Advanced Practice in Nursing
Under the Auspices of the *International Council of Nurses (ICN)*
Series Editor: Christophe Debout

Madrean Schober

Strategic Planning for Advanced Nursing Practice

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This series of concise monographs, endorsed by the International Council of Nurses, explores various aspects of advanced nursing practice at the international level.

The ICN International Nurse Practitioner/Advanced Practice Nursing Network definition has been adopted for this series to define advanced nursing practice: "A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level."

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Nurse practitioners (NPs) who have mastered advanced nursing practice, and are capable of diagnosing, making prescriptions for and referring patients. Though they mainly work in the community, some also work in hospitals. Clinical nurse specialists (CNSs) are expert nurses who deliver high-quality nursing care to patients and promote quality care and performance in nursing teams.

The duties performed by these two categories of advanced practice nurses on an everyday basis can be divided into five interrelated roles:

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Madrean Schober

Strategic Planning for Advanced Nursing Practice

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Preface

Enthusiasm for the concept of advanced nursing practice worldwide represents a paradigm shift in thinking not only for nursing but also in planning for the provision and coordination of healthcare services. Volume 1 of the Springer monograph series on advanced practice in nursing introduced the concept of advanced nursing practice from an international perspective. This volume demonstrates the diversity in trying to capture this emerging field of healthcare professionals.

The complexities of launching and refining an initiative focused on the advancement of nursing are increasingly revealed through research, narratives, and growth in the number and variety of publications. Too often the facts and accounts confirm that legislation and implementation strategies are missing in national schemes, resulting in negative consequences. Practice environments are not always prepared to welcome advanced practice nurses. Healthcare stakeholders and decision-makers do not understand the advanced nursing concept. This knowledge suggests that strategic planning, including an understanding of policy and the policy process, could be beneficial not only in promoting the advancement of nursing but also in supporting the sustainability of the concept. This volume presents a range of topics and themes to bear in mind when identifying strategies for policy development and role implementation.

Built on content from Vol. 1, this volume is intended to be a resource for healthcare professionals, decision-makers, key stakeholders, and others interested in the advancement of nursing. The focus is on strategic planning and development of policy supportive of advanced nursing practice. Chapter 1 defines strategy, strategic planning, policy, and the significance of considering a strategic approach. In addition, this chapter presents not only the significance of identifying strategies but also the complexities involved in formulating a strategic plan. Key factors to explore in developing or refining an advanced nursing practice initiative are identified in Chap. 2. This chapter introduces the reader to the topic of policymakers and their policy networks and spheres of influence that impact the policymaking process. In addition, implementation and policy frameworks are provided to offer guidance in planning. Theories of social healthcare policy are discussed in Chap. 3 together with commentary on how these theories relate to nursing. Chapter 4 describes the realities and effectiveness of evidence-based policy decision-making followed by a discussion in Chap. 5 of the need for nurses to acquire diplomacy, negotiation, and leadership skills to participate and be actively engaged in politics and the policy

process. Chapter 6 reviews options for the assessment of healthcare environments in order to promote effective reform that includes advanced nursing capacity. Indicators, outcomes, and policy analysis processes are the focus of Chap. 7. Dialogue from different perspectives challenges the notion that strategic planning and policymaking are rational or logical processes. This theme emerges throughout this volume but is the specific focus for debate and discussion in Chap. 8.

The author draws on extensive personal international experience with a variety of country initiatives and assimilation of literature (nursing and non-nursing). Based on empirical evidence from research conducted in Singapore, a Conceptual Policy Framework for Advanced Practice Nursing is proposed. Informants, selected from countries in different phases of advanced nursing practice development, have generously offered examples of their country experiences and challenges. In bringing all these details together, the hope is to provide the reader with a menu of options from which to have a productive conversation about "real" and common interests resulting in a convergence of views for promoting and implementing a level of advanced practice in nursing.

Indianapolis, IN, USA Madrean Schober, PhD, MSN, ANP, FAANP

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Introduction 1

Consideration of advanced nursing practice (ANP) and the integration of advanced practice nursing (APN) roles as part of the healthcare workforce require policy development supportive of this emerging concept. Developing strategies and policy that promote the optimal scope of practice for APNs is a dynamic and complex process that operates within a political, cultural, and historical context. The process is sensitive to the country in which nursing, professional development, and policy-making take place. In turn, the country milieu is comprised of representatives of government, healthcare institutions, employers, medicine, and consumer cultures where a variety of opinions arise and diverse policy decisions occur.

In this chapter, based on evidence and noted positive outcomes for ANP in the literature, strategic planning is introduced as an approach that could facilitate not only the introduction of APNs but also contribute to the sustainability of an ANP initiative. The complexities to consider with a strategic approach are discussed. In addition, the chapter proposes that a variety of viewpoints affect the identification of strategies that influence the integration of APN in the healthcare workforce. Definitions and descriptions of strategy, strategic planning, policy, policy theory, policy process, and the significance of a strategic approach are introduced. Critical points to consider for strategic planning and a Conceptual Policy Framework for Advanced Nursing Practice can be found in Chap. 2. Further in-depth discussion of the policy process, evidence-based policy decisions, and theories applicable to social policy are discussed in Chap. 3.

1.1 Defining Strategy and Strategic Planning

Strategic planning is, by definition, about integration, long-term thinking, and a disciplined approach to decision-making (Mintzberg et al. 2003). It can be viewed as a process of defining a strategy or direction and making decisions in pursuit of a strategy that includes diverse mechanisms and methods to guide implementation. A strategy usually involves setting goals and objectives, determining actions to achieve the goals along with describing the human and financial resources needed

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to achieve the intended purpose (see Chap. 7 for discussion of the use of evaluation and indicators in planning).

A strategic approach may be formal or informal, typically involving repetitive rounds of analysis including discussion and feedback loops throughout the process. Some elements may be continuous and others may be executed as discrete entities with a definitive start and ending. The objective is to reach an identified decision or outcome.

Strategic planning can also be seen as an effort to systematize strategic thinking. However, it can be argued that strategic thinking involves creative activities that involve synthesis or "connecting the dots" and key intention of the ideas and concepts. Therefore, strategic planning assists in coordinating planning and measuring progress on key objectives, occurring as a result of strategic thinking (Mintzberg and Quinn 1996).

Formulation and implementation of strategies are intertwined as complex interactive processes in which politics, values, organizational culture, and leadership styles determine or constrain particular strategic decisions and influence outcomes (Mintzberg et al. 2003). Although the reader may insist on a singular definition for strategy as a concept, it is acknowledged that the term strategy has multiple definitions. Multiple meanings are provided to assist the reader to maneuver through the field of strategy formulation. Definitions of strategy are presented in Table 1.1 followed by some of their interrelationships.

Table 1.1 Definitions of strategy

Type of strategy	Strategy definition
Strategy as a plan	Some sort of consciously intended course of action, a guideline or set of guidelines to deal with a situation. By this definition, strategies are made in advance of the actions to which they apply and are developed consciously and purposively. They can be general or specific and can be labeled as an intended strategy or deliberate strategy where previous intentions are realized. This definition deals with how leaders try to establish direction
Strategy as a pattern	Encompassing resultant behavior, strategy can be viewed as a pattern in a stream of actions (e.g., successful approaches merge into a pattern of action that becomes a strategy). This perspective can be viewed as emergent strategies where patterns are developed in the absence of or despite intentions. Focuses on action-taking behavior into account
Strategy as position	A means of identifying an entity/organization in an environment. By this definition strategy becomes a mediating influence between organization and environment or between internal and external context. Collective strategy can then be seen as strategy to promote cooperation between organizations and decision-making entities. Such strategies can range from informal discussions to formal directives or ventures and can be identified at times as political strategies
Strategy as perspective	Strategy is viewed as an innate way of perceiving the world and represents an ideology or culture, e.g., government, healthcare, nursing, and consumer. This can also be seen as a worldview or collective perception about how the world works. In this definition, a perspective is shared with individuals united by common thinking and/or behavior. It focuses on intention and behavior in a collective context

Adapted from Mintzberg et al. (2003)

The definitions of strategy as a plan or as a pattern can be viewed independently. Plans may go unrealized, while patterns may appear without preconception. Strategies, rather than being totally planned or totally unintended, sit on a continuum that exists, portraying deliberate action along with emergent aspects of strategy formulation. Strategy defined as position and/or perspective can be compatible with strategy as plan/or pattern. Realistically, the interrelationships are complicated when developing an in-depth understanding of strategy in the face of reality (Mintzberg et al. 2003).

Strategy is not just a concept of how to deal with challenges or difficulties but contributes to consideration of some of the fundamental issues related to collective perceptions and action. In providing different definitions of strategy, the author intends to broaden and expand on the use of the term. In this way, it may be possible to enrich the ability of the reader to understand and manage the processes which influence and impact formation of strategies for the implementation of advanced nursing practice.

1.2 Policy and Policy Theory Defined

The concept of policy has diverse definitions depending on the context in which the idea is being referred to. Porche (2012, p. 2) suggests that "the term policy can be used to refer to standing decisions or principles that serve as guidelines for actions." In addition, Porche (2012) suggests that "policy is not random but purpose and goal driven" (p. 1). According to Walt (2006, p. 41) policy represents "a series of more or less related activities and their intended or unintended consequences" rather than a distinct decision. Milstead (2013) defines policy as a purposeful plan of action that is developed in response to a problem and includes guidelines that command authority and impact practice. "Nor is policy to be confused with strategy… Policy is the selection of non-contradictory means to achieve non-contradictory ends over the medium to long term" (Ignatieff 1992, p. 25). The multiple definitions of policy reveal the diversity in articulating meaning to this term. Therefore, the context in which the term "policy" is used must be considered in order to identify the intended meaning (Porche 2012).

Health policy includes actions that affect institutions, organizations, services, and funding arrangements of the healthcare system. In addition, it can include actions or intended and unintended actions by entities that have an impact on healthcare services and professionals. Thus health policy is concerned with not only healthcare provision but also with environmental and socioeconomic effects on health.

Frameworks, theories, and models can assist in explaining the policy process and policy change. A theory is a set of statements or principles developed to attempt to explain the interrelationship of facts or a phenomenon. A framework is a conceptual structure of ideas designed to present a particular approach to a specific objective. A model serves as a prototype to imitate or follow because it is a good example of its intention and function.

Theories are useful in that they communicate systems of ideas. Making use of a theoretical framework provides a simpler way to systematize, make sense of, and remember some phenomenon rather than considering every small detail. However, theories tend to simplify reality in order to provide some understanding of a complex concept; thus, the reader must go beyond theory in trying to understand and utilize theoretical concepts.

Policy theory is a scholarly or academic attempt at seeking to explain and generalize the policy process. In linking particular elements of theory to policy and policymaking, theory can assist in understanding some of the key issues, provide a useful frame of reference for drawing conclusions, and potentially lead to action (Minzberg et al. 2003). While academics have developed useful theories to describe and explain policymaking, applications of theory to the reality of practice are not always easy to translate and implement (Cairney 2015). However, policy theory is a useful way to describe and explain policymaking.

Diverse theories portray an understanding of policy and the policy process slightly differently in an attempt to present a descriptive account of how actions and change take place.

