Empowerment and Enterprise: The Political Economy of Nursing

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Introduction

Dr. Stephanie Fox-Young, President, Debra Cerasa, Chief Executive Officer, Fellows and members, Royal College of Nursing Australia, and guests, it is a pleasure to be honoured with the invitation to give the 43rd Patricia Chomley Annual Address.

As we approach the end of the first decade of this century there is much to celebrate in nursing and midwifery, and much yet to do. Patricia Chomley would be pleased to see what we have accomplished by forging links with one another. And I'm sure she would be heartened by the path we are following into the future. This evening, I would like to address the political economy of nursing. As those planning the annual conference have recognised, advancing the professions of nursing and midwifery is a sound investment. This is an inherently political statement, given that the essence of politics is the prudent allocation of resources for the benefit of the general public. I know the other speakers at the conference will be providing important comments and research findings related to the soundness of investments in nursing and midwifery, so I will reflect on a more general set of ideas intended to nudge our collective wisdom and intentions.

The political economy of health revolves around the many ways political, economic and social structures and systems affect people's health (Beckfield & Krieger, 2009). Similarly, the political economy of nursing and midwifery reflects how our roles, and therefore our capacity, are shaped by those same structures and systems. However, this is only half of the equation, as it is a reciprocal relationship. As members of these professions each of us has an implicit contract with society to act in a socially responsive way for the better of all members of the populations we serve. This obligation is not taken lightly. It is enacted every day in multiple contexts, by different types of practitioners, to the advantage of a wide range of individuals, families, groups and communities. However, it is not well articulated. It is not

well researched. It is not yet empowered by policy, and it is not well focused in our collective professional decision-making. This is not an admonishment but rather a point of departure for the future. As ICN (2009:1) declared in dedicating this year's international nurses' day to nursing innovations, "nursing's contribution to health care innovation is seldom recognised, publicised or shared amongst nursing and the wider public". This challenges nurses and midwives across the world to energise and empower our professions; to see our work as an enterprise that has value and a sense of worth because of our compassion, commitment, competence, responsibility, honesty, and integrity (Bednarski, 2009) as well as the measurable political and economic contributions we make to health and wellbeing, quality of life and social justice.

The Political Economy of Nursing and Midwifery

So what is it that we're doing right? Despite global workforce shortages and inordinately high workloads we continue to attract new members to the professions (Buchan, 2009; Duffield et al., 2009a; Preston, 2009). This is good news, as it indicates that there is a continued interest in nursing and midwifery, albeit at a slower rate of growth than in the past (Preston, 2009). We also know that those who are practising are making a difference. A groundswell of evidence has provided us with a clear link between the provision of nursing care and positive patient outcomes (Aiken et al., 2003; Aiken, 2008; Dall et al., 2009; Klein, 2007; Lankshear et al., 2005). Most of this research has addressed the relationship between the sufficiency of nurse staffing and patient outcomes, demonstrating clear linkages between nursing activities, symptom alleviation, patient and nurse satisfaction and lower mortality rates (Aiken et al., 2003; Kane et al., 2007; Klein, 2007, Lankshear et al., 2005; Rafferty et al., 2007). A significant component of this line of research has been focusing on *nurse sensitive* outcomes, with 15 nurse sensitive outcomes defined to date from a wide range of studies (Rumay Alexander, 2007; A. Smith, 2007). These include findings from nursing interventions related

to post-surgical outcomes; the prevalence of pressure ulcers, falls and restraint use; injuries from falls; catheter related urinary tract and central line infections; and ventilator-associated pneumonia. Smoking cessation outcomes have also been designated nursing sensitive outcomes, as have a number of management outcomes such as skill mix, nursing care hours per patient day, quality practice environment measures and voluntary turnover (A. Smith, 2007). And work on nurse sensitive outcomes for pain and other symptom management continues (Rumay Alexander, 2007; West et al., 2009). The main conclusion of this body of work is that adequate nurse staffing mitigates complications, improving recovery time and better care for patients, as well as creating cost savings for the healthcare industry. On the other hand, overwork and staff shortages can interfere with surveillance and monitoring of patient condition, early detection of adverse events and measures that would prevent complications (West et al., 2009). Clearly this aspect of our research agenda is on track to convince policy makers, the healthcare industry and the public, of the significant political and economic value of a strong, viable and satisfied nursing and midwifery workforce.

