

**POLICY, POLITICS AND NURSING: A CASE STUDY OF POLICY  
FORMATION IN NEW ZEALAND**

**by**

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**CERTIFICATE OF AUTHORSHIP / ORIGINALITY**

I certify that this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of candidate

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## **Preface**

### ***The Journey***

Four years ago I commenced the journey of Doctoral studies. I came into these studies with a 20-year history in nursing as a clinician, academic and also as a nurse working in the health policy environment. From my early days I was interested in policy issues. I was involved in many different areas of practice and was often placed in the role of pioneering new ways of doing things.

Mental health became my practice setting and my passion. It was a green field in terms of assisting with change and making a difference. Here was a vulnerable population, a nursing workforce constantly criticised and professionally neglected by mainstream nursing. I was driven by a strong sense of social justice and from 1981 until 1995, I worked locally, regionally and nationally with other passionate nurses as we established systems and structures to support mental health nursing practice. We took psychiatric nursing into mental health nursing. I witnessed the best and worst of nursing practice as we de-institutionalised the largest psychiatric hospital in the southern hemisphere. I realised that policy and politics affected mental health nursing practice, and I saw a need to develop myself in this area.

I moved back into mainstream nursing (perceived by some as walking away from mental health) and became a public servant as the Senior Nursing Advisor within the Ministry of Health. I moved into this position when nursing in New Zealand was suffering from, and reacting and responding to, the national health reforms.

The Ministry of Health was another pioneering adventure. Within six months of being made Senior Nursing Advisor, I was acting as the Chief Nursing Advisor. This position did not come with any clear guidelines apart from the code for public servants. I moulded and shaped the position.

I realised very quickly that this role was like no other I had held. It was professionally isolated and I had no real peers apart from international colleagues. Even there the position of Chief Nursing was not well understood. In 1997, I chaired working parties for the Ministry on nurse prescribing and again found myself dealing with power and

politics – not just in nursing but also with wider interest groups. I became interested in the way nursing influences policy. I saw the range of ways that individuals and organisations use to have an influence. This came to a head when the 1998 Ministerial Taskforce on Nursing was established. That case exemplar became the core of this thesis.

The Ministerial Taskforce was the first time nursing had the attention of government since before the punishing reforms that had so marginalised nursing. It was also the first time nursing had a nationally future focused committee set up by the government about more effective utilisation of registered nurses.

My field of inquiry – nursing and policy formation – was born out of frustrating times with myself and my profession, feeling unable to influence decisions in health policy. My health policy course work became a literature review and analysis of the New Zealand policy environment and eventually moved into Chapter 2 here. New Zealand health reforms in the 1990s are renowned in the general health reform literature. Within this context was nursing. Little has been written about the impact of the reforms on nursing and in turn, consumers' [patients'] care.

As a nurse in government I had little time to fully analyse events and the role I played in them. The focus on policy as a field of study combined with the course work in the Professional Doctorate allowed this to occur. Nurses in New Zealand asked me to present my views on nursing in policy at a national lecture at Victoria University in 2001. It was well received and this lecture (which was an early draft of chapter 4) was later accepted for publication in a peer reviewed nursing journal in New Zealand. Through the study came the recognition of the role of the Chief Nurse in government and how it functioned in relation to health policy and my profession. The knowledge and understanding I was gaining about the role of the Chief Nurse in government also was of interest to other nurses in policy and Chief Nurses internationally. This resulted in an early draft of chapter 5 being submitted and accepted for publication to a peer reviewed international nursing policy journal. As interest grew in my views and analysis of the Chief Nurses role, I also was asked to write an editorial for *International Nursing Review*. All these articles have been very well received and used.

This study has concluded with discussion of implications and questions for practice, education, policy and research. Nurses are not always prepared for a policy role or for understanding policy. To develop, nurses in this area not only need exposure to role models and experience but a graduate pathway, which includes policy. Political and policy analytic skills are important for us to value and embrace as nurses. We want nurses to be part of the knowledge workers in the future as our clients, patients and health consumers need nurses to influence and lead health policy. A new role for nurses in policy is promoted in this study: the policy entrepreneur, a nurse with position, influence, vision and leadership who works to assist policy formation to improve the health of all people.

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I was awarded a 2001-2002 Harkness Fellowship in Health Care Policy from the Commonwealth Fund in New York, USA. This thesis would not have had its richness and depth had it not been for the chance to live and study in the USA for a year. It came at a crucial time for my Doctoral work (and at another crucial time: I arrived in New York September 10, 2001, to witness the World Trade Center collapse and attendant crisis). The Harkness Fellowship allowed me time and exposure to USA policy makers, nursing leaders who have shaped and lead the field in nursing policy and nursing leaders in organisations and the federal government. The exposure to Dr Linda Aiken, Dr Marla Salmon and Dr Shirley Smoyak especially has been instrumental in the development and refinement of my thinking about nursing and health policy.

The Professional Doctorate allowed me to combine my lived experience, graduate education and practice as a nurse in a policy environment of central government. I have exposed myself not only to literature but also to leaders in the field of policy and nursing. More importantly, it has allowed - and required - me to take the time and space to stand back, reflect, study and theorise on my role as a nurse in relation to policy, government and the profession of nursing. I have been able to unpack concepts of interest groups, conflict, power and politics which before were just influences I witnessed.

Peeling back and mining a piece of one's professional and personal life as I chose to do, with the case analysis at the core of this thesis without guidelines in either the literature or the blessedly loose rules of the Professional Doctorate, was both daunting and exhilarating. With every succeeding draft I felt myself changing, evolving and at times taking me outside my own comfortable mindset on policy.

At the end of this process I am surely supremely convinced not only of the role for nursing in policy, but of the various ways that it can be achieved and acted upon, including the role of Chief Nurse. Nursing in New Zealand, and everywhere else, can profit from the analytic strategies I have identified in this thesis. Working together however difficult that is, nurses can bring health care to a new level of understanding of our contributions if we can understand the contexts in which we operate.

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## **Abstract**

### **Policy, Politics and Nursing: A Case Study of Policy Formation in New Zealand**

The aims of this thesis were to: describe the political development of nursing in New Zealand; promote an understanding of policy and politics and the nursing profession; provide policy learning for the international nursing community; and provide insight into the role of the government Chief Nursing Advisor, especially in relation to engaging with professional groups and central government. The thesis focuses upon a significant event in the history of New Zealand nursing politics and policy: the 1998 Ministerial Taskforce on Nursing. In 1998, after public outcry at the excesses of the health reforms, nursing professionals took advantage of the opportunity to put nursing on the government's agenda through a Ministerial Taskforce on Nursing. The Taskforce ended its work in a flurry of publicly expressed controversy. To develop the case study an Expert Reference Group was established to assist in the selection of subject matter and to provide sources of material and validity of interpretation. Sources of data included participant observations, reports and documents in the public domain, media and secondary sources from nursing, medical and policy, literature and diary entries from the researchers own records. The researcher held multiple roles as Chief Nurse Advisor Taskforce member, public servant and nursing leader. Analysis from all of these points of view aimed to identify the stage of nursing's political development as defined by Cohen et al (1996) and to explicate how nurses engaged in agenda setting as described by Kingdon (1995). Analysis was informed by locating the Taskforce in the policy and political contexts, especially policy entrepreneurship. Analysis revealed the mechanisms nursing organisations use to engage in agenda setting. Moving from agenda to action was non-linear and fluid. No one organisation or individual brought about the events of the case nor their outcomes. Analysis suggests a refinement of the Cohen model to include behaviours of responsible actors in nursing politics and policy. The role of the policy entrepreneur is developed especially in the Chief Nurse position. The thesis widens the understanding of how nursing engages not only in policy formation among nursing organisations but also with government. Implications for policy, practice, education and research not only for New Zealand but also for other countries are presented.

## Chapter 1: Introduction

Fantasise for a moment about what it would be like if nursing were to emerge as a political force commensurate with its role in patient care (Ehrenreich, 2002, p. xxxiii).

Policy is about problems and options for their solution. Nursing is about assessing problems, gathering evidence and making decisions about options for care. Nurses are often thought of as being apolitical, but we all know that every day nurses express their concern for patients' care and health care services. In 1981, Aiken described nursing in the US as a "slumbering giant of health policy, its influence is not commensurate with its numbers [in workforce]" (p. 3). Twenty years later the international literature and research is still scarce on the way nursing engages in policy-making, and these comments are still relevant to countries like New Zealand.

Unfortunately, perhaps as a result of their socialisation and enculturation, nurses are not thinking about engaging in policy formation. To do so nursing needs to redefine the current view of what nursing is. Political activism and policy formation need to be seen as core functions. This will not only affect the way they respond to the policy community, but ultimately will also allow consumers to have true advocates through nursing in health care. Nursing will not only be influencing health care but also setting the agenda for health care.

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 be perceived as contributing in a broader strategic manner to health care. At the same time, the policy and political community needs to view nurses' potential contribution as being wider than operational issues. Increased knowledge and understanding of the interplay between power, politics and policy is required, because every day power, politics and policy affect the environment in which nurse's practise. In response to increased pressure on health care agendas around the world, "People want, need and are seeking not simply health care, but humanized health care" (Wieczorek, 1985, p.109). Nurses need to engage in the debates that will ensure they are able to provide this "humanised" health care.

Although some research has focused on health policy content in nursing education programmes (for example, Androeli, Musser & Otto, 1987; Cohen & Milone-Nuzzo, 2001) and the identification of specific political competencies for specialty practice (Misener, Alexander, Blaha, Clarke, Cover & Felton et al., 1997), some critics argue that to make good this gap, policy components need to be made mandatory in postgraduate study for nurses (Cohen & Milone-Nuzzo, 2001). In New Zealand the nursing profession has demonstrated an eagerness for influencing policy, but has lacked the ability to consistently influence policy. They also have not often been welcomed at the policy table.

### **The thesis**

The study is set in New Zealand in the late 1990s, when New Zealand had experienced a decade of economic reforms which affected every aspect of New Zealand society. Nursing in New Zealand during this time became exposed to new forces in health care: competition, managerialism, new labour relations, and hospital restructuring which removed nursing structures from organisations. The public service in New Zealand was also restructured, and this included the Ministry of Health. Within the Ministry there is the role of the Chief Nursing Advisor, and I have held this position since 1996. This role provides an important link between the nursing profession and government, and has provided a unique perspective on the operation of policy formation and agenda-setting in this area.

The aim of this thesis is to gain an understanding of how nursing organisations in New Zealand engaged in agenda-setting, and the kind of political development they exhibited, using a particular historical case. The study is therefore primarily a case study, focusing on the 1998 Ministerial Taskforce on Nursing, its context, and the public commentary surrounding the events. I use Kingdon's (1995) theories on policymaking and agenda-setting and Cohen, Mason, Kovner, Leavitt, Pulcini & Sochlaski's (1996) framework on the stages of the political development of nursing to analyse the case study material. Due to the central role the largest nursing organisation in New Zealand played in these events, the New Zealand Nursing Organisation (NZNO) features more prominently than other organisations in this study.

### **The case study**

On 12 February 1998, the New Zealand Minister of Health, Honourable Bill English, announced the establishment and membership of a Ministerial Taskforce on Nursing. The Taskforce's objective was "to develop strategies for developing nursing practice to enable the nursing workforce to better meet the emerging needs for responsive, flexible, cost effective and collaborative services" (Ministry of Health, 1998c, p. 2).

Nursing organisations eagerly awaited the work of this Taskforce, as for years the health reforms of the 1990s had been viewed as causing "poor morale, high staff turnover and low self esteem for nurses" (Gunn, 1997, p. 13). Many nursing leaders in New Zealand viewed the Taskforce as an opportunity to assert the nursing role in health care delivery.

On 20 July 1998, a week before the Ministerial Taskforce on Nursing delivered its report to the Minister of Health; the chief executive officer of the NZNO publicly terminated membership on the Taskforce and refused to endorse the report. This resulted in a media frenzy, with both nursing and the Government asking: "Why did nursing do this?" This study describes the politics surrounding the Taskforce and the way nursing engaged policy formation.

### **The significance of the study**

The significance of this study for nursing and policy-making is two-fold. Firstly, nursing globally is the largest health workforce, so it has the ability to influence the future directions of health care through its vast experience. Secondly, all countries are currently struggling with wide-ranging health issues, including quality of care, cost, and expanding growth in technology (to name just a few). The ability to solve these problematic issues requires a wider perspective on health care than just one discipline's knowledge or expertise. Understanding how nurses, through nursing organisations, engage in policy formation may assist those of us in policy positions to understand their processes and improve the mechanisms for engaging nursing in the policy process. The study offers insights for the nursing profession into policy making, and insight for policy makers regarding nursing's potential role and influence.

The aims of this thesis are to: (1) promote an understanding of the relationship among policy, politics and the nursing profession; (2) describe the political development of

nursing in New Zealand; (3) provide policy learning for the international and general theories on policy making; and (4) provide insight into the role of the Chief Nursing Advisor, especially in relation to engaging with professional groups and central government.

There has been little analysis of nursing and policy in the context of New Zealand health reforms. There is also little published work on the role of a chief nurse in government in any country, and no other published work that pulls nursing, policy and chief nurses role together in a real life case study. For New Zealand this study fills an important gap in the policy literature, in that there is no published study on the 1998 Ministerial Taskforce on Nursing. Nor has there been any analysis of the processes of agenda-setting and policy formulation in New Zealand nursing using a case study.

To meet the challenges of today's health care environment, nursing influence is required, not only in the clinical and management areas of health care, but also in health policy making. As a stakeholder group nurses need to be viewed as agenda-setters of health policy (Hughes, 2001). Nurses generate many great ideas, but as with many other good ideas these do not automatically turn into action. This is partly because the necessary political sophistication with regard to policy development and political processes is still developing (Cohen et al., 1996; Cohen & Milone-Nuzzo, 2001; Mechanic & Reinhard, 2002). This study highlights the links among nursing organisations, interest groups, policy formation, political development, and the role of the policy entrepreneur.

As Chief Nursing Advisor for the Ministry of Health in New Zealand, the work of the Ministerial Taskforce on Nursing has been of great personal interest. I was a member of the Taskforce and was made responsible for delivering its recommendations. The events surrounding the Taskforce brought out the best and the worst in New Zealand nursing politics, and raised questions about why the process happened the way it did.

The data for this study came from multiple sources, which will be outlined in Chapter 2. Within this study I played multiple roles, participant observer, Taskforce member, public servant and nurse leader. This created both limitations, inherent tensions and challenges, which will be described in more detail in Chapter 2. No one comes to such a

position without a developed set of philosophical and professional beliefs. Mine include strong belief in postgraduate education, the importance of balance between professional and industrial directions and nursing involvement in policy and decision-making. The benefit of methodology of this study is that it allowed me to be in a senior position in nursing and government, and research a key policy issue, in which I was intimately involved. The role of the Chief Nurse is a unique position, requiring knowledge of nursing and also government as a public servant. No other nurse has the knowledge of bureaucracy and no other bureaucrat has the same understanding of nursing as the Chief Nurse. In the role of a public servant there are tensions in relation to duty of confidentiality, which could be viewed by the profession as secrecy, or holding back of vital information, and lack of transparency, supposedly a requirement of the public service.

### **Structure of the thesis**

Chapters 1 and 2 provide the introduction and methodology used in the case study. Chapters 3, 4 and 5 then give the context for the Taskforce. Chapter 3 describes and analyses the New Zealand health reforms and political environment, and how these have affected nursing in New Zealand. It is here that Kingdon's (1995) theories of policy formation and Cohen et al.'s (1996) stages of political development are introduced. Chapters 4 and 5 analyse nursing's relationship with policy, and the formal organisations of New Zealand nursing. It is here, too, that the role of the Chief Nursing Advisor in policy is introduced, and the concept of a nurse as policy entrepreneur appears. These chapters build on the previous ones by overlaying the complexity of nursing on the already complex policy and political environment that existed in New Zealand in the mid-1990s.

Chapter 6 describes the events of the Ministerial Taskforce on Nursing, in chronological order, from November 1997 to September 1998. Chapter 7 analyses the events outlined in Chapter 6 using the lenses of Kingdon's (1995) theory of policy formation and agenda-setting and Cohen et al.'s (1996) stages of political development. Chapter 8 integrates the findings of the study and discusses their implications for the future of policy making and nursing. Finally, Chapter 9 is an epilogue, which gives an overview of the outcome of the Taskforce's recommendations post-1998.

## Chapter 2: Methodology

### Rationale

The questions that guided this study were:

What stage of political development, as defined by Cohen et al. (1996), were nurses in New Zealand exhibiting in relation to policy in this particular case?

How did nurses engage in agenda-setting in New Zealand, as evidenced by a particular case?

This thesis is an analytic case study of the 1998 Ministerial Taskforce on Nursing, and the data are primarily the public commentary that surrounded the Taskforce, supplemented by other sources as described later. The theories of Kingdon (1995) and the political development framework of Cohen et al. (1996) provide the lenses, or points of view, from which to analyse the case material. The context for this case is the New Zealand Health reforms in the 1990's and also the role of the government Chief Nursing Advisor.

### Case study method

Case studies have been used by social scientists for many years. The case study method is more suited to expansionist rather than reductionist pursuits (Becker, 1964; Yin, 1994), in that it allows an inquiry "to retain the holistic and meaningful characteristics of real life events" (Yin, 1994, p. 3). In doing so, case studies "inevitably mix the peculiar and the typical" (Marmor, 1970, p. 94). Case study as a method of inquiry is suited to the study of "complex, holistic systems" (Stake, 1978, p. 283), and is therefore well suited to the kinds of questions this study addresses.

In the case of the Ministerial Taskforce on Nursing, a case study approach allows for an investigation of the contextual conditions, the political environment, the mood of nursing in New Zealand, and the activities and influence of the Chief Nursing Advisor as policy entrepreneur. The strength and attraction of case study research is the ability to deal with the full range of data from a variety of sources, including personal observations and historical documents. Hypothesis is not a significant feature of this kind of methodology, and can typically be subordinate to an understanding of the case (Becker, 1964).

Yin (1994) recognises that concern is often expressed (by empirical researchers) about the rigour of case studies, and that the researcher must work hard to report all evidence fairly. Another common concern is that case studies “provide little basis for scientific generalization;” but, Yin, continues, “case studies, like experiments, are generalizable to theoretical propositions and not to populations of universes” (Yin, 1994, p. 11). A number of case studies can combine to substantially increase knowledge in a particular subject area, as Kingdon (1995) shows. It is worth noting that the body of literature on descriptive case studies of how nursing organisations engage in policy-making is very limited. So while the ability to generalise a single case study such as this one is limited, through the accumulation of case studies of nursing and policy making greater generalisation will be possible.

#### **Data sources and processes**

Data collection for this case study is from two main sources: participant observation and published documents in the public arena. The published document sources were from: firstly, government documents and reports; secondly, media clippings, transcripts or radio interviews; and thirdly, sources from nursing and medical literature. Members of the expert reference group (see below, this chapter) who were previously members of the Taskforce provided copies of memoranda, communications and briefing documents obtained by those members under the Official Information Act provisions.<sup>1</sup> I have also included notes from discussion with a Ministry of Health manager, whom I interviewed about the health reforms.

My own diary entries and experiences are used to provide anecdotes, which flesh out the contextual environment and publicly available information. Rochefort (1998) has analysed the role of anecdotes, and has identified both positive and negative aspects of their use. On the one hand they highlight “real issues and situations” and “help to supply information” (pp. 143-144). Politicians, in particular, like the use of anecdotes: “they are essential to the political game, and are used by both sides” (p. 146). Rochefort does, however, warn that they can be misused and need to be corroborated. In this study

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<sup>1</sup> The Official Information Act 1994 allows for individuals, groups or organisations to request information from the government or Crown services, which they hold or have written but not have not published.

anecdotes are used to complete the picture presented by other data and the wider literature.

### **Expert reference group**

From the outset I knew I would have difficulty undertaking an unbiased study of policy and nursing in New Zealand because of my position as Chief Nurse. I have attempted to mine my own subjectivity, first, by establishing an Expert Reference Group (ERG) to assist in the selection of subject matter; and second, by using data available in the public domain and not undertaking any personal interviews with key nursing leaders in New Zealand. The ERG assisted with the initial selection of events and materials, either available in the public domain or obtained from ERG members who were members of the Taskforce. These mechanisms acted as a buffer between me and my position, and also reduced the risk of bias of my own recall by corroborating my own memory and diary entries.

To set up the ERG I made initial contact with seven individuals to solicit their interest in being part of such a group. They were selected as they were the most senior nurses from practice, academia and policy in New Zealand, known for their strategic thinking and ability to influence. Three of these nurses were previous members of the 1998 Ministerial Taskforce on Nursing: Judy Kilpatrick, Dr Jenny Carryer and Julie Martin. They were contacted by email and responded in this manner. They were provided with an information sheet and consent forms (see Appendix 1), and asked if they were willing to be part of the ERG. If they were not interested, an alternative participant was to be sought if numbers were below six. Only one member declined to be involved, because she identified as a midwife, not a nurse, and did not wish to be involved in nursing issues. This person was not replaced.

The resulting six individuals who agreed to participate were selected for their experience and expertise in nursing in New Zealand, and were not selected to represent any particular professional organisation, although some had defined roles in New Zealand nursing organisations. The group's role was to suggest examples of New Zealand nursing organisations' [those groups that have national representation for nurses] involvement in policy-making that could be sourced through published material in the public domain.

The ERG teleconference was audiotaped, which allowed the researcher to engage in the free flow of discussion without the interruption of note taking. Patton (1980) recommends the use of a tape recorder for interviews and meetings. He argues that they are absolutely necessary, particularly with unstructured interviews, to ensure that a full and accurate record of the discussion is recorded. Minichiello, Aroni, Timewell & Alexander (1992) support this practice. Audiotaping also promotes a smooth and interactive interview style, so that the interviewer can focus on what the interviewee is saying.

Consent for this was incorporated in the general consent form to all participants, who were verbally reminded that their comments would not be individually identifiable to maintain confidentiality. They all agreed to be listed as participants in the ERG in the final dissertation (see Appendix 2 for a list of ERG members and their organisational affiliations).

A teleconference was set up with the six participants on 31 August 2001. Two participants were unable to take part on that date. They were followed up via email. Participants were reminded of the aim of the group and also asked if any clarification was required in regard to the study. Consent forms were discussed. They were also reminded that my role was one of researcher and chair, not Chief Nursing Advisor for New Zealand (accepting, of course, that the ability not to see me in this role is difficult). It was confirmed that all participants had received the information sheet, which outlined the process. I also explained to the ERG that I would be utilising the policy theories of Kingdon (1995), particularly policy-making processes and agenda-setting, to understand how nursing organisations engage in policy making, and also the work of Cohen et al. (1996)<sup>2</sup> to examine the political development of nursing.

The group raised different cases that I could consider for study, including the development of nurse prescribing, the re-introduction of enrolled nursing and the Ministerial Taskforce on Nursing. The majority of the discussion, however, was on the events and context of the 1998 Ministerial Taskforce on Nursing, possibly because two

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<sup>2</sup> A summary of Cohen et al's (1996) theory had also been provided in the information pack sent out to participants

of the ERG members were previous Taskforce members. The ERG's advice was to concentrate on one significant event: "The best example I can think of must be the Taskforce, it is full of everything" (Teleconference minutes, 13 August 2001).

Members kept returning to the 1998 Ministerial Taskforce as a key case that reflected nursing and policy. As a result, based on unanimous consensus, the Ministerial Taskforce on Nursing became the policy-making event that would be used for this study. There was historical material available in the public domain, and members of the ERG who had been members of the Taskforce agreed to provide me with additional material.

I transcribed the tape of the ERG teleconference verbatim, and all participants were sent a copy for comment. Key decisions and recommendations were noted and used for this dissertation. Names were removed from individual comments and replaced with participant numbers.

Following the teleconference I was in contact with all members of the group via email, and obtained from them information including public documents relating to the Taskforce. An outline of the case was drafted, to ensure that the events recorded were factually correct and to provide comments on missing components or any further sources. All members of the ERG were sent copies of this draft to critique. Edits were made based on the feedback of the ERG, which occurred via email. Based on the ERG's recommendations, material on the 1998 Ministerial Taskforce on Nursing in the public domain was collected.

The audiotapes were stored in a locked cabinet in my home office. Each cassette cover was clearly labelled with a code and a number identifying the date. The code key was kept in my family safe.

#### **Use of public documents and diaries**

After the ERG conference call, I conducted a literature search of public documents through the internet Google search engine relating to the Ministerial Taskforce on Nursing, and collected four radio transcripts, 24 print/journal articles, 46 media clippings (from January 1998 to September 1998) and an assortment of briefings

obtained through Official Information Act processes (by members of the ERG). I then collated my diary entries from that time and organised the material in chronological order from late 1997 through to September 1998. I filled in any gaps by sending a draft of the events to the members of ERG group, who provided comments by email, which I then used in my reconstruction of the events (Chapter 6).

### **The researcher's role in the study**

I have many roles in this study. I was the Chief Nursing Advisor for New Zealand, and thus undertook a central policy role with nursing organisations and government. From 1993 to 1995 I was the president and New Zealand councillor for the Australian and New Zealand College of Mental Health Nurses. I worked in the Ministry of Health, where the Taskforce secretariat was based, and was part of the public service in New Zealand. Finally, and most crucially, I was appointed by the Minister of Health to be a member of the Taskforce.

During late 1993 to August 1998 I undertook all of the above roles. I was also involved with advising the New Zealand Government regarding the establishment of the Taskforce, and as a member of the Taskforce witnessed all its workings and the surrounding public commentary. While the Taskforce was in progress I wrote regular briefings to the Minister of Health, and at times had to provide independent advice to the Minister as debates occurred publicly. I also analysed this case as researcher.

As a result of the above roles, my part in this study can be classified as that of a participant-observer. Yin (1994, p.87) notes this is a special role in which one is not merely a passive observer: "Instead you may assume a variety of roles within a case study situation and may actually participate in the events being studied." The richness that a participant-observer brings to a case study does need to be balanced, however:

First, the investigator has less ability to work as an external observer and may, at times, have to assume positions or advocacy roles contrary to the interest of good scientific practices. Second, the participant-observer is likely to follow a commonly known phenomenon and become a supporter of the group or organisation being studied, if such support does not exist. Third, the participant role may simply require too much attention relative to the observer role (Yin, 1994, p. 89).

Yin (1994) acknowledges that the participant-observer may also assume an advocacy role. A policy analyst can also assume this role. Jenkins-Smith (1990) argues that "the

role that an analyst assumes is intimately related to the context in which he or she operates” (p. 109). Analysts can therefore take different roles, and one of these is as an issue advocate, which is “an analyst who acts in accordance with a pre-existing belief system, pursuing specific substantial values and goals in the policy problems analysed and advice given” (p. 113). Because belief systems are involved, blurring can occur between the roles of analyst and participant-observer. This should not be seen as a limitation, but supports the concept that analysis involves “subsystems of actors, who engage their belief systems and positions” (Jenkins-Smiths, 1990, pp. 91-93). I could be categorised as an advocate analyst in this study: I was a nurse, held values and beliefs about nursing, and was a participant-observer, intimately involved in processes.

As a participant-observer I come to this analysis with philosophical and professional beliefs, which make it imperative for me to identify where my own accounts and opinions have been used. The style of writing I use in this study also reflects the roles I have undertaken. At times I use the first person “I” when the events or perspective relate to me as an individual, while at other times I discuss aspects of my official role and use “Chief Nurse” or “Chief Nursing Advisor” to reflect this.

### **Analytical approach**

I approached this analysis by using elements of both policy and political analysis. This involves problem identification, and understanding the background, the influence of stakeholders, values, the political setting and systems, all of which are outlined in the early chapters and come together in Chapter 7. Chapter 8 is where the discussion occurs, and different options are considered as a way forward.

To enhance the objectivity of the analysis of the case study I have used Kingdon’s (1995) and Cohen et al.’s (1996) theories and frameworks (see Chapter 4). Kingdon’s theory of agenda-setting includes the roles of policy entrepreneurs, policy streams, coupling, bandwagons, coalition building and interest groups. All of these components of agenda-setting became headings for the study, and helped to organise the material. Overlaying the analysis in terms of agenda-setting processes was Cohen et al.’s (1996) framework on the political development of nursing. This framework involved four stages of development. I took each stage and looked for evidence of it in the data.

The results of applying these analytical tools are described in detail in the chapters that follow.

### **Ethical approval**

Approval for this study was obtained from the Human Research Ethics Committee, University of Technology, Sydney.

### **Chapter 3: New Zealand Politics, Health Reforms and Nursing**

To understand the 1998 Ministerial Taskforce on Nursing and the events surrounding it, the Taskforce needs to be placed in its historical context. This chapter aims to provide an overview of the New Zealand political environment in the mid- to late 1990s, emphasising in particular the effects of the health care reforms on nursing.

#### **The political context: a changed electoral system**

New Zealand, as a former colony functions under the Westminster system of government inherited from Great Britain. The Queen of England is still recognised as the symbolic head of this system of government, and she has a representative in New Zealand, the Governor-General. The Governor-General must sign-off all legislation, and retains the power to dissolve the New Zealand government in a constitutional crisis. This is similar throughout the British Commonwealth countries (Martin & Salmond, 2001).

The head of the New Zealand government is the Prime Minister, who is the elected leader of the majority party. He/she rules with a group of elected members of Parliament called Cabinet ministers. Cabinet ministers are chosen by the leader of the majority party (who becomes the Prime Minister) from among the elected members of the majority party. They are allocated portfolios to manage (for example, health, education, defence) and are known to the New Zealand public as the Minister of/for the appropriate portfolio. Ministers have their own office staff and advisors, who are appointed by them but remain public servants.

The members of Parliament collectively form what is known as the House of Representatives (State Services Commission, 1996). The government remains in office as long as it keeps the majority support with the House of Representatives on “confidence” (supply of money etc) matters (Martin & Salmond, 2001, p. 45).

The Ministers and the government are supported by government departments or Ministries, which have accountability agreements with the government on what they will do. The staff are all public servants and are part of the New Zealand public service, which is the main advice mechanism to government. The Ministry of Health provides

advice to the Minister of Health, who is also free to consult and gain advice from other agencies or interest groups if he/she chooses (Martin & Salmond, 2001).

New Zealand has a general election every three years. Until the mid-1990s New Zealand used the first-past-the-post (FPP) electoral system, whereby party candidates compete against each other in every electorate, and the party with the most elected members wins the election. This gave the party in power the ability to formulate and act on policy largely unhindered.

By the early 1990s, the people of New Zealand had become tired of a system that was not representing their views, health being a particular and ongoing concern: “[the] process for change started as people became disenchanted with the two major parties (both over the previous 10 years had supported the reforms)” (Boston, Levine, McLeay & Roberts, 1996, p. 3). The mood of the country was changing: “As New Zealand moved towards a more independent and self-conscious identity, so too did its political structures come under review” (Boston, et al., 1996, p. 3).

In 1996 the New Zealand public was asked to vote on a referendum to change the political system. On offer was the possibility of moving away from FPP to a system of proportional representation, including mixed member proportional (MMP) representation. MMP was in place in a number of other countries, including the German Democratic Republic (Boston et al., 1996). The referendum favoured MMP, and New Zealand changed its political system.

MMP allows for two methods of voting members into Parliament (or government): enrolled electors have one vote for a candidate in the electorate (locality) in which they live (as under FPP), and then a second vote for the political party of their choice. The result under MMP is a government comprising people voted from their electorates, and people who have come in through their party gaining a proportion of votes. Just who is given a place in Parliament as a result of the party vote is determined by the candidates' ranking on the party “list”. In New Zealand this translated into having 25 more MPs, and also meant that it was far more likely that a majority government would be formed by coalitions between political parties, not just by one political party getting the most votes (as under FPP).

At the time of the 1998 Ministerial Taskforce on Nursing, New Zealand had a government formed by the National party. The National party has a right-wing, conservative ideology and was holding on to power with a slim majority following the collapse of the coalition with another right-wing party, New Zealand First. The next election would be held in 1999, and the Government hoped to hold power until November of that year. However, the 1998 polls indicated that National might not win the election. Many New Zealanders were suffering from reform fatigue and wanted the National Government out of power. It was not a time when any government would be prepared to deal with controversial health care policy issues – unless forced to.

### **National's key health policies**

The National Government's key principles at this time were articulated in a variety of government documents (including Creech, 1999; Ministry of Health, 1996a; 1996b; Shipley, 1994b; 1995a; 1995b; 1996; and Upton, 1991). These related to access to services; efficiency, flexibility and innovation; the importance of public health; affordability; improving the health of Maori; continued public ownership of major sector agencies; commitment to clinical safety and the quality of services; and achieving better quality and value for money through improved managerial practices.

These policy directions were to be implemented through six purchasing principles (Shipley, 1994). Following is a brief summary of the Government's understanding of the six purchasing principles, as outlined by Shipley (1994b; 1995a; 1995b).

1. *Equity*: the fair distribution of health services, in relation to people's needs, in terms of their ability to benefit from services. The key aspects are improving equality of access to services in terms of waiting times, geographical access and affordability, according to ability to benefit. This involves decreasing disparities in health status between population groups, giving relatively greater weighting to health gains for people with lower health status in all population groups, and Maori and child health gains (Shipley, 1995a; 1995b).

2. *Effectiveness*: ensuring that services result in better health outcomes. Services are to target people's needs, be clinically sound and be co-ordinated. The key aspects are targeting services according to the needs of, and ability to benefit, populations,

individuals and family/whanau;<sup>3</sup> improving clinical efficacy and the effectiveness of services; and improving co-ordination and continuity across the full range of services (Shipley, 1995a; 1995b).

3. *Efficiency*: recognising that resources are limited and choices have to be made between different types of services. The key aspects are improving the cost-effectiveness of services, minimising costs, encouraging innovation in service delivery, and encouraging comparisons of relative costs and benefits across services (Shipley, 1994).