In addition, theories about how decisions are made are an attempt to address who influences policy. Normative or prescriptive decision-making theory proposes to identify an approach to making the best decision, depicting an ideal decision-maker who is able to calculate with accuracy a fully rational decision. The practical application of this prescriptive approach (how people *ought to* make decisions), also called decision analysis, is aimed at finding tools and methodologies for individuals to make better-quality decisions (Luce and Winterfeldt 1994). This perspective is based on the notion that decision-making is a rational process. See Chap. 8 for an in-depth discussion and debate of rational decision-making as a reality.

1.3 Significance of a Strategic Approach

The concept of a strategic approach for ANP development implies that there is a focus on agreed challenges, opportunities, and identified responsibilities that lead to action. The process of strategic planning or identification of a strategy can be initiated by an individual or key stakeholder who happens to control key or precedent setting actions. In addition, a collection of people who are inspired by interest in a specific issue, through a process of informal and formal discussions, can organize to develop a proposal or a plan (Mintzberg et al. 2003).

Even though strategic planning and a strategic approach are not a straightforward flawless endeavor, the possibility is that a coordinated effort could facilitate discussion leading to sustainable development. Even with the current enthusiasm for ANP and APN roles, there remains uncertainty as to whether the concept can be achieved at a local, national, or regional level. Approaching the concept strategically is complex, bringing together different players, key stakeholders, and decision-makers to the same table to discuss and identify issues that require policy decisions and action.

A strategic approach requires time, negotiations, debate, dialogue, compromise, and ultimately new approaches from everyone. Effectively developing a strategic approach is not simple. For those who are used to more perfunctory techniques or quick fixes, this can seem tedious and time-consuming, sometimes frustrating to identify and deliver feasible actions. Ideally, participants in the planning have the opportunity to build on their ideas and shape them through use of a framework toward policy and proposal development (see Chap. 2, Sect. 2.2 for examples of frameworks).

1.3.1 Benefits to a Strategic Approach

Advantages of planning or identifying strategies vary with a common aim to decrease errors or problems and optimize benefits for an initiative or new venture. The benefits in relation to ANP include:

- Long-term sustainability for advanced nursing practice
- Identifying connections/networks
- Enabling different interests to work together
- Developing a common vision and objectives
- Identification of priorities
- Addressing problems and barriers at an early stage
- Avoiding inappropriate development

Dùthchas (2014)

Beneficial and skillful strategy develops from independent and thorough assessment of the circumstances, connecting individual insight to a carefully crafted purpose (Rumelt 2012). The ability to assess the fundamentals and identify the pivotal strategies needed to provide substance to a plan separates beneficial strategies from those that are less likely to succeed. A good strategic plan acknowledges the potential challenges and includes an approach to overcome them. In addition, an effective strategic plan focuses and coordinates efforts that include problem solving when unanticipated blockages or barriers might occur.

The strength of a strategic approach potentially works by focusing on one or very few pivotal objectives that when accomplished lead to favorable outcomes. In addition, an effective plan offers achievable ways of overcoming any key challenges. Ultimately, a good strategy is an educated judgment or hypothesis about a hoped for outcome.

1.3.2 Limitations to a Strategic Approach

The fundamental concept of developing a strategic approach is to develop strength and support for a promising opportunity (Rumelt 2012) or, in the case of ANP, the advantages of including this concept in provision of healthcare services. However, limitations or construct of a bad strategy can emerge from an inappropriate

assessment of the context and/or specific misconceptions of the intention of the plan along with dysfunctional leadership. Rumelt (2012) presents four major characteristics that limit effective strategic planning:

- Use of obscure or confusing terminology along with incomprehensible concepts that create the false impression of sophisticated thinking
- Failure to define the question or topic and identify the objectives of the plan
- Confusing goals with actual strategies and action
- Failure to address the critical issues and/or offering strategies that are impractical and unrealistic

A strategic plan with objectives that appear cluttered and disorderly with a long list of things that need to be done is not really a strategy. Unfortunately, when a collective of decision-makers and stakeholders develops a long list of objectives rather than a focus on important issues and proposed actions, there is a likelihood that few if any of the issues will be addressed properly. The hard work involved in creating a sound strategic plan will release potential rather than limitations in developing a beneficial approach for implementation of ANP.

Conclusion

Concepts such as strategy, strategic planning, sustainability, and policy development mean different things to various decision-makers. Differing views present challenges when attempting to identify important distinctions in an effort to establish policy and strategies supportive of advanced nursing practice. This chapter offers language and definition for terms and concepts as a background to facilitate discussion and encourage participation in decision-making.

Nurses and nursing leaders, especially those driving advanced nursing practice initiatives, should have an understanding of policy, policy development, and related political processes in order to clearly identify strategies for change. Resultant strategies impact health policy and the consequential healthcare provided to individuals, families, and communities that comprise a country's populations. The introduction to policy and strategy in this chapter begins to provide guidance for the possibility of strategic planning and strategic thinking for advanced nursing practice while also recognizing that these processes are not a clear, coherent, rank-ordered set of preferences. An awareness of some of the basic concepts is viewed as a starting point for becoming engaged in politics, policy processes, and strategy formulation.

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Strategic Planning for Advanced Nursing Practice

2

Despite extensive literature supporting the value of the concept of advanced nursing practice (ANP), the most favorable processes for development and implementation of advanced practice nursing (APN) roles remain unclear (Delamaire and Lafortune 2010; DiCenso et al. 2010; Horrocks et al. 2002; Sastre-Fullana et al. 2014; Schober 2016). Mounting evidence suggests that effective integration of APNs into the healthcare workforce must be tailored to meet a country's healthcare and population needs based in the respective healthcare environment. Frequently this is part of wider healthcare systems reform (Buchan et al. 2013; Fukuda et al. 2014; Gagan et al. 2014; Schober 2016; Vatankhan et al. 2013). Variability between countries and even within the same country appears to be dependent on national and local contexts including government, healthcare, nursing, and consumer cultures.

This chapter begins by proposing key factors to consider in exploring the possibilities of introducing an advanced nursing practice scheme. This is followed by an introduction to various aspects of the policy process along with recommendations of how nurses can participate in the policy process. Descriptions of theoretical frameworks and a country-specific illustration based on a theoretical conceptual policy framework are offered as guidance for planning, strategic thinking, and decision-making.

2.1 Key Factors to Consider in Exploring the Possibilities for an Advanced Nursing Practice Initiative

Based on a comprehensive review of the ANP and APN international literature for a study conducted in Singapore (Schober 2013) and development of Volume 1 of the Springer advanced practice in nursing monograph series, *Introduction to Advanced Nursing Practice: An International Focus* (Schober 2016), a number of key factors

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were found to be essential when considering the possibility of an ANP initiative. These factors include:

- The need to establish mechanisms and policy to support the full authority and scope of practice for APN roles
- A mandate to clearly differentiate APN roles from other healthcare professionals including other nurses
- The criterion to develop strategies for policy development and to increase awareness of the expected function of APNs
- The necessity for strong managerial leadership to facilitate effective implementation

Repeatedly, whether looking at a successful ANP initiative retrospectively or anticipating creation of a new scheme for the introduction of APNs, the topics of policy development, legislation, regulation, and standards relevant to this new nursing role emerge as necessary for supportive development and implementation (Schober 2016). Policy emerges as a product of the political environment that involves a course of action or procedure by government entities that supports a principle or idea. Legislation is the act of making or enacting laws. Regulation is an authoritative rule or order issued by an executive authority or regulatory agency. Standards refer to a universally agreed upon level of quality or achievement that is considered to be desirable in behavior or practice for a basis of comparison or as a model to emulate.

In a survey of 39 countries with varied levels of task shifting in primary care from physicians to nurses, Maier and Aiken (2016) concluded that a supportive policy context includes up-to-date regulation and education reform. In addition, this survey found, however, that even countries with more advanced experience with APN roles demonstrated variance in regulatory environments that were thought to impact practice patterns. For example, in the United States due to the decentralized, state-specific jurisdictional authority over scope of practice laws, changes have been ongoing for decades and vary from state to state. Decentralized regulation appears to result in uneven role implementation generating barriers to the effective integration of APNs into the healthcare workforce. The concept of advanced nursing practice is facing an era of attention and enthusiasm in noting evidence of positive outcomes for nurses functioning at an advanced level. However, the implication is that this increased awareness should move policy dialogue forward to effectively support and guide effective implementation of APN roles.

2.2 Defining the Policy Process

Policymaking is a complex, multidimensional, dynamic process influenced by the values of the individuals who establish the policy agenda, determine the policy alternatives, and define the goals to be achieved by the policy, the implementation methods, and ultimately the manner in which the policy is evaluated (Porche 2012). Theories about policymaking are usually concerned with processes. Walt (2006) suggests that macro theories of consensus and conflict and the micro theories of policymaking come together in describing who and what influences policy

development. Kingdon (2003) proposes that policymaking is a set of processes including at least:

- The setting of the agenda
- Specification of alternatives from which a choice is to be made
- An authoritative choice among specified alternatives such as in a legislative vote or governmental decision
- The implementation of the decision

Kingdon (2003) further emphasizes that success in one process does not necessarily imply success in others. An additional explanation is provided by Hogwood and Gunn (1984) who identify the following set of processes:

- Deciding to decide (issue search and agenda setting)
- Deciding how to decide (issue filtration)
- Issue definition
- Forecasting
- Setting objectives and priorities
- Option analysis
- Policy implementation, monitoring, and control
- Evaluation and review
- Policy maintenance, succession, or termination

While there is little disagreement that the policy process consists of various stages, there is a great deal of disagreement as to how far policy follows a rational or logical process from problem identification to policymaking. A point that is discussed throughout this chapter (see also Chap. 8) questions if it is possible to develop a rational strategic approach or to formulate rational policies. A contrasting viewpoint is that rationality does not fully describe the erratic nature that represents the real world of developing policy. There is an argument that theoretical frameworks give a false impression by implying that policymaking follows a linear process going through sequential phases. This variance in perspective will be discussed in further detail in later sections of this chapter and in Chap. 3 – Theories of Social and Healthcare Policy. Refer also to Chap. 8 – Rational Policy Decision Making: Idealism versus Realism.

2.2.1 Agenda Setting

Agenda setting is often considered to be part of the policymaking process when determining what topics or issues are likely to catch the attention of policymakers and are deserving of policy solutions and resolution. The agenda is a list of topics, issues, or concerns to which government officials, and people outside of government but closely associated with these officials, are paying some serious attention to at any given time. Theoretically, out of a set of identifiable issues to which policymakers could be paying attention, more consideration is paid to some topics rather than others.

In theory, the agenda setting process narrows the set of possible topics to a set of issues that actually become the focus of decision-makers' attention (Hall et al. 1975; Kingdon 2003). Within the domain of healthcare, for example, the ministry of health or health department will be considering a range of issues at any one time. Out of an array of issues or problems, some obtain serious attention in preference to others. The ministry of health may have a more specialized agenda such as health sector reform and cost of healthcare services, whereas decision-makers on the ground may be looking at effective access to care, preventative healthcare, or specific population needs (Walt 2006). As a result, before a policy can be formulated and adopted, the issue must compete for space on the agenda or list of items being actively taken into consideration. Agenda setting can be viewed as an early phase of the policymaking process following identification of the issue needing attention.