Nursing, Midwifery and Primary Health Care

The mounting evidence base for nursing outcomes is persuasive, but we also have to question its context, for a large element of the political economy of nursing and midwifery concerns the effects of our activities on the health and wellbeing of the population. Our activities are ultimately linked to the overarching goals of healthcare. These include equity, access, public participation in decision-making, health promotion, appropriate use of our tools and technologies, and collaboration between all public sectors and services of society. These healthcare system goals encompass the expectations of the population, and they resonate with the intentions of those of us who have committed our professional lives to caring for others. They constitute the strategies for shaping population health in both acute and community based care within our socio-economic political context (CSDH, 2008). They are the

principles of comprehensive primary health care, recently endorsed as a consensus view by all nursing organisations in this country (ANF, 2009).

 In an ideal world *all* health systems would be based on the primary health care model, which combines locally organised actions on the social determinants of health with strong primary care (CSDH, 2008). By placing people, our clients, at the centre of all activities, a primary health care approach can help overcome the systematic commodification, commercialisation and fragmentation of current health systems with their narrow, technical/medical focus and inequitable outcomes (CSDH, 2008; Graham & Norman, 2008). Because healthcare is a social good, those who stand to benefit from producing health care should not be the exclusive decision-makers. Instead, the community itself, engaging as full participants in what has been called 'deliberative democracy' should be central to decision-making (Mooney, 2008). This client-centred approach embodies the philosophy of primary health care, and it drives policies for good governance as well as for economic and social achievement. However, good governance must also be informed by those at the point of service, because with each step away there is a heightened risk of obscuring the purpose and potential of policies for the greater good (McMurray, 2007). Therefore our roles as health professionals are socially embedded in the communities we serve. The expectations of such a role includes our participation in policy-making, and this means we need to understand what actually constitutes health policies. Policies for good health are those that address not only states of health and illness but education, social protection, child care, housing, land use, the preservation of cultural and societal values, and adequate investment in health professionals, including the distribution of personnel across rural and urban areas, as well as permeable services that promote access for vulnerable people to move in and out of the system with ease (Beckfield & Krieger, 2009; CSDH, 2008; Peiris et al., 2008).

Our current health system is constantly challenged to provide good stewardship, quality, safety, efficiency and effectiveness. In being selective, and sometimes insular about our practice and research agenda we sometimes fail to see our role in helping overcome the socio-political forces that subjugate good health to political relations. Similarly, we sometimes fail to see how the political economy of health care can be a vehicle for professional development, and this can cause us to undervalue our work. Political action is integral to our role as advocates. It is a significant act of caring for others and our professions. This is described by one nurse leader as lifting "our lamps for the disenfranchised, devalued and forgotten" (G. Smith, 2007: 289). A good place to start would be to join our voices to contribute to the new National Women's Health Policy, and the Quality Use of Medicines Policy, both of which target the disadvantaged.

Solidarity is essential in any political action, and this is where we need our professional organisations. Together we can lobby for change and for equity. This involves pondering the functional components of social productivity, the policy levers that could be used to produce reasonable incomes and the elimination of poverty, and strategies for closing the gap between Aboriginal and non-Aboriginal people. As an organisational force we have a place at the table to also consider issues relevant to our ageing population, such as retirement and its funding, and the variable impacts of comprehensive and sustainable primary health care services on all population groups, including rural and remote living people (Villeneuve, 2009). Sharing professional research and clinical knowledge with our peers and with the global community has thus far attracted recognition for our contribution to health knowledge, learning and service design (Graham & Norman, 2008). The next logical steps are to translate our knowledge into better healthcare, and to cultivate health literacy among members of our communities to promote authentic partnerships for ongoing development.