4. *Safety*: this is concerned with purchasers adopting strategies that seek to protect consumers and the public from avoidable harm, both physical and non-physical. The key aspects are ensuring that adequate systems are in place to identify risk areas, and that adequate measures are adopted to eliminate, reduce or isolate identified risks of avoidable harm (Shipley, 1995a; 1995b).

5. *Acceptability*: closely linked with people's values and perceptions. Acceptability focuses on respect for and empowerment of people, and on people's autonomy and participation. The key aspects are improving people's choices and satisfaction, preserving personal dignity and privacy (involving informing and consulting people and communities), and improving service responsiveness to people's diverse needs, preferences and cultural values (Shipley, 1995a; 1995b).

6. *Risk management*: involves identifying the kinds and ranges of risk, managing uncertain events, and ensuring an appropriate level of control and resources. Risks may be financial or service related, controllable or uncontrollable. The key aspects are managing service risks to populations and the consumer, and ensuring that objectives are achieved to the extent possible within available funding and without exposing the taxpayer to greater burdens in the future (Shipley, 1995a; 1995b).

It is not the intention here to debate the strengths and weaknesses of the Government's policies, but to present their views as they existed in the late 1990s. This was the policy

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<sup>3</sup> Whanau is the Maori word for extended family.

and political climate that existed around the establishment and workings of the Ministerial Taskforce on Nursing in 1998.

### **The public service and its relationship with the Ministry of Health**

The public service, including the Ministry of Health, also underwent radical change from the late 1980s into the mid-1990s. “The public service, perceived in the mid 1980s to be risk-averse and over-centralized, has been encouraged to adopt an entrepreneurial results-based ‘business’ culture” (Martin & Salmond, 2001, p. 45). This translated into redesigning the relationship between government and its departments, with:

Greater lines of responsiveness to ministers and sharper lines of accountability... The machinery of government has been restructured to enhance efficiency in delivery of goods and services (including policy advice), and to inhibit the threat of “capture” by providers or interest groups (Martin & Salmond, 2001, p. 45).

*Your health and the public health* (Upton, 1991), commonly known as the “Green and White Paper” (discussed later in this chapter), reshaped the role of the Department of Health. The Department was to stand back from the delivery of health care and assume more of a monitoring role. This gave an outward impression that the Department, and later the Ministry, was no longer interested in health care delivery, as many clinical positions were replaced with analysts and economists. This was seen by many as the Government or centre transferring power and accountability to the “market”, and distancing the centre from the implementation of health services. As a nurse in clinical practice at this time it was unclear who was making the decisions, and who took national responsibility when things went wrong in health care.

The Ministry of Health (known in other countries often as the Department of Health) is the government’s principal advisor on health and disability in New Zealand. Until the late 1980s there was a division of nursing within the Department of Health, headed by the Chief Nurse and accountable to the Director-General of Health. The division had responsibility for workforce planning, appointing all senior nursing positions and distributing educational funds to hospitals. It was a large division, with analysts, managers and (before it was disestablished) 17 nursing advisors. It functioned under the Splane & Splane’s (1994) executive model of the Chief Nurse, which will be described in Chapter 5. With the changes that occurred to assert general management principles, as outlined in the State Sector Act 1988, the division of nursing disappeared and the Department of Health changed to the Ministry of Health. The only designated nursing

positions that survived the restructuring were the Chief Nursing and Senior Nursing advisory positions.

The Chief Nursing Advisor is located within the Ministry of Health and is recognised as a senior public servant.

### **The 1990s health reforms**

In the 1980s in New Zealand there developed a policy approach with similarities to the *blitzkrieg* in warfare. In each case the “lightning strike” involved a policy goal radically different from the existing configuration, to be attained in a short period, following a surprise announcement and a very rapid implementation.... Of course each policy *blitzkrieg* was different in detail, but at its heart was the aim to transform profoundly some substantial aspect of the economic and social framework (Easton, 1994, p. 215).

New Zealand entered the late 1980s with problems in its economy, characterised by poor performance and rising debt, with successive governments attempting to reduce the cost of services and achieve greater efficiencies in government agencies. However, the backdrop to the health reforms in New Zealand in the 1990s was the international rise in health expenditure. This caused general concern and a focus on cost containment, and had led to major reforms in health services in several other countries, including Britain, Denmark and Australia. Several reasons for this rise have been suggested. They include a general ageing of the population (causing an increased demand for health care); some technological development (which increases costs, for example, laparoscopic surgery and diagnostic aids); and general societal expectations that the latest treatment will be made available (improvements in communication disseminate this knowledge more widely than in the past). Despite a wide variation in approaches to reform, by the 1990s all developed nations were struggling with problems with the financing and delivery of health care (Blendon et al., 2002; Gauld, 2000; Kassler, 1994; Kreible, 2001; OECD, 1992).

The problem with reforming the New Zealand health sector was New Zealanders' long history (since 1938) of enjoying a health care system that guaranteed a publicly funded service free to consumers at the point of consumption, and universal access to care based on need. For decades New Zealand had experienced a health system that was relatively cheap and provided good service, but that was now costing the country dearly to maintain (Salmond, Mooney & Laugesen, 1994).

In keeping with “numerous” attempts over the past century to reduce health costs (Salmond et al., 1994), during the 1970s and 1980s the Government implemented minor restructuring to achieve cost reductions and greater efficiencies. Institutions and institutional structures have been shown in many countries to influence the pattern of health care reform, and New Zealand was no different. These attempts proved feeble, intensifying problems of cost, access and accountability, with “professional interests frustrat(ing) [the changes] or shap(ing) efforts to reshape the sector” (Laugesen & Salmond, 1994, p. 21). It would be fair to say there was an outward impression that during this time the National Government was anti professional groups, in particular medicine, as physicians were viewed as holding too much power and not enough accountability in relation to health care delivery:

The large majority of doctors operate as private practitioners with little government interference, accountable only to themselves... The Health and Disability Services Act 1993 revolutionised the relationship between GPs and government, through demanding that a contracting relationship be developed (Crompton, 2001, pp. 201-208).

Between 1983 and 1993 the health sector was thrown into chaos through successive restructuring. In 1983, 22 hospital boards were merged to form 14 area health boards (AHBs), charged with more effectively planning, co-ordinating and delivering health services (O’Brien, 1989; Laugesen & Salmond, 1994). The government environment at this time was not conducive to a top-down approach to solving health issues; that is, centralised workforce planning and interventions were deemed only to be appropriate when the market was seen to be failing, or barriers needed to be addressed (Salmond et al., 1994). The Government would only interfere when it had to.

Figure 1 outlines a timeline of key events that occurred as part of the New Zealand health reforms, all of which will be described in this section.

Figure 1

*Timeline of Key Events, 1983–1996*

Year	Event
1983	22 area health boards (AHBs) merged into 14
1988	State Sector Act Gibbs report published
1991	Employment Contracts Act <i>Your health and the public health</i> published
1993	Health and Disability Services Act
1993	Funder–provider split; 4 regional health authorities (RHAs) established
1993	AHBs disappear and Crown Health Enterprises (CHEs) established
1996	4 RHAs collapsed into one: Health Funding Agency (HFA)

In 1988 the State Sector Act was passed with the objective of redesigning government agencies based on market-driven private sector models (Ng, Jenkins, Dixon & Cram, 1992). Also, the “Gibbs Report” (*The hospital and related services taskforce report*) was released by the Government. This advocated major reforms of the health sector to improve equity, efficiency and “the serious morale problem” throughout the service (Ng et al., 1992). The report advocated that the Government fund the health sector based on services provided, that those services not be purchased solely from the public sector (instead would be determined by market forces), that the AHBs be replaced by regional health authorities (RHAs), and that the internal management structure be reformed.

Following a review of the health system and the publication of *Your health and the public health* (Upton, 1991), in 1993 a ministerial taskforce produced the National Government’s plan for the health sector. Ministerial taskforces are groups formed by government to work through problems of national significance and produce recommendations. The taskforce recommended that the “right structure and incentives need to be in place. The resulting competition would elicit efficiencies” (Gibbs, Fraser & Scott, 1998, p. 24).

During the early 1990s, there was a clear trend towards reducing control of the medical profession and the extent of public consultation in health policy making. “The role of the traditional health care community increasingly has been deliberately weakened” (Blank, 2001, p. 150). Klein et al. (1996) describe how medicine normally holds a dominant role within health policy due to its unchallenged capacity to license. Nursing did become one of the groups being excluded, but it appeared that medicine was the chief concern of the Government, and this group was mentioned frequently in policy documents during this time (Gauld, 2001). This is explained by the “privileged position that medicine held” and the fact that their interests were often in conflict with Government direction (Tenbensen & Gauld, 2001, p. 30).

The role of the public in public policy during this time was also marginalised. The health care system of which they were recipients changed, with little or no consultation with them as the end users, and their ability to act as an interest group, organised or not, in the public policy process was ignored.

With the deliberate exclusion of the public and health professionals from the policy process, consultants and business managers were increasingly relied upon to provide this advice. The New Zealand Business Roundtable influence on *Your health and the public health* was evident (Blank, 2001). International consultancy firms were also playing an influential role. The Roundtable’s own report was largely written by an American economist, Patricia Danzon, who was a CS First Boston (a US consulting company) visiting professor (Danzon & Begg, 1991). It is thus no wonder that health became exposed to such terminology as “competition”, “efficiency” and “effectiveness”.

### **The funder–provider split**

The major reforms of 1993 separated health purchasing and provision functions to create an internal market. This market was intended to unleash competitive forces that would yield further efficiencies at both the purchasing and provision levels (Ashton & Press, 1997). New Zealand thus moved from the vertically integrated area health board model to what the OECD (1992, p. 23) called a “a public contracts model”.

A distance was created between the Government and the health services through what is commonly known as the funder–provider split. “The New Zealand version of the public contracts model splits purchasing (responsibility for allocated efficiency) from provision of services (responsibility for productive efficiency)” (Kreible, 2001, p. 926). The funder (purchaser) and provider split separated those who funded services from those who provided them, which in turn allowed for competition to occur and reduced incentives for monopolies.

For nursing this meant that many nursing services suddenly became split under numerous contracts, or non-nurses were given contracts. District nursing and public health nurses (who were employed by hospitals to work in communities) are good examples of the fragmentation of services, such as the follow-up of post-discharge clients, or assessment and surveillance of children in schools. Nurses found that health promotion, immunisation, health education and follow-up visits were curtailed as other providers were given contracts because they offered a more competitive price. Many new providers came into the market, and nurses raised concerns about fragmentation and quality.

Nurses, nevertheless, continued to provide services during this time:

Nurses have borne the brunt of the efficiencies already made. Every nurse working in the public health system has gone an extra mile, worked extra time at the end of their shift, gone out of their way to ensure their patients don't suffer too much because of funding problems (“NZNO slams”, 1997, p. 8).

This fragmentation made it very difficult for labour unions to work with employees, as they had difficulty finding out who the employers were in health care delivery. NZNO as a union now had their members (nurses) spread out through many employers, under numerous different service contracts, and found itself marginalised in its bargaining powers by the 1991 Employment Contracts Act.

### **Reforms and labour relations**

Labour deregulation also occurred as part of the public sector reforms. In 1991 the Employment Contracts Act (ECA) was passed by the National Government. The ECA repealed the previous Labour government's Labour Relations Act. It meant that the national award disappeared, which “set the scene for the fragmentation, first into 14

Area Health Board contracts and now 23 Crown Health Enterprises” (Hine, 1994, p.18). This, combined with the Health and Disability Act 1993, “introduced competition and contestability into the public service and the two statutes have been instrumental in shaping the New Zealand nurses’ experience of employment” (Bickley, 1997, p. 304). New Zealand nurses were losing their ability to influence their employers, because their union, the New Zealand Nurses Association (as it was called in 1991), was now marginalised. Both acts effectively sidelined the unions and kept them from negotiating with government. “This shift was in keeping with the general trend for the withdrawal of the State from many areas of political and financial activity” (Bickley, 1997, p. 309).

In 1993 the New Zealand Council of Trade Unions (CTU) placed a complaint with the International Labour Organization (ILO) about the ECA. The ILO visited New Zealand in 1993. This was a significant event as ILO visits were normally done only where a country did not have the resources to be able to comply with the conventions, and it was unusual for such a visit to be made to an industrialised country such as New Zealand. The ILO found that “the ECA breached two of its conventions – the right of workers to freedom of associations and their rights to organised and collective bargaining” (Cronin, 1994b, p. 4). In addition:

There has been a substantial increase in the proportion of nurses on individual employment contracts... [along with] the removal of the legal and social structures available for mediation, conciliation and arbitration... strike action became the only legal and effective tool to resolve disagreements (Bickley, 1997, p. 305).

Despite both national and international concern over the ECA, the National Government proceeded to remodel the health sector in line with other public sector changes, and despite what the ILO report recommended, the ECA was not amended. This period (1988-1991) has been termed the “New Zealand health reforms” or “the Big Bang approach” to policy (Boston, et al 1991; Gauld, 2000; Upton, 1991).

The combination of these factors produced major changes in the health sector from 1991 to 1998. Consistent with the underlying concern over the previous decade, the driving force behind the changes was cost containment and improved use of resources. Led by the example of reform in state-owned enterprises, now commercialised, politicians decided to “jolt the system into a fundamentally different mode of operation”

(Salmond et al., 1994, p. 2) from the existing operation, which was founded on the concept of a welfare state and elected boards.

### **Reforms and hospitals**

The effect on hospital systems and structures during this period was major. Hospitals were renamed Crown Health Enterprises (CHEs) in 1993, and new organisational structures were developed. These new structures included human resource management, business management, and quality and contract departments (O'Connor, 1997).

Previously, purchasing and ownership interests were mixed, there were different funding mechanisms (primary, secondary and disability support), and there was a greater focus on inputs, so that cost increases were related to a heavily bureaucratic environment in which the central government controlled through, and services were bulk funded from, the Government accounts. This was seen to translate into:

- fragmentation of services;
  - inappropriate allocation of resources;
  - few incentives to be cost effective; and
  - lack of responsiveness to local needs
- (Davis, 1999, p. 2).

While some aspects of the system changed since 1998,<sup>4</sup> *Your health and the public health* set out the basic structure and ideological foundation. It introduced a new structure for the health and disability sector, which aimed to improve access for all New Zealanders to a health care system that is effective, fair and affordable; encourage efficiency, flexibility and innovation in the delivery of health care to the community; reduce waiting times for hospital operations; widen the choice of hospitals and health care services for consumers; enhance the working environment for health professionals; recognise the importance of the public health effort in preventing illness and injury and in promoting health; and increase the sensitivity of the health care system to the changing needs of people in our society (Upton, 1991, p. 6).

These goals were to be achieved by:

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<sup>4</sup> Aspects that have changed since 1998 are the dissolution of the Public Health Commission, the abandonment of the commitment to an explicitly defined 'core' of services to which everyone should be entitled, and the failure of health care plans to be implemented.

... creating an internal market within health by separating the purchase and provision roles of Area Health Boards (AHBs). Public, private and voluntary providers were thus able to “compete” for publicly funded contracts to provide health and disability support services. Elected AHBs were replaced with purchasing authorities known as Regional Health Authorities<sup>5</sup> and Crown Health Enterprises (CHEs) – previously the provision side of AHBS. CHEs [hospitals] were organised to be run along businesslike lines with appointed boards of directors. Many smaller communities were given the opportunity to take over their local hospitals as community trusts. Part-charges for some services were also introduced (Upton, 1991, p. 7).

The Ministry of Health had the role of monitoring the performance of the RHAs, and this new structure formally came into effect on 1 July 1993. Policies were to be implemented by the RHAs (and their successors) adhering to the six purchasing principles: equity, effectiveness, efficiency, safety, acceptability and risk management, and by applying these principles in accordance with *Whaia te Ora Mo te Iwi* (Regional Health Authority & Public Health Commission, 1992).<sup>6</sup>

Further Government policy change came in the form of the Coalition Agreement on Health in 1996. The Coalition Agreement amalgamated the four RHAs into a single national funding agency and removed the onus to realise a profit from Crown-owned providers (Steering Group to Oversee Health and Disability Changes, 1997).

The other significant development came with the Health and Disability Commissioner Act 1994, which strengthened the rights of consumers of health and disability support services and created another line of accountability for the providers of services. (The Canterbury Hospital Inquiry, which became an important development undertaken by the Health and Disability Commissioner, will be discussed later in this chapter).

The term “clinical viability” became common with respect to hospitals. It referred to the ability of hospitals to continue to operate services when they were costing too much and there were often insufficient volumes (operations, procedures occurring) to maintain staff. Reports of hospitals were often written by outside consultants, with little consultation with clinical staff. Coopers and Lybrand wrote one such report for the funding authority in the Wellington region, and reached the following conclusions:

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<sup>5</sup> When the health reforms were first introduced in 1991, purchasing authorities were known as regional health authorities (RHAs). These subsequently evolved into the Transitional Health Authority, then in 1998 into the Health Funding Authority, which merged with the Ministry of Health in 2001.

<sup>6</sup> *Whaia te Ora Mo te Iwi* outlines the Government’s response to Maori health issues.

The report assesses Masterton, Blenheim and Nelson Hospitals as not clinically viable and finds Wanganui is not clinically viable. [The report] recommends that these hospitals be axed instead of improved. They will be replaced with greater privatisation through privately owned independent associations [businesses] (“NZNO slams”, 1997, p. 8).

### **Reforms: failure or success?**

There has been much debate throughout New Zealand over whether the restructuring process and reforms actually worked. Anderson (1996) reports that the general public was confused by the reforms, which were overly marketed as a means for consumers to have a greater say in the delivery of health care. For most, little seemed to have changed except the names of the facilities that deliver care.

P. B. Davis, a Ministry of Health policy manager, during a discussion stated that the reforms brought about many benefits. The following are specific points from that discussion and examples:

Greater awareness and acceptance of need for rational prioritisation of scarce resources;

*An example of this is the clinical criteria that have been developed to ensure all individuals requiring a surgical procedure are assessed and given a rating. If the patient does not meet the level to require surgery he will not get it and be referred back to GP. Thus only those that absolutely need it will get it. This has resulted in some very hard decisions being made. One Maori man with a complex medical condition plus renal failure was refused renal dialysis on this scheme and later died. Prior to 1993 despite the fact this man had complicating factors treatment would have been offered.*

Innovation and responsiveness in purchasing and service delivery;

*An example of this is the development of Maori providers throughout the country who are offering by Maori and for Maori schemes. The unbundling of money into service contracts has made access to Maori-specific funding easier.*

Better information about what services now cost;

*An example of this is the substantive work on coding and implementation of case weights which have broken services in units and parts (P. B. Davis, personal communication, 3 February 1999).*

Along with the gains Davis points to, there have been trade-offs. Many clinicians and the general public would feel that the trade-offs are more like drastic cuts and a failure of the public health system. As a clinician, manager and a policy advisor (through my role as Chief Nursing Advisor), I have identified the following areas that have not worked.

1. The contractual environment provides only short-term contracts to services. Hospital and health services have had to build a large infrastructure of contracting personnel, as year by year they negotiate hundreds of varying service contracts.
2. There has been a failure to gain public confidence in the changes. The community has had difficulty understanding terminology such as “purchaser”, “CHE”, etc. They also could not see any improvement for them when they wanted or needed services.
3. There is a focus on financial bottom lines and prioritisations that appear to lack an understanding of how services actually work. Reduced full-time nursing staff positions have encouraged split shifts, which means less continuity of staff.
4. There has been an increase in transaction costs as a result of the legalistic contracting processes. Services have been divided into parts, and then into separate contracts, which create more costs through the need to report on these contracts, generate invoices, etc.
5. There has been a blurring of accountability for safety and quality. Contracts define which health services are to be performed, but often price and volume are the only elements specifically defined, and quality parameters are usually either minimal or absent.
6. The morale of health providers has declined as they no longer feel able to influence the system and the care they provide. This has translated into higher staff turnover and has added to health’s “brain drain”.

Kelsey (1995) describes how the restructuring of public hospitals into Crown Health Enterprises (CHEs) has not been particularly successful: CHEs were subject to an expenditure cap and had to compete for contracts; many exceeded revenues and the Government had to cover the debt; local hospitals started to close, which resulted in fewer public beds; hospitals were then forced to prioritise patients on the basis of cost containment.

O’Connor (1997/1998) describes problems of “privatisation, fragmentation of services and the very high costs of managing a contract-based funding system. Nurses are still

expected to provide quality patient services on the same and less resources”, and “Rationing is becoming more explicit” (p. 8).

As Bamford & Porter-O’Grady (2000) note, this environment had a negative effect on the quality of health care, and the “concept of corporatization has given providers the incentives to be cost minimizers in an effort to maximize market share” (p. 3). This was clearly demonstrated in the way nursing services started to be divided up, and previous aspects of nursing roles were lost, such as care co-ordination, health promotion and health education.

One of the benefits claimed for the reforms was that they would provide competition in the health market, which would result in greater efficiency. However, the level of competition was never real (Gauld, 2001). The result of the push for competition was that collaboration became non-existent between health care organisations. For nurses this meant they were no longer allowed to visit and share information with other nurses in other providing agencies. Meetings no longer occurred and regional teamwork became difficult.

The reforms lost the respect of not only the health professionals but also the public of New Zealand. Blank (2001) argues that “the deliberate attempt to bypass the general public and the health care professions certainly contributed to the failure... in a society with a high value on participatory democracy, this was too much to expect” (p.155).

By 1999 the National Government was clearly recognising that many of the structures set up in the early days of the reforms had not generated the intended gains or benefits. In an attempt to address this, the Government published the *Medium term strategy for health and disability*, which was released in May that year (Creech, 1999). This called for a return to collaboration and co-ordination, and a greater emphasis on population health. The challenge was to translate the 12 medium-term goals into implementation strategies, through clearly defined policies. This meant a change in the contracting environment away from individual services and price and volume towards more capitated processes with a population focus. It was also intended to provide a framework for more sustainable funding, rather than the previous lurching from year to

year (Creech 1999). By the beginning of 1999, with an election looming in 7 months, this change in policy was too late (Gauld, 2001).

I was appointed to the position of Chief Nursing Advisor for the New Zealand Ministry of Health in December 1997. Previously I was the Senior Nursing Advisor from October 1996 and commenced acting as Chief Nursing Advisor in April 1997. It became apparent to me that nurses and nursing organisations were not happy about the health care changes that were occurring during the past few years: they felt uninvolved in the changes, with little influence over what was rolling out across the country. Unions had become marginalised through changes in legislation (see above), and nursing conditions were being eroded (Gunn, 1997).

### **The health reforms and nursing**

As described earlier in this chapter, the move to marginalise not only the public but also the health professionals in the policy process has been well documented during the reform period (Ashton & Press, 1997; Bickley, 1999; Cronin, 1994a; Davis & Ashton, 2001; Gauld, 2000; 2001; Kreible, 2001). Health professionals (including nurses) were no longer considered the experts on health: “the experts are no longer the health professional but rather consultants and managers” (Blank, 2001, p. 156).

The impacts of the health reforms were felt at many levels. They not only affected *where* nurses worked but also *how* they worked. More importantly, they confronted the nursing philosophy of care. Hospitals were now viewed as businesses, and this meant competition with each other for business. Hand in hand with this philosophy was a new management ideology. Nursing structures were taken out of hospitals so that management structures could be inserted. Managers not only replaced nurses as the co-ordinators of services, but they also controlled nursing resources. This diminished the influence that nurses had within hospitals, and caused conflict between nurses and managers over what hospitals and health services were about:

With corporatization came managers from the non-health care sector who had no understanding of the complexities of health care. Accompanying managerialism is the notion that any able manager was capable of managing any agency, whether public or private. Naturally, there was an underlying conflict between the caring relationships and their related work in the clinical environment, and the desire for efficiency and economy. It seemed that we were dealing with contrasting themes of “the market” and “humanity”. (Bamford & Porter-O’Grady, 2000, p. 1).

Essentially, the health reforms caused a conflict between nursing and managerialism over *values*. Central to nursing is the concept of caring (Benner & Wrubel, 1989). The values that nursing has – of caring, collaboration, collectivity and high-touch care – brought it into conflict with the competitive business management style that had proliferated throughout New Zealand hospitals: “nursing’s values are often in conflict with the dominant values of society: competition, individuality, high tech care and profit” (MacPherson, 1987, p. 10).

The environment at this time was stressful, and this was not helped by the different roles nurses were being asked to play: “a trend towards managerialism has led to many nurses obtaining managerial positions divorced from their previous clinical roles, contributing to a lack of experienced nurses in clinical roles” (Carryer, 2001, p. 9). The values of managerialism and competition were central to the changes nursing was witnessing. The regionalisation of purchasing of health services and the competition between providers of health and hospital services meant that individual hospitals were restructured in various ways. Different service provision requirements and different staffing policies contributed to significant inconsistencies among nurse staffing in New Zealand’s hospitals. This translated into considerable variations between hospitals.

As early as 1993 NZNO was raising concerns about the loss of nursing leadership in hospitals. Gaye Williams, CEO of NZNO in 1993, wrote in *Nursing New Zealand*:

Quality and safety of nursing is being jeopardised by the continual loss of chief nurse advisors in our hospitals. When we asked the CEO of Otago Healthcare why the role was disestablished he replied “I don’t think we have any need for that type of position with the new organisation” (NZNO, 1993, p. 7).

In some hospitals existing organisational structures were dismantled with the elimination of nursing leadership positions, including those of principal nurses or directors of nursing, nursing supervisors and charge nurses. There was also a loss of experienced staff as many hospitals employed less skilled or unskilled care assistants to replace registered nurses (Gunn, 1997).

I can vividly recall what happened in 1993 to 23 charge nurses in the psychiatric hospital in which I worked. One Friday afternoon they were all called into a meeting with the new business manager of the hospital. We had already been advised that the hospital was being restructured as we had become part of a CHE, and all wards were to become business units. With this all nursing positions above charge nurse were to be

disestablished. Charge nurses had been advised they could apply for new positions as unit managers, but these positions did not require nursing experience and all positions were to be advertised externally. As a result, the majority of the charge nurses did not get their jobs back and either retired or were made redundant. In the process decades of nursing leadership were lost, as many of those made redundant were in their mid-40s. The new era of the non-nurse unit manager had begun.

### **Invisibility of nursing**

Although many of the changes in the hospital restructuring process affected nurses directly, nurses individually and collectively were largely invisible within hospital decision-making during the reform period (1988-mid 1990s) (Keith, 2000). Staffing levels, in terms of the skill mix and numbers of registered nurses, became a serious concern. Nursing leadership remained poorly defined as a consequence of losing the visibility of being a department and the elimination of senior positions. In response, some nurses actively opposed policies that appeared to undervalue their worth and contribution to health care delivery (O'Connor, 1993; Oliver, 1996). NZNO reported that as a result of the reorganisation of nursing, "poor staff morale, high staff turnover, problems with recruitment and retention, work stress, burnout and the lack of adequate training have all contributed to low professional self-esteem" (Gunn, 1997).

Nursing structures within the CHEs were dismantled. Generic managers replaced senior nurses, and business managers were *in situ*. Lady Jocelyn Keith, a prominent nursing leader in New Zealand, reflects back on this time: "I said we were in danger of losing a whole generation of New Zealand nurses. I was right and we have. We have lost much more" (Keith, 2000, p.18).

The nurses were also effectively marginalised from decision-making structures through their unions being unable to negotiate on their behalf, ignoring the fact that:

Industrial legislation is the foundation of the infrastructure that supports the professional nurse. Working conditions and income have to be right for working nurses because it is the only way that standards of health care can be maintained (Bickley, 1999, p. 24).

The ECA also redefined representation:

... representation of employees under the Employment Contracts Act 1991 is through authorisation and not union membership. As NZNO has to prove that its

members have authorised it as their bargaining agent, we have to obtain and keep written authorisations forms for thousands of members and argue with employers about whether we are the representative when we need access to members (Cronin, 1994a, p. 17).

In New Zealand 90.2% of the nursing workforce are women. To put this in context, women in New Zealand comprise almost half of the labour force. Health and community services remain the predominant industries of paid employment for women, who comprise 56% of the publicly funded services (17,757 of 31,440) (Statistics New Zealand, 2002).

Historically, “Over 50% of New Zealand union membership were women” (Harbridge & Hince, 1993, p. 233). With the ECA the protection unions provided for vulnerable workers was now gone, and nurses were often faced with employer’s individual employment contracts:

NZNO strongly opposes the Employment Contracts Act on the grounds that it 1. Tips the balance very much in the favour of employers, resulting in exploitation 2. Is used to drive down nurses’ wages and conditions 3. Undermines the ability to resolve at a national level (Cronin, 1994a, p.16).

The result of the changes and restructuring was that nurses started to leave nursing, and there was increased anecdotal evidence of nursing turnover (hospital turnover data during this period were difficult to obtain).

### **Nursing turnover and the effects on care**

Nursing turnover in the early 1990’s was becoming a problem for New Zealand hospitals (Cronin, 1994b). Much of the literature on the reasons for nurses leaving their jobs has focused on job satisfaction, confirming that nursing is too often a poorly paid, undervalued profession. The dominant causes for nurses to resign from a job are issues concerning work content and work environment, salary, work schedules, autonomy and job-related stress. High levels of turnover are both perpetuated by, and contribute to, inefficiencies in an organisation (Blegen & Vauhn, 1998; Cangelosi, Markham & Bounds, 1998; Cowin, 2002; Irvine and Evans, 1995; Shader, Broome, Broome, West & Nash, 2001). Job satisfaction has been found to be associated with nurses’ expectations of the job (Aiken, Clarke & Sloane, 2000; Buerhaus, Needleman, Mattke & Stewart, 2002; Sochalski, 2002; Stevens, 2002).

Those hospitals with a large degree of consistency in the length of service of nurses and which promote cohesiveness among their staff are in turn likely to have lower turnover and are viewed as valuing their staff (Kramer & Schmalenberg, 1991; Pfeffer and O'Reilly, 1987; Wai Chi Tai, Bame & Chester, 1988).

Nursing turnover has a significant impact on the economic efficiency of an organisation, as turnover creates costs – both directly through advertising and orientation, and indirectly through lost productivity, mentoring, etc. However, industrial psychologists have identified the effects of turnover as extending beyond economic factors into social costs to an organisation. The disruption of the workplace environment can have impacts on the behaviour of the remaining staff, such as decreased organisational effectiveness, because teamwork and interdisciplinary collaboration suffer (Aiken et al., 2001; Buchan & Seccombe, 1991; Mobley, 1982; Staw, 1980; Wai Chi Tai et al., 1988).

By the end of 1997 nursing organisations were frequently seeking audiences and meetings with the Minister of Health. The market model – or the economic era of health care, as some describe it – created an environment in which nurses felt powerless. All the directors of nursing and ongoing hospital educational programmes were disestablished in the public sector; nurses were disheartened, confused and lacked representation at the senior management level. Nursing leaders raised concerns about the invisibility of nursing within the services, low morale and safety issues.

In 1997 a major review was being carried out in a tertiary hospital in Christchurch regarding patient safety. Nurses had warned the government of their concerns in Christchurch 18 months earlier:

A case in point is Canterbury Health [which] plans to reduce its 24 million dollar deficit through changes to nursing services. Both nurses and doctors know that the planned changes, introduced under the guise of case management, will be a disaster for the quality of nursing care and a disaster for patient safety (Oliver, 1996, p. 25).

By 1997 the restructuring was showing its effects on quality and safety in this hospital. A review of Canterbury Health Ltd by the Health and Disability Commissioner, Robyn Stent, was conducted in 1997 (commonly known as the “Canterbury Inquiry”). The focus of this investigation was the deaths of four patients at Canterbury Health Ltd (a CHE, or public hospital, in Christchurch) and whether these patients had received their

rights to services as outlined in the Code of Health and Disability Services Consumers' Rights. The report released by Robyn Stent in late 1998 highlighted the considerable impact hospital restructuring had had on the nurses, their morale and their performance, and hence on patient outcomes: "clinicians at this stage felt totally disenfranchised and rightly so" (Stent, 1998, p. 13).

For nurses the report highlighted all the things they thought were wrong with the way health services had been restructured, as illustrated by this piece in the New Zealand nursing journal (*Kai Tiaki*):

[The report provides] an absolute and total vindication of nurses' concerns... Christchurch was not well served by the regional health authority in the way services were purchased or monitored... there is a message here for every CHE in the country because every CHE has had nursing numbers squeezed ("Commissioner's report damns", 1998, p. 8).

### **Positive change for nursing from the health reforms**

Despite the predominant view by nurses during this time that the reforms had a negative effect on them and the care they gave, competition did provide opportunity and innovation for some nurses. It was through the restructuring, the "dollar-driven health services" (Oliver, 1996, p. 25), that independent practice was born in New Zealand. This occurred for nurses, but more substantially for midwives.

The same environment that encouraged competition and contestability allowed for midwives in New Zealand to become independent and form partnership models with women. Through the New Zealand College of Midwives, midwives took action against the funders to claim equal work for equal pay. They were successful in being recognised as lead maternity providers with general practitioners, but, more importantly, they pushed for and got legislative changes that ensured they would be treated the same as physicians in regard to maternity care (this meant full prescriptive privilege and admitting rights) through amendments to the Nurses and Medicines Act 1991. This development in midwifery was the crucial event that severed the ties between nursing and midwifery, which since the early 1990s have been acknowledged as separate professions in New Zealand (Wood & Papps, 2001).

Nurses also started to contract directly for services from health funders. Occupational health nurses and sexual health nurses in small numbers began to obtain contracts and provide direct services to the public. The interesting difference in the way midwifery and nursing influenced these changes is that, in the case of nurses, the main nursing organisations did not drive this for them: nurses did so mainly on their own, or through the new professional groups, albeit small, that started to form in the early 1990s (these will be described in Chapter 4).

It was during this period that policy work began on considering the safety of other health professionals to prescribe medicines. The move for nurse prescribing at a policy level commenced in 1993 through the Government wanting more competition – not through any major influence of the nursing organisations (Dixon, 1996).