From this perspective, a topic or issue must make it on to the policy agenda in order to progress through the policy process to ultimately progress to formal legislation, regulation, and subsequent implementation. For policy change to occur, policymakers must be convinced that a problem or issue is serious and deserves their consideration. Reaching agreement among policymakers as to what constitutes a topic worthy of discussion toward a solution can be challenging and often requires strategic planning. In addition, developing strategies includes knowing the various decision-makers and their spheres of influence in order to identify possible ways to influence the policy process (refer to Chap. 3, Sects. 3.1 and 3.2 for further in-depth discussion of agenda setting).

2.2.2 Policymakers and Their Networks

Interpersonal social and political networks influence agenda setting (Porche 2012). Policymakers do not start with a blank sheet of possibilities. Previous decisions affect present policymaking (Walt 2006). Many individuals may have a say over discussion of policy, but in most situations, the government and government entities have ultimate control over legislation and the policy process. Within governmental structure, such as with the ministry of health, there may be some tension on the topic of ANP that may occur between key stakeholders representing medicine and nursing and the politicians (Walt 2006). However, in policy formulation, ministries of health and governmental agencies will have established structural and infrastructure mechanisms to facilitate consultation with a variety of professional bodies and/or interest groups.

The effectiveness of various consultants, advisors, and representatives of lobbying groups is likely to be dependent on the extent of decentralization or centralization in the political system (Maier and Aiken 2016; Walt 2006). In countries where power is tightly controlled at the top level or center, a small number of key decision-makers may have the power to resist, block, or delay either policy formulation or implementation (see Chap. 3 for further in-depth discussion of Walt's approach to policy development).

In attempting to identify what issues might be considered for a policy agenda, Walt (2006) proposes asking the following questions in order to focus attention on an issue:

- Who identifies a particular issue as a problem or concern?
- Is it a "real" problem and legitimate for policymakers to intervene?
- Is there likely to be agreement and support for the issue/concern?
- Is the time for policymaking premature?
- Is the policy context/environment acceptable?
- Is the issue being considered at the appropriate level of agency, unit, or decision-making body?
- Is the causal structure predisposing to the problem/concern understood?
- Can implications of the issue be specified and quantified?

Even though it would be preferred, policymaking seldom proceeds as a rational linear process. Identifying pointed questions may be a simplification of a very complex process but is intended to pique the interest of the reader to move toward creative thinking and strategic planning. Many different reforms or changes compete for policymakers' attention. As healthcare professionals, knowledgeable of healthcare cultures in the country, APNs have the opportunity to participate in and guide discussions to clearly identify topics that will catch the attention of policymakers.

2.2.3 Influencing Policy Decisions

There are multiple ways to influence the policy process and promote desired policies. However, it can be argued that power and the authority to set policy is decided by a small group of influential leaders within and/or outside of government. Alternatively, another view is that domestic policies on such topics as health are likely to be developed with some participation from different groups or individuals at different points in the policy process. The potential for participation such as lobbying on behalf of interest groups often exists; however, it is not always clear in what way and at what level participation can be influential and most effective.

Insightful discussion and analysis of the policymaking processes are useful in that it increases awareness of the gaps between what is considered to be rational procedures and what actually happens in real practice. Efforts from the rational to the erratic identification of the components of policy decision-making can lead to beneficial outcomes. The author suggests that knowledge of how policy processes function and identifying ways to influence it strengthens the position APNs will have in engaging in that process (see Chap. 5 for further discussion on nurses' stages of political engagement and acquiring the necessary skills).

2.2.4 Nurses' Participation in the Policy Process

The emergence of the concept of ANP has contributed to increased visibility for nurses and their various levels of practice. This increased visibility suggests that nurses must actively participate in policymaking, the policy process, and strategic planning dialogues. It is increasingly important that nurses, specifically APNs, take

on advocacy roles and strengthen their leadership skills to become policy leaders and influence the decision-making processes. In addition, APNs must recognize that policy and the impact of supportive policies are an integral part of everyday professional nursing practice (Stewart 2014).

Lack of advocacy and lack of efforts by the nursing community to educate others regarding the value and importance of APN roles are viewed by Shamian and Ellen (2014) as a major barrier to the advancement of ANP. This view implores nurses to strive to become politically knowledgeable and to actively participate in policy decision-making. We no longer live in an era where it is acceptable for decisions that impact nursing practice to continue to be made by individuals who have limited knowledge of nursing, especially in times of healthcare reform and dramatic change taking place in the profession.

Becoming participants in politics and the policy process requires an understanding of power relationships, the use of political power, key stakeholder networks, and their spheres of influence (Buchan 2016; Schober et al. 2016). Even when the principles promoted by nursing are sincere and intended for the good of communities and their populations, nursing needs to also demonstrate its value linked to public healthcare needs aimed at influencing the policy agenda. Buchan (2016) in speaking to policy engagement for nurses emphasizes that evidence has to be compelling and have a "popular impact and policy resonance" (p. 302) with a focus on cost effectiveness and improved outcomes.

In responding to a question on alternative ways nursing can influence political decision-making, Catton (2016) suggests that nurses need to shift the techniques they use in framing their recommendations. This perspective includes thinking and operating outside only nursing and health, beyond health departments to other governmental agencies and entities. In addition, Catton (2016) emphasizes that:

> Nursing is at the forefront of delivering services in new ways and through new models. We need to be more bullish and confident about advancing nursing roles and our profession's potential to help deliver solutions (p. 311).

In order to consider how APNs can be effective in the policy process, Harris (2014) advises that there are four components to consider when developing health policy. These are identified as the policy process, policy reform, policy environment, and policymakers. To engage in health policy development, Harris (2014) recommends that APNs:

- Review and discuss the identified issues based on obtainable information
- Remain informed and become involved in policy activities and meetings
- Maintain a visible presence that involves articulating a clear position and distribution of relevant information on the issue
- Demonstrate the value of APNs to policymakers and key stakeholders

An incremental approach for nurses to increase participation in policy and policy development seems safe and sensible; however, it is likely that an emergent and pivotal topic will arise to catch the attention of APNs and motivate them to become involved. This is particularly true of barriers to optimal practice such as lack of

prescriptive authority and limits to expected levels of autonomy along with obstructions for populations to access healthcare services provided by APNs.

Nurses are in a position to influence policy decisions at the government level, workplace, organizations, and in the community. Options may exist beyond country-only level, for example, nations in Europe may obtain assistance from the European Union. Moving from becoming leaders in clinical practice to assuming leadership positions in the health policy arena is not an obvious choice for nurses (Duffy 2015). Political literacy or knowing how the policy process works and identifying potential strategies for engaging at some point in the process enables beneficial representation for APNs and their relevant issues.

Policymakers and key stakeholders at multiple levels of decision-making influence APN practice, standards, regulation, and professional progression. This in turn shapes the direction of healthcare delivery and the resources needed to provide services. Duffy (2015) suggests that the skills nurses use in motivating populations to improve their health are the same skills that can influence policymakers to develop legislation and standards to support optimal APN practice (see Chap. 5 for further discussion on nursing's participation in the policy process).

2.3 Frameworks for Implementation of Advanced Nursing Practice

Models and frameworks conceptualizing ANP provide guidance for research and for understanding actions that could be helpful in practice settings and strategic planning. Although at times the terms are used interchangeably, model and framework have subtle differences in definition. Models provide an example to follow, imitate, or emulate. Frameworks provide a conceptual structure of ideas and how they interrelate. Common language in conceptual frameworks is intended to guide and/or evaluate practice, education, policy, and research.

Integration of advanced levels of nursing practice and APN roles involves processes that call for contemplation as to what models or frameworks are appropriate for use in the healthcare environment. No single model or framework is guaranteed to be suitable for all countries and practice settings. This section describes frameworks worthy of consideration for role implementation and/or policy development. Certain aspects of any framework may be suitable for a particular context, and key points of more than one model or framework may be combined to best suit specific circumstances. Selection of context-sensitive components takes place in the process of strategic thinking and planning.

2.3.1 PEPPA Framework

Canadian researchers Bryant-Lukosius and DiCenso (2004) developed the PEPPA (participatory, evidence-based, patient-focused process for advanced practice nursing) Framework to provide guidance in the development, implementation, and

evaluation of APN roles. This framework has been utilized in a variety of ways in 16 countries as nations seek to more clearly identify the issues that need to be considered when integrating ANP into the healthcare workforce (Bryant-Lukosius et al. 2016; Gagan et al. 2014; McNamara et al. 2009).

Boyko et al. (2016) in studying the utilization of the PEPPA Framework found that most frequently the framework was used in research studies and used to varying degrees as intended. Few citations refer to use in actual practice settings; however, there is documented use related to practice in New Zealand, Switzerland, and Thailand (Gagan et al. 2014; Bryant-Lukosius et al. 2016; Sathira-Angkura and Khwansatapornkoon, date in Thai). Based on principles of participatory action research, the PEPPA Framework (Fig. 2.1) is intended to establish a process supportive of ANP. Steps of the framework take into consideration the complexities of implementing a new role into an existing healthcare system.

The PEPPA Framework involves a nine-step process. Steps 1–6 concentrate on setting up role structures. Step 7 looks at role processes and beginning implementation and introduction of the APN roles. Steps 8 and 9 seek to accomplish short- and long-term evaluations of the APN role and model of care with an aim to assess progress and sustainability of agreed to target aims and outcomes (Schober 2016). The following is an interpretative synopsis of the steps in Fig. 2.1 developed by Schober (2016, p. 97) for Volume 1 of the Springer advanced practice in nursing monograph series.

2.3.1.1 PEPPA Framework Steps

Step 1 – Identify the target patient population and establish limits relative to the current model of care.

Step 2 – Key stakeholders and decision-makers (including populations and their families) representing the current model of care are invited to contribute input to the discussion of a new model of care that includes the APN role.

Step 3 – Determine the strengths and weakness of the current model of care.

Step 4 – Identify priorities for unmet healthcare concerns with an aim to improve healthcare outcomes.

Step 5 – Define the model of care and healthcare strategies including numbers and mix of healthcare providers. At this time participants in the process gain an understanding of ANP and various options for APN roles. If the decision is taken to include APNs, a job description and scope of practice are developed that are fit for purpose for the healthcare model.

Step 6 – Strategic implementation planning is done during this step to verify the readiness of the healthcare setting for ANP. This step includes identification of obstacles and facilitators that could influence implementation. Establishing timelines and goals are a critical aspect.

Step 7 – The plan developed in step 6 for APN implementation is initiated in this step. Full implementation is a continuous process that includes methods to scrutinize various aspects of changes in the approach to provision of healthcare services along with the status of APN role implementation.