Research and Empowerment

We conduct research in nursing and midwifery to provide evidence for good and better health care. But our research agenda and the practice changes it stimulates can also be professionally empowering. To date, nursing research related to policies has been criticised on the basis that it has tended to consist of scholarly opinion and policy *use* (Condell & Begley, 2007). To some extent, our failure to participate in *developing* the policy agenda lies in the narrowly defined discourses of nursing and midwifery. This may be as insidious as buying in to the view that our work is destined to prop up medically dominated hospital systems rather than be governed by higher ideals. To ensure that we are there where we are needed, and we are recognised for the full extent of our work, we need to continue to inform workforce policies, with an emphasis on nursing and midwifery work wherever it occurs. Existing nursing research has demonstrated the relationship between adequacy of staffing and nurse burnout with its consequent turnover or churn (Duffield et al., 2007; Klein, 2007; Rafferty et al., 2007; Spooner-Lane & Patton, 2007). Now we need to expand this agenda to the community and rural workforce, to refine measures of *production efficiency* to show how to deliver cost effective and efficient nursing and midwifery services in those contexts, and *allocative efficiency* to demonstrate the level of personnel, and the frequency and dose of practice processes that produce the maximum effect (Fawcett & Russell, 2001). Included in this research agenda would be a serious attempt to investigate the outcomes of the 'role drift' that occurs when duties are shifted from medical practitioners to nurses and from nurses to various assistants or health workers (McKenna et al., 2007; Shields & Watson, 2008).

Linda Aiken, whose research group has conducted some of the most powerful studies in nurse staffing and education, advocates deeper examination of policies governing

investments in both (Aiken et al., 2003; Aiken, 2008). She argues that by combining science based advocacy and evidence-based scepticism for holistic, patient-centred care, nursing can be best positioned for shaping the future of health care. Hers, and other research indicates that we are professionally imperilled by shrinking hospital budgets and their resultant cost containment measures, which have reduced patient length of stay (LOS) and intensified nursing care (Aiken, 2008; Chiang, 2009). Future research needs to construct a meaningful business case for investing in nursing on the basis of accurate costing of direct, hands-on care as well as indirect care, including the costs of administrative activities, referrals and supervising others (Chiang, 2009; Newbold, 2008; Weldon et al., 2006). It is a source of pride that Australian nurse researchers are accepting this position in advancing our knowledge base, particularly studies like Duffield et al.'s (2009b) analysis of the role of Australian nurse practitioners, which shows that the level of health care provided by them is beneficial, cost effective and highly regarded.

Globally, we have much to be proud of. Our former RCNA Executive Director and Commonwealth Chief Nurse and Midwifery Officer, has recently been elected President of the ICN. Clearly, we have come of age. As in other countries, our professional research profile is admirable, but it has not drawn nurse researchers together in a way that has been empowering. Wide variability in research methods, designs, settings and measures have not yet provided us with the level of clarity we need to make major policy changes in any country (Lankshear et al., 2005). To achieve this will require multi-site studies with a strong conceptual foundation that elucidate the mechanisms through which nursing affects outcomes. Research on nurse sensitive outcomes should also add to the existing base of knowledge with studies on educational preparation, care coordination, the role of care giving teams, and measures to link care outcomes for different cultural, demographic and clinical groups (A. Smith, 2007; Rumay Alexander, 2007). There is also a need for systematic studies

of the structures, relationships and costs involved in autonomous practice and their link to positive patient outcomes (Kramer et al., 2006). We also need to examine ethical and moral principles for deciding what is fair in health care to achieve equitable outcomes, and to address what practices promote social justice (Fawcett & Russell, 2001). To date, our hesitancy to engage in critical questioning and legitimised critiques of the racialised and gendered discrepancies that exist in the wider society, have inadvertently made us complicit with prevailing, unjust social and/or political values (Browne 2001). This disempowers our clients as well as ourselves.

Some argue that we have been seduced by the scientific model, overly focused on measuring interventions. This has failed to create understanding about human suffering and the primacy of relationships (G. Smith, 2007). Our own and others' autonomy and empowerment would be better served by a strong foundation of critical analysis of our work in relation to the health and wellbeing of those made vulnerable by race, ethnicity, location, age, gender or any other factor subordinating and disadvantaging them in relation to others (Beckfield & Krieger, 2009, Li et al., 2008; Lapierriere, 2008). This type of critical social perspective also brings the community to the policy table, incorporating their view of priorities for allocating resources (Mooney, 2008).

The recent consensus statement provides a conceptual foundation for this type of research (ANF, 2009). It also provides the stimulus for all nurses and midwives to see themselves as purveyors of knowledge. If Florence Nightingale is our role model, we are all researchers. Frontline practitioners in a variety of settings often spend the majority of their time defending their adherence to top down programmatic interventions and reporting requirements. Instead, we could be taking the initiative, "interlacing knowledge development with reflexive care practices in close proximity to local practice settings and with openness to interdisciplinary perspectives" (Lapierriere, 2008:394). This would generate more meaningful data from which

to plan locality specific, bottom up, client-centred interventions. This type of information would help expose some of the central tenets of the residual political philosophy of the past that has failed to address equity, tolerance, freedom and the contradictions inherent in a health system based on a market economy (Browne 2001).