### **Conclusions**

This chapter sets the scene of the health care environment and political climate in New Zealand in the late 1990s. The health environment was influenced and driven by many agendas. Restructuring had affected structures and systems of health care delivery, and, inevitably, the nurses. New Zealand's former electoral system, FPP, had provided opportunities for the Government to introduce reforms very rapidly in the early 1990s. In 1996, when MMP was introduced, it had the effect of slowing down the Government process because any policy decision required consultation with more than one party.

The national Government wanted greater efficiencies in the health system in the 1990s, including more flexibility. This included the labour market, of which nursing was a part. But the Government was beginning to realise that things were not all healthy in the health sector: there had been trade-offs and unforeseen consequences arising from all this change, and both the public and nurses were dissatisfied with the costs and consequences of the reforms.

The Ministerial Taskforce on Nursing was set up in the context of this health care and policy environment, with its public sector reform, corporate values, competition, managerialism, international criticism from the ILO and marginalised unions. Chapter 4 will describe how policy and nursing are related. It also provides more detail on how

nursing as a group engages in policy activity, and outlines the various New Zealand nursing organisations.

## **Chapter 4: Policy and New Zealand Nursing Organisations**

Nursing's inroads in reaching full professional status, such as receiving direct insurance reimbursement, prescriptive authority, major funding, high levels of autonomy in practice, are due largely to nurses' active involvement in state and federal policy making (Hanley, 2002, p. 1).

### **The importance of policy to nursing**

Nursing leaders note how difficult it is to understand why at times the profession can spend a great deal of energy trying to influence a course of action and nothing happens, while at other times certain courses of action occur "out of left field" and change happens quickly. Understanding policy processes allows nurses to make sense of their world and helps them to strategically align their energies to areas that will maximise opportunity and improve their services (Hughes, 2001).

It is interesting how often nurses are viewed by non-nurses as contributing to things nursing, but not contributing to things clinical, financial, operational or about patient outcomes. Just as Grace Neill (first Chief Nurse in the world, see Chapter 5) struggled 100 years ago for recognition of nursing, nurses now struggle to be invited to be present and participate at the table when 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, 1961; Stimpson & Hanley, 1991).

Nurses who are engaged in influencing policy often find that when they utilise policy and political analytical skills, they are more effective (Leavitt, Cohen & Mason, 2002). In contrast many nurses are frustrated when their ideas for change do not 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).

A number of authors (Aiken, 1981; Aiken, et al., 2000; Cohen et al., 1996; Cohen & Milone-Nuzzo, 2001; Fagin, 2001; Gebbie, Wakefield & Kerfoot, 2000; Mason et al., 2002; Munding, Kane, Lenz, Totten, Wei-Yann, Cleary, Friedewald, Siu & Shelanski, 2000) have noted the need for nurses to increase their participation in influencing legislation that affects health care, nursing practice and their patients. Many have also provided arguments as to why policy activity is important and how it should be taught;

they generally note that relatively little has been written on how these goals might be achieved.

An important part of nurses increasing their influence is understanding and accepting that such influence involves power and political activism. “There seems to be a fear that becoming political will damage the caring ethic, stability and respectability of nursing” (Maslin-Prothero & Masterson, 2002, p. 109). But the history of nursing is full of examples of nurses taking stances to bring about change, including better access to mental health services in New Zealand, so that it appears it is at times part of what we do. Yet “it is within general nursing that the nonpolitical attitude has seemed strongest” (p.110).

The ability to challenge the marginalisation and subordination of the nursing voice within policy decision-making circles as well as in the face of medicine is dependent upon knowledge. The power dynamic cannot be tackled unless it is known and understood (Maslin-Prothero & Masterson, 2002, p. 115).

To be a player in the game of policy, nursing as a profession must not only accept that understanding power, the current political system and policy has a legitimate place in graduate education, but must also be seen to be actively engaged with policy. So far nurses have been slow to participate in health-related political decision-making processes (Mechanic & Reinhard, 2002). Some research has been conducted on the health policy content in nursing education programmes (Androeli et al., 1987; Cohen & Milone-Nuzzo, 2001), and the identification of specific political competencies for specialty practice (Misener et al., 1997). However more research is required into the relationship between policy and nursing.

Some nurses argue that in order to make good this gap, policy components need to be made mandatory in postgraduate study for nurses (Cohen, Milone-Nuzzo, 2001; Hughes, 2001). In New Zealand, nurses have not shown an eagerness to be in policy positions or to study policy, as evidenced by the small number of nurses who enrol in public policy courses and the lack of policy papers offered in nursing graduate studies. The reason for this could be that either nurses do not understand policy, or they are not educated effectively on 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 relate to either pay issues or nurse shortages, and these events tend to be most visible when nursing issues reach the public policy agenda (Buerhaus & Needleman, 2001; Buerhaus et al., 2002; Ferguson, 1985; Rafferty, 1992). A glance at any daily newspaper in New Zealand at present will confirm this view. Nurses' perception of themselves as non-influential stakeholders in health also explains their large numbers not equating to influence. Buerhaus (1992) suggests that nurses often miss opportunities to participate, and when they do contribute they are unable to maximise the opportunity.

Antrobus and Kitson (1999) suggest that effort needs to be made to change the view of nurses so that they are seen as active contributors to a nation's health. Hewison (1999) uses the analogy of the factory worker:

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 (Hewison, 1999, p.1376).

This assumes that nursing is not really viewed as part of the health policy community. But nurses can influence policy on many fronts, by way of the advocacy role 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. Nurses in clinical practice are not the only contributors, however. Nurse researchers and nurses in management, policy and political positions can and do influence the policy processes. Gebbie et al. (2000, p. 309) write of a "passion for care" that drove nurses beyond clinical practice to reach out to policy- and decision-makers, and eventually to seek policy positions.

Through interviews with nurses working in policy, Gebbie et al. describe what they see nurses bringing to policy: the "application of clinical observation skills", emanating from nurses' extensive study of interpersonal communications; the ability to accumulate and use quantitative information accurately and often very rapidly; "a perspective on the real lives of people's experiences", which moves beyond balance sheets; "mastery of many people skills"; the ability to juggle competing demands; communicating with and

mobilising different groups; effective problem-solving processes; and the ability to deal with a wide range of issues, problems and criticism (2000, pp. 309-310). Ultimately, it is the combination of these skills by a nurse prepared at graduate level that shows the unique difference nursing can make.

### **Changes in health care: locating nursing**

As outlined in Chapter 3, 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 that have also created greater expectations from health consumers for “answers” to their health care problems.

Various studies (for example, Ministry of Health, 1999a) predict that by the year 2020 the top diseases/conditions that populations in Western countries will be facing will include heart disease, cancers, road accidents, depression, chronic respiratory problems, alcohol-related conditions, osteo-arthritis, and dementia / degenerative brain conditions. All of these can be viewed as lifestyle-related, so early intervention, health promotion, health education and chronic management will be keys to not only reducing their effects but also for effective management. Nurses will have a major role in prevention, early diagnosis and intervention, and in working with consumers and allied health members to treat and manage these health care problems (Hughes, 2001; Ministry of Health, 1999a).

New Zealand nursing and health care has changed a great deal since the early 1900s, when Grace Neill did her health policy work. Advances in knowledge and medical and nursing expertise have enabled a greater number of seriously ill patients to survive. The shortened length of hospital stays resulting from pressure on services means that more severely ill patients are being discharged sooner to nursing homes, rehabilitation facilities, or their own homes. This means that consumers who are admitted to our hospitals are sicker and stay shorter periods of time, compressing the time nurses have to provide quality care. Many patients and their families are now opting for care at home or in a hospice. Many are looking for a more humanistic approach to their health care (Hughes, 2001; 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 increasingly evident through research that quality nursing care by trained, skilled nurses is a crucial component of the modern health care environment, because quality of care has a direct effect on patient and consumer health outcomes (Aiken, 1981; Aiken et al., 2000; Aiken et al., 2001; 2002; Blegen & Vuhn, 1998; Buerhaus, 1997; Buerhaus & Needleman, 2001; Buerhaus et al., 2002). It is imperative that the evidence now available on nurse staffing and patient outcomes moves from the research domain into the policy domain, but this can only occur if nurses understand policy formation processes and maximise the mechanisms that exist through organised nursing leadership.

We saw in Chapter 3 how the reforms of the 1990s affected every aspect of nurses' philosophical beliefs, work environment and role within health care, as well as the quality of care. The irony is that to meet the challenges of today's health care environment, nursing influence is required more than ever, not only in the clinical and management areas of health care but also in health policy. As a stakeholder group nurses need to be more widely viewed as setting the agenda for health policy (Hughes, 2002b).

### **New Zealand professional nursing organisations in the 1990s**

In 1998 there were approximately 33,000 nurses actively practising in the workforce, at a ratio of 845 nurses per 100,000 population [please note that nursing organisations and media often quote different numbers throughout this study]. Registered nurses made up 70% of the health and disability workforce at a cost of nearly \$NZ 1 billion of health expenditure per year. Consequently, nurses were and are major stakeholders in health in terms of both numbers and costs, and will be instrumental in assisting the Government to deliver its key objectives for the health of New Zealanders (Ministry of Health, 1999a).

In the late 1990s there were eight nursing organisations recognised at a national level (personal communication from ERG group about nursing organisations, 2001), as summarised in Figure 2.

Figure 2

*New Zealand Nursing Organisations in the 1990s*

<b>Name of organisation</b>	<b>Role and function</b>	<b>Estimated membership</b>
Australian and New Zealand College of Mental Health Nurses	Formed in early 1994; provides a professional leadership function for mental health nurses across Australia and New Zealand.	Not publicly available
College of Nurses (Aotearoa)	Formed in early 1992; provides a professional voice for registered nurses.	Not publicly available
National Council of Maori Nurses	Established in 1982; a network of Maori nurses (New Zealand's indigenous nurses) throughout New Zealand. It has alliances with other national Maori organisations and is strongly aligned to iwi (tribal groups).	Not publicly available
New Zealand Nurses Organisation	Formed in early 1906; provides a professional leadership function, and also represents nurses industrially. It has 26 sections for specialist nurses within its structure.	30,000 health workers, including 17,000 registered nurses
New Zealand Occupational Health Nurses Association	Established in early 1973; provides professional leadership at a national level to nurses in occupational health.	Not publicly available
Nurse Education in the Tertiary Sector	Established in early 1992; is the national association of nurse educators in the education sector.	All 16 schools of nursing are represented.
Nurse Executives of New Zealand	Established originally as the Chief Nurses of New Zealand in the early 1900s; represents the senior nurses in major public and private hospitals, and nurses in government departments.	Approximately 30
Samoan Nurses Association	Established in 1991; provides professional representation to Samoan nurses at a national level.	Not publicly available

It is important to note that since the early 1990s midwifery has been recognised as a separate profession in New Zealand (see Chapter 3). Despite being regulated by the Nursing Council of New Zealand, it is not recognised as part of New Zealand nursing. When legislation is amended in 2003 a separate midwifery council will be established.

The regulatory body for nursing in New Zealand is the Nursing Council of New Zealand, which functions under the statutory requirements of the Nurses Act 1977. It is recognised by government as a statutory not a professional body (such as the

organisations listed in Figure 2) due to the statutory requirements for discipline and the setting of all entry requirements to the nursing and midwifery registers. In 1901 New Zealand was the first country to obtain separate legislation for the regulation of nursing, and it was this that brought about the establishment of the Nursing Council of New Zealand and the first Chief Nurse.

The dominant organisation in New Zealand since 1906 has been the New Zealand Nurses Association (NZNA). NZNA changed its name in 1993, when it amalgamated with the Nurses Union to form the New Zealand Nurses Organisation (NZNO). Even though NZNA had represented nurses industrially, it became more dominant in this domain when the amalgamation occurred. It is a historical irony that NZNO built up its industrial power base just as the Government was enacting legislation (the Employment Contracts Act 1991) which marginalised the unions. This occurred as nurses themselves took up union membership (encouraged by NZNO delegates) as they turned to NZNO in the hope they could help them with the crisis the reforms had caused in nursing, not realising their union did not have the same bargaining ability as previously.

The College of Nurses was established in response to a perceived need for an organisation that would focus entirely on the professional issues of nursing. Membership consisted of registered nurses and student nurses only, who met certain educational criteria (this was perceived by some as being élitist). The area of emphasis for the College was in the development of clinical practice, nursing education, leadership and research. The College attracted many nursing leaders and academics, and also provided recognition to these individuals by the ability to be reviewed and to become fellows. The College during this time was very strong on professional development and was perceived as critical of NZNO priorities for nursing.

The National Council of Maori Nurses has a long history in New Zealand nursing. It is integrally linked not only with the development of Maori nurses but also with Maori health providers, and Maori health. They have strong alliances with many other national Maori groups and work within traditional systems of Maori, including whanau (family) and iwi (tribe). The health reforms brought about major developments for Maori in New Zealand, and the National Council of Maori Nurses was very much involved during this time. Maori nurses were represented nationally by both NZNO and the National Council

of Maori Nurses, which caused conflict at times, as Maori nurses wanted separate international representation for Maori nurses as the indigenous people of New Zealand (not through a mainstream nursing group). Maori nurses also developed the concept of cultural safety and its application to New Zealand nursing.

Nurse Educators of the Tertiary Sector (now Nurse Education in the Tertiary Sector) represented nurse educators in nursing programmes. Their focus was to provide comment, direction and policy direction in education. They were active through their own group, and many were also active within the College of Nurses in promoting increased access to graduate education.

Nurse Executives of New Zealand represented senior nurses in public and private hospitals. The emphasis for this group was on providing strategic leadership. The majority were employees of the public hospitals, so were often in a difficult position in regard to public commentary about the reforms in hospitals (as they would be talking about their own employers).

I established the New Zealand branch of the Australian and New Zealand College of Mental Health Nursing (ANZCMHN) in 1994 and became the New Zealand president and New Zealand councillor. Historically, psychiatric / mental health nurses were treated as the poorer cousins of the nursing profession, and ANZCMHN for the first time provided a national voice for mental health nurses. As new organisations such as the College of Nursing and ANZCMHN started to develop, there was little collaboration between them and NZNO. I remember the resentment towards nursing leaders of the newer organisations at various conferences and meetings I attended. This was partly an issue of old versus new organisations, but it was also influenced by new nursing leaders, who were articulate, well educated and challenged the old ways of doing things. All organisations were trying to claim their own ground; some even barred their members from holding positions in their organisations if they were also members of other organisations, and declared open competition with other organisations.

It is interesting to note that many of the above organisations were formed in the 1990s. These offered stronger professional representation and indemnity insurance – not union representation. The newer nursing organisations were attractive to those nurses who had

come through tertiary education both at undergraduate and at postgraduate levels, as their emphasis was on issues wider than conditions of employment; i.e., education developments, advanced practice developments, research and autonomy of practice. Due to their size and membership, none of the above organisations apart from NZNO had permanent paid staff. This meant they relied heavily on voluntary services from their members to undertake policy development, briefing, submissions and media comment.

In this small country, it is not unusual that members and/or representatives of some of the newer organisations join together in response to government initiatives or other matters in loose configurations or support. For example in 2000 a group of nurses from varying organisations wrote a paper titled *Locating Nursing in Primary Health Care: Report for the National Health Committee* (Carryer, Dignam, Horsburgh, Hughes, & Martin, 2000).

Organisations, including nursing organisations, are inherently “complex in nature” (Dixon, 2002, p. 113). Organisational systems create dimensions that in themselves cause conflict. Members of the ANZCMHN whom I represented were frustrated with the changes occurring in their practice settings. As a purely professional organisation, ANZCHMN assisted with developing standards, clinical indicators, provided mental health nursing representation on committees and commented on mental health policy. It was hard keeping members happy. It was a time when organisations were focused on establishing themselves and/or on surviving. It was also clear that unions were not being looked upon favourably by the Government, and those of us in “pure” professional organisations were looked on more favourably by policy makers compared to union representatives.

I learnt early on, as president of the NZ branch of ANZCMHN, that even if I could have represented our members industrially it would have been an unenviable role. Instead I was able to make gains for mental health nurses in New Zealand by accessing funds for mental health nursing education by taking advantage of the competitive, contestable market environment. It was, I believe, a time when being both a union and a professional organisation inevitably created conflict.

The individuals who eventually became members of the Ministerial Taskforce on Nursing 1998 (see Chapter 6) came from these organisations; they all held a role within New Zealand nursing (apart from the non-nursing members), and their values, beliefs and differences were carried through into the Taskforce context. All of us on the Taskforce were progressive individuals, who for some time had been challenging the status quo of not only nursing but also health and education. I will briefly background some of these individuals.

Judy Kilpatrick, prior to being chair of the Nursing Council, was a high-profile nursing academic. In 1996 she challenged an NZNO member concerning comments about polytechnics (nursing schools) failing nursing by stating, “Yet again the ills of the nursing profession are laid at the door of nursing education. It is important that the debate in the area of nursing education is objective and reasoned” (Kilpatrick & Baker, 1996).

Jenny Carryer, Executive Director of the College of Nurses, had been at odds with NZNO over many issues, one of which was the debate around enrolled nursing and nursing education. Jenny Carryer became so concerned about letters and comments that were appearing in the NZNO journal (for example, “the move to get rid of enrolled nurses is being spearheaded by a small group of elitist nurses”, Carryer, 1995, p.4), that she wrote to NZNO stating, “I find the anti-educationist stance taken in some of the letters written in *Kai Tiaki: Nursing New Zealand* perplexing. Please do not discredit the voices and views of nurses who are academics or educators” (Carryer, 1995).

Julie Martin came from a strong primary health care background. She held strong beliefs about the development of nursing: “nurses need to acquire new skills to take their place as equal partners in new primary care. Nurses will be able to develop their own caseloads and become equal partners rather than employees” (NZNO, 1996, p. 9). Judy Kilpatrick, Jenny Carryer and Julie Martin also served on the ERG for this study.

Denise Wilson was a recognised Maori nurse educator. She was instrumental, with other Maori nurses, in the promotion and development of cultural safety in New Zealand nursing. Maori nursing for many years had felt invisible in nursing; the health

reforms and the strong support for recognition of cultural safety in care raised their profile.

### **New Zealand nursing seeking change**

There is no doubt that nursing in New Zealand was seeking change during this time, not just because of the effects of the health reforms but for the development of their profession. With the development of these new nursing organisations came expectations of different agendas and a changing of the guard within nursing politics in New Zealand. Nursing leaders within these new nursing organisations were unhappy with the status quo and how the older nursing organisations (of which many of us had been members for years) were “running the show”, and representing (or not representing) the professional interests of nursing. This put pressure on existing organisations and also on the regulatory body, the Nursing Council of New Zealand. By 1995 NZNO recognised that they were being perceived as only being interested in industrial issues – concerned for nurses, not nursing: “there is an active campaign by senior nursing and health sector providers to suggest that NZNO is only interested in industrial issues” (Wilson, 1995).

The Nursing Council of New Zealand (a regulatory and statutory body) started to change its role in the mid 1990s. It began to develop a more strategic approach and released its first strategic plan in 1995. This was aided by the National Government giving a clear mandate in the regulation of nursing, in opposition to NZNO political stance (Oliver, 1998). Judy Kilpatrick commented on her role as Nursing Council chair during this time: “The 1990s were turbulent times... many nurses wanted the Council to lead the profession... the council started to take a more visible role... when I came in [as chair, in 1996] people were looking for a new direction” (Wood & Papps, 2001, p. 110). The development of the Nursing Council role into scope of practice and competency brought it into conflict with NZNO: “NZNO opposed the council taking the professional leadership because of their [NZNO’s] professional arm” (p.110).

The lack of coalition building among the nursing organisations was evident by the health care and policy environment in which they were located. The reforms had the effect of “divide and conquer”, and organisation members were so exhausted confronting the reforms in the workplace that there was little energy for forward-looking coalition building. Nursing organisations, as described in Figure 2, were not a

national cohesive group: NZNO was marginalised as a union, and other organisations were trying to establish their professional role with small memberships. The Nursing Council took a stronger role in professional leadership than it had in previous years. It should not have been surprising, then, that when the Ministerial Taskforce on Nursing was established in 1998, conflict arose. Despite these groups not being represented as such, agendas for change and disunity were already present.

### **Regulating nursing**

Nurses and nursing organisations were confronted by many challenges during the implementation of the health reforms between 1993 and 1998. One area in particular was the regulatory policy of nursing. The whole issue of who should regulate nursing was being debated by government and nursing. (This becomes a crucial issue in the events surrounding the Ministerial Taskforce on Nursing, as discussed in later chapters.)

Regulatory policies impose restrictions on the behaviour of individuals or groups; for example, legislation that sets limits to the practice of health professionals, or that regulates the competitive behaviour of private enterprise. Regulatory policies historically have been prescriptive. The losses associated with regulatory policies can be substantial; for example, regulating the behaviour of health professionals can affect the ability of a group of professionals to earn a substantial income, or the cost associated with compliance with regulatory regimes can be high (Safreit, 2002). Conversely, regulatory policy can protect the income of health professionals.

Regulatory policies are often controversial and have sparked debate over the extent to which behaviour ought to be governed by regulation as opposed to the market or competition. Who should be regulated and public safety are important issues for any government. They also involve issues of power and control. Often the process by which behaviour is to be governed depends on influence and lobbying. An example is the case of advanced nursing practice, and the constant fight by the American Medical Association at state and federal level to restrict nurse practitioners through petitioning Senate and Congress (Bauer, 1998). In this context Safreit (2002) notes that the:

... ferocity and frequency of these extremely costly battles have frustrated, exhausted, befuddled, and cowed many seasoned legislators, and with good reason. Whenever scope of practice issues arise, legislators are bombarded by heavily

financed lobbying efforts emanating from state and national professional associations (p. 304).

Despite these obstacles, nurse practitioners in the USA have succeeded to get laws passed and achieved legislative success.

A sub-category of regulatory policy is self-regulation. Self-regulation involves a group setting the standards for their own behaviour; for example, medical practitioners may set the standards of practice for physicians. Self-regulation is often sought by groups in order to enhance their status and control their profession (Palmer & Short, 1994). In some instances the government may devolve responsibility for standard-setting to professional groups (Weissert & Weissert, 1996). Devolution of responsibility for standards is evident in New Zealand via the roles of the medical and nursing councils of New Zealand, which register and discipline their members.

In the mid-1990s the Ministry of Health was leading this policy work and had been advising the Minister of Health on options for regulating ongoing competency under the Nurses Act 1977. The nursing profession had been hotly debating the issue of regulation versus self-regulation in relation to ongoing competencies (Oliver, 1996). NZNO believed nursing should function through self-regulation: “what other profession would hand over core professional functions, like development of competencies, to a statutory agency which is not under the control of the profession?”(Oliver, 1998, p. 12).

In 1998 the National Government believed there should be minimal regulation of competency through the Nursing Council of New Zealand, because the Council’s role was protection of patient safety. NZNO expressed concern that regulation would make it difficult for nurses to practise and would create barriers, thus putting nursing jobs in jeopardy (Oliver, 1998).

In my view NZNO’s mandate as a nursing union was to look after nurses’ jobs, not their competencies. The question was one of whose interests were being served. NZNO argued that the profession must control its own regulation, but because NZNO is a trade union it is pertinent to ask whose interests are being served if they have the power to regulate for ongoing competency: the consumers in New Zealand through the government? The profession? Or the union’s own industrial power base? While there

was controversy over this issue within the profession, no government heading into an election in November 1999 would have taken the issue further. NZNO became a member of the 1998 Ministerial Taskforce on Nursing with this issue unresolved.

### **Policy, politics, nursing and agenda-setting**

Palmer & Short (1994) consider that policy on health issues “embraces courses of action that affect that set of institutions, organisations, services and funding arrangements that we have called the health care system” (p. 23). Policy encompasses the authoritative guidelines that direct human behaviour towards specific goals, in either the private or public sector. It includes the broad range of activities through which authority figures make decisions directed towards a goal, and levy sanctions that affect the conduct of affairs. Policy is shaped and influenced by the choices that a society or part of a society wants to make regarding its goals and the way it wishes to allocate resources. It is heavily influenced by values (Hanley, 2002; Kalisch & Kalisch, 1982; Lindblom, 1987; Hanley, 2002).

Policy has been defined as a “course or principle of action adopted or proposed by a government, party business or individual”.<sup>7</sup> It can also be considered as a set of processes, for which many different models exist – sequential, linear and circular. Davis & Ashton (2001, p. 4) note that in the New Zealand context we define health policy:

... as being a systematic course of action undertaken by government agencies that not only affects the formal institutions of the health care system but that also has an influence more broadly on the health of the community.

In general, policy processes can be categorised as a sequence of problem identification, policy formulation, policy adoption, policy implementation and policy evaluation (Hanley, 2002; Kingdon, 1995; Lindblom, 1987; Weissert & Weissert, 1996; Wieczorek, 1985).

Weissert & Weissert (1996) describe the policy influences differently in adopting Cohen, March & Olsen’s (1972) categorisation, which records four separate streams flowing into the policy-making process: problems, solutions, participants and choice opportunities. In contrast, Kingdon (1995) views policy making as a very fluid process, which means that policy agendas and options are very unpredictable and not as tidy,

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<sup>7</sup> *Concise Oxford dictionary*, Oxford University Press, London, 1998.

rational or neat as other writers appear to suggest. In the same vein, Almond & Genco (1977) wrote that to understand and capture political phenomena, “we should think of clouds not clocks; we would come to prefer fluid metaphors to mechanical ones” (p. 490).

Walt (1994), Weissert & Weissert (1996) and Kingdon (1995) all challenge the use of simple linear or circular models of policy development, which assume that the state is neutral in handling demands and balancing different values. In simple linear or circular models, policy making and policy formation processes are seen as powerfully influenced by the relative power of those making demands and the processes available to exert that power. The availability of time and other resources in order to make decisions or implement policy change also had a strong influence.

Problem identification is crucial to policy formation in all these theories. This stage involves asking several questions to define the nature of the problem: “What is the scope, duration, history and whom does it affect? What data are available to describe the issue? ... What are the gaps in the data?” (Leavitt, Cohen & Mason, 2002, p. 73). Policy formulation involves setting the agenda, and specifying alternatives from which a choice is to be made. Policy adoption involves making an authoritative choice among those specified alternatives, as in a legislative vote or government decision (Davis & Ashton, 2001; Hancock, 1999; Kingdon, 1995; Wieczorek, 1985).

Policy analysis, on the other hand, is the systematic study of the content and anticipated or actual standing of 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 inaction is just as important as the study of decisions and actions. All areas are interrelated, and the policy community (of which nursing is a part) has roles in all these stages. As outlined in Chapter 3 with respect to the health reforms, policy either works or fails depending on how successful these steps are and the depth of analysis that surrounds them.

From these definitions it can be seen that a definite, coherent definition of exactly what constitutes policy can be difficult, and we may need to resort to description. Thus policy is always developed within a political context, and as such involves a degree of

compromise (Stephenson, 1985; Weissert & Weissert, 1996). However, we need to be careful here in what we mean by “politics”: “Politics is a neutral term... it means simply the process of influencing the allocation of scarce resources” (Mason et al., 2002, p. 11). Historically, a change in nursing has involved political activity, and the relationship between nurses and policy formation should not be viewed any differently. It inevitably involves conflict.

### **Policy, politics and conflict**

The process of working in policy and politics involves working with conflict. “Conflicts can occur between political parties, between those with different ideological values and between stakeholders” (Leavitt, Cohen & Mason, 2001, p. 71). Conflict is unavoidable and often occurs when groups oppose each other. Jenkins-Smith (1990) describes how when core values of different groups are less directly threatened by an analytical issue, the level of conflict is only moderate; the more the core values are affected, the greater the conflict. There are two sides to conflict. Firstly, individuals engaged and secondly, the audience they attract. Neither are neutral. Once engagement in conflict occurs, people take sides and influence the outcome. Conflict becomes political when the wider public arena is involved (Lange & Cheek, 1997).

Schattschneider (1960) describes how groups can expand their political influence through expanding their scope of conflict, so that conflict can be used as a political strategy. “The most important strategy of politics is concerned with the scope of the conflict” (p.3). The conflict that resulted in NZNO being depicted as only being interested in industrial issues by other Colleges of Nursing could be viewed as an example of the Colleges trying to increase their span of influence by promoting conflict. This becomes important as we look at the role of nursing in influencing policy and politics, and as the case of Ministerial Taskforce on Nursing 1998 is outlined in later chapters.

Mason et al. (2002) identify four spheres of political influence and action available to nurses: workplace, government, professional organisations and community. “The four spheres are interconnected and overlapping. The political effectiveness of nurses in one sphere will be influenced by nurses’ involvement in the other spheres” (p.13). They suggest that the “interrelationship between the spheres becomes more distinct as nurses’

political skills develop” (p. 13). Mason et al.’s spheres have an interesting link with Cohen et al.’s (1996) stages of political development of nursing (discussed later in this chapter). Both spheres and stages rely on connections and relationships, and have application to both groups and individuals.

It should be noted that it may be no accident that the nature of policy making is hard to pin down. Policy is often deliberately vague and ambiguous so that those with different perspectives can see their own position reflected. A degree of ambiguity is understandable where the policy maker wishes to maintain flexibility, but this can create problems for those interpreting policy. Vague definition can also work to the advantage of interest groups, especially policy entrepreneurs who wish to voice their objectives in the terminology of the government (or other agency) in order to have their agenda achieved (Oliver & Paul-Shaheen, 1997).

The New Zealand health care policy environment is certainly not immune from this ambiguity. For example, in 1997 the New Zealand Government undertook a policy commitment to “quality services.” This term does not provide any real implementation guidance to policy makers, purchasers, health professionals or consumers. In such circumstances the ability of advisors and political lobbyists to influence decision-making and call agencies to account is considerable. Without clarity, groups can use their own interpretation to achieve their own political ends.

A policy community is made up of experts in academia, consultants, think tanks and agencies who play a part in policy formation and implementation (Davis & Ashton, 2001; Kingdon, 1995; Weissert & Weissert, 1996). During this time not only was New Zealand’s policy community faced with ambiguity of policy, but (as noted in Chapter 3) the health policy community (of which nursing is a part) was deliberately excluded from participation. The cry from nurses was that the quality of health care was being affected, but whose interpretations of quality were being listened to and why did it take so long for changes to occur?

### **Kingdon's policy theories**

Kingdon's (1995) theories of agenda-setting and policy formation provide an important anchor for this study. First these theories will be described, before seeing how they apply to nursing.

An agenda is a "list of subjects or problems to which people pay serious attention at any given time. The process of agenda-setting, narrows this set of conceivable subjects to the set that actually becomes the focus of attention" (Kingdon, 1995, p. 3). Crucial to agenda-setting is problem recognition: "the chances of a given proposal or subject rising on an agenda are markedly enhanced if it is connected to an important problem"(p. 198).

Kingdon's approach to analysing policy formation utilises the idea of three streams:

1. *Problem* stream deals with the complexities in getting policy makers 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 (p. 20).

Streams come 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).

Kingdon's streams are based on Cohen et al.'s (1972) conceptualisation of the policy process as a series of options floating around seeking a problem, in what is referred to as the "policy primeval soup." All of these streams have their own origins, with different sets of people involved: at times some of the streams come together as people seek to connect problems with solutions. All three streams join at crucial junctures; this occurs when policy "windows" open up. Creating opportunities for influencing policy is

thus time limited: if “change does not occur while the window is open, the problems and options return to the soup and continue floating” (Hanley, 2002, p. 59).

Key to Kingdon’s theory of agenda-setting and policy formation is the importance of climate: “It is not where an idea came from that is important but what makes it take hold” (Kingdon, 1995, p. 72). Kingdon describes the attempt to “track down the origins of a case of policy making” as being involved in an “infinite regression.” In other words, tracing history inevitably means there is no logical place to stop the process, so “tracing origins is futile.” Concepts and ideas take hold, and it is the interactions between those involved in policy where the real understanding occurs in policy making.

Government agendas are set, according to Kingdon, mainly through the problem and political streams, with the assistance of skilful entrepreneurs. Policy windows are opened by political and problem events; the greater the linkage between these two streams via a policy option, the greater the likelihood of action. The scarcity of windows opening constrains the policy community from pushing their own policy agendas, but by connecting with problem and political streams they can enhance agenda items. Kingdon’s concepts will be further outlined and expanded in relation to the role of the Chief Nursing Advisor, nursing organisations and the Ministerial Taskforce on Nursing in the chapters that follow.

#### **Policy and the political development of nursing: the theories of Cohen et al.**

The development of political skills and policy in nursing is important at an individual and organisational level. Influencing policy is important not just for consumers but for the process of “learning the ropes” (Leavitt, Chaffee & Vance, 2002, p. 31). As noted above, Mason et al. (2002) describe the relationship between the political activity of nursing, policy and the development of nursing using a model with four spheres of political action.

Cohen et al. (1996) provides a useful framework for analysing nursing’s political development. This framework was developed for organised nursing, but “it mirrors the stages that individual nurses navigate to become players in policy arenas” (Mason et al., 2002, p. 7). A summary of the stages is given in Figure 3.

Figure 3

*The Progress of Nursing through the Four Stages of Political Development*

	<b>Stage 1 (Buy-in)</b>	<b>Stage 2 (Self-interest)</b>	<b>Stage 3 (Political sophistication)</b>	<b>Stage 4 (Leading the way)</b>
<b>Nature of action</b>	Reactive, with a focus on nursing issues	Reactive to nursing issues (e.g. funding for nursing education) and broader issues (e.g. long-term care and immunisations)	Proactive on nursing and other health issues (e.g. nursing's agenda for health care reform)	Proactive on leadership and agenda-setting for a broad range of health and social policy issues
<b>Language</b>	Learning political language	Using nursing jargon (e.g. caring, nursing diagnosis)	Using parlance and rhetoric common to health policy deliberations	Introducing terms that reorder the debate
<b>Coalition building</b>	Political awareness; occasional participation in coalitions	Coalition forming among nursing organisations	Coalition forming among nursing groups; active and significant participation in broader health care groups (e.g. Clinton taskforce on health care reform)	Initiating coalitions beyond nursing for broad health policy concerns
<b>Nurses as policy shapers</b>	Isolated cases of nurses being appointed to policy positions, primarily because of individual accomplishments	Professional associations get nurses into nursing-related positions	Professional organisations get nurses appointed to health-related policy positions (e.g. nurse position on ProPAC)	Many nurses sought to fill nursing and health policy positions because of the value of their nursing expertise and knowledge

Source: Cohen et al., 1996, p.260.