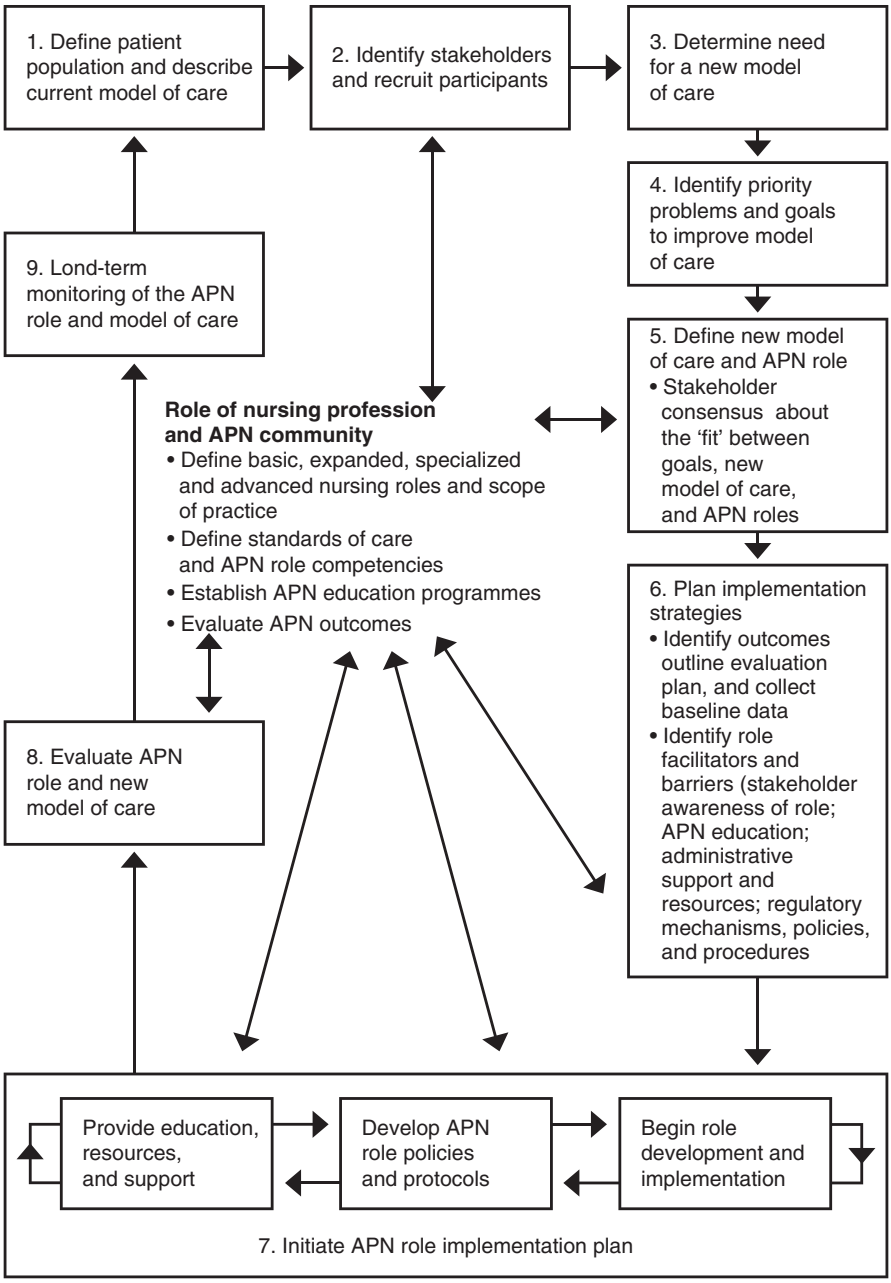

Fig. 2.1 PEPPA Framework (Bryant-Lukosius and DiCenso 2004, p. 532)

Step 8 – Outcomes specific to the identified changes in the model of care are evaluated with a view to identify any needs for APN role development or further role enhancement.

Step 9 – Long-term, periodic, and continuous monitoring are emphasized in this step to assess if the model of care integrating APN role continues to be relevant and sustainable

Bryant-Lukosius and DiCenso (2004)

In considering the usefulness of the PEPPA framework, it is worth noting that the focus is on role integration and evaluation outcomes of role implementation. Although aspects of the step-by-step process could be helpful for strategic planning and policy development, the described intent is not directly aimed at policymaking and the policy process. This framework is useful from a theoretical perspective as well as use in countries that have sought its guidance (Gagan et al. 2014; Bryant-Lukosius et al. 2016; Sathira-Angkura and Khwansatapornkoon, date in Thai).

2.3.2 Schober Conceptual Policy Framework for Advanced Practice Nursing

Supportive policies are essential for APNs to practice to their full potential. The policy process is the product of a system, influenced by and influencing the context in which it operates. Literature provides various models and frameworks describing various aspects relevant to ANP (refer to Sect. 2.2.3). However, following a comprehensive literature review in preparation for conduct of research in Singapore, Schober (2013) was unable to find a specific framework to guide policy decision-making for advanced nursing practice. Knowledge gained from a study conducted in Singapore from 2008 to 2012 led to development of a Conceptual Policy Framework for Advanced Practice Nursing (see Fig. 2.2). Based on research findings and empirical inductive reasoning, the framework was developed to guide and promote a coordinated effort for policy development and implementation when considering the integration of APNs into the healthcare workforce.

The levels of autonomy and scope of practice that define ANP unlock a profound extension of nursing practice both as clinical nurse specialists and advanced nurse practitioners. Without supportive policies, legislation, and professional regulation supportive of the full potential for these roles, barriers arise that pose problems not only for APNs but for the populations who seek their healthcare services. The intention of a policy framework is to promote fewer miscalculations in the policy development and implementation processes.

2.3.2.1 Literature Review Leading to Framework Development

The aims of the literature review for the research were to identify and review published and unpublished literature in order to (1) demonstrate the global presence of ANP, (2) provide validation on topics of relevance to ANP development, and (3)

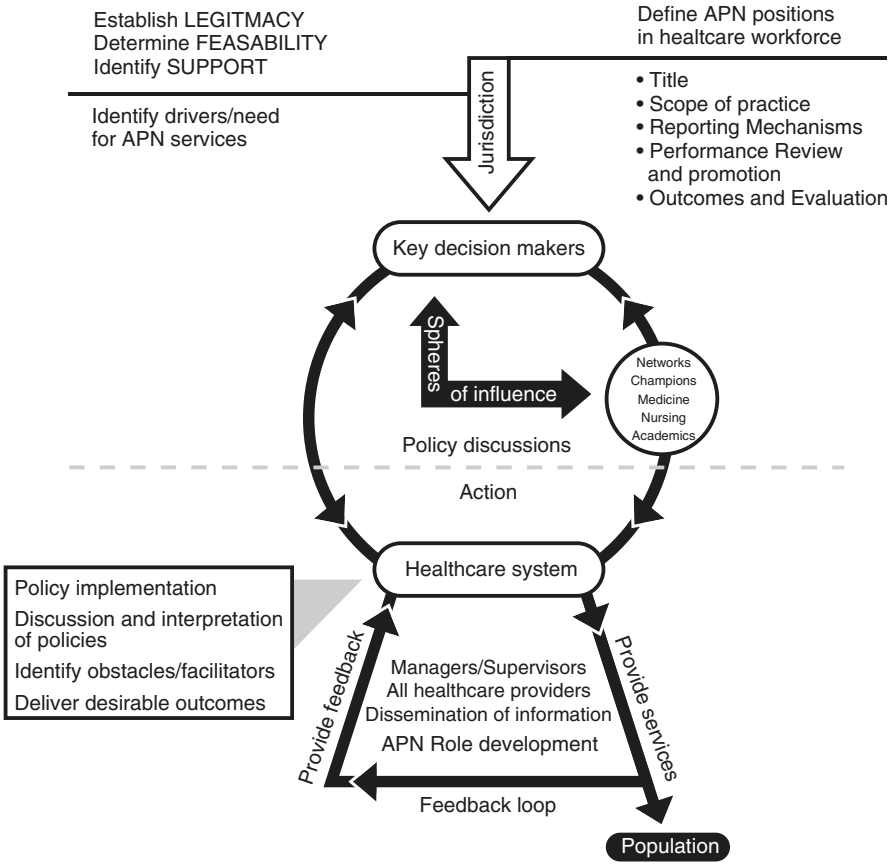

Fig. 2.2 Conceptual Policy Framework for Advanced Practice Nursing (Schober et al. 2016)

identify policies and policy decision-making essential to the integration of APNs into healthcare systems. Five strategies were used to obtain relevant literature:

- Electronic data bases were searched using free text keywords pertinent to advanced practice nurse, advanced nursing practice, nurse practitioner, and clinical nurse specialist. Individual and combined search terms were used to be as certain as possible to obtain relevant publications.
- A search of the reference lists of included papers was conducted to identify relevant papers that were not captured in the database search.
- A purposeful exploration of web sites of professional organizations (e.g., American Association of Nurse Practitioners, International Council of Nurses, Royal College of Nurses, UK), governmental agencies (e.g., National Council of State Boards of Nursing, USA; New Zealand Ministry of Health; Nurses Registration Board of New South Wales), and research institutions (e.g., McMaster University, Canada) thought to have relevance to ANP was carried out.

- A review was conducted of literature already on hand as a result of authorship of previously published journal articles, book chapters, and a book on advanced nursing practice by the researcher
- Professional colleagues familiar with ANP contributed relevant peer-reviewed and unpublished literature.

The ICN (2008) definition of advanced practice nursing was used as a baseline reference to establish inclusion/exclusion criteria of the cited literature. If a publication referred to general nursing and did not clearly address components associated with ANP or APN roles, the publication or document was excluded. The criteria for inclusion or exclusion were based not on the quality of the studies, but on the relevance to the aims of the literature review.

A number of key factors (see Sect. 2.1) viewed as essential to the successful integration of APNs emerged from the comprehensive review of ANP and APN literature. Analysis of the literature consistently confirmed that policy and legislation germane to ANP are essential in order to authorize nurses to practice to the optimal level of their advanced knowledge and skill. The literature further indicated that without policies to address issues explicit to ANP, the resultant inclusion of APN roles all too often faces a turbulent process. Uneven and uncertain beginnings in a new initiative were found to result in stress, tension, and conflict throughout the healthcare system and settings. Although the presence of supportive policy is viewed as critical to successful APN development, no literature was found that demonstrated elements of appropriate policy development and policy processes.

2.3.2.2 Framework Development

Knowledge gained from the literature review and empirical findings from the study conducted in Singapore led to the development of a Conceptual Policy Framework for Advanced Practice Nursing.

Design and Conduct of Study in Singapore

Ethnography with an instrumental case study approach was selected to provide an understanding of the complex course of actions undertaken by a range of policymakers, the interface of individuals, and their interpretation of related events that took place. In order to gain knowledge and understanding of relevant ANP policy as it evolved in one country, Singapore was selected as a country in the early stages of their initiative. The study comprised four phases:

- Document analysis of any documents linked to ANP development in Singapore (Phase 1)
- Interviews with key policymakers and stakeholders (Phase 2)
- Interviews with nursing managers, medical directors, and administrators (Phase 3)
- Interviews and clinical participant observation with APNs (Phase 4)

The data were collected in four sequential phases. Phases 1 and 2 focused on gaining insight into policy development. Phases 3 and 4 focused on how policy was

then realized or implemented in practice. Analysis of data was done at the completion of each phase of the study with analysis of earlier phases informing conduct and analysis of subsequent phases. A composite analysis of findings from all four phases was done at the completion of the study (Schober et al. 2016).

