make important contributions to debate in, and indeed to become significant architects of, health policy. To do so, like other leading health professionals, they require a lexicon, skill set and the confidence to engage in the policy development, implementation and evaluation processes. Health policy can serve as a vehicle for further enabling and expanding nursing’s contribution to healthcare in partnership with other health professional policy leaders.

**REFLECTIVE EXERCISE**

Consider nursing in relation to the types of policies influencing healthcare and delivery.

1. Can you describe examples of nurse involvement in the various forms of policy?
   a. Distributive?
   b. Redistributive?
   c. Constituent?
   d. Regulatory?
   e. Symbolic?

2. How can nursing’s involvement in creating and implementing the various types of policy be improved?

3. Conduct an internet search to establish how nursing has contributed to policy development from the local to the international context.

**Recommended Readings**


References