*Stage 1, buy-in*, represents the profession's recognition of the importance of political activism and encompasses activities that encourage and promote the political awareness of nurses. For individual nurses this could be when they decide to become actively involved.

*Stage 2, self-interest*, is where nursing develops and uses its political expertise as it relates to the profession's self-interest. For individual nurses this could be when they take special interest in their practice environment. Nurses and nursing organisations would start to advocate for their own issues in this stage.

*Stage 3, political sophistication*, is where the profession goes beyond self-interest and recognises the importance of activism on behalf of the public while achieving increased sophistication in political strategies. At this stage policy makers often view nurses as having expertise in health policy. Nurses and nursing organisations are now

participating in broader health policy discussions. For individual nurses this could be the time they get appointed onto an advisory committee.

*Stage 4* is where the profession is *leading the way*. It is the highest level of political involvement. The profession is envisaged as providing true political leadership on broader health care issues that speak to the public interests. For individual nurses this could mean appointment to posts outside of nursing, acknowledging the wider contribution that nursing can make. It also more importantly means that nurses' ideas and visions pave the way and generate policy proposals.

Cohen et al. (1996) stress that stage 4 is not necessarily the end of the process. Firstly, they suggest that additional stages may be needed as nursing or nurses evolve politically. Secondly, nursing and nurses can straddle more than one stage: "The stages of nursing's political activism are not time bound, and nursing has straddled more than one stage of political development at a time" (p. 259).

Coalition building in stage 1 is characterised by occasional participation in coalitions. Stage 2 sees the development of coalitions forming among nursing organisations, where "whatever the differences among these organisations and despite conflicts over competition and the claiming of credit, the ability to forge coalitions and compromises symbolises a new level of maturity for the profession" (Cohen et al., 1996, p. 261). In stages 3 and 4 coalitions in nursing show involvement and activity in broader health groups, and coalitions are initiated with broader health groups.

Being the largest workforce group is not enough to determine influence. Political and policy processes need to be developed. Hand in hand with this is the need to understand where organised nursing is in its stage of development, and the direction it wants to take on certain issues. Capacity and capability are important in regard not only to influence, but also in providing leadership of policy agendas.

By utilising Cohen et al.'s theory of the political development of nursing, how nurses engage in policymaking can be understood. In particular, the theory provides a staged process for understanding how nurses became engaged in the process of the 1998 Ministerial Taskforce on Nursing.

## **Conclusions**

This chapter has described nursing and its relationship to policy, and discussed it in the context of policy-making theories. The chapter provides background for why the nursing role in policy is important, and how policy and nursing are important to the political development of nursing. Kingdon (1995) provides the policy theory, and Cohen et al. (1996) provide a framework for understanding the political development of nursing, which is important in maximising the contributions of nursing to health policy formation.

The background of New Zealand nursing organisations as they existed in the 1990s has been discussed briefly. The relationship among politics, policy and nursing becomes important if we are to understand how nursing organisations in New Zealand engaged in policy formation surrounding the Ministerial Taskforce on Nursing. We now turn to look at the central role of the Chief Nurse in policy.

## **Chapter 5: The Role of the Government Chief Nurse in Policy**

This chapter explores the role and function of the Chief Nurse and the challenges facing the position today. Particular emphasis is placed on the role as a public servant, and how this relates to the policy community, which includes the nursing profession. I will also describe this role in relation to Kingdon's (1995) theory of policy entrepreneurs.

Through the research of Splane & Splane (1994), the reports from the Chief Nurses' meeting in Atlanta, USA, in October 2001 and my own experience as a Chief Nurse I discuss the complexities of this position and the various dimensions that provide a vital resource to the policy, nursing and health communities. It is through this discussion that the context for my role as a Chief Nursing Advisor in relation to New Zealand nursing and the 1998 Ministerial Taskforce of Nursing will become clearer.

### **Background**

It is becoming increasingly evident through current research that the quality of care given by trained skilled nurses affects the health outcomes of consumers (Aiken, 1981; Aiken et al., 2000; 2001; 2002; Needleman, Buerhaus, Mattke & Zelevinsky, 2001; Sochalski, 2001; Sochalski, 2002). But many countries are facing a continuing struggle to educate, retain and recruit registered nurses, and to place nursing as a player in wider health policy (Hughes, 2002b).

Government within any country impacts on the way nursing develops and the conditions under which nurses practice. "Government puts in place key elements of the regulatory system governing nursing. Other policies and actions of government, especially funding and management decisions, form part of the regulation or governance of nursing" (NZNO, 1998a, p.11).

Within this complex environment there is a nursing role that has to provide leadership and direction, implement health policy for the government, and provide a vehicle for government and the nursing community to engage in health policy. This complex role, often poorly understood, has been filled throughout the world for 100 years (Hughes, 2001; 2002b). To date there has only been one substantive piece of international research and few published articles on it.

The role is that of the Chief Nursing Advisor/Officer, sometimes known as the senior nurse in government. The role is clearly influenced by the political structures and systems within the country in which it is located. This role, like many other nursing roles and positions, has been affected by the reforms and restructuring that have occurred in health and public sectors around the globe.

The majority of developed and developing countries have nurses in government positions. They may or may not be at a senior level, and the position may or may not be recognised or identified as a nursing position. Where the position exists, it usually has the title of Chief Nurse or Nursing Advisor/Officer. There is, however, a great deal in common among the roles the Chief Nurse fills around the globe (PAHO/WHO, 1996). Wider recognition and understanding of this role and its contributions will not only benefit the formulation and delivery of health policy, but also help to maximise nurses' and ultimately consumers' involvement in health care (Hughes, 2001; Chief Nurses Conference Report, 2001).

Despite the fact that nurses have been in governments around the globe for many decades, in October 2001 for the first time Chief Nurses from around the globe gathered for their own caucus meetings in Atlanta, Georgia, USA. Before this Chief Nurses would only meet as part of other meetings, such as the International Council of Nurses, World Health Assembly and Commonwealth nurse meetings. The Atlanta meeting was sponsored by Dean and Professor Marla Salmon of Emory University.

In the following discussion I will use the term "ministry of health" to apply to health departments or other governmental departments of health. "Chief Nurse" will mean the most senior nurse in government who has "nurse" in the title.

### **Role and models of the Chief Nurse**

The role of Chief Nurse was first developed in New Zealand in 1901, and the first Chief Nurse was Grace Neill:

She was a strong determined woman, who fought for nursing to be an educated and regulated profession. Neill formulated strategies with politicians, nurses, hospitals and consumer groups to bring about positive changes in nursing and also in public health care in New Zealand (Hughes, 2002a, p. 130).

In 1994 the first international review of the role of Chief Nurse was conducted by Splane & Splane (1994). Through this research, the historical development of the role was identified, and an analysis made of the Chief Nurse's influence and relationships with government and professional nursing associations in the countries in which they reside. Their research was based on surveys and interviews of Chief Nurses and national nursing organisations around the globe. As a result of this analysis, Splane & Splane characterised three models of Chief Nurses: executive, advisory and dispersal.

In conducting their research Splane & Splane posed the following question to the interviewees: "Who would formulate policy and make day to day decisions respecting nursing in the Ministry if there was no chief nursing officer position?" (p. 217). The answer was, "Doctors or general managers." The next question was, "What consequences would that have?" The answer to that question was very thought provoking: "the quality of nursing and the contributions to nursing and to health would be gravely affected."

Over the past 100 years this role has developed. Splane & Splane's (1994) three classification models for Chief Nurse positions (executive, advisory and dispersal) allow the various contexts and settings to be acknowledged and understood in different countries.

In the executive model, the Chief Nurse is more likely to be found in those countries where the ministry of health directly administers the health care system throughout the country (for example, Barbados and Guyana). This model also appears in countries that are quite small in population and geographical area. The Chief Nurse would thus exercise line authority over nurses and nursing services throughout their jurisdiction (Chief Nurses Conference Report, 2001, p. 3; Splane & Splane, 1994, pp. 26-27).

The executive model existed in New Zealand until the late 1980s, during which time there was a division of nursing within the Department of Health. After the public sector reforms, the Chief Nurse model changed to advisory. As noted in Chapter 4, the division of nursing was replaced by a Chief Nurse and Senior Nursing Advisor, with the Chief Nurse role having characteristics of the Splane & Splane (1994) advisory model.

The advisory model that now exists in New Zealand is also the predominant model in England, Canada, Ireland, Scotland, Wales and the majority of Western countries. Australia has the advisory model of the Chief Nurse at state and territory level only: a Chief Nurse does not exist at federal or national level. The Chief Nurse carries out executive model activities, but does not carry out line responsibility for the nursing workforce, although, for optimal effectiveness the reporting relationships of the position are at the senior level. This is an important difference, which can cause conflict with the policy community, who often believe that the Chief Nurse controls all of nursing within a country.

Nursing in New Zealand did not, I believe, understand or accept the changes that had occurred to the Chief Nurse role as it changed from executive to advisory. For many decades nurses had seen the Chief Nurse of New Zealand as controlling the nursing workforce, and the reforms distanced the role at a time when expectations from nursing were very high. Despite the fact that I was the second Chief Nurse in New Zealand who fulfilled the role in an advisory capacity, every day I experienced nurses and organised groups thinking I could solve their workplace problems and control workplace conditions. I may have been the highest nursing voice in the country and the closest to government, but my role was deliberately distanced from the delivery of nursing practice. This distancing occurred as the health reforms positioned central government agencies away from the health providers, through the funder provider split.

There is a clear expectation that, despite the inability to influence nursing resources, the Chief Nurse is perceived by nursing as being responsible for what the ministry of health does or does not do in regard to nursing. The Chief Nurse thus walks a difficult path:

It is at times a position you love to hate. The role of Chief Nurse is demanding, vulnerable, stressful, fraught with conflicts between interest groups, and yet fulfilling and rewarding. It requires an innate sense of judgment and an element of elasticity as you walk the paths with politicians, consumer groups, researchers, nursing organisations and stay true to yourself and the values of public service (Hughes, 2002a, p. 130).

The dispersal model covers the situation where no Chief Nurse exists, or where different areas of government have Chief Nurses (for example, South Africa, Papua New Guinea,

the USA and Botswana). Often there are nurses in government, but nurses are dispersed under various titles and positions.

In the US there are different Chief Nurse positions at the federal level, who are recognised internationally as Chief Nurses: the Director of the Division of Nursing within the Department of Health and Human Services, Chief Nurse of the US Veteran Administration and the Director of Nursing for the US Public Health System. The US has a unique government structure through federal and state systems (Tuohy, 1999).

Despite these differences in government systems between countries, these nurses may exercise some influence on policy and management as part of multidisciplinary teams. Often, although relatively senior, they remain at a distance from central decision-making (Splane & Splane, 1994; Chief Nurses Conference Report, 2001). They exert their influence through personality and connections than through positions.

In 1996 the Pan American Health Organisation of the World Health Organisation (PAHO/WHO) developed a set of key functions and desirable arrangements for the role of Chief Nurse to make a positive impact on the ministry and its work. They defined the role of Chief Nurses as:

... the leading nursing expert in the Ministry of Health responsible for providing the professional nursing contribution to health policy, planning and programs. The Chief Nurse will lead the development of the profession in the interests of health care and assist the Ministry in developing and managing the health care system (PAHO/WHO, 1996, p. 48).

PAHO/WHO's functions required the Chief Nurse to have skills in providing advice, consultation, leadership in strategy, nursing practice, nursing education, legislation, regulation and intelligence gathering. These duties cover many levels, from working with elected officials in government office, ministers and other government departments, to working with numerous non-government stakeholders, including nurses and consumer groups.

Whatever the model in any particular country, the expectations on the Chief Nurse are great. The position is influenced by many factors, all of which, I believe, make the position unique to the country in which it is located.

### **Influences on the Chief Nurse role**

In my experience, which is also reflected in the writings of Splane & Splane (1994) and PAHO/WHO (1996), there are three key influences on this role which either aid its success or its demise: (1) the way the position interacts and engages with the political systems and structures within a country; (2) the relationship with the ministry of health; and (3) the relationship with the organised nursing profession. This does not deny the influence of others within the policy community, but these three are key to maximising the potential of the role. All ultimately affect the way the Chief Nurse functions in the role and influences national health policy.

It is clear from the outline of Splane & Splane's (1994) models and description of the role of a senior public servant that the position of Chief Nurse is not isolated from the political systems and structures of the country in which he/she resides. Litman & Robbins (1971) describe how "Each nation's health care system is unique, based on its own social, political, cultural and economic history and foundation" (p. 577). The ministry of health is a complex environment. In some countries senior public servants are appointed by politicians, and so, as politicians change, officials also change. Here the political agendas will largely determine the priorities and plans of the particular ministry. Permanent officials will strongly influence who carries out the work of the ministry, how officials are appointed and how the work of the ministry is supported (PAHO/WHO, 1996).

In countries with a more democratic system of government, such as New Zealand and most other developed countries, the Chief Nurse is a senior public servant, appointed by senior management (executives) in the ministry of health. The position is not dependent on electoral cycles and who is in government, so is not deemed to be a political appointment. In the USA there is a difference between political appointment and a civil servant / bureaucrat professional (Tuohy, 1999). Whether the position is appointed by politicians or by the public service processes, however, the Chief Nurse is expected to serve and be loyal to the government. This requires the Chief Nurse to adopt the values of the government and public service. The relationship of the Chief Nurse to the government minister responsible for the health portfolio can provide opportunities to influence health policy agendas by the provision of expert advice, but can also at times cause conflict. Lady Jocelyn Keith ( a New Zealand nursing leader), commenting about

the role of the Chief Nurse in New Zealand, wrote, “She, like her fellow public servants, must be loyal to and advocate for the position of whatever government is in power” (2000, p. 20).

It has been my experience that those outside the public service or government circles often poorly understand the role of the public servant. Those of us who work in this domain can be disciplined or dismissed from service, according to our Code of Conduct, if there is evidence that this loyalty has not occurred. Freedom to express personal opinions is curtailed if they could be viewed as critical of government policy (State Services Commission, 1995).

The Chief Nurse has a role in working with the key interest groups, such as nursing organisations, regarding early involvement in policy initiatives. The person who holds the position of Chief Nurse is expected to provide leadership for the profession. Managing the process of being a government servant while also providing leadership to the profession is vital to ensuring that policy and professional practice are not isolated from each other (Splane & Splane, 1994).

The nursing profession has expectations of the Chief Nurse role which at times cause conflict with the Chief Nurse’s role as a public servant. Many Chief Nurses describe this conflict as “like walking a fine line”, “having two masters” or being “the meat in the sandwich” (Chief Nurses Conference Report, 2001). The art and the skill of the Chief Nurse are to safely navigate between both so that neither is compromised and the agendas are aligned. However, the reality is that the Chief Nurse is there for the public good and to deliver on government agendas in health. Regardless of skill, there are times when conflict is inevitable and the Chief Nurse, on behalf of the ministry, has to manage it (Chief Nurses Conference Report, 2001).

Splane & Splane (1994) have identified the characteristics of constructive relationships between the Chief Nurse and the national nurses’ association (NNA), or main nursing organisations in each country. They should:

- discourage invidious comparisons of the relative importance of their respective positions;

- attain a mature knowledge and appreciation of the other's work and the limitations and problems faced in terms of resources and internal relationships;
- jointly agree through formal and informal communication linkages to the regular exchange of information on their respective goals and strategies being employed to deal with them;
- the NNA informs the Chief Nurse of the association's intention to meet with the Minister of Health or other government officials;
- collaborate in all measures to define and redefine nursing standards throughout the health system;
- collaborate in raising standards of nursing education to meet changing needs; and
- collaborate in international nursing endeavours (p. 203).

Keith (2000) compares the relationship between the Chief Nurse and the NNA to a pair of hands: "for the left hand to make an effective noise, it needs the right hand to clap" (p. 20).

Other professional staff within the ministry also influence this position, particularly the Chief Medical Advisor (PAHO/WHO, 1996). From my own experience the relationship between the Chief Nurse and the Chief Medical Advisor is crucial. It is also not without conflict, like the interface of nursing and medicine in everyday practice.

Nursing literature on the influence and control of nursing practice by medicine is well known, so it is not surprising that the role of Chief Nurse reflects similar problems (Abbott, 1988; Allen, 1986; Bates, 1975; Bullough, 1983; D'Antonio, 1993; Fairman, 1998a; 1998b; Kalisch & Kalisch, 1982). Group & Roberts (2001) describe the dynamics of the relationship between physicians and nurses, including how the attempts by nurses to reform health services and provide differing views on health care are often thwarted as physicians strive to maintain their monopoly in health advice.

The most constructive relationship between these two positions is one of equal partnership, where a team approach prevails. Sadly, despite good individual intentions, organisational systems often skew the two positions by placing different levels within the ministry of health or by resourcing each position differently. It is also common in most of the Commonwealth countries for the head of the ministry or director-general of health to be a physician (Splane & Splane, 1994). New Zealand has only ever had one

director-general who was not a medical practitioner. That was during the period of the health reforms in the early 1990s.

### **The Chief Nurse as policy entrepreneur**

In many countries, like New Zealand, health officials and other non-nursing policy stakeholders do not think of nursing as a contributor or player in the “game of health care policy” (Hughes, 2001 p. 24). Yet is important to have mechanisms to translate valuable health and nursing research into the policy environment, and even more important to ensure that this research becomes a policy solution to a policy problem. The Chief Nurse, as part of the policy environment, has a role in providing such mechanisms.

I was appointed Chief Nurse in New Zealand at the end of 1997, when the relationship between the government and the NZNO was hostile, but distant when it came to other nursing organisations. I found this a very difficult time. I constantly experienced the anger of the profession at an organisational and individual level, as they became frustrated with government processes. I also found that the government expected me to placate nursing groups, when it was clear that the ideologies of some nursing organisations (such as NZNO, as a union) and the National government were poles apart.

The role of Chief Nurse is immersed in the policy-making process, in particular in what Kingdon (1995) describes as the three streams of policy process: problems, politics and policy. All Chief Nurses have to develop mechanisms within their ministries of health to make nursing issues more visible. One of the difficulties of the Chief Nurse, is that the different policy constituencies may have multiple and/or conflicting issues which make it difficult to determine which issue should be made visible. Those Chief Nurses who are successful in getting nursing more attention and nursing issues converted into policy agenda items could be likened to what Kingdon describes as “policy entrepreneurs”.

Policy entrepreneurs play a major part in waiting and watching for the right time to attach solutions to problems, identifying constraints, and taking advantage of politically

propitious events. They exist in various positions, inside and outside government. Kingdon (1995) uses the analogy of a surfer, waiting on the board to catch the wave:

Without the presence of an entrepreneur, the linking of the streams many not come together. Good ideas lie fallow for lack of an advocate. Problems are unsolved for lack of a solution. Political events are not capitalized for the lack of inventive and developed proposals (p.182).

Oliver & Paul-Shaheen (1997) describe how policy entrepreneurs “exhibit a wider horizon of choice” (p. 748), and can influence policy streams through taking advantage of the ambiguity of policy by offering proposals as a “plausible solution” (p. 749). They can also influence the political stream by influencing interest groups or political parties when changes in national mood are occurring. Oliver & Paul-Shaheen also raise another point, not highlighted in Kingdon’s theory of policy entrepreneurs: policy entrepreneurs can “create agenda items” (p. 752).

Policy entrepreneurs perform activities that fit with my view of the Chief Nurse. They help develop ideas, expertise and proposals well ahead of time. They work within the different levels of organisational structures, within and outside government, to create linkages and “couple up” streams, thus performing a softening-up process so that proposals may gradually become supported. They can also, as Oliver & Paul-Shaheen (1997) argue, create agenda items. The Chief Nurse scans the environment for opportunities to see when certain proposals may be more likely to be viewed more seriously than others, taking advantage of when the time is right or, as Kingdon would say, when the “window is open.”

They bring several key resources into the fray: their claims to a hearing, their political connections and negotiating skills, and their sheer persistence. Items’ chances of moving up on an agenda are enhanced considerably by the presence of a skilful entrepreneur (Kingdon, 1995, p. 205).

Oliver & Paul-Shaheen researched in six states of the USA the factors that create the right environments for policy innovation and change. They concluded that “the critical factor these states shared in common was skilled committed leadership from policy entrepreneurs” (1997, p. 721). Leadership is the key characteristic of the policy entrepreneur, which “is needed to recognise opportunities for change” and to “organise the development of options to ameliorate the most pressing problems” (p. 742).

Even though Kingdon does not comment on nursing, I believe he would include the Chief Nurse role among public servants who have an impact on developing and implementing policy. “Their resources include their longevity, their expertise, the pattern of their relationships with interest groups” (p. 43).

As a nurse, public servant and policy entrepreneur, the Chief Nurse offers important advice to the ministry and government, and is also key to the implementation of policy that affects and influences nurses and nursing. “They [bureaucrats] are critical with respect to their professional advice and consultation in pursuing approaches which they have generated” (Kingdon, 1995, p. 32).

The role of the Chief Nurse in policy is multi-faceted, and requires the person to influence, engage with and constantly respond to a changing environment in health and different political agendas with the best evidence and advice possible. Thus the personal attributes of the Chief Nurse in managing the relationships between government and the profession are vital for the success of nursing involvement in policy.

Sadly, I have listened to many Chief Nurses who have entered their position with no previous experience in policy development and the machinery of government. Many ministries have down-sized nursing positions as they underwent public service reform. In my own case I was lucky enough to enter government as a Senior Advisor of Nursing, but within four months was acting as Chief Nursing Advisor. Since my appointment as Chief Nurse in 1997, the Senior Advisor’s position has been eliminated. I have become the only dedicated nursing advisor. This occurred as the ministry down-sized its staff, and clinical positions continued to be replaced by analysts or abolished.

### **Challenges facing the Chief Nurse**

No country is currently immune from the pressing concerns of losing skilled health workers through emigration and growing shortages of nursing personnel. Doctors in five countries recently ranked the shortage of nurses as a serious impediment to the provision of high-quality health care (Blendon et al., 2001). The Chief Nurse continually has to provide advice, direction and leadership on these issues to his/her government and ministry.

The Chief Nurses present at the Atlanta Chief Nursing Officer conference in 2001 were asked to identify the challenges facing them in their positions. The following is a summary of their main challenges (in no particular order):

- quality of care;
- financial resources;
- no representative at the national level or a strong nursing voice in health policy and planning;
- the impact of health sector reform on nursing services and nursing personnel;
- breaking barriers to working together, sustaining partners with national nursing associations;
- globalisation;
- the impact of education, recruitment and retention;
- the political environment; and
- developing a sustainable workforce to provide quality of care (Chief Nurses Conference Report, 2001, p. 3).

It is clear from this list that the Chief Nurses are describing the current issues facing nursing, and I found it validating to my experience in the role to have my international peers recognise the challenge of health reforms, the political environment, etc. It provided me with a sense of not being alone, despite the geographical isolation.

The report of this conference highlights the strategic level at which Chief Nurses are currently working, and demonstrates how, despite differences, there are common issues across international borders. It is also clear that the pursuit of answers and actions to these issues requires, as Sochalski (2000) puts it, “input from every branch of the profession: practice, administration, education, research, and policy” (p. 11).

The Chief Nurses functioning at this level with the influences previously described require a supportive structure. This supportive structure includes not just whatever exists within the ministries in which they are situated, but also the relationships they have with the nursing profession and the wider health community.

### **Conclusions**

The Chief Nurse provides a crucial link between the nursing and policy community and the government. It is a complex role, a mixture of professional advisor, leader and policy entrepreneur, and it is key to the implementation of government policy. The role

is specific to each country, but can be categorised as executive, advisory or dispersal. It is a role not without conflict, but which can provide enormous opportunities.

Through this role the Chief Nurse provides a perspective on health care in the policy arena, different to and wider than the bio-medical perspective. The Chief Nurse role brings a perspective of care and organisation that nurses every day provide to their clients. The role is wider than nursing; its influence affects public health.

Nursing around the globe is the largest workforce contributor to health care, and the services nurses provide not only affect quality of care, but also have financial and safety implications. Thus the nursing perspective provided by the Chief Nurses in policy gives a unique, consumer-focused angle on health care:

There can only be a single rational argument for the existence of a government Chief Nurse: that the nursing professional makes a major contribution to the health care of people and is therefore an integral and vital asset to the health care system (PAHO/WHO, 1996, p. 43).

## Chapter 6: The Ministerial Taskforce on Nursing: The Case

The establishment and operations of the Ministerial Taskforce on Nursing was selected as the case exemplar to study after formal consultation and consensus of an expert reference group. It was seen to be the most significant and complex event, in which nursing in New Zealand had been involved in several decades. This chapter outlines, in chronological order, the establishment and workings of the 1998 Ministerial Taskforce on Nursing from late 1997 to September 1998.<sup>8</sup>

### Establishment of the Ministerial Taskforce on Nursing

In the latter part of 1997, nursing groups were separately seeking audiences with the then Minister of Health, Honourable Bill English, to discuss their concerns. It was normal for any individual or group who wanted to see the Minister of Health to make appointments directly with the Minister's office. They would contact the Ministry of Health if any official (such as the Chief Nursing Advisor) was required. The concerns nursing groups were raising included a lack of ability to influence decision-making, staffing conditions, the marginalisation of unions through the Employment Contracts Act (ECA), consumers being unable to access services, and philosophical differences in the way nurses and management work. Sage et al. (2001), in research into hospital reform strategies in New Zealand, commented on how nurses and doctors were feeling "non-alignment" and how this "persistently limits their ability to deliver" (p. 9).

As the Chief Nursing Advisor I naturally became aware of nursing group's meeting and asking for appointments with the Minister of Health (often with no clear proposals to remedy their concerns). It became obvious from the conversations I was having that frustration was growing. From the time I took up my position in the Ministry in 1996 there had been ongoing tension between the nursing groups, partly in response to the upheaval and change in the health sector, and the issue of who to trust was apparent<sup>9</sup>.

In November 1997, after discussions with leaders of the various nursing organisations and with the Minister of Health, I called a meeting with all the national nursing organisations to discuss their concerns. The agenda was to have a discussion with all

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<sup>8</sup> See chapter 2 for a description of the method of collation.

<sup>9</sup> See chapter 4 page 47 for description of members of Taskforce.

nursing groups (together, in the same room) about what their issues were and their suggestions for change. This meeting, held at the Ministry of Health, was very much “off the record” and no minutes were taken (F. Hughes, Diary notes, November 1997). It was evident from chairing the meeting that there was tension among the groups, many of which had not worked collaboratively together for some time, and some even viewed each other as competition (for example, NZNO versus the College of Nurses and the Australian and New Zealand College of Mental Health Nurses). But there was a degree of desperation in taking advantage of getting attention from the government, and a need to try a different approach.

The outcome of the meeting was an expressed desire for a national focus on nursing through a committee or taskforce, given that individual organisational approaches to government had not been effective. It was proposed that a paper should be written defining the current problems and making suggestions on how to proceed. All the national nursing organisations agreed to seek a meeting with the Minister of Health to present and discuss this paper. The director of the College of Nurses, Jenny Carryer, agreed to draft the paper, organise another meeting with the same groups, and then invite the Minister of Health to a discussion.

After the November meeting, Jenny Carryer met with Bill English (Minister of Health in National [conservative] government) to discuss the concept of a high-level group being set up to tackle the nursing issues:

... when I met on my own with Bill, he said he would support a task force if I could pull all the nursing groups together and get their agreement to a task force. (J. Carryer, personal communication, 8 November 2001).

Over the period December 1997 to January 1998 a paper was written (by Jenny Carryer, with help of the Chief Nursing Advisor) entitled *Improving flexibility in the health sector labour market*. This set out the background issues and suggested a way forward. The language and writing style used were key to the paper’s ultimate success. Jenny Carryer and I worked closely together to ensure that the paper encapsulated the appropriate business language, including key policy terms, to ensure it would be of interest to the Government (“flexibility of workforce”, “effectiveness”, and “efficiency”). I advised Jenny that for the Government to be interested in a national approach the paper had to outline *why* the Government would want to intervene in a

market-driven economy. I used my knowledge of policy and central government, but I could not be seen to be writing the paper (as this paper was meant to be from nursing organisations, not from a government official). Jenny drafted the paper for the next meeting. The following is an excerpt:

There are strong theoretical grounds, as well as anecdotal evidence, to suggest that the health sector labour market is less flexible and less responsive to the needs of employers, employees and professionals, and consumers than desired in the context of current ways of viewing health care, ie labour market flexibility (J. Carryer, January 1998).

This paper became part of the paper presented to the Minister of Health entitled *A national strategy which supports nurses able to deliver flexible, responsive patient focused services* (J. Carryer, personal communication, January 1998). This paper was to be discussed with the Minister of Health on 30 January, when all nursing groups would meet (see Appendix 3). The main recommendation was the need for “The formation of a Ministerial Taskforce to recommend to the Minister of Health the actions required by government to support the evolving role of nurses” (Ministry of Health, 1998a, p. 2). The paper also outlined a possible composition, objectives, terms of reference for the group, and timelines. It was sent by Jenny Carryer on behalf of the group to the Minister of Health for the meeting on 30 January 1998.

On 30 January the Minister of Health met with representatives from all the national nursing organisations at the Ministry of Health in Wellington. The following key issues (which were in the paper) were identified by nursing representatives as barriers to efficiently utilising nursing, which in turn impeded their ability to deliver health care:

- historical barriers: nursing advice and research not being utilised;
  - training: lack of strategic direction, sustainable funding and barriers for students;
  - regulatory issues: outdated Nurses Act;
  - contracting issues: the way the HFA and ACC reimburse nurses.
- (Ministry of Health, 1998a, p. 2).

At the meeting it was verbally agreed by the Minister of Health that a nursing taskforce should be established to make progress towards resolving registered nurse workforce issues. Bill English agreed to consider nominations, and advised that he would appoint members and the chair. Interestingly, prior to the Minister’s arrival at the meeting, representatives had started to discuss membership of the taskforce. I advised the group

that I did not believe the Minister would agree to the group being solely representative of various organisations, as this would curtail his choice of individuals and we might not get the Taskforce off the ground. The representatives agreed between themselves that only two groups should be there by right: Maori and NZNO, and that this was *not* to be a representative group:

I advocated strongly to the representatives present that NZNO and Maori should be represented by right. Firstly as NZNO was the largest group and they would not agree to be part of any group where their dominance in NZ nursing was not recognised, and secondly Maori right under the Treaty of Waitangi to equal partnership (F. Hughes, Diary notes, 30 January 1998).

On 12 February 1998 the Minister of Health formally signed a briefing by the Ministry of Health agreeing to the establishment of a ministerial taskforce and the establishment of a secretariat (administrative and analytical staff, for which a budget would be provided). The Ministry clearly viewed the Taskforce as having the potential to “help reduce some of the resistance in the health sector to a more flexible and innovative health sector workforce” (Ministry of Health, 1998a, p. 3). There already existed in the Ministry a project on labour market flexibility (getting the current health workforce to do things differently), focusing on labour market efficiencies and on balancing the need for safety with the need for workforce flexibility (Ministry of Health, 1998a). An example of this was Philip Davies, a Ministry policy manager in 1997, who commented to an international review team that “we are looking to nurse prescribing where appropriate to improve access and reduce costs. In the longer term, more flexible labour markets might offer the possibility of greater responsiveness” (PriceWaterhouseCoopers, 1999, p. 37).

Nominations for the membership of the Taskforce came from all the nursing organisations, and the Ministry of Health. The Ministry in particular was required to provide names of non-nurses for the group, and also options for the chair. These were submitted to the Minister for consideration. The final selection was made by the Minister. I found this a difficult time: it was a fine balance between meeting the needs of the Ministry (which had a policy agenda of a flexible workforce), the Minister’s political agenda, and the agendas of nursing.

The objective of the Taskforce was:

To develop strategies for developing nursing practice to enable the nursing workforce to better meet the emerging needs for responsive, flexible, cost effective and collaborative services (Ministry of Health, 1998c, p. 2).

The membership of the Taskforce was approved by the Minister on 12 February 1998, and the following people were appointed from a range of nominations:

- Dame Anne Hercus, Chair;
  - Frances Hughes, Chief Nursing Advisor;
  - Judy Kilpatrick\*, Nursing Council of New Zealand;
  - Julie Martin\*, Manager, Nursing Services North Health (primary health care focus);
  - Brenda Wilson, Chief Executive Officer, NZNO;
  - Denise Wilson, Maori representative;
  - Dr Jenny Carryer\*, Professor of Nursing, Massey University.
  - Beth Coopers-Liversedge, Director of Nursing in a hospital;
  - Toni Ashton, Health Economist;
- (Ministry of Health, 1998c, p. 4).

\* Were also members of the ERG.

Dame Anne Hercus was a prominent statesperson in New Zealand, who was previously the New Zealand High Commissioner to the USA and an ex-Labour party Cabinet minister for police. She chaired the Taskforce until the end of June, when she was appointed as the head of UN peacekeeping for Cyprus, whereupon Toni Ashton took over as chair (vacancy created by Dame Anne was not filled). Judy Kilpatrick was a nursing leader with a long history in education, and was at the time chair of the Nursing Council of New Zealand. Julie Martin was a nurse with a primary health care and contracting background, who worked for the Health Funding Authority in Auckland. Brenda Wilson, representing NZNO, had been the Chief Executive Officer of NZNO since 1996 was previously CEO of the Asthma Foundation and had a long nursing history in Christchurch. Denise Wilson was representing Maori nurses and had a background of clinical work and education in nursing. Jenny Carryer was a long-standing nursing academic, and was Director of the College of Nurses. Beth Coopers-Liversedge was a director of nursing from a provincial hospital, with a history of leadership in clinical nursing. Toni Ashton was a nationally recognised health economist, academic and researcher from Auckland University. Only two members,

Brenda Wilson and Denise Wilson, were on the group as representatives; the others, despite their roles within other organisations, were there as individuals.