Our Optimistic Future

Although we are part of a global network of like-minded professionals, there are some influences and issues affecting nurses that are uniquely Australian. Recent preliminary reports from the National Reviews of Primary Health Care and the Health and Hospitals Reform Committee, the Maternity Services Review and various state and Commonwealth health departments have created a unique opportunity to refocus our health policy and funding strategies (ANF, 2009). With primary health care clearly entrenched as the central focus for the future of Australia's health, our political landscape foreshadows a more equitable health system, one that is more inclusive and that seeks to improve continuity of care through closer linkages between hospital and general practice. The policy rhetoric of the current government also demonstrates heightened recognition of the fundamental role of practice nurses (PNs), who are currently experiencing a 'renaissance'; nurse practitioners (NP's) who are bringing the mantra of primary health care to previously neglected areas; midwives, who are adopting new collaborative models of care and community nurses, who have been 'doing' primary health care forever (ANF, 2009).

Like our counterparts in other countries, we continue to advance professional knowledge through research in health promotion, prevention of chronic illness, continuity of care, patient participation and self-management, appropriate, timely and effective interventions, symptom management, and the development of staff capacity and optimal skill mix (Hinshaw, 2000; Polit & Tatano Beck, 2009; Ross et al., 2004). We know this research

can create the momentum for change (Ross et al., 2004). Equally as important is the need to strengthen our research into leadership and management capacity to create pathways to professional empowerment (WHO, 2009). There remains a need for nurse leaders to also provide exemplars for responding appropriately in our internet savvy, 'googlized' society (Ratzan, 2007). This means that a careful balance must be struck between those studies that will provide hard, scientific evidence for change, and those that use alternative methods to help us understand the complexities of contemporary life. The research agenda should also continue to inform education, providing not only content for competence and intellectual challenge, but a depth of critique that allows us to examine how our pedagogies and ideologies nourish the soul, provide self-affirmation, and build inclusive societies, as distinct from the corporate agenda with its aim of producing employees who are 'fit for purpose' (Nolan et al., 2000). We would also advance our empowerment through an unwavering mandate to sustain the critical higher order skills engendered in degree level education (Shields & Watson, 2008). And our formal education system also needs to renew its commitment to understand the factors that motivate new entrants (Mimura et al., 2009), and those in the workplace who provide the professional socialisation and role modelling that are the key to their empowered survival (Mooney, 2007).

The challenges are profound. We need to continue to inform advanced practice and primary care nursing (Halcomb et al., 2008; Keleher et al., 2009; Middleton et al., 2007), collaborative practice (Patterson & McMurray, 2003), and new models of maternity care (Commonwealth of Australia, 2009). We should apply and extend this work to help transform apprehensions about the change in status and relationships in healthcare teams in a way that accommodates one another's vested interests and relationships. This challenge lies in forging cooperative links across traditional boundaries, modifying our assumptions of autonomy, reinterpreting our roles in terms of caring, excellence, professionalism and shared purpose

(Carroll & Quijada, 2004) rather than buying in to the turf wars of the past. It will require some major revisioning of our work and our enterprise.

Conclusion

In summary, our professions would be better empowered by development of a more critical ideology, refinement of the way we articulate our position, and a commitment to culturally appropriate socially just actions. We could do some 'anticipatory thinking 'to consider the actual and the possible and any obstacles to alternative interventions (Lapierriere, 2008). We could learn to 'read' the policy environment, to understand the convergence or differences in government and professional philosophies and priorities (Rafferty & Traynor, 2004), and we could cultivate greater understanding of how policies shape the way we promote health (Raphael & Bryant, 2006). These insights are empowering for us as professionals, and those around us, especially when they foster autonomy, creativity and conviviality. Introspection will help us crystallise professional values, ideologies and practices. In addition we need mutual support and self-affirmation from time to time, especially when change fatigue sets in on top of other stressors. We should be proud to be members of an enduring, enquiring discipline. We could do not greater service to our professions than to use our knowledge wisely, to gather it enthusiastically, and embolden it with voices that will be inspirational to the next generation. Today we have an opportunity to create a more equitable future, one we all deserve.

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