Framework Development
Development of the conceptual policy framework was based on study findings along with integration of principles from theoretical frameworks proposed by Hall et al. (1975) in regard to social policy development and Walt (2006) in relation to health policy implementation. Key tenets of these two frameworks were analyzed in light of policy implications for ANP. Each was found to be lacking as a single theoretical foundation for the purpose of the APN policy framework; however, when considered together along with the concept of "disjointed incrementalism" (Lindblom 1979), the combination brought understanding to the complexities of APN policy development and implementation as revealed in the study findings (further discussion on theories of social and health policy and how they relate to nursing can be found in Chap. 3).

2.3.2.3 Intended Use of the Conceptual Policy Framework

The proposed Conceptual Policy Framework for Advanced Practice Nursing (see Fig. 2.2) is intended to assist those who are influencing consideration of new ANP initiatives as well as those implementing and/or refining the role and/or level of advanced nursing. The framework is a comprehensive approach to considering policy and the policy processes that impact ANP, its implementation, and evaluation.

Effective integration of APNs into the healthcare workforce requires a role transition from generalist nursing practice to advanced practice. To enable a generalist nurse to progress to an advanced level of practice, policies and pivotal decisions are required in the initial stages of deliberation to support the full potential of the role and to legitimatize it to the public and other healthcare professionals. Additional research from Canada (DiCenso et al. 2010), Australia (Gardner et al. 2004), and analysis by Hamric (2014) in the United States support the contention that a policy framework could facilitate the processes associated with policymaking and role development.

The Conceptual Policy Framework (see Fig. 2.2) is recommended for policymakers, academics, nurse leaders, medical directors, administrators, employers, and others in a position to inform, direct, and facilitate policy development. With this focus in mind, the framework is intended to demonstrate how multiple factors interact and influence initiation and progression of ANP policy. Noting the complexities associated with integrating APNs into the healthcare workforce, it is anticipated that guidance with a framework will encourage strategic thinking to promote a strategic approach from intent of policy to realization in practice by identifying critical points to take into consideration.

2.3.2.4 Critical Points of the Conceptual Policy Framework

Critical and pragmatic points to take into account emerged from the creation of the Conceptual Policy Framework for Advanced Practice Nursing (see Fig. 2.2). The

Table 2.1 Critical points of the conceptual policy framework for ANP

Point 1. Policy development and the policy process
Establish legitimacy of the APN concept Determine feasibility of an APN initiative. Is it achievable? Verify broad-based support from those in positions of authority as well as managers, administrators, and other healthcare professionals on the ground Assess the need for APN services. Identify drivers, rationale, and/or need Identify title and establish title protection Define the role and anticipated scope of practice Identify pivotal decision-makers and their spheres of influence Identify measures needed to accomplish action for policy and subsequent implementation
Point 2. Service discussions for role implementation
Include managers, administrators, medical directors, other nurses, and ancillary staff in anticipatory and informative initial discussions Develop clear role/job descriptions, scope of practice, and function Define reporting mechanisms and performance review. What are the reporting lines for the APN? Nursing, medicine, administrators, or others? Establish infrastructure for collegial communication, e.g., APN councils, journal club, professional, and interprofessional continuing education
Point 3. Dissemination of information
Plan and provide extensive and thorough distribution of information on the APN role and services to other healthcare professionals and the public Offer multiple and continuous opportunities for questions and discussion
Point 4. Evaluation and follow-up
Promote and establish processes for managers to observe and evaluate the APN in actual practice in their clinical settings In the event of problems, concerns, or adverse events, establish an interactive responsive process Identify a feedback mechanism to report outcomes and responses beneficial to composite and future development Distribute ideas, based on implementation experiences, for discussion, interpretation, and possible adaptation of the role

author acknowledges that it is not always possible to follow ideal processes in the sequence in which they are presented; however, the framework presents a view of critical points to think through when determining the feasibility of ANP for provision of healthcare services. A checklist of critical points to bear in mind is provided in Table 2.1 followed by a discussion of each issue in Sect. 2.3.2.5.

2.3.2.5 Discussion of Critical Points

This section elaborates on and provides discussion on the points identified as vital to successful development and sustainable implementation. In viewing the diagrammatic image of the Conceptual Policy Framework (see Fig. 2.2), two cornerstones at the top of the image are considered to be key components for initiating policy development.

Cornerstone One

- Establish the legitimacy of considering the ANP concept
- Determine the feasibility of pursuing such an initiative
- Identify broad-based support for the scheme

This cornerstone, based on principles from the Hall et al. framework (Hall et al. 1975), rests on identification of population healthcare needs and the motivation or driver for considering the ANP concept and APN services. In order to gain the attention of policymakers, issues or topics requiring policy must reach the attention or agenda of decision-makers. At the point when the matter is seen as legitimate, feasible, and has support, action for policy development can take place (Hall et al. 1975; Schober 2013). The significance of establishing legitimacy, feasibility, and support for the ANP concept is discussed in the following paragraphs (see also in-depth discussion in Chap. 3 of the Hall et al. framework).

Legitimacy
For key policymakers to carry policymaking forward, they need to view the concept as legitimate and under their jurisdiction and their spheres of influence. Identifying individuals at the highest level of authority, associated communication networks, and personal or professional interests can influence the policy process. Policymakers' attitudes toward nurses in general may play a role in facilitating or blocking the policy process. Not only do nurses need to gain knowledge of the policy process but policymakers require enhanced knowledge of nursing as a profession. A key question to consider: How will the ANP concept catch policymakers attention and is it a legitimate concern for their intervention? (Hall et al. 1975).

Feasibility
Determining the feasibility of ANP is fundamental to an initiative. At some point, key decision-makers will assess the potential for action and implementation or the achievability of a new nursing role and relevant policy directives. Key questions to consider: Is the concept of the APN role achievable? Is the healthcare environment receptive and in a position to educate qualified APNs? Are there candidates for role preparation? What is the attitude of the medical fraternity and the nursing culture toward the role? Are there adequate human and financial resources? Has opinion from the healthcare workforce at the ground level been taken into consideration? How will the consumer view another healthcare professional? (Hall et al. 1975; Walt 2006).

Support
Finally, in Cornerstone One, broad-based support is sought from those at high levels of authority who are making policy to those who are implementing policy and the APN roles. Key questions to consider: Is there broad-based support from both those in positions of authority as well as administrators and managers and other professionals who will facilitate implementation? Have stakeholders in positions of authority and interested parties or interest groups who could block or facilitate the initiative and key policies been identified? (Hall et al. 1975; Walt 2006; DiCenso et al. 2010).

Motivation and Drivers for the ANP Concept
Identification of the rationale for consideration of ANP provides the foundation in Cornerstone One for seeking the attention of decision-makers. Key questions and issues to consider: What are the anticipated benefits? Is there a population healthcare need? If the impetus is professional development for nursing, what are the

expected criteria and role components? Is there support in the healthcare community to include APNs as healthcare providers? Clarify if APNs will be in a position to provide the healthcare services as intended and in what capacity. Issues of level of autonomy, prescriptive authority, and collaborative practice/teams can be discussed with this component (DiCenso et al. 2010; Hamric 2014; Schober 2013; Schober et al. 2016).

In addition to gaining the attention of key decision-makers and their spheres of influence, physician champions and their connections to the medical fraternity are essential in most healthcare environments. Perspectives and attitudes toward nursing and the nursing culture are aligned with this issue. Questions to consider: What are the prevailing attitudes regarding nurses? What are the views of key decision-makers regarding nurses seeking academic qualifications? How do other nurses and nurse leaders view the role of an advanced clinical nurse? (DiCenso et al. 2010; Schober 2013; Schober et al. 2016).

Based on findings from the study conducted in Singapore (Schober 2013), evidence revealed that formal and informal discussions took place over a number of years as key decision-makers worked to overcome an impasse by high-level stakeholders who blocked progress. The turning point required key people to negotiate and persuade other key decision-makers to move toward standard setting, establishing regulation, and developing policy. Ultimately, with this approach, development in Singapore accomplished all aspects of Cornerstone One and stabilized one aspect of the ANP initiative as depicted in the Conceptual Policy Framework for Advanced Practice Nursing (see Fig. 2.2). Further in-depth discussion on the Singapore context in relationship to the Conceptual Policy Framework can be found in Sect. 2.3.3

Cornerstone Two

- Clearly identify and define the APN role.
- Describe the position the APN will have in the healthcare workforce.

This cornerstone rests on identification of a title, defining a distinct scope of practice, identifying reporting mechanisms along with a system for review of outcomes, and evaluation of APN services (see Fig. 2.2). Literature consistently and extensively identifies lack of role clarity and role ambiguity as major blockages for successful role implementation. Some APN functions overlap with medicine, and this contributes to dialogue as to whether the advanced nursing practice has deserted nursing. The necessity to differentiate APN healthcare services from other nursing and medical roles becomes fundamental in establishing supportive policy, legislation, and professional regulation. An initiative that lacks role clarity lends itself to multiple and divergent interpretations among managers, administrators, institutions who employ the APNs, other healthcare professionals, and the public. Not only does role clarity impact the policy process, but also a definition of expected APN practice impacts curriculum development and organization of education programs (Schober 2013).

Key features of the two cornerstones of the framework come together to form the basis for key stakeholders and their networks to utilize collective data for jurisdictional decisions (see Fig. 2.2). Ensuing discussion and decisions recognize that key stakeholders and their spheres of influence lead to actions that affect not only the policy process but also progress to impact healthcare systems. The keyhole image rests with implementation of policy in a healthcare system. Managers, administrators, medical staff, and nursing leaders can enable or impede integration of APN roles with the potential for a bottleneck at the healthcare setting level depending on support for policy and the ANP concept. The bidirectional arrows represent optimal discussion, interaction, and feedback among stakeholders and those on the ground implementing policy and the ANP concept. In addition, focal positions along the directional arrows have the capacity of taking into account unanticipated events and outcomes based on reevaluation and ongoing decisions. Ultimately, the framework emphasizes inclusion of a bottom-up approach and on the ground participation for optimal implementation and adaptation of ANP.

2.3.2.6 Strategic Planning and the Conceptual Policy Framework

The development of a conceptual policy framework suggests that in an ideal world, strategic planning for the introduction of ANP could facilitate the implementation process. Study findings in Singapore revealed a top-down approach in decision-making with those on the ground level expecting that the ministry of health would have developed a strategic plan and coordination for implementation of APN roles. However, even though policy was established early on, there was no evidence of a national strategy, coordination, or input from those on the ground level who would ultimately implement policy and the role.

As a result, this missing component supportive of implementation in Singapore contributed to various interpretations and adaptive approaches for ANP. Without a comprehensive plan, managers, administrators, and medical directors along with APNs themselves responded to the implementation process with disparate solutions and interpretations for implementation. In pursuing what appears to be a trial-and-error approach, the initiative continued to move forward. This process is consistent with the concept of "disjointed incrementalism" (Lindblom 1979) and represents one view of reality in the evolving nature of introducing a new concept such as this new nursing concept. Disjointed incrementalism is used here to describe the ad hoc nature that occurs at times in decision-making, while also implying the new evidence that fits in is helpful on a case-by-case basis when presented at the right time (see Chap. 3 for further discussion of disjointed incrementalism).