I felt pleased with the membership of the Taskforce. All individuals had credibility and had a collective wisdom about health and nursing. My only concern was how NZNO was going to function as a representative group with other members. To date they had not worked well with other nursing leaders and organisations. I knew it was a gamble, but without them we could not have had a Taskforce. The Minister made it clear to all the nursing groups that they had to be in agreement about having a Taskforce, which translated into having NZNO as a representative group.

The first meeting was held on 6 March 1998, and the Taskforce was due to report on 31 May 1998. Following the meeting the Minister of Health was briefed by the Chief Nurse and Ministry officials, and asked to consider refined terms of reference and an extension of the reporting date to 31 July 1998. The members of the Taskforce were clear that this report was forward-looking and future-focused, looking at barriers to utilisation, not a report on the status quo.

The Minister of Health agreed to the reporting date being changed to 31 July 1998, and to the refined terms of reference:

The objective of the Taskforce is to recommend strategies to remove the barriers, which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders (Ministry of Health, 1998c, p. 2).

This change in the terms of reference was so that the industrial issues and current state of play in nursing would not be the focus. It also fitted with the Government's agenda for a competitive environment and a need for a flexible workforce to deliver services differently. The terms of reference, right from the early meeting in January 1998, were aimed at being future focused and externally oriented. This was driven by the group members, and particularly the chair, Dame Ann Hercus, a seasoned politician.

### **The work of the Taskforce**

During March, April, May and June 1998 the Taskforce met monthly with frequent conference calls in between. The following consultation process occurred:

30,000 nurses were sent a one page questionnaire (via the nursing council data base) with a covering letter explaining the Terms of Reference of the Taskforce (1137 were returned)<sup>10</sup>.

Over 400 sector agencies were invited to make submissions to the Taskforce.

Consultation with key stakeholders through invitation to Taskforce meetings.

Consultation with Maori (through a series of national hui [meetings]).

Ten focus groups occurred with nurses throughout the country (Ministry of Health, 1998c, pp.10-11).

The above process was chosen so that the Taskforce could obtain as accurately as possible the views of the health and nursing community, reducing any criticism that a comprehensive consultation had not occurred. All questionnaires and submissions were analysed by Ministry analysts. The Taskforce members viewed all major written submissions. The issues raised through the consultation process were clustered into themes, which became the focus of the Taskforce analysis and final report. These were: expanding the scope of practice; access to funding, education and research; management and leadership; workforce resourcing; and issues for Maori.

The Taskforce met in April 1998 to review the initial analysis from the written submissions and the material from oral submissions. There was much debate and discussion. The Taskforce members agreed on key points of importance, and contracted writers were present to gather information to commence writing the first draft of the Taskforce's findings. In June 1998 a first draft was given to Taskforce members by the secretariat. This draft was very rough and members then worked through it to ensure it was an accurate reflection of the submission process. All members of the Taskforce commented on the drafts.

This was a key decision-making time for the Taskforce. The members needed to agree on strategies to address the issues and problems raised in the analysis. The Taskforce was not charged with simply reporting the problems, but with devising high-level integrated strategies to address them. During the lengthy discussions that took place many of us were conscious that strategies had to be delivered, and that this was not a time for wish-lists but a time when we had an opportunity to make a difference and should not waste it.

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<sup>10</sup> The relative low response rate was not surprising, that is why other methods were also used. It was important to survey all nurses, however.

The Taskforce report made 38 recommendations (see Appendix 4). “The Taskforce stresses that the issues raised in this report are multi-dimensional and interwoven. In turn, the strategies require a high degree of collaboration between agencies and professional groups” (Ministry of Health, 1998c, p. 15). The recommendations and strategies were aimed at 11 specific organisations: the Ministry of Health, Health Funding Authority, Ministry of Women’s Affairs, Clinical Training Agency (a division of the Health Funding Authority), Accident Rehabilitation and Compensation Insurance Corporation, Directors of Area Mental Health Services, Nursing Council of New Zealand, Health Research Council, Ministry of Education, New Zealand Insurance Council, and Nurse Executives and Nurse Educators of New Zealand.

It is not the purpose of this study to undertake an analysis of the content of the Taskforce report. It is, however, important to describe some of the main themes that came out in the report, as these are the issues that were to cause contention.

The report placed emphasis on the changing role of nurses and the need to address barriers. Many of the recommendations were aimed at improving the legislation that affects nursing practice, through supporting the Nursing Council of New Zealand to develop ongoing competencies and scopes of practice, including prescribing. As stated in Chapter 4, the issue of who should regulate nursing had been in contention between NZNO and the Government for some time. The fragmented approach to this through professional bodies had not been working:

Appropriate nursing competencies will need to be developed, validated and formally recognised for both on-going competency and specialist and advanced nursing. So that these competencies can be enforced, the Nursing Act 1977 must be amended to give enforcement powers to the Nursing Council (Ministry of Health, 1998c, p. 38).

The report also strongly advocated better access for nurses to funding for education and direct payment of services. It stressed that nurses need support to deliver what they are trained to do, and opportunities for professional clinical development. Advanced practice was strongly supported:

New nursing roles are needed that are not confined to the traditional community/hospital boundaries. Collaborative health-care service is hampered as requirements for advanced and specialist nursing have not been developed (Ministry of Health, 1998c, p. 27).

### **NZNO concerns about the Taskforce**

As a member of the Taskforce it became apparent after the first meeting that NZNO had concerns about some of the terms of reference: being restricted to registered nurses, not concentrating on working conditions, and being future-focused rather than acknowledging current nursing issues. The other members of the group took part in debates but did not have the concerns that NZNO did about the terms of reference or how the report was progressing. There was always an underlying tension in the meetings. NZNO was representing its members, while everyone else (except the Maori nurse) was there as an individual.

One example was the proposed idea of a funded fourth year of practice (at present it takes only three years of study to become a nurse). This would constitute a provisional registration year, which would function as a transition into practice before becoming registered as a nurse. NZNO raised concerns, but many of us in the Taskforce were unclear what these were based on. Comments from NZNO were:

This is not an approach that NZNO can endorse. It is neither supported by our current policies nor is it consistent with the spirit and intent of current policies (NZNO, correspondence to Taskforce members, 17 June 1998).

The rest of us on the Taskforce supported the concept of a fourth year of practice and viewed it as a transition process, with full registration as a nurse occurring at the end of that year. This was based on the analysis of the submissions.

In relation to the first draft, the following is a representative comment from NZNO:

In the document NZNO is seen as merely one organisation among several, we do not accept this perspective. The ordering of chapters is of serious concern. Is it safe to assume that workforces will cover everything to do with understaffing, skill mix, regulation or patient safety, and employment of unregulated caregivers (NZNO correspondence to Taskforce members, 23 June 1998).

Between drafts, constant amendments were made to accommodate feedback, but on 20 July 1998 NZNO CEO Brenda Wilson advised her executive and the Chair of the Taskforce that she was no longer part of the Taskforce, and that NZNO did not endorse the Taskforce report:

As Chief Executive Officer I have to confirm that I have today reluctantly refused to endorse the Ministerial Taskforce draft report. ... All agreed [listed those consulted within NZNO] that the draft report presented a distorted model

for nursing which failed to recognise the contribution of those in clinical practice and failed to acknowledge the models and options presented by NZNO to the Taskforce (Brenda Wilson, memorandum to NZNO board and sections, 20 July 1998).

Subsequent to this announcement, NZNO released a press release and the media became involved. NZNO's concerns in this release were that the Taskforce was too focused on education and advancement of nurses, and gave too much power to the Nursing Council:

... [the] report does not analyse, recognise or include the submissions made by a large number of individual nurses ... [it is] biased towards the Tertiary education sector and the Nursing Council of New Zealand having a monopoly on approval of nursing education programmes and standards. ... [The] report has a confrontational approach to the medical profession... not all skill development needs to be part of a postgraduate pathway (NZNO, 1998e).

In response to NZNO's media release, the new Chair of the Taskforce, Toni Ashton, stated that all nursing organisations needed to have a wider look at nursing, and released the following media statement:

The Ministerial Taskforce on Nursing has written to NZNO urging them to reconsider their decision to leave the Taskforce on the eve of its report back to the Minister. ... All members of the Taskforce have had to look outside the boundaries of their own organisations in the better interests of all nurses. This is the task we were asked to undertake and that we intended to deliver on (Toni Ashton, press release, 20 July 1998).

The Minister of Health, Bill English, also released a media statement, which stated that he was disappointed to learn that NZNO had withdrawn its support:

I am disappointed the Taskforce wasn't able to reach consensus, but equally I am sure that nurses would not want to see differences within the profession hold back progress in nursing in this country (Office of Minister of Health, media release, 20 July 1998).

Due to concern over NZNO's withdrawal, Bill English requested the Ministry secretariat to send out 100 embargoed copies of the report to key agencies and nursing leaders to get their feedback. All feedback was to go directly to the Minister's office. The feedback from those who read the embargoed copies was reported from the Minister's office to me to be overwhelmingly supportive of the report.

On 21 July 1998 Radio New Zealand's *Morning Report* interviewed both the Chair of the Taskforce, Toni Ashton, and Brenda Wilson, CEO of NZNO. The following is the

complete transcript, from the Newztel monitoring service (Radio New Zealand, 21 July 1998, pp.1-3).

**Presenter:** Well a major report on the future of nursing is being dismissed as inaccurate and unprofessional by a member of the Ministerial Taskforce which wrote it. The results of the first significant review of nursing in New Zealand for more than 15 years will be submitted to the Minister of Health later today. However one of the Taskforce members, the Nurses Organisation, claims the report is elitist and encourages nurses to compete with doctors. The nurses' organisation's Chief Executive is Brenda Wilson and Toni Ashton chairs the Taskforce... Brenda.

**Brenda Wilson:** We realise how important it is and representing 22,000 nurses as we do and being the professional organisation for nurses we take it very seriously. This is the first major report we have had on nursing for some 10 years. It's very important to us that it fully represents nursing's future vision and that it is very professionally presented and well argued because we know that many of the topics in this document are going to be carefully looked at by other people working in the health system and the report needs to articulate very clearly and be very well referenced and not have inaccuracies in it to ensure that any desires we have to move forward actually happen.

**Presenter:** Toni Ashton, could you respond to that. I mean – fairly damning things there, it's not professionally written, it's not representing the range of nursing views?

**Toni Ashton:** As far as I can gather Brenda seems to be referring to the draft report rather than the final report. The draft report was simply that, a draft, and such things as referencing were not tidy. The final report, which we submit to the minister this morning, looks considerably different. Secondly, I must emphasise that the taskforce had a very wide consultation process in order to ensure as many nurses completed questionnaires. We have consulted or we asked for key stakeholders and we have held 16 Hui and focus groups throughout New Zealand. The nurses' organisation has been a complete and integral part of that process and so our report represents all of those voices.

**Presenter:** Brenda Wilson that seems like a fairly strong answer to your comments. This is just a draft, what's the point of condemning a draft and undermining perhaps the efficacy of the final report?

**Wilson:** Well I don't know where... how you get a final report if you don't have a draft which you work on.

**Presenter:** But the issue of referencing, Toni Ashton has said that will be in the final report, so why can't you wait until that comes out and then see if it doesn't measure up to your expectations?

**Wilson:** Oh there is substantial changes in the draft that we required. This was the second draft. The first draft was produced for us and delivered to us on the

22nd of June requiring a meeting that was supposed to be a sign off on the 23rd June we received an extension. Three weeks later we received the second draft. We received it on the 10th July requiring feedback by the 13th July.

**Presenter:** That doesn't seem a very long time, Toni Ashton, do you think that is realistic in retrospect?

**Ashton:** Brenda has been at the table with the Taskforce five months and has been an integral part of this process. So it's not as if this suddenly appeared out of the blue. Indeed she was invited and has contributed and written some of the sections of this report. It has been a tight timeframe, I agree, but we have tried to consult as I say with as many groups as possible and certainly the nurses organisation is one of those groups who has been privy to the whole process.

**Presenter:** That's Toni Ashton, and Brenda Wilson.

Ends

After the media commentary on 30 July, NZNO made a public position statement entitled *The Ministerial Taskforce on Nursing*. NZNO comments included concerns about the membership of Taskforce, the time frame to complete work, the quality of drafts, the emphasis on nursing education and the role of the Nursing Council of New Zealand. The following are extracts from it:

There were always problems with the Taskforce process. The timeframe was rushed; the terms of reference were set behind closed doors and there was no open process for members to be appointed. The first draft specifically attacked NZNO, didn't reflect the submissions and was poorly written. There was no process to resolve policy issues between the first and second drafts. When we received the second draft we had serious policy concerns about the recommendations, which appeared for the first time. It also contained the same inflammatory material about NZNO. We asked for more time to allow the issues to be addressed. The Taskforce rejected these proposals, said it wouldn't make major changes and couldn't give us more time. It was at this point that NZNO refused to endorse the second draft of the report on 21 July 1998. The remaining members of the Taskforce decided to go forward and present the report to the minister without NZNO endorsement. We continued to have discussions with the Taskforce but they have consistently refused to make changes or to agree to reasonable process to deal with NZNO's concerns.

Our major concerns are:

- increased role and function of the Nursing Council; regulation of specialist practice; develop and control and enforcement of competencies for advanced practice;
- profession should set its own standards; NZNO sections and colleges are an appropriate national structure for this;
- reliance on master's level education; costs are prohibitive for nurses;

- report uses a flawed model ...[the] Nursing Council adds nothing to the equation (NZNO, 1998e, pp. 1-2).

On 30 July 1998 NZNO Chief Executive Brenda Wilson wrote to all CEOs of public hospitals about the Taskforce. In this letter she stated:

As you may have heard the NZNO has refused to endorse the report of the Ministerial Taskforce on Nursing. The recommendations of the Taskforce have a direct relation to the role, funding and development of nursing in all health and disability services. I am writing to inform you about our concerns with the report, which propose a retrograde and rigid model for nursing practice [referring to the Nursing Council developing competencies ] (NZNO correspondence, 30 July 1998).

The Taskforce presented the report to the Minister on 31 July 1998 and it was launched (made public) on 20 August 1998 by Bill English at Hutt Hospital district nursing base.

The Taskforce report does not have an executive summary, but in the preface of the final report the two Chairs (Hercus and Ashton) wrote:

The NZNO is the largest nursing organisation in New Zealand. This does not mean that it is the only organisation that can represent nurses. The unwillingness of the NZNO to join consensus in forward-looking recommendations is, in the Taskforce's view, itself a major barrier to progress for nursing practice of the NZNO... We urge nurses to read the report and to judge it on its own merits. (Ministry of Health, 1998c, p. 5).

Over the next weeks and months there was a public airing of views on the report in both the public and nursing media. Headlines included "Welcome tonic for health system" (*Nelson Mail*, 21 August 1998); "Nurses urged to consider Taskforce ideas" (*Nelson Mail*, 22 August 1998); "Union says they were shut out in talks" (*Dominion*, 22 August 1998); and "Nurses group to boycott govt report launch" (NZPA, 19 August 1998).

The media portrayed the Taskforce work as nurses not knowing what they wanted. "The public was constantly seeing nurses bickering in public" (Wood & Papps, 2001, p.110).

The Director of the College of Nurses, Jenny Carryer, a member of the Taskforce herself, wrote a letter to nurses (viewed as an unusual move), which was distributed throughout services in the country. In this letter she stated:

I am deeply concerned about the way forward for nursing as a result of the events of recent weeks associated with the Ministerial Taskforce. I think we have experienced the surfacing of a fairly fundamental philosophical division which must be healed if we're to progress ... [the] NZNO rejection was a

fundamental difference of opinion about who and what nursing is and how nurses should be prepared ... it is not going to be easy for other nursing groups to work trustingly with the NZNO again, yet collaboration is vital if we are to move forward (J. Carryer, correspondence, 11 August 1998).

In late August, after an Official Information Act request by NZNO on 20 July, the Ministry of Health released to NZNO 1,137 individual submissions, 60 group submissions, all working papers and the Ministry's analysis of barriers and strategies identified in submissions (Ministry of Health, 1998c, p. 2). The Ministry of Health was not contacted again by NZNO regarding this information.

The commentary generated from the events of the Ministerial Taskforce on Nursing spread beyond the public and nursing media. In September 1998 the *New Zealand Medical Journal* dedicated its editorial to the Taskforce. Its headline read "Two professions share misgivings". The editorial goes on to discuss NZNO's rationale for withdrawing from the Taskforce, and asks its members, "Can you imagine how much confidence doctors would have in a report for a ministerial-appointed Taskforce on medicine if the NZMA rejected it?" (Editorial, 1998a, p. 2). This comment by the main professional medical body in New Zealand is important as we move on to analyse these events from a policy perspective.

The Taskforce was disbanded by the Minister of Health on 11 September 1998, and the responsibility for implementing the Taskforce recommendations was passed to the Ministry of Health through the Chief Nursing Advisor. No resources, either personnel or financial, were provided for its implementation. This did not surprise me as the Ministry of Health had not received any extra funds from Government.

## **Chapter 7: Analysis of the Case**

This chapter analyses the establishment and work of the 1998 Ministerial Taskforce on Nursing using the agenda-setting and policy formation theories of Kingdon (1995), and Cohen et al.'s (1996) framework of stages of the political development of nursing. In Chapters 2 and 4 an outline of the analytical framework using Kingdon and Cohen was described. It may be helpful, however, to briefly delineate the relationship of policy and political analysis to this case. A rigid framework was not applied, but elements of both forms of analysis were used.

Policy analysis was described in Chapter 3. It involves a structured approach to problem solving and decision-making. Political analysis is also structured, in that it includes a number of steps, commencing with identifying problems (similar to policy analysis), but it moves on to an analysis of stakeholders, values and the political settings and structures involved, all of which have been discussed previously in relation to this case (Gerston, 1997; Leavitt, Cohen & Mason, 2002; Litman & Robins, 1997; Stephenson, 1995).

The earlier chapters set the scene for this analysis by providing a background of the political structures and context, and the use of Kingdon's (1995) streams. They clearly outline why a Ministerial Taskforce on Nursing warranted government attention. The analysis in this chapter captures the political and policy context. Terms like "coupling", "bandwagon", "coalition building" and "interest groups" are all familiar in the political arenas, and they are used to help frame the analysis in this chapter.

Policy and political analysis often occur simultaneously, using elements from both. Leavitt, Cohen & Mason (2002) suggest how these two analytical processes should actually be carried out simultaneously, and describe the demise of President Clinton's health reforms in the early 1990s as an example of where this did not occur.

In establishing the facts of the case (as outlined in Chapter 6), problems/issues were identified, the background was explored, and questions will be asked as to how these related to Kingdon's (1995) and Cohen et al.'s (1996) theories and stages. This chapter uses this lens in its analysis. Key areas of the analysis have formed the sub-headings.

Chapter 8 then offers ways forward, which in policy analysis terms would be classed as developing options.

### **Agenda-setting (pre-Taskforce)**

In the months and years leading up to the 1998 Ministerial Taskforce on Nursing, nursing organisations in New Zealand were feeling intense pressure to speak out on behalf of their members about the impact of the health restructuring and reforms (Gunn, 1997; Oliver, 1996). Not only were nurses speaking out but physicians were also publicly commenting on nursing. The *Timaru Herald* stated: “Nurses under incredible burden. Funding cuts and health reforms have placed an incredible burden on Timaru Hospital nurses, hospital consultant Physician Dr John Doran said yesterday” (Fox, 1998, p. 3).

Until the latter part of 1998 the various nursing organisations, including NZNO, had been unsuccessful in getting their issues and problems on to the Government’s agenda. The new contracting mechanisms that had developed to purchase health services, abolishment of national collectives for employees (nurses), combined with many new health providers now in the sector meant that NZNO attributed this difficulty to “Fragmentation within the health sector [which] has made it difficult to obtain generalised advances in our work with government and its agencies” (NZNO, 1998a, p. 4).

NZNO in particular had made it very apparent that it did not feel supported by the National government that was in power:

July 1 [1997] is the fourth birthday of the government reforms: conceived in a hasty and unhealthy liaison between youthful Minister of Health Simon Upton and a gang of New Right wing ideologues. ... There was an understudy in the form of Bill English ... [who] became Minister of CHEs and now is Minister of Health ... this birthday is hardly worth celebrating (O’Connor, 1997, p. 2).

Nursing organisations themselves were not working well together and had not done so for many years. This was particularly apparent in the relationship between NZNO and the College of Nurses. Until the establishment of the College of Nurses and the New Zealand branch of the Australian and New Zealand College of Mental Health Nurses, there was no choice of a professional organisation for a nurse. As president of a nursing organisation during this time I remember many times when the relationship between

NZNO and the College of Nurses was demonstrably strained. This included going to meetings at which members of the executive of NZNO would walk out of if members of other organisations attended.

This was a time of fragmentation and disorganisation of nursing as a political force due to the restructuring that had occurred in the health sector<sup>11</sup>. Nursing was so disillusioned, injured and demoralised that it was difficult to build energy for any activism. Nursing had been worn down. Sadly, most of the media coverage on nursing reported reaction rather than proactivity. Brenda Wilson CEO of NZNO stated:

... nurses have borne the brunt of the efficiencies already made. Every nurse working in the public system has gone the extra mile, worked extra time at the end of their shift, gone out of their way to ensure patients don't suffer too much (Wilson, 1997, p. 8).

D. M. Wilson's (2002) study on the political action undertaken by nurses and non-nurses in the US describes how, often, "Nurses are often thought of as an apolitical group. If this were true, nurses around the world would be unconcerned about the many health and social-sector changes influencing health care and nursing practice" (p. 30). Nurses in New Zealand during the 1990s were concerned about health changes, but were also viewed as apolitical (unable to bring about change).

Nursing organisations only met together formally to discuss strategic nursing issues if this was organised by the Chief Nursing Advisor. This had occurred only twice in the previous year (1996) (F. Hughes, Diary notes, September 1997). Distrust was always high even when this occurred, as many of the newer organisations were dissatisfied with the lack of professional leadership from NZNO, which had more resources, and NZNO saw many of these organisations as competing for their membership.

As outlined in Chapter 4, Cohen et al. (1996, p. 260) provide an interesting commentary on the political development within nursing in the US. Through the lens of these stages a useful insight can be gained into this period of New Zealand nursing's political development. Cohen et al. define four stages of political development (see Figure 3): stage 1 (buy in) encompasses activities that encourage and promote the political awareness of nurses; in stage 2 the profession develops its identity, and self-interest is

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<sup>11</sup> See Chapter 3 for detail discussion on these issues.

the focus; in stage 3 nursing develops more complex and sophisticated methods of political activism; and, finally, in stage 4 nurses become the initiators of crucial health policy ideas. New Zealand nursing organisations in early 1997 would not have even been in stage 2, as there was no coalition building occurring between organisations. During this time, within organisations there was a definite political awareness of the issues and problems, but very little problem solving with other nursing organisations on ways forward, and little in the way of solutions to offer government. Individual nurses were profiled during this time, more for their own accomplishments than for representing nursing organisations. An example was the appointment of a nurse to the Minister's staff as a health advisor. This person did not, however, identify herself as a nurse nor have any involvement or relationship with the nursing sector. This demonstrates how, collectively, nurses were at stage 1 even if individually nurses were at higher stages.

In Chapter 3 the health care environment in New Zealand was described, and in particular the effects of health care restructuring. During this time many events occurring in the health sector began to suggest that the market environment of health was in difficulty. For nurses, the Canterbury Hospital Inquiry (see Chapter 3, p. 34) was a critical event. Here for the first time a key government watchdog, the Health and Disability Commissioner, was saying the same things – that nursing conditions were causing safety and quality issues in hospitals: “The drive for financial efficiencies has endangered standards of care by undermining acceptable standards of staffing and staffing practices” (Stent, 1998, p. 26). These events had the effect of galvanising nursing, and nursing organisations started to focus on these issues and develop a common agenda.

NZNO began to comment frequently about the health environment that nurses were working in:

This environment has major impacts on nursing in the areas of: career development and education provision, a lack of national standards of care and treatment in many areas. Pay and conditions of employment, recruitment and retention of skilled practitioners, leading to a recent fall in the number of RN's (sic) [registered nurses] in practice. The lack of workforce planning, consequent shortages of personnel, and need to import expertise (sic). Insufficient management and leadership for nurses, a high level of concern regarding standards of patient safety, lack of support for the development of advanced and

specialty roles, insufficient support for beginning practitioners in the workplace (NZNO, 1998a, p. 12).

NZNO as an organisation was now displaying the characteristics of stage 2 (self-interest) of Cohen et al.'s framework of political development. It was reactive to nursing issues and using its political expertise to advocate for issues. The development of NZNO through the stages reflects Mason et al.'s (2002) description (see Chapter 4) of changes in nursing as a political activity. NZNO was transferring its learning from the workplace sphere through into the government sphere: in other words, it was learning to play hard ball. As NZNO undertook such activity, it developed politically. The Government and officials were now beginning to pay attention; the time was right for solutions to be developed for current problems.

Kingdon (1995) describes the issues being raised in policy, political and problem streams as contributing to policy formation, which is the "process by which public policy is formed" (p. 230). The importance of these streams occurs when they come together, which then opens the policy "window" for them to become significant agenda items.

In the latter part of 1997, problem and political streams were developing, through health issues and nursing. The problem stream was influenced by the Canterbury Inquiry, and nursing organisations continually seeking audiences with officials and the Minister, about staffing and patient safety. This demonstrated that nursing (particularly NZNO) was at Cohen et al.'s stage 2. The political stream (as previously described in Chapter 4) can be composed of such things as public mood and pressure groups. At this time the public was becoming more disgruntled, there had been electoral reform, the current government was planning how they would market themselves for the elections in 1999, and the unions were planning campaigns to oust the government:

For so long NZNO has been a voice crying in the wilderness but now other nursing groups and the public are realising the extent of the damage to our public health system and the need to preserve it... health has emerged as the issue which will decide the fate of the government (O'Connor, 1997/98, p. 26).

I was well aware of this mounting tension: "NZNO feels they are not being listened to no matter how often they see the minister, they have little patience" (F. Hughes, Diary notes, November 1997). The Chief Nursing Advisor was now continually strategising

between the nursing organisations and the Government, attempting to find a solution to the frustration that was occurring on all sides. The role the Chief Nurse was playing was one described by Kingdon (1995) as that of “policy entrepreneur”.

### **The development of policy entrepreneur**

The policy entrepreneur has a critical role in “softening” the environment (Kingdon, 1995). Through the process of feeding in ideas, getting people “warmed up” and building acceptance to an idea, the policy entrepreneur – in this case the Chief Nursing Advisor – paves the way for ideas to gain acceptance as options to government issues. Other groups may hold different views if their needs are not being met by the intercession of the policy entrepreneur.

During this time the Minister of Health was showing a strategic interest in the health workforce, which included (but was not limited to) nursing. The Ministry of Health was responsible for delivering on key Government workforce objectives, one of which was to increase flexibility. The Government wanted greater flexibility within the workforce, to create greater productivity and gain more efficiency (The philosophical underpinnings have already been discussed in chapter 3). This meant expanding the scope of nurses and other professional groups, stopping restrictive trade practices, and encouraging multi-skilling:

There are strong theoretical grounds, as well as anecdotal evidence, to suggest that the health sector labour market is less flexible and less responsive than other markets (de Raad, 1998, p. 2).

The Minister and Minister’s office staff were also requesting that the Chief Nursing Advisor attend meetings with them to provide advice on nursing issues that were coming to their attention.

Opportunities were starting to arise and the entrepreneurial capacity of the Chief Nursing Advisor was beginning to emerge. I started to see that the work of the Ministry and the concerns of the nursing organisations were not dissimilar. The Ministry wanted greater flexibility and productivity out of the workforce and had concerns about safety and quality issues. The majority of nursing organisations wanted increased visibility, input into decision-making, and improved working conditions for nurses. I had also

started to raise the notion of a ministerial taskforce on nursing to the attention of the Minister, through private conversations and also in a formal briefing in early 1998:

The concept of a nursing taskforce coincides with and complements projects currently underway in the ministry. If carefully tasked the taskforce has the potential to help reduce some of the resistance in the health sector to more flexible and innovative forms of labour. Nursing organisations have been concerned for some time about the perceived inefficient utilisation of the forty thousand registered nurses (Ministry of Health, 1998a, p.2).

As Chief Nursing Advisor I worked both internally and externally in an attempt to raise consciousness of areas of commonality. Oliver & Paul-Shaheen (1997) describe how policy entrepreneurs “help seize the moment... they grasp when the occasion is politically at hand... [and] also determine precisely what policy alternatives are advantaged and then communicate both aspects persuasively to other responsible political actors” (p. 745).

I was sowing the seed with nursing organisations and the Ministry that a national approach could meet the objectives of all, and that it could be a “win-win” situation for current problems in policy, politics and nursing. As Chief Nursing Advisor I also took on the role of what Kingdon (1995, p. 165) describes as “the surfer”, waiting for the “wave”, positioning, connecting and coupling events to achieve an objective or goal. My goal was to achieve a national work plan to more effectively align nursing to Government policy. This is reflected in the job description of the Chief Nursing Advisor:

The chief advisor’s role provides the link between the Ministry’s role of policy advice, monitoring and Ministerial servicing and the sector (health). They contribute to the main functions of the Ministry by:

- Provide early warning of emerging issues, and a reality check for new work, through the development of strong relationships with key stakeholders;
- Provide and help obtain expert technical advice and sector scanning for policy development;
- Assist with alignment of government policy to the health sector

(F. Hughes, job description, 1996).

But the entrepreneurial role I was undertaking was not just part of the job; it was part of who I am. Kingdon (1995) describes the qualities of the policy entrepreneur:

First they have a claim of a hearing through expertise, leadership; secondly the person has political connections or negotiating skills; thirdly, and most

importantly, they are persistent, they spend time thinking, writing papers, they spend a great deal of one's own resource (pp. 180-181).

Despite the fact that Kingdon's role of policy entrepreneur was formulated predominantly on a position outside of government, he does include civil servants. I accept there are clear differences in the way the entrepreneur can function depending on whether they are inside or outside of government, but the qualities of the individuals are similar (this will be discussed in more detail in Chapter 8). A government employee (as discussed in Chapter 5) must be loyal to government policy, and this constrains many activities that one would normally envisage as entrepreneurial. As a nurse and a public servant this creates tension, this will be discussed later in Chapter 8. I have no doubt that my ability to communicate and "wheel and deal" between and with the government and nursing groups maximised the opportunity when the policy window opened and a national approach in the form of the Taskforce was selected as the way forward.

The Chief Nurse Advisor can function as a policy entrepreneur, and may show the strengths of a visionary leader. A visionary leader is one "who remains simultaneously tenacious and decisive, as well as caring and flexible" (Christopher, Miller, Beck & Toughill, 2002, p. 698). Bennis (1991, p. 13) has identified four basic dimensions as contributing to this aspect: "management of attention, of meaning, of trust and of self".

*Management of attention* is defined as the "ability to focus on the vision, even in times of uncertainty" (p. 13). I worked within a complex political environment: the health system was suffering from reform fatigue and both the health sector and Government were looking for answers. The vision, however, prevailed: effective utilisation of nurses and a strategic national strategy were needed. *Management of meaning* relates to the ability to communicate. I demonstrated this at all levels, between individuals, groups and Ministers. *Management of trust* describes the ability to ensure all stakeholders are involved, and collaborators stay involved over time. I ensured that all national nursing organisations were involved in the decision-making of the establishment of the Ministerial Taskforce on Nursing, and actively worked with stakeholders (including the Government) to ensure that the purpose of the Taskforce was not lost. I also ensured that the Taskforce's recommendations were still part of the Government's agenda in 2002 (see Chapter 9). Mine was mainly a "back room" role, to avoid becoming the

focus, which would have detracted from the vision. Finally, *management of self* involves the Chief Nursing Advisor being sensitive to her own strengths and weaknesses. This was demonstrated in walking the fine line between being a public servant and being a nurse.

As a result of personal meetings with the Minister of Health by senior members of nursing organisations and the Director of the College of Nurses (Aotearoa), NZNO's raising safety issues, the behind-the-scenes work of the Chief Nursing Advisor, and the ongoing inquiry of the Health and Disability Commissioner, the profile of nursing and safety concerns was very high. The Government was looking for ways to address the concerns from all of these stakeholders, for solutions to a problem that was not going away. A coming together of problems, policy, politics and solutions was occurring.

### **Policy streams**

Kingdon (1995) attributes this development of problems and solutions to Cohen et al.'s (1972) "garbage can model", which describes the policy process as a series of options floating around seeking a problem. Kingdon describes this floating around of the various policy streams as the "policy primeval soup," out of which problems, policies and politics start to come together.

For many years the agenda and the agenda-setting of the National Government in New Zealand, with its market philosophy, took a "hands-off" approach to the health workforce (de Raad, 1998). With the mounting nursing and health safety problems, a need for change in policy and the next election only 18 months away, the time was right for looking at things differently. The Minister of Health, Hon Bill English, commented that he himself had been thinking of establishing a nursing taskforce:

The profession has felt pushed around over the last few years, and has suffered from low morale. The profession sought my [Bill English's] support to establish such a taskforce and I was in fact thinking along fairly similar lines (O'Connor, 1998, p. 10).

The establishment of a taskforce was not the only option for the Government. When policy options are developed they range from the status quo (do nothing), to a variety of other suggestions. In this case the main options offered to the Minister (apart from establishing a taskforce) were: (1) requesting the Nursing Council of New Zealand to undertake a review (this would have met with hostility from NZNO, which already had

concerns about the powers of the regulatory body); or (2) a cluster of one-off interventions with targeted funding, piloting staffing systems, etc.

