Nurses and policy making: You have a seat at the table? So what?

by

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If you have had anything to do with nursing and healthcare policy decision making in recent years you will no doubt have heard the phrase: ‘If you’re not at the table, you will end up on the menu.’

For nurses, this image reflects the reality that nursing is still often seen as a profession with very little power, one that is consequently a passive recipient of policy decisions, a profession that has things done to it without any say in the doing or the outcome.

In recent decades and in many parts of the world, we have seen an increase in managerialism in healthcare, with health being treated as a commodity that can be bought and sold. As a consequence, the roles of nurses and other healthcare professions have been squeezed, and in many places, they have been marginalised and removed from the management of healthcare organisations.

This has meant that healthcare services have increasingly been managed by businesspeople - mostly men, often with little or no experience of healthcare - and the locus of power has shifted to the management of medicine as a business, the focus of which is to generate revenue.

Having a seat at the table implies that our first job as nurse leaders is to make sure that we are in the room when policy decisions are made, and in addition, assumes that by occupying a seat we are actively involved and influencing discussions and decision making. But is that necessarily always the case?

To continue the dinner table metaphor, it is the guests who actively participate and make an impact that are remembered and invited back again. Just having a seat, rather than being actively involved and contributing to the discussions is never going to be enough. In fact, if having a nurse present is merely a tokenistic gesture, it can do the profession more harm than good.

To truly influence where policies are decided, nurses need to contribute, to demonstrate our knowledge and intelligence, including our emotional intelligence, and to be good listeners.

We need to have the facts at our fingertips and to bring with us the research and practice evidence, the analysis and the solutions to the problems we are confronted with. We need to know when to challenge and when to compromise, when to lead and when to forge partnerships. We need to have the backbone and the confidence to make nursing a central part of the dialogue, and to be persuasive influencers to make the changes that we see are needed.

To do all this, nurses need to demonstrate their knowledge of the evidence to deal with a situation, and their understanding of other people’s positions and priorities. We also need to use our networking skills to negotiate the way through problems, enter into collaborations and, perhaps most importantly of all, understand the organisation’s politics so that we can use our influencing skills to get what is the best evidence-based solution to the issue at hand. By being a significant player in the process, patients, healthcare services, communities, societies and nursing will benefit.

The nursing profession should never be shy of promoting the breadth and depth of its experience. For example, and as demonstrated in the research article “Beyond shots in arms: Assessing the country-level involvement of nurses in COVID-19 vaccination campaigns: A qualitative study”, by Moriah Ellen and Saritte Perlman et al (2023), nurses’ contributions to vaccination programmes go far beyond the physical act of injecting a vaccine. They include health education advice and prevention, the coordination of services, and that they provide a holistic, people-centred approach at all times.

Yet all too often, and even during the pandemic, the health and economic benefits of all of these nursing interventions are invisible, specifically because nurses’ voices are not heard at the top tables where they can increase the presence of nursing and have a greater influence to bring about positive changes and health improvements.

If nurses do not take the opportunities afforded them when they are sat in policymaking forums, they are missing an opportunity to influence healthcare, and they risk letting down patients and the generations of nurses who will follow in their footsteps.

That is one of the many reasons why ICN campaigned for the World Health Organization (WHO) to appoint a Chief Nursing Officer (CNO), which it did in 2017, and for the WHO regions to appoint their own regional Nursing leads. It is also why we campaigned so strongly and for so long for each country to have its own government-level Chief Nursing Officer (GCNO). As the largest professional group in the healthcare workforce, it goes without saying that nurses and nursing should be managed by nurses.

And yet, as our snapshot survey revealed (ICN 2020a), only half the countries in the world have a GCNO, and we have seen some so-called GCNO roles with no staff, budget or decision making authority, and even some GCNOs who are not registered nurses. Setting Nursing leadership up to fail in these ways, or using such elevated titles merely as window dressing, is worse than having no nursing leader at all.

Nursing is the profession that leads on the delivery of care 24 hours a day, and it is nurses who have the experience, the expertise and the research evidence that gives them a unique insight into issues such as patient safety, and the coordination, effectiveness, efficiency and integration of services. Nursing holds the perspective, insights, evidence and solutions to very many of the health needs and challenges the world is currently facing. Nurses can also be major contributors to cost-effective solutions to the problems people are facing, provide clinically safe access to care across the continuum of health and social care.

In our GCNO Briefing (ICN 2020b), ICN described GCNOs who have their own staff and their own budget, and who are plugged into the government’s decision-making processes at the very top level make a real difference. They can substantially influence government policy, and not just in healthcare, and coordinate and optimise the efficiency of the nursing profession.

But governments will only give us one chance, and rest assured, that if the first GCNO is ineffective, they will not be replaced, setting nursing back a generation. ‘Puppet’ GCNO roles with no budget or staff are doomed to fail and to produce an ‘I told you so’ reaction from those in authority who do not want to give nursing (a gendered profession) a seat of power.

A recent technical briefing from the WHO European region (WHO 2022) on strengthening the nursing and midwifery workforce to improve health outcomes demonstrated the benefits of having GCNOs. It was produced in response to a World Health Assembly resolution (74.15) calling on all member states to establish and strengthen very senior national and subnational leadership roles, and their input into health decision making.

The briefing identified five models of GCNO currently in place in Europe:

- Focal point model: there is a designated 'focal point' who communicates with nursing and midwifery forums, WHO and the government.
- Dispersal model: there are nursing and midwifery experts who perform separate functions in different departments and divisions within the Health Department.
- Programme model: there is a chief nurse and/or midwife who manages a specific programme.
- Advisory model: there is an expert advisor to senior policymakers (often chief medical officers) who is engaged in national decision-making but has no jurisdiction.
- Executive model: there is a nurse and/or midwife with line authority over nursing and/or midwifery who also shapes health policy by providing expert advice on nursing-related issues.

While undoubtedly there is value in all these roles, let's be clear that the executive model is what we should aspire to and be working towards in all healthcare organisations, and the advisory model within national and international policy and political decision-making bodies.

Nurses' knowledge and their insights mean that they should, in many situations, not just be the implementers of policies and systems, but the designers of such systems. For example, efforts to tackle the big challenges, such as the delivery of universal healthcare and the prevention and treatment of non-communicable disease, are overwhelmingly nurses' work, and so nurses should be put in charge of the actions required to achieve successful outcomes.

It is important to remember that while GCNOs can make a significant contribution and have a huge impact, it is also essential to have strong NNAs that collaborate synergistically with GCNOs and the healthcare system.

For nurses who are seeking these top-level jobs, and those who are enroute but not yet ready for them, ICN's own Global Nursing Leadership Institute is one programme that senior nurses can join that will prepare them properly for the rigours of policymaking at the very highest level. Its curriculum is all about turning the most senior nurses into the most effective leaders, with the influencing skills to match.

So, rather than having nurses on the menu, let's have them as equal partners at the policymaking table. And instead of people saying they sat and said nothing, let them say of nurses: 'They came, they sat, they conquered.'

- For more information about the GNLI, go to its website here.

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