A strategic plan and well-intended policy development require comprehensive dissemination of information and ongoing communication, especially service discussions on the ground level. Well-designed policy has the potential for facing a bottleneck at the managerial level if there is only a vague notion of who the APN is and how the APN should function in the various healthcare settings (Schober 2013; DiCenso et al. 2010). Accurate dissemination of information beyond key decision-makers and their networks that includes some level of feedback and communication within organizational structures and infrastructures is viewed as essential, as depicted in the conceptual policy framework (see Fig. 2.2), for realization of policy and implementation of ANP.

The processes from intent of policy to realization in practice are complex and frequently fraught with unanticipated events. Even though a fully rationale approach will not solve all problems, it is envisaged that a conceptual policy framework for ANP would provide guidance or a reference point to assist in policy and APN implementation.

2.3.3 Conceptual Policy Framework: Singapore Exemplar

The Conceptual Policy Framework for Advanced Practice Nursing is based on empirical evidence from the research conducted in Singapore; however, as an exemplar Singapore did not smoothly and completely accomplish the tenets proposed in the ideal framework. Figure 2.3 provides a diagrammatic representation of events in Singapore and how it compares and contrasts with the theoretical framework.

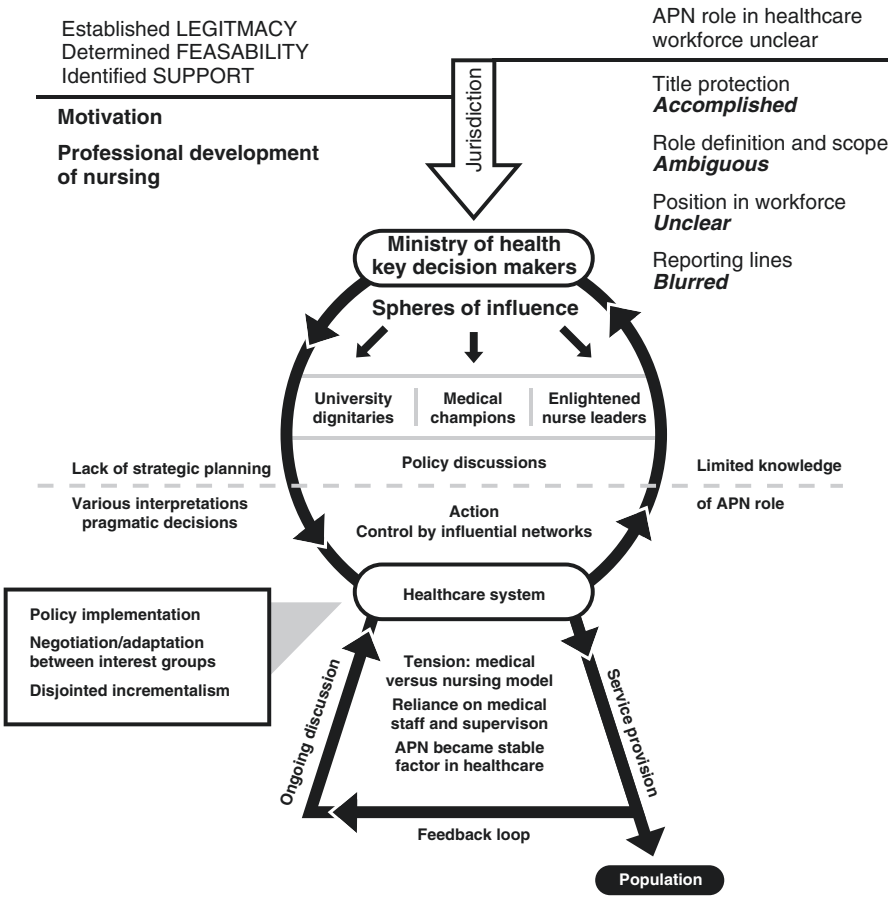

Fig. 2.3 Conceptual Policy Framework for Advanced Practice Nursing: Singapore context (Schober 2013)

2.3.3.1 Cornerstone One: Singapore Context (Legitimacy, Feasibility, Support, and Motivation for Advanced Nursing Practice Concept)

As the APN initiative in Singapore took hold, decisions began to proliferate among various individuals in positions of authority. Formal and informal discussion among key stakeholders and nursing leaders took place over a number of years. However, in early discussion key decision-makers with power and authority blocked progress. One key issue that arose was that persons at the governmental level did not think that nurses needed an academic degree to practice.

The initiative seemed to have reached an impasse; however, with the appointment of new and pivotal decision-makers who in turn had new networks, the concept took hold. Legitimacy of the APN concept was established, feasibility of the idea was determined, and support for the scheme was identified. The motivation for ANP focused on professional development for nursing in the country. Cornerstone One of the framework was accomplished; however, it was not a straightforward path to implementation. Study findings demonstrated that accomplishing this milestone required key people to negotiate and persuade others to move to standard setting, regulation, and related policy. As these issues were realized, turbulence was revealed in other areas of development; however, with policies in place, study participants from Phases 3 and 4 voiced confidence that the initiative was likely to be sustainable. Achieving aspects of Cornerstone One stabilized one component of the ANP initiative (Schober 2013; Schober et al. 2016).

2.3.3.2 Cornerstone Two: Singapore Context (Definition of APN and Function in Healthcare Settings)

Cornerstone Two focuses on a clear definition for the APN and a description of what function the APN will have in healthcare systems and various settings. Mandates in this cornerstone include identification of a title and title protection, role definition, and a distinct scope of practice with clear reporting lines for performance review. In Fig. 2.3 each point is labeled as to how or if they were achieved in Singapore. It is worth noting that title protection was established early in the initiative. Description or definition of this level of nursing and scope of practice was ambiguous. The position and function of the APN was unclear and reporting lines, especially between medicine and nursing, were blurred.

From the time of the announcement of legislation and regulation for APNs in 2006, the title "advanced practice nurse" was protected, and it was illegal to assume the title "advanced practice nurse" if an individual did not fulfill licensure criteria to use the title. The Singapore Nursing Board adopted a generic scope of practice and role characteristics based on recommendations by the International Council of Nurses. However, in practice the role definition and scope of practice were ambiguous and subject to multiple and divergent interpretation among administrators, managers, and other healthcare professionals. The function of the APN within varied healthcare settings was unclear, and reporting lines for clinical responsibility and performance review were blurred.

Lack of role clarity adversely impacted curriculum development, contributed to stress, and tension between other nurses and physicians and led to frustration as new

APNs tried to introduce the role based on theory learned in their graduate program. Confusion was accentuated by indecision as to whether this was a nursing model or a medical model or both. Nursing perceived that the APN had deserted nursing, and other healthcare professionals viewed the APNs as "minidoctors" or physician assistants. In spite of all this, the APNs themselves, for the most part, exhibited varying degrees of autonomy, revealed a passion for clinical practice, and carved a niche to rise above conflict and tension (Schober 2013).

2.3.3.3 Strategic Planning and Coordination: Singapore Context

Based on study findings of research conducted in Singapore, there was no evidence of a coordinated approach or strategic plan for implementation of policy and the APN role on the ground. The study revealed that there was a belief that the ministry of health must have devised a plan, but there was no substantiation found for this. Instead, administrators and managers did not have a clear idea of what to do with this new level of nurse. A clinical career ladder had been announced for clinical advancement; however, managers were unwilling to promote APNs unless they took on managerial, education, and/or research tasks.

Furthermore, findings indicated that key decision-makers had not resourced managers, staff, or healthcare professionals on the ground to assess what they thought about the ease of integrating a new nursing role. Lacking a national strategic plan, individual institutions and healthcare settings devised their own policies. As a result there were various interpretation and adaptive approaches to implementation. This appeared consistent with principles of what have been identified by Lindblom (1979) as the concept of "disjointed incrementalism." Without a national plan, miscalculations and oversights occurred. Administrators, managers, and medical consultants on the ground responded to various scenarios of implementation with disparate solutions to ease the missteps and therefore incrementally moved forward.

Evidence demonstrated that there was a disconnect initially between those in positions of authority and those implementing policy and roles in practice on the ground level. Even though those in decision-making positions thought they had disseminated directives and guidelines, a bottleneck appeared to occur at the managerial level. Administrators, managers, physicians, and other nurses voiced that they had acquired only a vague notion of the ANP concept. Key decision-makers and stakeholders were not always cognizant of significant issues associated with the reality of policy and role implementation. Study findings suggest that APN development was more complex and turbulent than originally envisaged by the initial discussions (Schober 2013). The author contends that attempting a strategic approach and use of a framework could facilitate a smoother transition when introducing a new level of nurse in the healthcare workforce.

2.3.4 Additional Models/Frameworks for Advanced Nursing Practice

Various views and perspectives of ANP are guided by a model or framework. Even though the practicing APN relies on clinical guidelines and common language with colleagues to achieve role expectations, frameworks and models are useful to

communicate to stakeholders and other definitive aspects of ANP. Conceptual models or frameworks provide a frame of reference and offer a systematic approach in trying to understand this field of nursing. Conceptualization of a concept such as advanced nursing within a framework is an analytical tool that uses variations and contexts to make distinctions and organize ideas. Strong conceptual frameworks or models are abstract or empirical representations that are able to capture reality in a way that is understandable and applicable.

Spross (2014) identifies categories of models or frameworks that exemplify aspects associated with ANP that can provide guidelines. Classifications include:

- Curriculum design
- Organizational/managerial structure
- Differentiation of different APN or other nursing roles
- Describing the nature of the advanced practice role
- Role development and implementation
- Regulation, legislation, and credentialing
- Inter disciplinary practice
- Evaluation of outcomes

In addition, there are specific models/frameworks developed for use within countries. It is not within the scope of this chapter to discuss all the various country-specific models or frameworks characterizing ANP but to note an increasing presence of literature portraying some aspect of development. The Consensus Model for APRN (Advanced Practice Registered Nurse) Regulation (NCSBN 2008) has advanced the conceptualization of ANP in the United States. In countries where ANP exists, a variety of frameworks and models are described: the United Kingdom (Barton et al. 2012), Ireland (Begley et al. 2010, Government of Ireland (2011), Canada (CNA 2008), and Switzerland (De Geest et al. 2008).

Contextual factors differ from country to country; however, a review of diverse global perspectives and guidelines provides opportunities for strategic thinking in order to enhance the dialogue on ANP, associated APN roles, levels of advanced nursing practice, and useful frameworks for decision-making. In approaching analyses of various frameworks, it is worth mentioning that terminology is used differently from country to country and in different ways in different settings within the same country. In addition, the author notes that concepts and principles proposed in most publications originate mainly in countries with a history of success with ANP and/or a well-defined political system that includes regulatory processes for nursing. Country illustrations provided in Volume 1 of the Springer advanced practice in nursing monograph series presents a range and more in-depth discussion of these differences (Schober 2016). The following illustrations from Scotland and Ireland are selected to illustrate country-based approaches that have influenced ANP development.