The issues that any government faces in this situation are: What are the benefits to the government? and What are the political and fiscal costs involved? A taskforce was a relatively safe option, because: it showed Government concern. Moreover, all the nursing groups agreed to it, it gave the Government breathing space, and cost very little money (final cost of Taskforce was around \$100,00). When the Taskforce had completed its work, the Government could choose whether to agree or disagree with the recommendations, and could even distance itself from it by asking the Ministry of Health to analyse it and advise.

### **Setting the agenda**

Kingdon's (1995) theory on policymaking involves a set of processes, including:

- (1) the setting of the agenda, (2) the specification of alternatives from which a choice is to be made, (3) an authoritative choice around those specific alternatives, as in a legislative vote or presidential decision, and (4) the implementation of the decision (pp. 2-3).

The agenda is "the list of subjects or problems to which government officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time" (p 3). Agenda-setting also refers to the process of narrowing a set of problems, which then become the focus of attention for policy makers and government.

Kingdon describes how items can go up and down the agenda, and how there is usually not one single factor but several. "Coupling" helps to push things up the agenda. In this study the factors include nursing discontent, public safety concerns, reform fatigue by the general public, and the Government needing to build their electoral support to go into the 1999 elections under a new system.

### **Coupling**

Kingdon describes the concept of "coupling" (p.175) as being when the government is looking for a solution to a problem or a political event, so the likelihood of adopting solutions and putting them on their agenda is higher if the potential solution helps to deal ("couples") with the problem. Coupling is not a process of manipulation of the

agenda *per se*, but more a process of assisting the items to gain more attention. It is usually a short-term strategy, as items on an agenda (as discussed in Chapter 4) are often unpredictable, but a strategy that can be used frequently. According to this concept, there are very few single-factor explanations for high placement on government agendas. Thus the creation of a Ministerial Taskforce on Nursing could have been a solution to many political concerns about health care, as the carefully chosen language of the following briefing to the Minister of Health from the Chief Nursing Advisor illustrates:

The development of a Nursing Taskforce coincides with and complements projects currently underway in the Ministry on labour market flexibility, nurse prescribing, integrated care, we need to deliver on the strengthening families and Child Health Strategy, service delivery gaps could be filled by the efficient utilisation of nurses (Ministry of Health, 1998a, p.3).

The political aim for which the Taskforce was a solution could have been to silence the nursing community, or it could have just been luck that it was to do with nursing. But the danger of coupling is that there is unpredictability and an inability to control events once they are set in motion. Opportunities for coupling need to be carefully analysed, and a quick response is often required so the opportunity does not pass. In this case there was an element of what Oliver & Paul-Shaheen (1997, p. 745) describe as “seizing the moment” by the Chief Nursing Advisor and leaders of the nursing organisations, as a result of the opportunities that were opening up to get the Government’s attention. The need for a nursing Taskforce became a solution not only to political issues but also to nursing and policy.

A situation now existed whereby Government and nursing were aligned. The Taskforce was becoming an option high on the Government’s agenda, but all players had a different rationale for wanting it and different ideas as to what it could achieve. I believe this was at the root of why, in July 1998, NZNO walked out of the Taskforce. NZNO helped to create the option of the Taskforce then lost control of the process.

Nursing leaders and organisations were coupling problems and solutions through their activities. It was also becoming apparent that there were many different views on what the Taskforce was going to achieve. For example, the College of Nurses wanted the Taskforce to address nursing education problems, such as access to advanced-practice

programmes. Jenny Carryer, Director of the College of Nurses (Aotearoa), has reflected how the Taskforce started to become a real option for the nursing organisations in January 1998, and the College wanted access to education and nursing autonomy addressed (J. Carryer, personal communication, 8 November 2001).

NZNO wanted the Taskforce to “face up to the issues of poor working conditions, but Wilson said NZNO was not expecting any dramatic changes in how nursing was practised because of the taskforce” (O’Connor, 1998, p. 10). At the same time Bill English stated that he wanted to see “greater flexibility which will match skills needed” (O’Connor, 1998, p. 10). The Minister of Health, in another media statement, clearly articulated that the Taskforce would not specifically tackle nurses’ concerns about staffing levels, workloads or pay:

These were industrial issues and the taskforce brief was to look at professional matters. During the 1990s nursing had suffered from low morale but it is now taking another step. The government would take serious notice of the taskforce recommendations (Vasil, 1998, p. 2).

The concept of coupling provides valuable insight into the processes that surrounded the Ministerial Taskforce on Nursing once it was established. Could it have been the mere fact that there were so many agendas and conflicting purposes from nursing groups and government for the establishment of the Taskforce that ultimately led to friction, and made an eventual walkout of NZNO in July 1998 inevitable? Or was it that NZNO left because they could not “couple” and could not get their agenda delivered?

Kingdon (1995, p. 178) warns that “[lobbyists] need to ask themselves before latching on [to solutions to policy, politics and problems] whether they risk setting in motion an unmanageable chain of events that might produce a result not to their liking.” Another term Kingdon uses for this phenomenon of latching on is joining the “bandwagon.”

### **Bandwagons**

Why do some organisations decide to support or get involved with others over certain policy processes? Understanding the concept of bandwagons offers insight into this process, and why the Taskforce in this case study was established. The term “bandwagon” is intuitively appealing, as we can all visualise a wagon moving along, literally picking up people as it goes, and this is what Kingdon’s concept is about. As interest grows in a certain option or solution to a problem, groups that previously were

not interested start to join up “out of fear of being excluded from participation in the goodies to be obtained” (Kingdon, 1995, p. 141).

The establishment of coalitions between the nursing organisations may have been an instance of groups getting on the bandwagon in their own self-interest, not of forming coalitions as instances of stage 2 of the Cohen et al. (1996) framework. (I will discuss a suggested amendment to Cohen et al.’s framework in Chapter 8.) NZNO’s rationale for joining may well have been based on not wanting to be seen to be missing out – wanting to “fly the union flag”, so to speak.

NZNO’s definition of the problem was different from that of other groups: as a union, working conditions and jobs for their members were very important. Brenda Wilson, the NZNO CEO, made the following comments in the NZNO journal:

NZNO wanted to see some real initiatives regarding the health workforce. These would include a national system of stating ratios linked to patient acuity. My fear is that there would be an attempt to minimise the substantial contribution of NZNO (“Nursing taskforce report”, 1998, p. 8).

Another example of this came later, when NZNO had publicly denounced the Taskforce (NZNO also wrote an alternative report discussed on page 112). Brenda Wilson wrote the following in an editorial in the NZNO journal:

We are this country’s largest professional nursing organisation. We represent the professional and employment aspirations of 22,000 registered nurses. No other taskforce representative can claim that mandate. NZNO has major difficulties with the expanded role of the Nursing Council. It is the voice of nurses in practice which must be heard if the profession is to advance. It is to remain true to the aspirations of nurses in clinical practice the NZNO has made its decision [to withdraw from the taskforce] (Wilson, 1998, p. 2).

The New Zealand Medical Association also jumped on the same bandwagon. In previous months the NZMA had been vocally questioning why the Government had been giving attention to nursing through the establishment of the Taskforce. The following comments were made in the New Zealand Medical Association newsletter:

Memory fails when I try and remember the last time a Minister of Health chose to make such an announcement while being flanked by representatives of the medical profession. Perhaps doctors are not politically correct. I have heard the cynical suggestions that nurses – with over 60,000 predominantly female members – have greater political appeal to women voters, but I can’t believe that

a Minister would play around with a health system just to attract women votes (Editorial, 1998d, p. 4).

When NZNO first went public about their withdrawn support, the NZMA took advantage of this and supported NZNO in discrediting the Taskforce with an editorial in the NZMA newsletter entitled “Two professions share misgivings”:

The Taskforce wants nurses to have much more than prescribing rights e.g. access to laboratories and diagnostic tests, specialist referrals and ACC payments. It endorses Ministry proposals for changes in nursing about which NZNO has major reservations....The tendency to marginalise and exclude nurses in practice is a central problem with this report.... can you imagine how much confidence doctors would have in a Report from a Ministerially appointed Taskforce on Medicine if the NZMA rejected it (Editorial, 1998a, p.1).

Through the processes of softening, coupling and bandwagons the window of opportunity was open for the agenda of a national approach to nursing issues to become the agenda set by government. For complex reasons, the problems, politics and policy streams were lined up and the idea of a taskforce was a good option for a government with a problem.

### **Coalition building**

Ironically, through the process of separately attempting to draw attention to the plight of nurses and nursing, the nursing organisations started to move closer together. This occurred as the policy entrepreneurial activities of the Chief Nursing Advisor and other nurse leaders started to take effect. Cohen et al.’s stage 2 was starting to develop. In this stage, groups begin to react to nursing issues and focus inwardly on the profession’s interests, and coalition building starts to occur among nursing organisations. It had taken the nurses’ frustration with different barriers to their practice (staffing, education etc.) becoming serious enough for the nursing organisations to realise they needed to work together:

Internationally, the nursing workforce has faced increasing stress and pressure in recent years. This often results in nurses feeling undervalued and dissatisfied. These sentiments were expressed to the Taskforce in submissions received from individual nurses (Ministry of Health, 1998c, p.75).

Nursing organisations were realising that a different approach was needed because they were getting nowhere with current strategies. The Minister of Health made it clear to the Chief Nursing Advisor that if he was to consider a national approach then all (nursing) groups had to support it (F. Hughes, Diary notes, November 1997).

Cohen et al. (1996) describe how nursing is able to straddle more than one development phase at a time. As shown previously, we have nursing groups on the one hand agreeing to work together, and on the other pushing their own agendas, as NZNO did with staffing and work conditions, and as the College of Nurses (Aotearoa) did in pushing education. The New Zealand nursing organisations at this time were oscillating between stages 1 and 2 of the framework with regard to coalition building. They had political awareness and their self-interest was strong, but they were also coming together in wanting to raise nursing issues.

Coalition building in stage 1 is characterised by occasional participation in coalitions, while stage 2 shows the development of coalitions forming among nursing organisations where “whatever the differences among these organisations and despite conflicts over competition and the claiming of credit, the ability to forge coalitions and compromises symbolises a new level of maturity for the profession” (Cohen et al., 1996, p. 261).

By 1998 New Zealand nursing had reached a new level of maturity. Through the problems in health services, nursing staffing and conditions, the political need to have greater flexibility in the health workforce (the largest component being nursing), New Zealand nursing had come together. In January 1998 they, aided by the persistence and strategising of the Chief Nursing Advisor and the Director of the College of Nurses, managed to get agreement from the Minister of Health that a ministerial taskforce on nursing would become a Government priority. It could be argued that through this process they had not only moved into stage 2 of Cohen et al.’s political stages of development, but also displayed characteristics of stages 3 and some aspects of stage 4.

Stage 3 is political sophistication. Nursing organisations and individuals that have reached this stage are proactive on nursing and health issues, are still building coalitions with other nursing groups, and are commonly using health policy rhetoric rather than nursing jargon. Stage 4 is where nursing organisations are proactive on leadership and agenda-setting for a broad range of health and social policy issues. In this stage they are also building coalitions beyond nursing. An example of nursing meeting aspects of stage 4 in New Zealand was that no other workforce group – including medicine – had managed to set a government agenda on workforce through proactive leadership in the

preceding years, but it still was a nursing not a health agenda. But, as Kingdon (1995) so aptly puts it, things usually “ain’t that simple.” Many events and streams became linked, through processes that eventually maximised the opportunity when the “window opened”. Nursing leadership in New Zealand during this time was demonstrating a leadership role within the policy community in its support for the Taskforce.

So we can see that in a short period of time in 1997, nursing in New Zealand travelled through all of Cohen et al.’s stages of political development: buy-in, self-interest, political sophistication and leading the way. There are two explanations for this: (1) the magnitude of the problems in the policy streams; or (2) it was a reflection of Kingdon’s theory that policy is not a linear process. Just as policy-making is fluid, so too, perhaps, is political development. Movement is ongoing and the process is evolutionary. Holland (1975, p. 110) describes how “evolution proceeds not so much by mutation, or by sudden appearance of wholly new structure as by recombination, or new packaging of already similar elements”. Thus stages are not actually separate but merely in a continuous state of flux; areas are constantly being built on or repackaged.

Cohen et al. (1996) themselves suggest that “the stages of nursing’s political activism are not time bound, nursing has straddled more than one stage of political development at a time” (p. 259). Collectively the organisations supported the establishment of the Taskforce, despite the fact that only one (NZNO) was represented on it. The organisations were demonstrating stage 3 – political sophistication – by being proactive with regard to lobbying for a taskforce. Meanwhile, individual organisations like NZNO were maintaining buy-in (stage 1) and self-interest (stage 2) within their organisations. This is reflected in a statement by NZNO to the Taskforce about the education direction that the Taskforce was taking, and how it was in conflict with NZNO’s own policies: “it is neither supported by our current policies nor is it consistent with the spirit and intent of current polices” (NZNO correspondence to Taskforce, 17 June 1998). This suggests that rather than the buy-in stage being always externally focused, as Cohen et al. suggest, it can also reflect buy-in *within* organisations. It is interesting that NZNO believed that a taskforce set up and accountable at the ministerial level would be influenced by NZNO’s own organisational policies.

In the case of New Zealand nursing, the quick development through the stages could not be sustained for long. I believe this occurred for the following reasons. For a start, the nursing organisations were either naïve in how they engaged in their policy making, or did not realise that different motives existed for getting things on to an agenda. Once on the agenda, there were events beyond their control. Finally, the cynic in hindsight may suggest that some participants never really wanted the Taskforce to succeed, and that this was their agenda from the beginning. Involvement of this kind is described by Kingdon (1995) as a “blocking” mechanism. (I will discuss negative blocking later in this chapter.) The organisations could not maintain stage 2 coalition building together as interest groups, as a foundation for success in other phases.

### **The Taskforce in action**

The 1998 Taskforce was announced with media coverage and photo opportunities. The Minister hailed it as a positive strategy not only for nursing but also for the whole New Zealand health sector:

We have sought a high calibre and diverse membership for the Taskforce both because of the importance of the work and because its findings need to reflect the current and potential diversity of modern nursing. The Taskforce will deal with issues critical to the future of nursing in this country (Office of the Minister of Health, media release, 12 February 1998).

The chair, Dame Anne Hercus, was an interesting choice, being retired from a political party (the Labour party) in opposition to the current government, a seasoned politician who had held positions as Minister of Police, Social Welfare and Women’s Affairs, and who was renowned for her ability to manage conflict and difficult groups. This suggests that the Minister perceived that the Taskforce would need a strong chair as things were not going to be easy.

The objective of the Taskforce was “to recommend strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders” (Ministry of Health, 1998c, p. 2). The Taskforce met every month between February 1998 and July 1998. As the months wore on it became apparent that NZNO was having difficulty with the direction of the Taskforce and made this known at every meeting. Where other members had differing opinions and issues, these were worked through and resolution occurred. This was not the case for issues raised by Brenda

Wilson, CEO of NZNO, whose concerns ranged from the formatting of the draft report to the status of NZNO as an organisation.

Many of the issues causing concern were outside the terms of reference (for example, pay issues, enrolled nursing and staffing ratios). Bill English was very clear about what was to be covered in the Taskforce, and was described as saying that “concerns about staffing levels, workloads and pay... these were industrial issues and the taskforce brief was to look at professional matters” (Vasil, 1998, p. 2). Through this statement the Minister was clearly challenging NZNO’s role as a union on the Taskforce: they were now involved with a Taskforce that could not address their members’ interests industrially.

Despite the Minister being clear that staffing, pay and work conditions were industrial issues, the profession – and particularly NZNO – did not agree with this perspective. In my experience this is a common problem when a professional organisation also represents its members industrially. Other nursing organisations around the world would share NZNO’s perspective, and believe that to truly represent the profession, pay, working conditions and professional standards and education are all related (Bickley, 1997).

Clark & Clark (2002) suggest that priorities differ depending on the mandate of the nursing organisation. They conducted a worldwide survey of 298 nurses’ associations and unions, and found a significant difference between the way nursing associations (representing the professional interests of nurses only) and nursing unions (which have an industrial mandate on behalf of nurses) assess members’ priorities. Associations reported that their members’ first priority was patient care issues, while unions reported salaries and benefits as the membership’s top concerns. Professional development was listed as a higher priority by associations than it was by unions, and a voice in the workplace and safety and health, in turn, were listed as higher priorities by unions than by associations. This suggests a tension in nursing priorities when an association has both a union and a professional mandate.

By April 1998, NZNO was clearly showing they disagreed with the terms of reference and the direction the Taskforce was taking:

If we don't deal with the issue of staffing levels and skill mix then any broader roles will mean higher work loads.... it would be a pity if the Taskforce ended up damaging the profession by contributing to the already serious problem of safe staffing and overwork (NZNO correspondence to Taskforce, April 1998).

As a member of the group I became aware (as did others) that NZNO's CEO held different views to those of the rest of group as to what the group should be covering in its report. It is difficult to report this period of time without appearing prejudicial against NZNO. However, they would themselves admit to being the group with the most problems with the Taskforce, and also the group that generated media coverage. Signs of mistrust and confrontation started to surface:

I remember specifically at one meeting, Dame Anne Hercus had a stand up argument in the corridor of the ministry, with the CEO of NZNO, Taskforce member Brenda Wilson, regarding accusations that had been made about the Taskforce work, the ground rules were very clear re making media statements etc... it was not a nice time (J. Carryer, personal communication, 10 November 2001).

On reflection, the CEO of NZNO was a rather lonely voice within this group, dragging a heavy weight of thousands of nurses behind her. The terms of reference of the Minister made it clear that the union's interests were not going to be paramount. These terms of reference were the result of a meeting of 30 January 1998, but finalised by the Ministers own staff. The Minister established the Ministerial Taskforce chaired by a seasoned politician with the consensus of all nursing groups, with terms of reference that would not meet the needs of the largest nursing organisation in New Zealand nor make the Government address key platforms of their health reform policy – employment relations and conditions.

Cohen et al.'s stage 2 of political development was starting to unravel. Self-interest better reflects the activities that were starting to play out within the Taskforce group, and that were now starting to be seen by those outside. Members of the Taskforce, except NZNO, fought to keep the Taskforce going, which could be viewed as self-interest in as much as it fulfilled their requirements. An analyst from NZNO wrote the following to the NZNO journal: "Since July 21 the process has moved towards breakdown.... for these people it has become a matter of assigning blame and pointing the finger at NZNO" (Oliver, 1998, p. 12).

One could describe stage 2 as self-interest within an organisation, which is what NZNO were starting to display. They were now pulling away and distancing themselves from the group. Brenda Wilson wrote that a “flawed process beset the taskforce from the outset, the process from its establishment and choice of nursing representatives” (Wilson, 1998b, p. 2). This could have occurred because NZNO realised they could not control the agenda and that their interests were not going to be met. Or it could have been because NZNO did not read the signals correctly.

On July 20 Brenda Wilson released a media statement announcing NZNO’s refusal to endorse the latest draft of the Taskforce’s report. In this release the following statements were made:

[NZNO have experienced] frustration over inaccuracies and elitist, insular attitudes expressed. It [the report] is an unprofessional document which is so poorly written and argued, it is not a credible statement about either the problems facing the profession in the future. It [the report] fails to recognize the impact of the Employment Contracts Act and the health reforms. The document is biased towards the nursing council and the education sector. [The report] has a confrontational approach to the medical profession and encourages nurses to act in competition against doctors (NZNO, 1998e, p. 1).

The above statement was the first public indication that NZNO were now outwardly agreeing with what NZMA had been arguing regarding the Ministerial Taskforce on Nursing and advanced nursing. It provided NZMA with ammunition to attack the Ministerial Taskforce on Nursing from a nursing professional viewpoint. This failure to endorse the latest draft of the Taskforce translated into the NZNO walking out of the 1998 Ministerial Taskforce on Nursing. The rationale behind such a public reaction to concern over one of the many drafts was difficult for most of the other Taskforce members to understand. It did grab immediate attention from the media and nurses around the country. The actual reasons NZNO withdrew its support from the Taskforce will never be agreed upon, with one exception. In Chapter 3 regulatory policy was described. The Taskforce controversy highlighted self-regulation and NZNO’s concerns that the Government believed this was the jurisdiction of the Nursing Council of New Zealand rather than the profession. This issue regarding the powers of the Nursing Council of New Zealand was longstanding, and the Taskforce merely fuelled an existing issue.

The focus of this analysis is how nursing organisations, such as NZNO engaged in policy making. They engaged in policy making primarily as an interest group, so it is helpful now to examine the role of interest groups.

### **Nursing organisations as interest groups**

Walt (1994) identifies the important role played by interest groups in policy making and implementation. Interest groups are voluntary bodies aiming to achieve some desired goals, and functioning outside the formal policy development process. In contrast, the policy community is “made up of experts in academia, think tanks, and agencies who play a part in policy formation and implementation” (Weissert & Weissert, 1996, p. 34).

The role of the policy community lies in the constant exchange of ideas and the flow of information within the community and with government agencies (Walt, 1994). The aim of the policy community is to influence government policy making, or, as is the case here, policy formation. As we have already noted, the ambiguity of policy statements can enhance the role and sphere of influence of the policy community.

Kalisch & Kalisch (1982, p. 391) define an interest group as “an association of people concerned with protecting and promoting shared values through the use of the political process.” Lindblom (1987) describes how interest groups have a better chance of influencing policy when they interact with and gain the support of government officials and bureaucrats. Interest groups are important to agenda-setting: “Interest group activity is varied. Some of it affects the agenda; other activity affects the alternatives considered by policymakers” (Kingdon, 1995, p. 48).

Lembruch & Schmitter (1982) describe the concept of “corporatism” (p. 32), whereby government (parliamentary) and its agencies bargain and negotiate with particular interest groups, typically those that governments choose to involve and those that are too strong to be ignored. By 1998 the fact that the Government took notice of nursing as an interest group, especially NZNO, could have been because the National Government no longer wanted to be seen to be ignoring nursing.

Kingdon (1995, p. 49) describes how the role of interest groups is not so much about positive promotion (promoting new agenda items and support) as it is about “negative

blocking". This is where interest groups seek to preserve the status quo by blocking any moves towards change. But, as previously noted, once the agenda is set, groups have little or no power to control what occurs. Thus interest groups can deliberately become involved in policy making to engage in negative blocking activities, or they can do so at a later period once they realise things are not turning out the way they had planned (Lindblom, 1987).

Kalisch & Kalisch (1982) go further and describe two types of interest groups: those that are economically motivated and those that are professionally motivated (in other words, money versus service). This is an important contrast as we look at how the New Zealand nursing organisations acted as interest groups.

The members of the Taskforce, despite coming from various organisations, were not meant to be representing their organisations (that was the criteria for membership). Nevertheless, like me, they came with an orientation of beliefs and values from the employers and organisations to which they were affiliated. NZNO played a central role as an interest group as it was the largest nursing organisation in New Zealand. Other nursing organisations played a role of being polarised against NZNO during this time, but did so in relative silence (lack of media or published data) and (apart from the College of Nurses) passively. This was not an unfamiliar position for NZNO (as discussed in Chapter 4), and could be seen as quite predictable.

### **NZNO as an interest group**

New Zealand nursing organisations in the early stages of 1997 were still acting separately, but by the latter part of 1997 had formed one strong lobby or interest group. NZNO appeared on the surface to be moving from stage 2 of Cohen et al.'s framework of self-interest on to other stages of coalition building and influencing health agendas, thus assisting to bring about the Ministerial Taskforce. NZNO was the most publicly vocal group with regard to nursing conditions leading up to the establishment of the Taskforce. In its union role it was raising both industrial and economic issues related to nursing conditions.

NZNO's stance in continuing to want industrial matters put on the Taskforce agenda contrary to the terms of reference could be perceived as pushing for its agenda, or it

could be perceived as negative blocking. There was also its ongoing concern about the power of the Nursing Council of New Zealand: "Council will develop, control and enforce competencies for advanced practice. NZNO does not believe the council is the appropriate body to control advanced practice" (NZNO, 1998g, p.1). Both examples show NZNO not only pushing for the status quo, but also attempting to stop the advancement of nursing through the Nursing Council of New Zealand and the ongoing control of regulation of nursing by them.

NZNO's status as a union also affected its relationship with the government. Any government treats unions differently to other interest groups, as through their actions they can tie up the labour market and thus the economy (Kalisch & Kalisch, 1982). NZNO at this time was unable to wield its union power, however, because like other unions it had been marginalised by the Employment Contracts Act 1991, which restricted its ability to have national collectives and initiate strike action (Gauld, 2000).

NZNO was struggling to have its industrial interests addressed, and the Taskforce was now turning out not to be a vehicle for doing so: "NZNO is also concerned about issues which the Taskforce report does not address... recognition of the impact of the Employment Contracts Act on nursing employment and morale" (NZNO, 1998g, p. 2).

The way nursing organisations act as interest groups was just one of the factors that led to the establishment of the Taskforce. But it was also because nursing organisations were acting as interest groups that the coalition between the nursing organisations broke down and NZNO walked away from the Taskforce. NZNO could not give up its individual interests to serve a larger, more collective agenda. It is important to note that interest group pressure alone is never enough to determine the agenda, despite what interest groups commonly think (Kingdon, 1995).

An important aspect of an interest group is its resources, which strongly determine its ability or inability to influence government policy. This can be an ability to mobilise members, numbers, status and wealth, and cohesion with other groups (Kalisch & Kalisch, 1982; Litman & Robins, 1997). NZNO was the largest organisation representing nurses; it thus assumed the status of being the major nursing organisation

and also assumed certain powers and privileges: “As our submission made clear NZNO is qualitatively distinct from any other nurse grouping by virtue of its size, scope of activity and representatives” (NZNO correspondence to Taskforce, May 1998). The following appeared in an NZNO journal editorial at this time, supporting this perspective:

NZNO, with its elected board of directors, its workplace delegate structure and its publicly declared membership is the only nursing organisation which can lay claim to being democratic and thus truly representative (O’Connor, 1998/1999, p. 2).

A member of NZNO also wrote in letters to the editor: “I believe that without the support of New Zealand’s largest nursing organization, the document’s credibility and potential for successful implementation is seriously diminished” (Crowe, 1998, p. 2).

It could be argued that NZNO as an interest group realised that the only way forward was to work with other nursing groups and support the establishment of the Taskforce. Once there they realised they could not control the outcome because of the processes of the Taskforce and the activities of other interest groups in nursing (that is, the College of Nurses), and so left in a very public manner discrediting both the Taskforce and the Minister of Health and drawing support from the medical profession through the NZMA. This was demonstrated in an interview by an NZNO organiser to a local newspaper:

Only a select group of nurses had their ideas heard, such as nurse educators, the College of Nurses and nurses’ regulatory body the Nursing Council.... all he [Mr English] is trying to do is get cheaper mini doctors.... I think Bill English is trying to set doctors and nurses against each other (*Nelson Mail*, 21 August, p. 2).

Kingdon (1995) describes another group resource for influencing government policy: cohesion. Cohesion is where a “group utilizes its membership numbers, expertise to convince others that it speaks with one voice and truly represents the preferences of its members” (p. 52). By February 1998, after the Minister of Health met with all the nursing organisations, the Government was led to believe that there was cohesion, coalition and agreement between all nursing groups, and that they supported the establishment of the Taskforce. The Minister of Health was very clear with the Ministry that the membership of the Taskforce was deliberately *not* to be representative, as there

was a need for strategic thinkers with individual credibility and expertise without the restriction of being a representative (except for NZNO and Maori). The Taskforce was set up recognising there would be conflict with NZNO, but with the belief that it could be managed, as unless they were represented there would have been no Taskforce. NZNO in May 1998 themselves identified that tension was occurring: “Wilson said her role was to represent NZNO’s 26,000 members [only 17,000 are nurses] and this sometimes caused tension with other Taskforce members” (“Nursing taskforce granted”, 1998, p. 5).

By June 1998 there was no longer any cohesion between the interest groups (nursing) of New Zealand. Cohesion had become the sole preserve of NZNO and its members. NZNO had to preserve its membership. The public comments by the CEO of NZNO to and about the Taskforce reflected its position (“we represent the views of New Zealand nursing”), thus claiming status and privilege. The following was written by the Taskforce Chairs (Hercus and Ashton) in the preface to the report:

The NZNO is the largest nursing organisation in New Zealand. This does not mean that it is the only organisation that can represent nurses. The unwillingness of the NZNO to join consensus in forward-looking recommendations is, in the Taskforce view, itself a major barrier to progress for nursing practice. The outstanding issues, as far as we can determine, relate primarily to the status and role of NZNO rather than to the Taskforce’s terms of reference or to patient outcomes (Ministry of Health, 1998c, p. 5).

Kingdon (1995, p. 52) describes how “if a group is plagued by internal dissension its effectiveness is seriously impaired”. As the Taskforce report was reaching its final drafts, dissension was mounting. Once this became publicly apparent, there were a number of developments around the issue of cohesion. NZNO not only went public that it would not support the Taskforce, but also wrote to all hospital executives stating it did not support the Taskforce report. In this letter, Brenda Wilson stated that “I am writing to inform you about our concerns with the report which propose a retrograde and rigid model for nursing practice”. The letter reiterates concerns over “advanced practice at master’s level” as well as “immense expansion in the role and power of the Nursing Council” (NZNO letter to CEOs, 30 July 1998).

NZNO decided to write a shadow report *Building partnerships: Developing the future of nursing*, separate from the official Taskforce report. It requested all the material that the

Taskforce had obtained under the Official Information Act request. This was published in September 1998, and in the foreword the president, Judy Mulholland, wrote:” I am very proud of the stand which NZNO has taken over the Ministerial Taskforce on Nursing” (NZNO, 1998a, p. 2):

*Building partnerships: Developing the future of nursing*, has a wide perspective. It recognises nurses’ significant contribution to health. Moreover, this document embodies and addresses the health and social issues facing people in our communities. It relates back to NZNO social policy statements, which challenge nurses... it also acknowledges the negative impact of the health reforms and the Employment Contracts Act on nursing morale... it [*Building partnerships*] is immensely readable and reflects nursing realities (Mulholland, 1998, p. 2).

NZNO’s shadow report was 16 pages long and broken into four sections: 1. The regulation of nursing; 2. The importance of the clinical and social context; 3. Building a professional organisation; and 4. Building partnerships. Under each section the text described NZNO’s policies and their philosophy. The document did not appear to use any of the data that was released to NZNO under the Official Information Act request.

NZNO was claiming to speak for New Zealand nursing, yet individual members of NZNO became vocal and disagreed with the stand NZNO had taken, as in this letter to the editor:

I am deeply saddened by the position NZNO has taken over the Ministerial Taskforce on Nursing and appalled by the reporting in the August *Kai Tiaki: Nursing New Zealand*. I have read that eight members of the taskforce were wrong, difficult to believe and NZNO Chief Executive Brenda Wilson was right. I believe NZNO has put the interests of union above the interests of registered nurses. This is the difficulty RNs face when NZNO is said to represent them professionally and as their union. It does not work.... The real issue is that power is being taken away from NZNO and NZNO is not happy about it (Sylvester, 1998, p.4).

Thus the process of dissension was not only occurring between the nursing groups but also now within NZNO. Kingdon (1995, p. 52) highlights how “interest group leaders find it difficult to argue for their position if they face opposition from their own ranks”. I believe that this dissension impacted on the profile of the shadow report when it was published, and also affected the way NZNO responded to the Taskforce material it had obtained. The *Building partnerships* shadow report was not implemented, and none of the material obtained under the Official Information Act request from the Ministry of Health was ever published.

The dissension within and between the interest groups of nursing may not have created positive support for NZNO within the profession, but NZNO did manage through its public comments to negatively block the Taskforce report. This was demonstrated by the actions of the Minister of Health, who supported the recommendations but directed no money or resources to implement them. The report became my responsibility as the Chief Nurse within the Ministry of Health to implement (see Chapter 9 for more detail).

By August 1998 the Government had a completed report, which was highly controversial. There was no clear understanding within the health and nursing sector as to why NZNO disagreed with it, apart from high-level statements such as that it was “elitist and encourages nurses to compete with doctors” and had ended up “not reflecting the views of nurses, not outlining current situation – pay and conditions etc” (Newztel transcript, Radio New Zealand, 21 July 21 1998). *Building partnerships* did not provide any clarity on the issues, or any real solutions. The issues that NZNO was opposed to in the Taskforce were not addressed in any substantive way in the Building Partnerships report. Nor did they offer a way forward.

Nurses in various positions in New Zealand started to express their feelings about the events surrounding the Taskforce. Faxes and letters were appearing in New Zealand nursing journals and at the Minister’s office from NZNO members outraged at what their executive had done; for example: “I’m sure the Medical Association will be grateful to New Zealand nurse leaders for helping keep us in our place” (Cronin, 1998, p. 3). The Minister of Health, speaking at the launch of the report, was reported to have “regretted the report did not represent the views of all nursing groups... nursing will only make progress if united and I will be discussing with the NZNO how we can bring nursing together” (NZNO, 1998d, p. 4).

The Taskforce had come out advocating that the role of self-regulation occur through the Nursing Council of New Zealand, which the Government had supported for a number of years and with which NZNO had repeatedly disagreed. As a result, NZNO had used its power base to make the Government pull back from overtly supporting the Taskforce. The outcome of the Government supporting the recommendations but not allocating any budget and resources was not surprising. Delegating it to the Ministry of

Health was a face-saving strategy – being seen to do something but not taking it seriously. It was a way to deal with the fact that the report was controversial. “If there is intense opposition to a proposal, an advocate will often back off just like a politician facing intense opposition... if too many people get angry it is not worth it” (Kingdon, 1995, p. 151).

Kingdon also notes that interest groups who take advantage of a given “window of opportunity” (p. 190) sometimes establish a principle that will guide them in future policymaking. In Chapter 8 I will use this analysis and the context of the previous chapters to describe the relevance of these policy-making events, and address the questions: What can we learn from the way the nursing organisations in New Zealand engaged in policy making? What can we strengthen? What can we avoid?

## **Chapter 8: Looking Forward: Implications for Policy making and Nursing**

The demand for intelligent nursing care today and in the future could not be greater. The old certainties and safety structure of the welfare state are breaking down as advancement in technology and also changes in service delivery occur. Complex combinations of services – state, voluntary, social, health, educational and environmental – are often struggling to articulate with each other. More than managerial magic will be needed to turn rhetoric into partnership. Above all it will need intelligent, imaginative nurses capable of navigating and delivering complex courses of care. To do this will take tremendous practical, political, organisational and technical abilities – skills of the higher order (Ministry of Health, 1998c, p. 27).

This study set out to answer two questions: What stage of political development (as defined by Cohen et al. 1996) are nurses in New Zealand exhibiting in relation to policy? and How do nurses engage in agenda-setting in New Zealand? The exemplar case chosen for analysis was the establishment and work of the 1998 Ministerial Taskforce on Nursing. Analysis of the public commentary on this event and description provided by myself as participant-observer provide a rich snapshot of the engagement of New Zealand nursing in policy formation. Case study methodology was chosen because it provided the best method for understanding the events and the context.

This chapter examines the limitations of the study and the study findings, and discusses these in relation to practice, research, policy-making and theories on policy formation, and frameworks for the political development of nursing. The implications for the future will be summarised at the end of the chapter.

The Ministerial Taskforce on Nursing was established by the Minister of Health at a time of great change and discord within the health sector in New Zealand. With it came numerous expectations from practice, policy and politics. New Zealand's experience with economic and health reforms has become a fishbowl for the international community. Boston et al. (1996, p 1) stated: "explain New Zealand and the world falls into place". Bickley (1997) describes how "we have been taken where no one has gone before.... If other countries aren't interested in these changes they should be" (p. 303).

### **Limitations of the study**

The limitations to this study are three-fold.

1. I did not conduct any new data collection or any personal interviews with nursing leaders involved with the establishment and workings of the Taskforce. This was not done because I hold the position of Chief Nursing Advisor with the Ministry of Health in New Zealand. In undertaking such interviews findings could have been skewed or biased, as potential respondents could have other agendas with me in the Chief Nursing Advisors role at later date.
2. As outlined in Chapter 5, the relationship between the Chief Nursing Advisor and nursing organisations can at times involve conflict. I had difficulty reporting the events of this study because of my central role in these events. I have attempted to reduce the level of personal bias through the use of an expert advisory group, and through corroborating diary entries and personal anecdotes with information from documents in the public domain. Chapter 4 outlines the way in which policy is not neutral, and in my role as an analyst I have recognised that I hold beliefs and values.
3. Case study methodology has its own limitations, which relate to the rigour of the evidence presented. I used data that was in the public domain. This, combined with the advice sought on selecting the case study and feedback regarding the accuracy of my reporting of the Ministerial Taskforce on Nursing by the expert advisory group, helped to reduce bias. This study involved only one case, and a single case study has much less validity and less ability to be generalised than a comparative case. There is some disagreement among researchers on the ability to generalise from case studies, which could also be seen as a limitation. Yin (1994) holds the view, supported by my own experience, that case studies are able to be generalised to theoretical propositions but not to populations. Kingdon's (1995) theory was developed through multiple case studies, which allowed him to generalise extensively.

### **Study findings**

The study findings can be summarised as follows as themes. New Zealand nursing organisations utilised mechanisms to engage in agenda-setting, just as other interest groups do. Nursing is influenced and contributes to policy formation, and policy formation was shown to be non-linear and fluid, reacting to events in the environment.

A relationship was shown between agenda-setting processes and the political development stages of nursing. Leadership has been shown to be important in two areas: coalition building and policy entrepreneurial activity. Climate and timing played a major part in how nursing managed to assist with contributing agenda items in the various streams, but also with moving problems to solutions. No one individual or group brought about the events, as is demonstrated by the fact that once the agenda was set it could not be controlled by those who contributed to it. The strongest finding was that a nurse can act as a policy entrepreneur, as demonstrated through the role of the Chief Nurse.

### **Nurses can and do influence policy formation**

This study has provided us with good examples of the use of policy windows and the complex and fluid way in which items go on and off agendas. It has also demonstrated how policy-making really works, supporting Kingdon's (1995) view that policy is not rational:

Policy making is often a process of creating intellectual puzzles, getting into intellectual binds, and then extracting people from these dilemmas. Items might be held off a public policy agenda for a considerable amount of time while such puzzles are being solved (Kingdon, 1995, p. 126).

The process of agenda-setting and policy formation that surrounded the Ministerial Taskforce on Nursing was not a rational process; it was multi-dimensional and complex, occurring through a mixture of political, problem and policy agendas. Rational policymaking "models do not very accurately describe reality" (Kingdon, 1995, p. 78). In the case of the Taskforce, no one factor alone led to its setting up and the resulting conflicts:

Problems or politics by themselves can structure the *government* agenda. But the probability of an item rising on the *decision* agenda is dramatically increased if all three streams – problems, policies and politics – are joined (Kingdon, 1995, p. 178).

As we have seen, policy making is not without conflict, partly because every player has an agenda and an interest they represent. Given such complexity we should not be concerned when conflict does arise. Managing demands and conflicts is part of everyday life for nurses, and the political and policy world is no different. This does, however, raise the question of whether nurses see practice conflict and professional

conflict differently. Sabatier & Jenkins-Smith (1993) discuss how policy learning often takes place when various groups compete for power and influence. The greatest policy learning occurs “when conflicting coalitions engage in dialogue and are prepared to make adjustments that do not seriously threaten the core elements of their belief systems” (pp. 48-50).

The Minister of Health, the Chief Nursing Advisor, the members of the Taskforce and nursing generally all approached the Taskforce with their own expectations. The expectations and issues these groups raised assisted the three policy streams to combine and raise issues, but they alone did not make the Taskforce become the solution for government, or a priority choice. No one single individual or organisation was solely responsible, but the ability to build coalitions and the role of policy entrepreneur enabled nursing options to be part of what was considered by the Minister.

The analysis has shed light on where ideas came from for the Taskforce, although in the end the origin of an idea is unimportant:

... the critical factor that explains the prominence of an item on the agenda is not its source, but instead the climate in government or the receptivity to ideas of a given type, regardless of source (Kingdon, 1995, p. 72).

The issue of the origin of an idea can become an issue, however, if blame or credit is being allocated for the success or failure of a policy-making activity. Politically there is often a need to claim credit or apportion blame, and nurses are not dissimilar in this respect. Everyone wanted to claim credit for the establishment of the Taskforce at the beginning, but towards the end fingers were being pointed as to who was to blame for the conflict that arose.

This blame reaction was more about point scoring off those who did not support the same philosophical beliefs. It also could be viewed as a political tactic to gain attention (Jenkins-Smith, 1990). My experience has been that political sophistication by nurses is demonstrated in their ability to let go, pass the baton and allow others to claim ideas as theirs. This is why, four years on, the Ministerial Taskforce on Nursing has delivered on all of its recommendations except for one recommending a new Nurses Act (see ‘Chapter 9: Epilogue’). The link between policy and practice is often not well understood by nurses. Policy is viewed by nurses as not being in their domain, but

involvement in policy can occur at many different levels – from individual actions, to those of professional organisations, and research, education and dedicated positions (Gebbie et al., 2000; Hughes, 2001). Influencing policy is a way to influence care: “nursing has yet to rise to the impending challenge or become sufficiently organised.... far too few nurses presently are acquiring the policy expertise or the practice interest to meet the demand for care” (Mechanic & Reinhard, 2002, p.12).

There is no doubt that nursing in New Zealand has influenced policy for decades through different mechanisms. We were the first country to gain separate legislation for regulating nursing, to obtain a 40-hour working week for nurses, and, unlike many other countries, we prepare all our registered nurses to enter practice with an undergraduate degree (Dixon, 1996; Neill, 1961). However, nurses have often not seen what they are doing as influencing policy, nor recognised and acknowledged that policy is part of nursing (Hughes, 2001).

When one discusses the role of the nurse, both within and outside the profession or the contribution nurses make to health care in New Zealand, one hears a wide array of comments. These range from descriptions of the most basic physical care, to highly technical procedures, and include reference to advice, information, emotional support (and the style in which these are given), through to personal comments on how nurses “were there for me” and how they are the backbone and “salt of the earth.” References to health policy are not usually evident. 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 of its health problems. A more policy-orientated nursing workforce will assist the society it serves to become more politically informed and facilitate more active democracy (Gebbie et al., 2000; Hughes 2001; Lange & Cheek, 1997).

This study has highlighted the fact that policy is often ambiguous, often deliberately so, such that different meanings can be taken. Policy is about politics, compromise and ambiguity. Policy is always developed within a political context (Stephenson, 1985), and as such involves a degree of compromise (Weissert & Weissert, 1996). The nature of this ambiguity was not understood by the nursing groups. Those of us who work in public policy every day know that policy ambiguity is part of life. It was taken

advantage of by the policy entrepreneurial activity of the Chief Nurse, providing language and direction to the nursing groups so that their proposals would fit with Government direction and policy. Oliver & Paul-Shaheen (1997) describe how the “greater the uncertainty, the more likely a leader will be able to define a situation and offer a corresponding solution” (p. 749).

This case study revealed a link between political activism, agenda-setting and the political development of nursing. Nurses in New Zealand became exposed in the worst possible way to policy making in health care in the 1990s. They were also isolated and marginalised from decision-making – although this exposure, being harsh, probably helped to galvanise their interests. They had reached their “ah ha moment”, where they no longer wanted to accept the status quo and realised a different approach was required. They had attempted to raise their concerns and no one listened; they attempted to influence agendas by themselves, but had a range of different agendas.

Nurses in New Zealand had experienced decades of a highly structured system, where sheer numbers wielded authority through the nursing organisational structure: the matron in charge, the Chief Nurse who controlled nursing, and unions having collectives. The events in this study show that we cannot rely on structures to automatically provide us with influence, as the health sector is constantly changing. NZNO showed that they could not wield power through membership, and claiming the ground through being the largest and the biggest may have blocked some processes but not changed government intent. What became important – and what is needed in the future – is knowledge about policy formation, networks, strategic alliances and relationships with influential people in key places, such as the Chief Nurse in government. This translates into the development of nurses with a set of skills necessary for facilitating practical solutions in situations where the participants have widely divergent interest or values.

### **It is all about timing and political climate**

Kingdon’s (1995) theories articulate the importance of understanding the climate for agenda-setting, policy making and policy formation. Central to this is that agenda-setting and policy making do not occur in isolation of the wider political environment in which they are located. Oliver & Paul-Shaheen (1997) describe how reforms often create environments ready for innovation. The Ministerial Taskforce on Nursing

provided the direction for innovation in nursing; four years later it is still the direction that many are following as the way forward.

In New Zealand the health reforms and the political background clearly demonstrated how nursing had become marginalised. Despite nursing being the largest health workforce group in New Zealand, nursing had traditionally had little ability to influence the reform processes as demonstrated in health reforms in New Zealand. The legitimate role that nurses have in policy was not endorsed during this time, and it has been through understanding the importance of climate as it relates to this study that I have come to appreciate this more.

NZNO had been vocal in their concerns about staffing and working conditions, but were distanced from influencing government by an inability to undertake national industrial action through employment contract legislation passed in 1993. Nursing organisations during this time were not a cohesive group; they rarely worked collaboratively and did not even demonstrate stage 1 of Cohen et al.'s (1996) stage of political development – self-interest. Their ability to engage in policy making that brought about change during this time was rare. But the mere fact that they were advocating concern is, in itself, an expression of public interest, a form of engagement and a sign of political activism: “nurses have put a great deal of time and energy into trying to protect the public and we weren’t listened to” (NZNO, 1998d, p. 4).

It is difficult to see how, even if well organised, nursing organisations could have stopped this train (the reforms) once it was on the tracks and rolling. At the end it was the failure of systems and the intolerance of the New Zealand public that slowed down the reforms and reintroduced the “public” into public health. The issue this study raises now in hindsight is: Could things have been different if nursing had been more politically developed in the early days of the reforms? By the time it got to the mid- to late 1990s, it was like trying to change the meal when you are eating dessert.

### **Policy entrepreneurs**

Nursing organisations and the Government had similar problems. Both had constituents who were unhappy; both wanted to have a prominent role in influencing policy. The

streams were being mixed, and the nursing profession and political climate were conducive to looking for other ways to gain influence.

New Zealand nursing agenda-setting and policy influence only gained momentum when the following occurred. First, its problems became attractive as agenda solutions. Second, goal congruency occurred, through the use of language and an understanding of the wider socio-political context, as developed in a paper that outlined key components attractive to the Government, such as the effective utilisation of nursing, a flexible workforce, etc. Third, it began to form coalitions, and lastly policy entrepreneurial roles existed. One of the main mechanisms for assisting in coupling problems with solutions, and thus raising items up the agenda, is the policy entrepreneurial role of the Chief Nursing Advisor.

The policy entrepreneur is alert, with an ear to the ground, has mechanisms that can scan and interpret the horizon, builds up contacts in key agencies, networks with others to be clear about direction and statements, and exercises perseverance and patience in waiting for that “window of opportunity” to open. When the window opens, strategies have already been worked out in coalition with others and are ready to go forward.

Oliver & Paul-Shaheen (1997) describe how policy entrepreneurs “do more than chase problems and decision opportunities when they arise – they often create them” (p. 752). The CEO of NZNO and the Director of the College of Nurses could also be viewed as policy entrepreneurs in this description: policy entrepreneurs do not always have success, and even when they are successful they do not always win.

The role of Chief Nursing Advisor as policy entrepreneur is an exciting development. There is limited literature on this role, either generally or with respect to being a policy entrepreneur (Hughes, 2001; 2002b). This study has substantially added to the understanding of the role of the Chief Nursing Advisor within government, the profession and the policy arena as a policy entrepreneur. More light has now been shed on the relationship between nursing and government.

This study highlighted two limitations in Kingdon’s (1995) theory on the policy entrepreneur, however. First, his theory applies to a US model of the civil or public servant, which differs from the Westminster system in which New Zealand operates. In

a centralised system of government like New Zealand's, the public servant takes on a greater advisory role. In my experience New Zealand public servants have fewer layers between them and members of government. Tenbensen & Gauld (2001) highlight the difference in government processes between the US and New Zealand.

President Clinton, for instance, was unable to steer his ambitious programme of health care reform through the rocks of the US's federal structure. New Zealand's political institutional design is very different in that there is little to stop governments from making quite radical changes to policy provided they command majority support in Parliament ( p. 28).

This difference translates into public servants having to respond quickly in formulating and implementing policy in the New Zealand context. These structural differences between US and New Zealand also contribute to different interest group interaction with Government i.e. corporatist vs. more pluralistic model in the US.

Second, Oliver & Paul-Shaheen (1997) stress leadership much more strongly in relationship to policy entrepreneurs than does Kingdon (1995). They state that the "leadership role in policy innovation [and in] policy entrepreneurial activities is in fact understated" (p. 782). Kingdon identified the entrepreneurial qualities as expertise, an ability to speak for others, having political connections or negotiating skills, and persistence and sheer tenacity. But as demonstrated in this study, wider qualities of a policy entrepreneur were also evident, most notably visionary leadership. Oliver & Paul-Shaheen see the policy entrepreneur's response to change as differentiating them from other leaders: "for most people change is uncomfortable or even threatening... for entrepreneurs change is the norm and healthy... they have an uncommon alertness to opportunity and a more creative, risky pattern of response" (p. 748).

Chapter 5 clearly described the fine line the Chief Nursing Advisor walks when working with nursing organisations and thus being a policy entrepreneur. How can we find more policy entrepreneurs in nursing and, more importantly, how can we develop more nurses as policy entrepreneurs? The role of a nurse as policy entrepreneur needs further research, and understanding and strengthening this role could be the missing link in nursing political development. It appears to combine the qualities of what many researchers have previously identified as transformational leadership, visionary leadership and entrepreneurial activity (Bennis, 1991; Bernard & Walsh, 1995; Porter-

O'Grady, 1997; Oliver & Paul-Shaheen, 1997, Wheatley & Kellner-Rogers, 1996). These qualities could be utilised to identify nurses who can assist in policy activities, but could also be used as a means of developing and educating nurses into this role. Nurses in all positions in nursing can be developed and identified as policy entrepreneurs. The nursing policy entrepreneurs should not just be viewed as working for the profession, but for policy outcomes based on the values of nursing to improve the health of consumers.

### **Nursing as an interest group and political development**

Kingdon (1995, p.199) states that the "combination of national mood and elections is a more potent agenda setter than organised interests." Organised interests may not be as strong a force as the national mood, but I suggest that the full effect of organised nursing is still largely unknown and untapped. For example, nursing can help to frame the national mood through its networks and clinical perspective on care, and the partnership of nursing and consumers in the future could be a powerful interest group. It can also add items to the various streams through utilising anecdotes from practice, research evidence and policy entrepreneurs.

Nursing organisations, through this policy-making process, functioned during the Taskforce events as both part of the policy community and as separate interest groups. Nursing is part of the wider policy group within health, but is also located in a nursing policy community through the sheer size of the nursing population. This in itself makes nursing a group of different interest groups in policy formation. Agendas within policy communities are at times "stable and at times fragmented" (Kingdon, 1995, p. 121). Nursing organisations in New Zealand were clearly functioning in a fragmented nursing and health policy community in mid-1997. Kingdon (1995, p.120) notes this is demonstrated by "few agreed-upon paradigms and greater susceptibility to crisis." Through the lack of structure within nursing's policy community, agendas were free-floating and volatile. As a group of organisations working collectively, nursing demonstrates some confusion over whether its political actions were based on self-interest or the public interest.

Nursing organisations are not unique as interest groups, and in fact appear to behave in similar ways to other interest groups (Kingdon, 1995) But nursing is different in its

being a very large group of predominantly female workers. Its size has not translated into influence, but then neither have other large female professions, such as child care. There are few studies on the political action taken by nursing organisations, which means that few “research tools are available to aid individual or group involvement in political action and thus support effective political activism” (Wilson, 2002, p. 30).

### **Values make a difference**

Nursing has a strong value base in the humanities, a feature common to all nurses (Bamford & Porter-O’Grady, 2000). This feature could be used in the future to build ongoing coalitions. It differentiates nursing from other interest groups – the art and science of our profession is our common foundation. It was this value base that was threatened by the reforms in New Zealand, and was part of the reason the “ah ha” moments of political consciousness occurred for nursing. These moments were demonstrated when nursing groups realised they needed to work together to achieve greater political attention. This suggests that nursing has to come under severe threat to act. Should we not be looking at ways of initiating the “ah ha” moments of consciousness rather than waiting for them to occur? Exposure to policy formation, political activism and postgraduate education in policy are all far less stressful ways to achieve this.

Mason et al. (2002, p.13) note that “nurses can and do influence workplace, government, professional organisations and the community... [and the] political effectiveness of a nurse in one sphere will be influenced by nurse involvement in another”. I suggest that the government sphere can also be influenced through the role of Chief Nursing Advisors as policy entrepreneurs (this will be further discussed later in this chapter).

Nursing organisations that function as a union also behave like other interest groups with industrial mandates (Bickley, 1997). Professional and union roles co-exist, and often this duality causes value conflicts within the organisation as the two roles are balanced. “Nurses who believe that it is necessary to strike to achieve better wages and conditions may feel as if they are abandoning their patients by not providing them with the benefits of their professional practice” (Bickley, 1997, p. 307). When a nursing organisation has both a professional and an economic interest, it will behave differently

to an organisation without a union mandate (Clark & Clark, 2002; Kalisch & Kalisch, 1982).

With nurses being marginalised in practice and in their industrial ability with respect to government and employers, the only way they could express themselves was through strike action. At a local level this did not have much affect during this time, so when the Government did start to take notice of nursing and the Ministerial Taskforce on Nursing was formed, it was a big issue for New Zealand nursing, especially NZNO: at last nursing had the sustained attention of the Government. This could have contributed to the way organised nursing during this time responded to the Taskforce.

NZNO could be interpreted as functioning at stage 4 of Cohen et al.'s (1996) stages of political development. The issues they were raising could be viewed as leading the health agenda, raising the profile of patient safety and nursing conditions, and being willing to be in a coalition with other nursing groups (in the Ministerial Taskforce on Nursing) for the broader health concerns. They could be responding, as Bickley (1997, p. 311) describes it, in the "only way they can to defend the New Zealand health service". This means leading the health agenda by calling attention to the relationship between nursing conditions and patient safety and care, and this is not self-interest (stage 2), which it could appear at face value.

### **Coalition building and leadership**

New Zealand nursing organisations used various mechanisms to engage in agenda-setting and policy formation. From the outside these activities appear chaotic and unrelated, but by viewing the case through Kingdon's theory, many of the nursing organisations' activities can be seen as being part of agenda-setting and policy-making processes. Coalition building and bandwagoning are two examples. Bandwagoning implies that people literally join a policy agenda when they want to, sometimes uninvited, as with the NZMA's input into the Taskforce. There appears to be little control over bandwagoning processes, unlike coalition building, which involves more active relationship building. Nursing needs to recognise this. Who do we want to hitch our wagon to, or who do we want to encourage to join our wagon train? With this perspective, groups could work differently together to prevent conflict occurring. At times it may be better to form coalitions; at other times, join bandwagons.

The stage of political development nursing achieves now will largely determine whether nursing will be able to respond to and address policy formation. I suggest that there is a predictable strong linkage between interest group behaviour and Cohen et al.'s (1996) political stages of development. Cohen and Kingdon use similar language (for example, "coalition building", "reactivity" and "proactivity in leadership"), all highlighting processes of engagement between groups and individuals.

It is through policy making that the political nature of nursing can be understood, but it is through leadership and coalition building that we can increase our influence. Mechanic & Reinhard (2002) reinforce this:

Nurses need to resist the comforts of isolation and collaborate aggressively. Only through close collaboration can we devise practical solutions to such tough issues as long-term care, mental health services, hospital safety, and end-of-life care (p. 14).

But to be able to influence health agendas, political development is required, beyond self-interest. Policy acumen, policy entrepreneurial activity and leadership are imperatives. This study highlights three important lessons for leadership. First, be clear about what you are leading and its purpose. The public commentary about the Taskforce revolved around nurses disagreeing with each other, such that the purpose of the effective utilisation of nurses and their contribution to health care was lost. Second, leadership requires followers: this study highlighted how groups can lose their power and mandate when fragmentation and dissension occur. Finally, leadership and policy entrepreneurship are strongly related.

### **Softening and contributing to policy**

Nursing can help to soften the policy environment and can maximise the opening of the policy window. The role of the nurse as policy entrepreneur in these respects was clearly shown in this study. The success of nursing in influencing policy and increasing political sophistication is to expose nurses not only to events like the Taskforce, but also to the theoretical and conceptual processes that convert it from experience to applied learning. Many nurses in New Zealand were left with feelings of disbelief and discontentment over what occurred, taking sides between NZNO, the Taskforce and the Government. The opportunity for learning from a policy perspective never occurred, and is still needed, so that we can apply what we have learned in the future.

Nursing organisations worked within many policy formation streams to raise issues, as demonstrated by the following activities.

1. Groups functioned in isolation to each other, but came together when government was looking for a solution.
2. NZNO used the media to profile concerns over patient safety and nursing staffing, in particular highlighting the problems in Canterbury Health where the Health and Disability Commissioner was conducting a review.
3. Individual meetings occurred between nursing groups and the Minister of Health, which raised problems with him but initially did not provide real solutions the Government could agree with.
4. There was agreement over the (pre Taskforce) draft paper, suggesting how a nursing taskforce could meet government agendas.
5. NZNO was unable to influence the Government successfully as a major health union. Frustration was high among its members (as depicted by the NZNO journal articles and media reports during this time), so other approaches were needed.
6. The College of Nurses was the only nursing group that publicly spoke out against NZNO's stance; other groups were publicly silent. This was perceived outwardly as support for the Taskforce.
7. There was negative blocking by NZNO as an interest group once they realised their agenda was not going to be met through the Taskforce ("Nursing taskforce report ready", 1998; "Commissioner's report damns", 1998; "Nursing taskforce granted", 1998; O'Connor, 1997; 1997/98; 1998/99; Oliver, 1997; 1998).

The question I would like to pose is: did nursing organisations know that their activities at this time were building up agendas in the "policy soup"? And if they had, would it have made a difference? I do not believe they were thinking in policy terms at the time,

despite engaging in it. This was due to the political development process that was occurring within the groups, which is demonstrated as follows.

1. NZNO felt it could control the Taskforce, yet it was clear from a policy perspective that once an item is on an agenda, control is lost.
2. The terms of reference of the Taskforce were indeed forward thinking – barriers to effective utilisation of nurses was a major issue for any group to tackle. The reality of nursing is that many factors affect the way nurses feel about their work, the way they practice and their reasons for staying in the profession. Neither the nursing organisations nor the Taskforce members negotiated with the government to have these issues included in the terms of reference.
3. All the media coverage was about how the Taskforce and NZNO were disagreeing with each other. The real issue of effective utilisation of registered nurses for better consumer care etc. was lost.

Cohen et al's stages of the political development of nursing have provided a means of viewing nursing organisations at the time of the Taskforce, and how they progress through the four stages. The conflict over the terms of reference, for example: was this a reflection of NZNO's stage of political sophistication, or was it because their role as an interest group meant they were still functioning according to self-interest, so that certain issues were claimed as belonging to them and their members?

Cohen et al.'s stages do not provide insight into policy making (this was not their intent), but nicely complement Kingdon's theories; in particular, the area of political activity, which is an important stream in agenda-setting and policy formation. The stages were developed out of a historical review of nursing activism in the 1970s (Wilson, 2002), and so far have lacked application in practice with nursing organisations. Detailed descriptions and the application of stages have not been available.

However, the stages do appear very linear and stagnant compared to the processes described by Kingdon. The concept of policy making being fluid is not captured by the

stages, nor by the four components. Cohen et al (1996) do acknowledge that nursing organisations can move between stages, and be at more than one stage at any given time. Cohen et al could be applied in a non-linear way, which is where the application of Mason et al.'s (2002) four spheres is attractive. The interweaving of Cohen et al.'s stages is required, combining the individual and organisational political development. Individuals and organisations can develop at different levels of political development, as shown in this study. I have suggested that an artistic (visual) redesign of Cohen et al.'s stages is required to acknowledge not only this but also the interactions between other organisations and context-specific requirements for international application.

Mason et al.'s (2002) second sphere of political action is government. Relationship with and influence of government has come through strongly in analysis of the Chief Nurse's role. Mason et al.'s government sphere should be more clearly reflected in Cohen et al.'s stages of political development of nursing, with more description under the *nurses as policy shapers category*. This study demonstrated how government processes influence nursing, through laws, regulations and policies. The New Zealand government mandated a stronger role for the Nursing Council of New Zealand, which in turn set up much of the conflict with NZNO and the Taskforce.

In providing insight into the development phase of nursing organisations, Cohen et al. sometimes raise more questions than they answer. For example, how do the stages acknowledge political activity by nursing organisations over longer periods of time? Can both positive and negative activity be demonstrated? Insights provided by Kingdon's theory on policy making, involving randomness and unpredictability, are helpful here. Kingdon believes that the stages are not linear, and that movement between stages is in a constant state of flux. Finally, the growth and development of nursing organisations continues through negative and positive events, as demonstrated by the Ministerial Taskforce on Nursing.

Cohen et al.'s stages in general require more description and definition. Take, for example, stage 2, self-interest: this study has shown that self-interest could be perceived as existing both within and between organisations. Self-interest within organisations could act in the public interest, which may explain NZNO's role. Self-interest is also inherent in interest group behaviour. This finding is supported by D. M. Wilson's

(2002) research on political action taken by nurses and non-nurses, utilising Cohen et al.'s stages of political development. Wilson suggests that “confusions over classifying both forms (public and self interest) of political action as stage 2... would not exist if this stage was labelled ‘political action engagement’” (p. 33).

### **Building relationships as an amendment to Cohen et al.'s stages**

There is a need for an extra category to be developed in Cohen et al.'s (1996) framework – *building relationships*. Leavitt, Cohen & Mason (2002) describe how success in a political situation depends on “one’s ability to establish and sustain strong interpersonal relationships”, (p.71) but this is not adequately covered by coalition building. Coalition building does not address the level of individual or organisational skills and processes required nor does it address relationships as a building block. Because of the significance of building relationships to the development of organisations and individual nurses, it warrants its own category in political development. It would build from the identification that one’s own organisation or self has a problem (stage 1), through to stage 4, where other individuals and organisations are modelling themselves on the relationship processes used.

In Stage 1 (Buy-in) the individual or the organisation realises they have a problem with relationships, this can occur through a significant event or through reflection and insight into issues of individual or organisational development.

In Stage 2 (Self-interest), attempts are being made by individuals or organisation to act on this recognition or problem and address it, through more active engagement with others.

In Stage 3 (Political sophistication), individuals and organisations become known and recognised for their ability to forge relationships, they join with other groups through coupling and bandwagoning activities.

In Stage 4 (Leading the way), individual and organisations develop new ways of working and others model their relationship styles and processes.

Each stage would reflect not only differing behaviours but also changes in language. It would show nurses building relationships to shape policy beyond and different to coalition building. It would encompass organisational and individual behavioural elements, as shown in Figure 4.

Figure 4

*Category-Building Relationships*

	<b>Stage 1 (Buy-in)</b>	<b>Stage 2 (Self-interest)</b>	<b>Stage 3 (Political sophistication)</b>	<b>Stage 4 (Leading the way)</b>
<b>Building relationships</b>	<p>Identification that there is a problem in one's relationships with others.</p> <p>Recognition occurs that relationships with others are integral to development</p>	<p>There are attempts to engage and listen to others, and ad hoc meetings occur.</p> <p>Learning occurs in regard to oneself and one's organisation, that relationships need to be built, networks are established.</p>	<p>Groups or individuals are categorised for their ability to problem-solve and manage relationships.</p> <p>Coupling or joining other groups (bandwagoning) occurs.</p>	<p>Relationship styles and process are modelled by other groups.</p> <p>A new strategic approach is developed, which others follow.</p> <p>Strategic alliances are common.</p>

This study has demonstrated how organised nursing needs to have a clearer understanding of what collaboration means between its component groups. That is, what are the things we can agree on and work together on, and how do we balance organisational needs and policies with wider professional needs? Would these types of discussions have helped prevent some of the events that occurred around the Taskforce? In hindsight I believe they would have, but the basis of any relationship is trust, and that was not there. The future, however, can be different.

**Implications for practice, policy and research**

How can we take what we have learnt from this study and apply it to practice, policy and research? We need to encourage more nurses to develop their practice in terms of influencing policy and thinking about policy in their everyday work. This needs to be a multi-faceted approach, from the individual nurse through to organised nursing, nurse researchers and policy makers. The following are suggestions for a way forward based on the findings from this study.

***Workforce implications: developing policy entrepreneurs and policy skills***

Policy entrepreneurs are visionary leaders. They trade in the world of ideas and action. They are people in positions of influence who thrive in the world of uncertainty. They are dedicated to their cause. They scan political horizons, help to orchestrate events and help move innovative ideas into action. The individuals who hold these positions came to be there for many reasons. For nurses to become policy entrepreneurs we need to create opportunities and support nurses to be in positions of influence, within and outside of nursing. But position alone does not a policy entrepreneur make. They require interpersonal skills of tenacity, perseverance, dedication, vision, risk-taking and high-level relationship management, and they must be well connected and networked. All of these can be developed, but such skills need to be identified early in individual nurses as they come through practice. With earlier identification, support, mentorship and different work exposure in the policy arenas, we can create a stream of policy entrepreneurs for the future. Nursing needs to think about its workforce for the policy arena, not just for clinical practice. Other industries plan and develop research strategies to develop their knowledge workers for the future. We also need to think about our workforce in this light.

Developing policy skills as a nurse is vital for our role in all facets of nursing. Recognising the “ah ha” moments is important. If supported and developed, nurses can increase their own policy skills and also contribute to the political development of nursing as a whole. This study demonstrates how complex fluid policy formation can be. Skilled nurses are needed not only to influence agendas through promoting issues into various streams, but also to assist with the development of policy options so that when choices are made nursing creates options to choose from.

Exposure to the policymaking process from a practical sense is also important. In New Zealand there is a need to develop practice placements for nurses in policy settings such as the Ministry of Health, Nursing Council of New Zealand and Ministry of Social Development. These would be similar to policy internships that exist in the US. Not only would this assist with learning about the machinery of government and the process of advising government, but it would also allow nurses to take a wider public policy perspective.

Nurses in all areas need to be professionally engaged in health and nursing issues. This can occur not only in the workplace, but through their engaging with their communities and professional organisations. Professional organisations cannot represent the views of nurses if nurses are not members.

Nurses developing these skills need to be offered mentorship and leadership. There are often experienced nurses in public policy positions who, despite not being in nursing positions, can offer a great deal of support and advice, either for those entering policy positions, or for those who want to develop policy skills in relation to their clinical, educational or research roles.

***Nursing organisations: building relationships and coalitions***

Nursing organisations, as shown in this study, play an important role in either positively or negatively influencing agendas. Building relationships between nursing organisations and other strategic interest groups is important. Part of building this relationship is being clear about what each other's positions are in regard to key areas in health. This study has shown that the conflict that arose between the nursing organisations and the Taskforce was partly preventable. There are areas where groups can agree to support each other and not compromise their own organisation's policies. This, however, requires regular communication and trust. Usual process of coalition building is that meeting occurs outside of formal meetings, but this did not occur because the climate was not conducive to this happening as outlined in previous chapters.

Leadership within nursing organisations either provides this communication positively or negatively. The leader–follower scenario was an important aspect to come out of this study. We need strong, confident, visionary leaders, and therefore need to support the ones we have and actively manage those who are holding us back from progressing.