2.3.4.1 Scotland: An Advanced Practice Toolkit

The Advanced Nursing Practice Toolkit developed by Scotland as part of modernizing nursing careers draws together international work and work in the United Kingdom on the advanced level of nursing practice. Developed on behalf of the four countries in

the United Kingdom, it provides a framework to consider and can be accessed at http://www.advancedpractice.scot.nhs.uk/. The web-based toolkit consists of:

- A nationally agreed definition of advanced practice for nurses
- Competency map
- A national Agenda for Change (AFC) job profile for advanced practice and exemplar/template Knowledge and Skills Framework (KSF) outlines and job descriptions/role profiles
- Activity analysis tools
- Skills analysis/Educational Needs Analysis Tools
- Portfolio development support
- Mapping of education program outcomes to competencies and capabilities
- Assessment of competence – theory and practice guidance
- Links to qualifications frameworks
- Regulatory guidance

The Toolkit recognizes advanced practice roles as present across all clinical contexts. Advanced practice is viewed as a level of practice, not necessarily a specific role. In addition, this framework identifies practitioners functioning at an advanced level who work in research, education, and management/leader, not specifically in clinical roles.

2.3.4.2 Ireland: Advanced Nurse Practitioner and Advanced Midwife Practitioner

Advanced practice in Ireland refers to registered nurses and registered midwives who engage in continuing professional development (CPD) and clinical supervision to practice as expert practitioners and demonstrate exemplary clinical leadership. Advanced practice is defined as "a continuum along which practitioners develop their professional knowledge, clinical reasoning, clinical judgment, skills, and behaviors to higher levels of capability that is recognisable" (http://www.nmbi.ie/Registration/Advanced-Practice). Registered Advanced Nurse Practitioners (RANPs) and Registered Advanced Midwife Practitioners (RAMPs) work within an agreed scope of practice and meet established criteria set by the Nursing and Midwifery Board of Ireland (NMBI) to register as either an RANP or a RAMP.

In Ireland the Nursing and Midwifery Board of Ireland (NMBI) is the independent, statutory body which regulates the nursing and midwifery professions in the country (http://www.NMBI.ie). Under the auspices of the National Council for the Professional Development of Nursing and Midwifery, the fourth edition of the Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts was provided in January 2008 (NCNM 2008). Viewed as a way to provide a clinical career pathway, this framework includes:

- Definition of advanced nursing practice/advanced midwifery practice
- Core concepts of advanced nursing practice/advanced midwifery practice
- Process for the establishment of advanced nursing practice/advanced midwifery practice posts
- Template for approval of advanced nursing practice/advanced midwifery practice posts

An Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland (SCAPE) in 2010 (Begley et al. 2010) followed provision of this framework. The Irish healthcare system has moved toward a population health approach for the provision of health services and healthcare. In the context of this focus as of November 10, 2016, NMBI began a Public Consultation: NMBI Statement of Strategy 2017–2019.

The development of a clinical career pathway for nurses and midwives in Ireland has taken place against a background of health service reform. In addition to confirmation of positive outcomes for ANP, the framework and subsequent reports provide structure to take into consideration for development or refinement for a national framework. An explanation of development of a job description for a position of Registered Advanced Nurse Practitioner in Ireland can be found at http://www.nmbi.ie/Registration/Advanced-Practice/Advanced-Practice-Post/Template-Job-Description

Conclusion

Enthusiasm for advanced nursing practice worldwide is exciting yet fraught with multiple challenges in the process of facing the realities of policy development and advanced nursing practice implementation. Identification of strategies to accomplish supportive policies is seen as essential for long-term sustainability of this concept. Theoretical frameworks specific to advanced nursing practice are proposed to aid in the developmental processes. Illustrations of country-specific frameworks provide additional guidance in developing a strategic approach.

This chapter introduces the complexities of policymaking. Key policymakers in positions of authority are not always aware of significant factors on the ground that need to be taken into account, resulting in a potential disconnect between those in decision-making positions and those attempting to implement policy and new nursing roles or levels of practice. The author proposes that theoretical frameworks can provide guidance through these processes and that increased participation of nurses in the policy process is essential. The practice and experience of nurses in healthcare together with an acquired ability to question the policy process provide a foundation to steer advanced practice nurses toward politically competent action and advocacy.

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Theories of Social and Healthcare Policy 3

A theory is often viewed as a hypothesis or system of ideas intended to explain and predict a phenomenon or justify a course of action. For the purpose of this publication, theory is also defined "generically to mean a range of approaches that specify the scope of inquiry, lay out assumptions, provide a shared vocabulary among members of a research team, and clearly define and relate concepts in the form of principles and testable hypotheses and propositions" (Weible 2014, pp. 3–4).

Theories of social and healthcare policy mean disparate things to different people. One perspective is that these policies are mostly concerned with content that includes the best method for considering financing services or service delivery. However, a look at policy requires an exploration into how policy is formulated and implemented as well as who or what influences policymaking. The theories selected for discussion in this chapter focus on policy as it relates to the processes of policy formulation and/or implementation and are considered to be classic illustrations of policy processes as referred to in additional publications (Klein 2014; O'Grady and Johnson 2014; Porche 2012; Schober et al. 2016; Walt 2006). The criterion for inclusion of a theory in this publication is not the newness of an article or reference but the quality of its insight, that is, its ability to explain some aspect of the policy process and/or policymaking. Finally, this chapter offers commentary on the relevance of social and healthcare theory to nursing.

3.1 Hall, Land, Parker, and Webb Agenda-Setting Framework

The Hall et al. agenda-setting framework (Hall et al. 1975) based on the theory of bounded pluralism suggests a compromise theory of power as it influences policymaking. The theoretical framework proposes that issues of high politics (e.g., economic issues) are decided by influential leaders but that most domestic or routine policies such as health and education are likely to be developed at a level that includes some participation of interest groups at different stages of the policy

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process. This theory proposes that government decision-makers may be open to influence from a variety of sources as long as the policymakers perceive the sources for the policy topic as legitimate. This idea lends itself to the notion of agenda setting as introduced in Chap. 2, Sect. 2.1.1.

The Hall et al. (1975) framework identifies three conditions that help to explain why policymakers might act on any particular concern or give precedence to a specific issue. The framework identifies the following concepts:

- Legitimacy
- Feasibility
- Support

The suggestion is that only when an issue is high in relation to all three concepts does it become an item on the policymaking agenda. This provides a simple approach for assessing what issues might be considered by governments and key policymakers. Sections 3.1.1, 3.1.2, and 3.1.3 provide further discussion of these three concepts.

3.1.1 Legitimacy

Legitimacy refers to the issues that key policymakers/governments/organizations feel they should be concerned with and in which they have the right or authority to intervene. Conversely, these topics are issues where decision-makers feel people will accept, e.g., government intervention. Issues range from low to high legitimacy. The identification of legitimacy differs from country to country (Hall et al. 1975).

3.1.2 Feasibility

Feasibility refers to the potential for implementing the policy. Does the government/state/organization have the capacity to ensure implementation? Is the plan achievable? Implementation efforts face technological, financial, or personnel limitations that might, even in the early stages, suggest that a specific policy may be impossible to implement even if it is seen as legitimate (Hall et al. 1975).

3.1.3 Support

Support refers to the vague but important aspect of public support for or public trust in government or organization action. For certain issues, there may be strong support from interest groups or relatively weak visible support for a policy.

If support is lacking or dissatisfaction is high, it may be difficult to implement policy (Hall et al. 1975). For an example of this point, there is increasing evidence that the quality of care provided by APNs is positive. In addition, support for APN

services in many healthcare environments is at a very high level. However, there is also evidence in various countries that factors such as opposition by medical associations can delay or totally block policies essential to support APN practice.

Findings from a study conducted in Singapore (Schober 2013) revealed that following years of formal and informal discussion, support was eventually established for the APN concept. In addition, there was an expectation that the government would develop policy and coordinate a strategic plan for further support and implementation. However, the ability to begin to move forward depended on action from three key decision-makers with power and authority to influence particularly the medical fraternity. Even though conditions of legitimacy and feasibility for ANP were met, further issues of support had to be addressed for the initiative to progress.

According to Hall et al. (1975), using these three conditions, governments and key decision-makers assess whether an issue falls high or low on a continuum. A position of high legitimacy (a view that they have the right to intervene), high feasibility (sufficient resources and infrastructure), and high support (significant interest groups are supportive or at least not opposed) suggests that the issue may likely come onto the policy agenda. However, there are times when representatives of governmental agencies will place an issue on the policy agenda to make a statement about it or to show they have a position on the topic, but they do not necessarily expect it to be put into practice. Thus, it remains policy on paper only (Walt 2006).

3.2 Kingdon's "Windows of Opportunity"

In offering a description of the policy environment, Kingdon (2003) indicates that policy starts with agenda setting and conceptualizes an open policy window or "window of opportunity" based on a three streams approach (see Fig. 3.1). This approach suggests that complex policy processes occur in three separate streams and only when

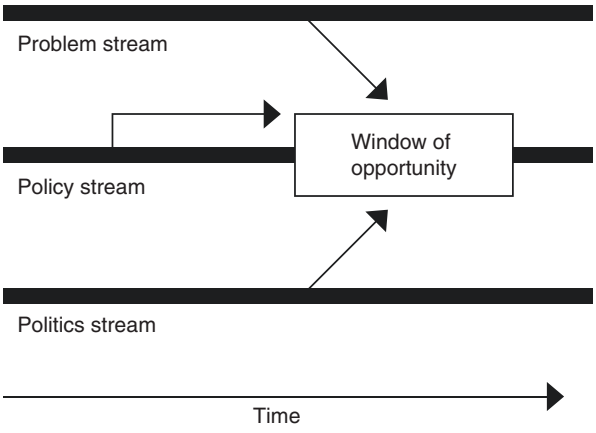

Fig. 3.1 Kingdon's window of opportunity (Birkland 2005, p. 226)

they come together does an issue make the policy agenda. This concept suggests that policies are only considered when a major "window of opportunity" opens up in the three streams (problem stream, politics stream, policy stream) at the same time:

- The problem or issue must come to the attention of the policymaker.
- The issue must have a menu of possible policy solutions that have potential to actually solve the problem.
- The right political circumstances have to be in place.

This perspective emphasizes that the three separate streams of problems, politics, and policies have lives of their own. When the streams are joined, it is when policy change occurs. As a result, Kingdon (2003) provides an interactive theory that aims to take into account the dynamic nature of policymaking. This convergence of three streams is viewed as often chaotic and unpredictable.

In contrast to the three conditions for policymaking proposed by Hall et al. (1975) (see Sect. 3.1) and incremental stages suggested by Lindblom (1979) (see Sect. 3.3), Kingdon (2003) proposes that policies are not made in stages, steps, or phases. What contributes to the three streams coming together may be due to individuals, media attention, a crises, or evidence of a problem. As a result, alternatives may be supported and promoted for long periods of time before the opportunity takes place for them to be accepted or placed on the policy agenda.

The streams as identified by Kingdon (2003) take place in parallel and somewhat independent streams until something happens to cause two or more of the streams to meet in a "window of opportunity." This window is the possibility of change; however, the open window does not guarantee that policy change will occur. The origin can be a change in understanding of a problem, a change in the political environment that is favorable to change or increased focus on an issue that attracts attention to the topic (Birkland 2005).