The process of bandwagoning could be more widely used, so that smaller groups can achieve their agendas despite limited resources by “hooking” on to the momentum provided by other groups. Nursing organisations should also think more widely than just other nursing groups when considering joining a bandwagon or forming a coalition: they could identify non-nursing groups and consumers. Many health issues are commonly felt. This is where the development of the policy entrepreneur needs to

occur. Nursing organisations should identify mechanisms that can ensure their members are engaged in current issues.

Collectively, New Zealand nursing organisations could facilitate a policy summit, to meet with other stakeholders in the health policy community and debate the key issues challenging health care.

### ***Policy makers' exposure to nursing***

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 their organisation and the financing of care is shaped. At the same time, policy makers also need exposure to the perspectives on health and illness that nurses acquire in their daily work (Gebbie et al., 2000, p. 314).

Writers on nursing need to think about policy makers 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. Policy makers need research they can clearly understand and from which they can draw conclusions (Hewison, 1999).

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 these that provide the platform for the nursing profession to become directly involved in decision-making at all levels.

### ***Agenda-setting and the media***

The media played a major role in how the Taskforce was portrayed, not only to the nursing community but also to other stakeholders. Communication is an important part of influencing decision-making. Items can find their way into problem, policy or political streams through constructive and planned media strategies; this, of course, is how politicians use "spin doctors." One of the things learnt from this study is that media may not cover the issues you want covered. The opportunity to profile the Taskforce as working positively to ensure the utilisation of and support for thousands of registered nurses was lost. The messages were about nurses disagreeing with each other, implying

that nursing did not “have its act together.” Media coverage also assisted in fulfilling other interest groups’ agendas, as witnessed by NZMA criticism on advanced nursing practice. Media training for nursing leaders is important. Proactive media liaison is better than being reactive (Buresh & Gordon, 2000; Mason, Dodd & Glickstein, 2002).

There is an urgent need also for New Zealand nursing to influence the professional policy community, through its publications. New Zealand is small, so there is a lack of specialist media and journals in this area. A more policy-oriented nursing profession could influence this. In the future we could see New Zealand nursing authors on editorial boards, and not only publishing existing journals but also assisting to establish new international ones.

### **Issues for research**

This study has raised many questions about nursing, agenda-setting and political development. A comprehensive analysis of the effects of the health reforms on New Zealand nursing is called for. This study has been about one case; more cases would allow the policy learning to be more widely understood and generalisations to be made. None of the current policy texts about the health reforms in New Zealand analyse its effects on nursing, and, in turn, how this affects not only the health workforce but also patient care.

There is a real need to conduct comparative research internationally within nursing and policy. The majority of the research and literature on policy and nursing is from the US, which has a different socio-political context from New Zealand and other countries that have the Westminster style of government. What are the differences between how nurses and nursing organisations function as interest groups, or influence agendas and policy formation? Cross-national comparisons of organisational development and nursing’s political and policy evolution would enable an understanding of how nursing organisations in different countries address similar professional issues, such as nurse prescribing, advanced practice and the transfer of education into the university (tertiary) sector.

This study adds to our international knowledge, but there is much more that could be done now that globalisation is a reality. Issues for research are two-fold: those who conduct research and questions that need to be part of future studies.

Our nursing academics, who supervise and support thousands of students with research, need to not only think about policy when recommendations are being formulated, but also present and publish their findings. The use of case studies provides a wonderful richness to the context of policy formation, and there is a growing need to undertake more case study research in the area of nursing and policy formation.

Cohen et al.'s (1996) stages of political development, although useful in this study as a lens through which to study nursing organisations, require further exploration in practice. The relationship between political development and the attributes of policy entrepreneurship is ripe for research: What is the relationship between the style of organisational leaders and their organisation's stages of political development?

The issue of how nursing organisations manage and use conflict as a political strategy, as an interest group, is key to understanding political development further. Is management and use of conflict different within or among organisations? How does the level of interpersonal skills of those leading the organisations affect this? I suggest there is a strong link between the political development of organisations and how they handle and deal with conflict, and that the policy entrepreneurial role is key to this development.

Building on Kingdon's (1995) and Oliver & Paul-Shaheen's (1997) theories on policy entrepreneurs, what is the relationship between policy entrepreneurs and nurses as leaders, and how do nurses compare and contrast with other policy entrepreneurs? Research could be designed using interviews, surveys or attribute rating systems with wide samples to tease out answers to such questions.

The role of nurses in policy positions also needs further research, especially those in government agencies. The whole area of nurses in government is ripe for study. This could have enormous benefits, both for raising the issue of having nurses in policy positions, and for making this role more visible to the nursing community.

An area of international research could be in the experiences of “professional” organisations versus (or and) nursing collectives/union across the world. How do activities of nursing “unionisation” (recognising that term has different meanings across the globe) conflict, confront, activities of professional organisations. Another area of research could be a policy study of the differential success of the nursing professional organisations across the world.

For other nurses and people in senior policy positions in government, this study has highlighted how we can research policy issues, which we are intimately involved with. The challenges that this study posed to the researcher are comparable to any other nurse in government public service role. It is important that those of us in these positions do not shy away from awkward or sensitive policy and political issues, as it is through this kind of research that policy learning can occur.

## **Conclusions**

Policy is a legitimate component of nursing practice. It cannot be left to those in “official” policy-related positions, such as Chief Nurses, to undertake all that needs to be done. 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.

Understanding the concepts, approaches and strategies in policy making and having basic skills in policy and political analysis are essential to nurses’ meaningful contribution to health policy development (Hanley, 2002, p. 1). Without understanding the nature and complexity of the policy and political environment, efforts by nursing leaders and advocates to enhance their political sophistication and to articulate nursing interests with maximum effectiveness will be compromised.

This study has shown the potential for the kind of influence we as nurses can have, and how linked our political development is to processes of agenda-setting and policy formation. It has shown the negative and the positive sides of influence, but most importantly it has provided a body of knowledge about what to strengthen in New Zealand nursing and what to avoid in the future.

The policy entrepreneurial role of the Chief Nursing Advisor has demonstrated the importance of nursing's involvement in policy formation. What does this mean for nursing? It implies that we should concentrate on the present climate; just as meteorologists watch patterns of the weather, we need to watch the political, problem and policy patterns that are happening, right now. The complexities of the role of the Chief Nurse have also been unpacked in this study, tensions around being both a public servant and a nurse; relationships with own professional colleagues when one is also bound by the constraints of disclosure are highlighted.

This study showed New Zealand nursing the impact of working apart and together, and nursing came out the other side a stronger profession. We need to develop and support and let loose more nursing policy entrepreneurs on health. Their attributes are the missing link in political development. They not only work and enjoy change and reform, they also help to create it.

It is only through studies like this on the Taskforce that New Zealand nursing can have a policy-orientated learning experience of this significant event. Jenkins-Smith (1990) describes policy-orientated learning as the ability to understand the movement one makes (adjustments to thinking, actions, and processes) when confronted with constraints or opportunities that affect core values (p. 91). The reactions and adjustments nursing has made since this time is not the topic of this thesis, but by capturing this time and event we can now stand back and see the movement that has been made in nursing as a body politic in New Zealand.

New Zealand nursing survived, and was strengthened in its ability to influence policy at a national level, through the events of the Ministerial Taskforce on Nursing. Policy learning occurred because of the conflict that occurred and the ability of individuals and groups to stay focused, and determined to keep finding solutions to practical problems despite divergent interests. Just as in the past 100 years, international nursing leaders will continue to learn a great deal from New Zealand nursing, despite our size and geographical isolation.

## Chapter 9: Epilogue

The Ministerial Taskforce on Nursing completed its report in July 1998. The Minister of Health launched the report at a small district (community nursing) base in the Hutt Valley (24 kilometres out of Wellington). This sent two messages: the Government backs the report, but does not want it to have a high profile. After the launch, the Minister of Health communicated that the Chief Nursing Advisor would implement the recommendations. The Ministry had no extra budget or resources to do this. This was of no surprise to me personally, as I realised the Ministries workplan was set and without extra funds no new work would not occur. I did not however expect to have to try to undertake work with no resources.

Many of the recommendations were not to the Ministry of Health but to a total of 11 agencies (see appendix 4). As Chief Nursing Advisor I found myself in a situation in which I had worked hard to establish the Taskforce, managed on behalf of the Ministry all media responses to the conflict that later developed, and now had to somehow deliver on the recommendations, which were “multi-dimensional and interwoven... requiring a high degree of collaboration between agencies” (Ministry of Health, 1998c, p. 15).

I developed a project plan, scoping out all the recommendations and actions. Representatives from the 11 agencies affected by the recommendations were asked to meet with the Chief Nursing Advisor and other Ministry officials. Agency representatives outlined what actions they would undertake and identified any barriers. I regularly liaised with all of the agencies, and a reporting template was developed to track their progress against the recommendations.

In November 1999 the National government lost the election and a Labour government came into power. The health sector again changed, which affected the ongoing political and policy stream. The Health Funding Authority was abolished and all its functions devolved to the Ministry of Health. Hospital and Health Services were restructured into District Health Boards. Profit requirements were removed. Boards were required to be population-focused, and responsible for primary health care funding and provision. In a great example of how agendas change, we were now back to primary health care and

hospitals. The Employment Contracts Act was immediately amended to bring back bargaining and the representational roles of unions.

All of these changes affected the way the Taskforce's recommendations were to be actioned. They also affected the way nursing organisations responded to the recommendations. For example, NZNO now had a government that was philosophically aligned with the labour unions.

With the Health Funding Authority's staff, functions and role being taken over by the Ministry, many of the Taskforce recommendations were also inherited, including the need to address funding of nurse-led pilots, reviewing policies on nurses having access to laboratories, and mechanisms for increasing nursing advice into nursing organisations. Another thesis could be written on the implementation of the Taskforce recommendations.

From the end of 1998 through to 2000 there were regular meetings with national nursing organisations and other agencies responsible for implementing the recommendations. The Chief Nursing Advisor identified key people within the various groups to help drive the changes required. As many agencies changed, I aligned the policy work required to other areas – to Ministry of Health personnel, particularly. I regularly briefed the incoming government on nursing and the significance of the work of the Taskforce, using new terminology (collaboration, co-operation, reducing inequalities etc) to suit the new style of government. Often with changes of government comes a distancing of any work undertaken by previous administrations. The direction of the Taskforce survived, despite its rocky birth. This occurred as I adapted my style of policy advice to the new administration; I repackaged the significance of the nursing recommendations to deliver on their policy platforms.

The Labour government has been very supportive of the direction outlined in the report of the Ministerial Taskforce on Nursing. The report's influence may not be openly acknowledged, but the direction certainly is. For example, in 1999 the Medicines Act Amendment was passed, which made the legislative changes to allow health professionals other than physicians to prescribe medicines. In 2001 \$8.1 million was

provided for funding nursing models in primary health care and the development of a national policy framework for nurse practitioners in New Zealand.

Suffice to say it took sheer perseverance on the part of the Chief Nursing Advisor and the tolerance and hard work of nursing leaders, who trusted me as we wove many strategies into various policy opportunities that arose. The College of Nurses and Nurse Executives of New Zealand were key partners in this delivery. They undertook work on top of an already heavy workload to ensure the intentions of these recommendations did not get lost in the ever-changing health policy environment. During this time NZNO had no active role with the recommendations, and media attention stopped, they were concentrating on the new government and changes to the Employment Contracts Act, and internal organisational matters.

Despite the fact that the Ministerial Taskforce on Nursing was such a significant event in New Zealand nursing, its impact on the political development of nursing in New Zealand is still not well understood by the nursing community, partly due to its not being researched or significantly analysed. Those of us in nursing leadership positions openly acknowledge its significance as we use its policy platform to deliver the new developments in nursing. The content of the Ministerial Taskforce on Nursing is frequently cited in policy documents and also in business cases done by nursing executives in our hospitals and health services. It has become a major historical nursing report of the 20th century.

Since 2000 the various nursing groups attend regular meetings together under the auspices of national nursing organisations meetings, chaired by myself. There is a more positive climate now in regard to working together. We are making significant gains in policy as we work together, and that is another case waiting to be studied.

# Appendices

### Appendix 1: Information Sheet given to Expert Reference Group

My name is Frances Hughes. I am a registered nurse and I am currently studying towards a Doctor of Nursing at University of Technology, Sydney.

It is my intention to study the development of nursing as a body politic in New Zealand. This will occur through the examination of a framework of political development developed by Cohen, Mason, Kovner, Leavitt, Pulcini and Sochaiski (1996).

Through the use of an expert reference group and review of published material, the relevance and meaning of this framework in the New Zealand context will be explained and potential theory refined.

**Fig 1 THE PROGRESS OF NURSING THROUGH FOUR STAGES OF POLITICAL DEVELOPMENT**

	<b>Stage 1 (Buy-in)</b>	<b>Stage 2 (Self-interest)</b>	<b>Stage 3 (Political sophistication)</b>	<b>Stage 4 (Leading the way)</b>
Nature of action	Reactive, with a focus on nursing issues	Reactive to nursing issues (e.g. funding for nursing education) and broader issues (e.g. long-term care and immunisations)	Proactive on nursing and other health issues (e.g. Nursing's Agenda for Health Care Reform)	Proactive on leadership and agenda-setting for a broad range of health and social policy issues
Language	Learning political language	Using nurse jargon (e.g. caring, nursing diagnosis)	Using parlance and rhetoric common to health policy deliberations	Introducing terms that reorder the debate
Coalition building	Political awareness; occasional participation in coalitions	Coalition forming among nursing organisations	Coalition forming among nursing groups; active and significant participation in broader health care groups (e.g. Clinton taskforce on health care reform)	Initiating coalitions beyond nursing for broad health policy concerns
Nurses as policy shapers	Isolated cases of nurses being appointed to policy positions, primarily because of individual accomplishments	Professional associations get nurses into nursing-related positions	Professional organisations get nurses appointed to health-related policy positions (e.g. nurse position on ProPAC)	Many nurses sought to fill nursing and health policy positions because of value of nursing expertise and knowledge

Stage 1, the buy-in stage, represents the profession's recognition of the importance of political activism, encompasses activities that encourage and promote the political awareness of nurses. In stage 2, the "self interest" of nursing develops and uses its political expertise as it relates to the profession's self interest. In stage 3, the "political sophistication" stage, the profession goes beyond self interest and recognises the importance of activism on behalf of the public while attaining increased sophistication in its political strategies. Stage 4 is proposed as the "profession leading the way stage", in which the profession is envisioned as providing true political leadership on broader health care issues that speak to the public interests.

It is important to note that Cohen et al. (1996) stress that stage 4 is not necessarily the end of the stages, but the totality of the stages that they had developed at time of writing. They believe that new stages may be formed as nursing evolves.

The stages of nursing's political activism are not time bound. Nursing has straddled more than one stage of political development at a time (Cohen et al. 1996,p 259)

I have hypothesised that New Zealand nursing in general is somewhere between stages 1 and 2 of the model with regard to coalition building. Coalition building in stage 1 is characterised by occasional participation in coalitions, and stage 2 shows the development of coalitions forming among nursing organisations where "whatever the differences among these organisations and despite conflicts over competition and the claiming of credit, the ability to forge coalitions and compromises symbolises a new level of maturity for the profession" (p. 261).

Through the process of analysis, the applicability and validity of the framework to the New Zealand setting will be established. I am proposing firstly to test this framework, as this has not been done before, and secondly to establish whether there are new and evolving stages developing.

This framework is informative in that it provides a staged process of political development: "These stages are based on information gathered in a review of literature

of nursing's political activism and analyses of nursing's political involvement”  
(Cohen et al., p. 259).

Examining this framework against New Zealand nursing's political development will not only provide another perspective to nursing's political growth but also add to international debate on the subject.

### **Expert reference group**

An expert group will be established to provide advice on practical examples of stages from their own expert opinion; secondly, to provide commentary on the framework. Through this process, they will be validating the applicability of Cohen et al.'s (1996) framework. Practical examples will be from public information combined with commentary of the expert group. The group members will be selected by their specific political nursing experience and knowledge of New Zealand's nursing development over the last 10 years.

I am inviting you to be part of this expert reference group. Your involvement will require you to undertake a consultative process as a member of the expert reference group.

1. You will be required to provide published examples of major political issues in NZ nursing, which will lend themselves towards textual analysis.
2. A consultative process will occur by which the expert reference group will agree on 3–4 examples of publications which they believe most accurately reflect the stages of political development in New Zealand nursing.
3. The group will be asked to provide commentary and analysis of these examples through a focus group technique.
4. The commentary and analysis will then be analysed by the researcher against the model of political development identified by Cohen et al. (1996). Congruence and incongruence will be identified and mapped.
5. This mapping will be referred back to the expert reference group for validation, which will either occur by focus group or teleconference technique.

Your involvement in this process will be acknowledged by including your name, experience and reason for inviting you to be a member of the expert reference group within the methodology. If this is unacceptable to you, please advise me, as I will need to seek an alternative reference group member.

Data will be collected in the form of audiotapes and transcripts will be made. This data will be stored for the purposes of this research for a period of 2 years. It will only be accessible to my supervisors and myself. At the end of this period it will be shredded and tapes destroyed.

You are welcome to ask any questions and clarify or check any points or concerns with my supervisor or co supervisor at any stage of the research.

**Contact details of Supervisors are as follows:**

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**NOTE:**

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you may contact the Ethics Committee through the Research Ethics Officer, Ms Susanna Davis (ph: 0061 29514 1279), or by email on [Susanna.Davis@uts.edu.au](mailto:Susanna.Davis@uts.edu.au). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.



## **Appendix 2: Expert Reference Group Membership**

- **Jenny Carryer (Dr)**
  - National Director College of Nurses (Aotearoa)
  - Professor, Massey University Palmerston North
  - Previous Taskforce member
- **Marion Clark**
  - CEO Nursing Council of New Zealand
- **Julia Hennessy**
  - Mental Health manager, Hutt Valley Health
- **Judy Kilpatrick**
  - Chair of Nursing Council of New Zealand
  - Professor, Auckland University.
  - Previous Taskforce member
- **Julie Martin**
  - Previous Taskforce member
  - Nurse manager, Presbyterian Social Services
- **Gay Williams (Dr)**
  - Nursing leader and 3<sup>rd</sup> vice president ICN.
  - Ex NZNO president

**Appendix 3: Proposal to Minister of Health from New Zealand nursing organisations, for meeting 30<sup>th</sup> January 1998.**

**Re: A national strategy which supports Nurses able to deliver flexible, responsive patient-focused services.**

***Background and context***

There is currently significant under-utilisation of approximately forty-thousand registered nurses in the New Zealand health service. There is international recognition that nurses are key primary health care practitioners and are the boundary spanners to cost effective health care delivery. Evolution of the nursing role in both the primary and acute context is a core aspect of effective utilisation of nurses. This proposal seeks to initiate mechanisms whereby an existing resource can be fully and appropriately utilised.

Barriers to full utilisation are already well recognised but there is no strategy to address the barriers and the complex links which exist between them. There is also a need to remain cognisant of work already in progress; for example, work related to prescribing. Because of the complex links it is inappropriate for single agencies to address this issue; rather, a high-level strategy is required.

Barriers already identified include:

- a) difficulties with transition to practice due to poor mechanisms for supporting new graduates and significant changes in practice contexts (Consensus Conference, AK 1994)
- b) no recognised pathways to support new graduates into primary health care settings
- c) very low investment in postgraduate nursing education, especially of a clinical nature
- d) structural and legislative issues such as payment of practice nurse subsidy to GPs, ACC payments, laboratory access and prescribing restrictions
- e) the precarious nature of practice generated by the existence of standing orders
- f) an outdated Nurses and Midwives Act.

### ***Recommendations***

1. That legislative priority be given to the passage of a new Nurses and Midwives Act.
2. The formation of a ministerial task force to recommend to the Minister of Health the actions required by Government to support the evolving role of nurses.
3. We recommend the following composition, terms of reference and time line for the task force:
  - 3.1 ***Possible Composition of Task Force***  
 (Minimum only: others to be decided)  
 Chair: lay person (to be decided)  
 CHE senior nurse  
 Nurse educator with national focus  
 Primary health care nurse  
 Professional organisation representation  
 Chief Nurse Advisor  
 Economic advisor at senior level  
 Secretariat support via Ministry of Health, for example, as per CAPE secretariat.
  - 3.2 ***Objectives*** should include but not be limited to the following:
    - Identify existing barriers to full nurse utilisation of nursing personnel, research and knowledge.
    - Review possible funding mechanisms to better support transition to practice.
    - Review postgraduate educational requirements focusing on appropriate mechanisms for funding.
    - Make recommendations to Government.
  - 3.3 ***Terms of reference*** include:
    - To identify existing barriers limiting the potential scope of nursing practice
    - To make recommendations to the Minister of Health
    - To identify work streams necessary within this context to achieve recommendations
  - 3.4 ***Time line***
    - Announce Task Force early February 1998 (precede announcement with meeting between Minister and national nurse leaders)
    - Require report of Task Force by May 1998
    - Form professional advisory group to oversee identified streams of work required to dismantle barriers

### ***Improving flexibility in the health sector labour market***

#### **Problem definition**

Expectations for greater customer focus and advances in technology and knowledge are driving changes in how health services are best delivered over the decades ahead. Services will be increasingly organised around the needs of patients in their communities, with a shift of focus away from the traditional hospital setting.

Providers of health services need to be able to access and develop the skills and knowledge to match the different ways in which health and disability services will be managed and delivered, to keep abreast of changes in clinical practice and technology, and to work effectively with different population groups.

The health labour market will be guided by many factors: technological advancements, health service providers care models and available supply of practitioners. Provider demands are disciplined by the costs and practicalities of training, the preferences of potential trainees, and the merits of alternative careers. In a well-functioning labour-market, information and incentives combine so that labour inputs are attracted to areas where they add most value (in the right quantity and quality in the right place, at the right time, and at the right prices). Educators would also read these labour market signals and respond to them in a timely fashion by offering curricula that produce relevant combinations of skills and knowledge; new forms of labour can be expected to be produced as substitutes for, or complements to, established forms of labour.

The need for a highly intelligent nursing workforce in this environment is paramount. Nursing in New Zealand is prepared at an undergraduate level in a comprehensive nature; RNs enter the workforce as our multi-skilled worker in health care, but there are many barriers to their effective utilisation.

#### **Barriers to flexibility**

There are strong theoretical grounds, as well as anecdotal evidence, to suggest that the health sector labour market is less flexible and less responsive to the needs of employers, employees and professionals, and consumers than desired.

- labour and education markets are slow to adjust (for example, most education and training continues to be focused on specialisation in hospital settings, but the trend is community-based care)
- there is resistance to innovation, particularly from medicine (for example, resistance to share fields of practice as in nurse prescribing, and compared to international developments the introduction of new forms of labour is slow)

- barriers through government policies and funding mechanisms – subsidising medicine for nursing services (i.e. practice nurse subsidy), which affects access for consumers to direct nursing care
- some purchasing and contracting practices constrain substitution (for example, criteria to access GMS hinders substitution of nurse practitioners for GPs)
- funding mechanisms for education and training which exacerbate principal-agent issues (the HFA, through the CTA, purchases post-entry training that prepares some inputs of providers. The separation from pre-entry education which is subsidised by the Ministry of Education also introduces continuity/border issues).

As labour inputs account for 70–80% of the costs of health services the efficient operation of the labour market is of great importance to maximise health care per dollar; if the labour market is less flexible than optimal, there will be very significant costs. Health expenditure on nursing is currently \$1 billion per year.

There is currently incongruity between standards and professional practice preparation and what the nurse in practice can provide. Some of the barriers to date to the full utilisation of nurses are: lack of autonomy in practice, lack of defined support structures, access to sustainable postgraduate education, and funding and reimbursement for services.

Overall, a good system should only have relevant barriers to change; that is, those that address real safety issues and recognise the costs of change. The current system appears not to change optimally. It appears to be set up around what services want to provide rather than what consumers need. Investing and strengthening nursing can not only liberate care but also reduce barriers that are causing inefficiencies.

## **Appendix 4: Ministerial Taskforce on Nursing 1998 recommendations**

### **Recommendations**

In making its recommendations to the Minister of Health, the Taskforce stresses that the issues raised in this report are multi-dimensional and interwoven. In turn, the strategies require a high degree of collaboration between agencies and professional groups. It is *imperative* that the strategies are implemented in a cohesive manner. The contribution that nursing can potentially make to a more responsive, innovative, effective, efficient, accessible, and collaborative health-care service for New Zealanders will be less if strategies are chosen and implemented in a fragmented and piecemeal fashion.

### **The Ministry of Health (Manatu Hauora)**

The Taskforce recommends that the Minister of Health require the Ministry of Health to:

1. design an overarching framework for occupational regulation, which allows the requirements recommended in the review of the Nurses Act 1977 to occur. We recommend an approach that best achieves the following objectives:
  - speedy implementation
  - consistency across professions
  - flexibility (in allowing new areas of practice to develop)
  - consumer safety
  - accountability (Strategy 6, Chapter 2, section 2.5).
2. take responsibility for initiating the legislative change necessary to ensure that nurses have legal protection similar to that offered to medical practitioners (under the Medical Practitioners Act 1995) when undertaking quality audit procedures (Strategy 3, Chapter 2, section 2.5)
3. urgently address the current limitations of the Nurses Act 1977 which prevent the Nursing Council enforcing competency-based practising certificates and specialist and advanced competencies for practitioners. The Ministry will be required to address this issue in advance of the review proposed above in point 1 (Strategy 6, Chapter 2, section 2.5)
4. actively encourage and support nursing groups to submit proposals for other scopes of practice to be considered for nurse prescribing; and provide advice on how these can gain approval without each having to be considered separately by Cabinet (Strategy 1, Chapter 2, section 2.5)
5. develop a memorandum of understanding between the Ministry of Health and nursing organisations which emphasises and formalises the contribution nurses can make to policy (Strategy 1, Chapter 6, section 6.4)
6. require the Chief Nursing Advisor and Te Kete Hauora (the Maori health group within the Ministry of Health) to work with the Maori Health Commission, Te Puni Kokiri and national nursing groups representing Maori nurses to develop a plan and process for furthering the recommendations contained in Chapter 8.

7. work with the Ministry of Education to review the current arrangements for the purchase of undergraduate clinical training; in particular, investigating the cost implications created by the original unbundling exercise (Strategy 1, Chapter 4, section 4.4)
8. facilitate a process with the Crown Health Association and nursing organisations to discuss issues surrounding clinical career pathways, and an acuity system, for nurses and their impact on clinical practice. This will build on the existing work already achieved by the New Zealand Nurses Organisation and the Nurse Executives of New Zealand (Strategy 2, Chapter 7, section 7.5)
9. work with the Ministry of Education in undertaking a review of the number of polytechnics offering undergraduate nursing programmes, for the purposes of ensuring the provision of education and clinical experience of a high quality which matches the needs of the health and disability services sector (Strategy 1, Chapter 4, section 4.4)
10. undertake policy development work in consultation with the Ministry of Education and the Clinical Training Agency to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme is clinical experience (Strategy 4, Chapter 4, section 4.4).

### **Health Funding Authority (HFA)**

The Taskforce recommends that the Minister of Health require the HFA to:

1. make policy changes which allow nurses to order laboratory and diagnostic tests, and specialist-referral rights (Strategy 2, Chapter 2, section 3.4)
2. encourage the primary-care organisations with which it contracts to make more effective use of practice nurses, including direct access to nurses by patients and including nurses within management structures (Strategy 3, Chapter 3, section 2.5)
3. make the policy changes necessary to allow practice-nurse services to be purchased directly by the HFA in those situations where the general practice continues to receive the General Medical Services benefit (Strategy 1, Chapter 3, section 3.4)
4. fund and support the development of a project group to develop costing models for nursing services and the contribution that nursing services make to consumer care. The outcome of the project group will be a tool to assist the HFA in costing the services they provide (Strategy 3, Chapter 7, section 7.5)
5. re-prioritise in order to fund and support the development of nurse-led services (Strategy 2, Chapter 3, section 3.4); in particular:

- a) nurse-led integrated services, similar to the nurse-led pilots currently operating in the United Kingdom
- b) innovative services in identified 'health-gain' areas
- c) services that assist in developing clinical experience for nurses, for example, community health centres (Strategy 2, Chapter 4, section 4.4).

These nurse-led projects will need financial support similar to that provided to Independent Practitioner Associations during their establishment phase, and developmental support as nurses establish familiarity with the required information systems requirements, contracting and negotiation skills, and evaluation and monitoring skills. The HFA will undertake a project management role in the initial stages of establishment

6. develop an HFA organisational policy which requires involvement of, and advice from, nurses and nursing organisations on all health and disability policies, funding strategies, standards-development and service specifications
7. re-prioritise in order to fund and support senior clinical nurses to undertake management and leadership education (Strategy 3, Chapter 6, section 6.4; Strategy 5, Chapter 8, section 8.7).

### **Ministry of Women's Affairs**

The Taskforce recommends that work, led by the Ministry of Women's Affairs, be undertaken on gender barriers and work-measurement systems as they relate to nursing, with particular reference to the future forecasting of the nursing workforce (Strategy 4, Chapter 7, section 7.5). The Ministry of Women's Affairs will need to work with the proposed Maori issues interagency team in addressing issues which impact particularly on Maori (Strategy 4, Chapter 8, section 8.7).

### **Clinical Training Agency (a division of the HFA)**

The Taskforce recommends that the Minister of Health require the Clinical Training Agency, via the Chief Executive Officer of the HFA, to:

1. work with nursing organisations to develop and fund a national framework for the first year of clinical practice (Strategy 2, Chapter 4, section 4.4)
2. undertake policy development work in consultation with the Ministry of Health and the Ministry of Education, to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme is clinical experience (Strategy 4, Chapter 4, section 4.4)
3. examine urgently the inadequate funding of postgraduate nursing education, to ensure that any decisions are in line with the broad principles outlined by the Taskforce in this report (Strategy 4, Chapter 4, section 4.4).

### **Accident Rehabilitation and Compensation Insurance Corporation (ACC)**

The Taskforce recommends that the Minister of Health encourage ACC to:

1. work with the Nursing Council and nursing organisations to clearly identify the services ACC wishes to purchase from nurses and the competencies required to deliver those services (Strategy 4, Chapter 3, section 3.4)
2. continue the initiative in moving away from fee-per-treatment funding toward funding on a 'case' basis (Strategy 5, Chapter 3, section 3.4)
3. continue to improve their focus on purchasing preventive services (Strategy 5, Chapter 3, section 3.4)
4. take responsibility for initiating legislative change to the General Practitioner Cost Regulations (1993), which allow nurses to claim reimbursement from ACC for injury-related assessment or treatment services in primary care settings (Strategy 4, Chapter 3, section 3.4)
5. take responsibility for initiating legislative change to the Referred Treatment Cost Regulations (1990), which allow nurses to be identified as preferred providers of ACC services (Strategy 4, Chapter 3, section 3.4).

### **Directors of area mental health services (DAMHS)**

The Taskforce recommends that the Minister of Health, through the Director of Mental Health, direct the DAMHS to develop a clear and transparent process for the appointment of responsible clinicians under the Mental Health (CAT) Act 1992. This process is to reflect the spirit of the Act (Strategy 5, Chapter 2, section 2.5).

### **Nursing Council of New Zealand (the Council)**

The Taskforce recommends that the Minister of Health direct the Council to:

1. develop and, immediately following the required legislative change in the Ministry of Health recommendation 4 above, implement competency-based practising certificates for all registered nurses (Strategy 6, Chapter 2, section 2.5)
2. work with nursing organisations, agencies in the health and disability services sector, and postgraduate education providers to develop, recognise and validate specialist competencies, within a larger framework, which are linked to nationally consistent titles (Strategy 6, Chapter 2, section 2.5)
3. work with ACC to clearly identify the services which ACC wishes to purchase from nurses and the competencies required to deliver those services (Strategy 4, Chapter 3, section 3.4)
4. urgently audit schools of nursing on the teaching of competencies for mental-health nursing that were developed in 1997 and incorporated into the

undergraduate curriculum; and report on this to the National Mental Health Workforce Co-ordinating Body and the Ministry Of Health (Strategy 1, Chapter 4, section 4.4)

5. establish accreditation criteria for community-based clinical settings to allow nurses to more readily specialise in community care (Strategy 2, Chapter 4, section 4.4).

### **Health Research Council (HRC)**

The Taskforce recommends that the Minister of Health request the HRC to give priority to establishing, funding and supporting a nursing research centre. Such a centre would require support to eventually become self-funding (Strategy 1, Chapter 5, section 5.3; Strategy 3, Chapter 8, section 8.7).

### **Ministry of Education**

The Taskforce recommends that the Minister of Health invite the Minister of Education to:

1. co-operate with him in endorsing a joint Ministry of Health and Ministry of Education undertaking to review the number of polytechnics offering undergraduate nursing programmes, for the purposes of ensuring the provision of education and clinical experience of a high quality which matches the needs of the health and disability services sector (Strategy 1, Chapter 4, section 4.4)
2. undertake policy development work, in consultation with the Ministry of Health and the Clinical Training Agency, to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programmes is clinical experience (Strategy 4, Chapter 4, section 4.4).

### **New Zealand Insurance Council and the New Zealand Hospitals Association**

The Taskforce recommends that the Minister of Health make this report available to the New Zealand Insurance Council and the New Zealand Hospitals Association (Strategy 6, Chapter 3, section 3.4).

### **Nurse Executives of New Zealand and Nurse Educators in the Tertiary Sector**

The Taskforce recommends that the Minister of Health encourage the Nurse Executives of New Zealand and Nurse Educators in the Tertiary Sector to meet and consider the development of joint clinical/educator appointments (Strategy 2, Chapter 5, section 5.3).

### **Continuation of the Taskforce**

The Taskforce recommends that the Minister of Health support and resource the continuation of the Taskforce, in its current form, until March 1999 with the specific objective of overseeing the implementation of the recommendations and strategies in this report.

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