In critiquing the Kingdon theory, Zahariadis (1993) proposes that the Kingdon approach can be applied to decision opportunities, not just for agenda setting. Therefore, a decision to make new or existing policy may be more likely when the streams come together. In addition, Sabatier (2007) suggests that the streams metaphor may be an incomplete description of policymaking as it does not describe the policy process beyond the opening of the windows of opportunity. The multiple streams theory supports the contention that policymaking is messy, complex, costly, and not necessarily logical but does try to make sense of an ambiguous process (Zahariadis 2014). In any case, the Kingdon theory provides a multilayered image of policymaking (see Fig. 3.1) from the early acceptance of new ideas about an issue to active consideration of actions by introducing the idea of focusing on events that can be examined for their influence on the policy agenda (Birkland 2005).

3.3 Lindblom's Incrementalism and Disjointed Incrementalism

Lindblom is considered to be the creator and best-known proponent of the incrementalist policy theory (Lindblom 1959, 1979). In referring to the policy process as one of incrementalism or more realistically, disjointed incrementalism, Lindblom

notes that policymaking is a process of negotiation, bargaining, and adjustment between different interest groups to influence policy. Lindblom's emphasis is on what is happening rather than what ought to happen. As a result, it can be argued that what is feasible is only slightly different from existing policy. Beneficial points of the view of incremental change imply the following:

- Policymakers focus on what is familiar based on their experience.
- It reduces the number of possible alternatives to consider.
- The number and complexity of factors policymakers need to analyze are reduced.

This description of the policy process is both a theory of how decisions are made and a description of how competing interests behave in policymaking (Birkland 2005).

Policy issues according to Lindblom (1959, 1979) are divided into two categories, ordinary questions of policy and grand issues pertaining to politico-economic life and structure. In situations of ordinary questions of policy, Lindblom sees many groups actively participating. However, on grand issues, Lindblom suggests that participation outside of key decision-makers may be ineffectual or nonexistent. Incrementalism can be seen as based on deliberate incomplete analysis of an issue; thus, this theory in turn proposes that policymakers make decisions in a political world which introduces many constraints to the process thus little policymaking is really revolutionary (Lindblom 1979).

Incrementalism views political change by small steps; thus, incrementalism varies by degree. As a result, the size of the step in policymaking can be arranged on a continuum from small to large. Lindblom (1979) distinguishes three meanings of incrementalism as policy analysis: simple incremental analysis, disjointed incrementalism, and strategic analysis. The next section explains disjointed incrementalism and proposes that it is a realistic view of some aspects of policymaking.

3.3.1 Disjointed Incrementalism

Disjointed incrementalism can be viewed as one form of strategic analysis, and simple incremental analysis is one element in disjointed incrementalism.

Stratagems considered to be descriptive of disjointed incrementalism include:

- Limiting analysis to a few familiar policy alternatives
- Linking analysis of policy goals with pragmatic aspects of the issue
- Increased concern with problems to be resolved rather than only goals to be sought after
- A sequence of trials, errors, and revised trials
- Analysis that explores some but not necessarily all the important possibilities of a potential alternative
- Fragmentation of work to multiple participants in policymaking

In reference to more conventional theories, Lindblom (1979) emphasizes that no person, committee, or research team can fully complete the analysis of a complex

issue. There are too many matters at stake, too many possible alternatives, and too many potential consequences (anticipated and unanticipated) to fully comprehend the full complexity of any situation. The best attempts achieve a partial analysis. This perspective implies that a strategy alone does not identify expedient tasks but instead proposes an aspiration to develop improved strategies.

Although incrementalism and disjointed incrementalism were not conceptualized with nursing and healthcare policy in mind, the principles are usable in this context. Refer to the Schober APN Conceptual Policy Framework for Advanced Practice Nursing in Chap. 2, Sect. 2.2.2, for application of aspects of incrementalism and disjointed incrementalism in construct of the framework.

3.3.2 Strengths and Limitations of Incrementalism

Recognizing the strengths and limitations of any policy theory must be done within the context of the relevant political environment where the policy decisions are being made. Sections 3.3.2.1 and 3.3.2.2 discuss the strengths and limitations of incrementalism.

3.3.2.1 Strengths of Incrementalism

Identifying incremental strategies of policymaking adds articulation and organization to ideas that may already be in wide circulation. In addition, the idea of fragmentation of policymaking and consequent interaction among decision-makers has the potential of raising the level of accessible information and rational thinking that could impact decisions. For someone who embraces disjointed incrementalism, there is never a last word; the work is always in progress.

The reality is that all scrutiny of an issue or situation is incomplete and may fail to understand what ultimately turns out to be critical or beneficial policy. Disjointed incrementalism, according to Lindblom (1979), is a strategy that makes the most of the limited ability of a broad range of decision-makers to understand all aspects of an issue or case. Their mutual adjustments in the process of negotiating during the policy process will to some degree bring them together in their roles as policymakers.

3.3.2.2 Limitations of Incrementalism

There are two identifiable problems with incrementalism (Birkland 2005; Kingdon 2003). First of all, some issues require bold decisions; thus, taking slower incremental steps may not be advantageous. Secondly, some objectives cannot be met in incremental steps and must be envisioned from a more comprehensive viewpoint. If a new policy requires only marginal change from the current situation, the risks of mistakes are minimal. However, if there is a need to reach a major agreement more quickly under a specific crisis situation and in an unstable environment, the situation is not conducive to incrementalism (Walt 2006). Another critique is that incrementalism is too gradual and too conservative and as a result encourages inaction (Dror 1989).

3.4 Walt's Framework for Policy Implementation

In response to requests for clarification on a definition for health policy, Walt (2006) developed a framework that focuses on process and power as it relates to policy development. The emphasis of the framework is in how policy is formulated and implemented and who influences policymaking. The concentration of the framework is concerned with who influences whom in the making of policy and how that happens. It can be said that politics cannot be separated from policy; however, few explanations of policy development provide explicit details about political systems, power and influence, and participation at the grassroots level in policymaking.

The intention of the Walt framework is to provide the initial step into the complex and challenging environment of policy choice and change. Those interested in healthcare, such as APNs, will find the framework helpful in understanding the policy processes associated with change and implementation of change. Walt (2006) proposes that a common conceptual framework (refer also to Sect. 2.3.2 – Conceptual Policy Framework for Advanced Practice Nursing) for the healthcare policy process is useful for representatives of both healthcare and policy. Procedures and routines in policymaking are likely to be similar from country to country, even if the setting, range of concerns, and solutions are different. However, incongruities exist in habits, in behavioral patterns, as well as in the political and social culture.

3.4.1 Principles of the Walt Framework

The eclectic approach of this framework includes theories and principles from different social science disciplines. These include:

- Pluralism, elitism, and interest groups – political science
- Decision-making from rationalism to incrementalism – policy analysts
- Actors pursuing their own goals – public choice theorists
- Interrelationship of politics and economics – political economists

This combination is thought by Walt (2006) to provide concepts derived from different theories to create an overarching framework as a way to understand the complex world of health policy. There is extensive dialogue in the political science and policy analysis literature regarding an ideal approach; however, Walt did not see a single proposal as satisfactory in its own right. Taken into consideration in this broad framework are the basic structural concerns of society-centered approaches about where power lies. Healthcare is one of the most visible products of policy, from healthcare professionals to institutional campaigns for the public to transport. Decision-making in healthcare is in a unique position in comparison to other social issues. Most individuals and populations come in contact with health sector institutions and personnel many times in their lives. In spite of this, there have been limited broad-based frameworks visible in the healthcare sector dealing with health policy.

Health policy crosses multiple sectors, some of which have little to do directly with healthcare or services (e.g., violence, climate change, pollution, sanitation). However, all have a potential impact on levels of morbidity and mortality. Walt (2006) proposes that health policy is best understood by looking at processes and power thus exploring roles of the state (national and international), actors/players in the arena, external influences, and mechanisms for participation in policymaking. Noting this focus, this framework is about the policy process, not about policy options or planning. For Walt (2006, p. 6) "planning follows policy: planners help to put policies into practice, although the planning process itself may help to develop and refine policies."

Layers of the Walt (2006) framework explore the political system as a whole, starting with a systems approach. In this way, all different parts of the political system that affect health policy is assessed including direct and indirect participation in the process. The way power is distributed in society is explored and how it influences the policy process. The power debate revolves around the extent to which policymaking is dominated by a few influential players who control policy decisions while noting that different individuals may be influential at different stages. The structure of this framework moves from agenda setting and achieving the attention of policymakers to formulation of policy. This framework can be used as a starting point for engaging in the policy process. The finale of the policy process, as Walt sees it, is implementation (e.g., moving from intent of policy to actual implementation in practice), a phase that Walt suggests is all too often neglected by other models and frameworks.

3.4.2 The Policy Process According to Walt

Getting on the policy agenda, processes of formulation, influential actors, and implementation of policy comprise the key factors for the policy process from Walt's perspective (2006). Political culture and structure differ from country to country and place different limitations on policymaking and the extent to which the ordinary citizen can influence the policy process. A discussion of the policy process according to Walt (2006) identifies two questions:

- How far does the structure of the policy process allow or encourage participation in public policymaking?
- What are the beliefs in the country about the government and politics? How far do these attitudes affect participation in the policy process?

In this framework, political power is perceived as the ability of government to decide collectively and put agreed policies into practice. An additional theme is focused on who makes policy: a small number of privileged leaders or many different groups. How decisions are made takes note of who influences policy and raises the question "is it possible to devise rational policies if many different groups are insisting on their demands being met?" (Walt 2006, p 35). A commonly held view

in a democratic system of government is that there are many ways to participate in the policy process. However, this view is not universal, and it is argued that policy is decided by a small group of influential decision-makers. A research conducted by Schober in Singapore highlighted how select leaders in positions of authority and their networks influenced policy decisions and moved the APN agenda forward or impeded progress at different stages (Schober 2013; Schober et al. 2016).

3.4.3 Implementation: Do Those Who Implement Policy Decide Policy Formulation?

In discussing intent of policy to realization in practice, Walt (2006) asks the following question: "Can we assume that once a policy decision has been made, it will be implemented as intended?" (p 153) Commenting on this question, Walt sees policymaking as interactive, with formulation and implementation as two elements in a continuous loop. In other words, the policy process is not a linear process where policy formulation is seen separately from implementation. However, the idea of an interactive continuous loop of communication may be fantasy rather than a version of reality.

Implementation of intended policy is in the hands of many different groups, some of whom might be involved in policy formulation. Implementation is heavily dependent on the extent to which policymakers and key stakeholders can expect those on the ground to follow policy guidelines. As a result, because policy is understood in fairly general terms, it is left to those implementing policy to decide specifically how to carry it out.

Those managing implementation on the ground often have considerable discretion in interpreting policy because their expertise is in the interpretation of assigned tasks. In addition, the implementation process may not be visible to policymakers and the key decision-makers who orchestrated policy development. Implementing agencies and institutions are likely to be more sensitive to a range of responses thus contributing to dissimilar approaches in realization of policy.

Empirical evidence based on research conducted by Schober (2013) in Singapore found this to be consistent in the beginning phases of APN implementation in the country (see Sect. 2.3.3 for description of the Singapore context). Policy at the highest level was developed, while implementation and interpretation of APN policy were left to the management level and APNs themselves. Various institutions interpreted policy and the APN role differently. Study findings demonstrated that management felt uninformed and were ill prepared to implement policy as intended by the policymakers.

To ensure policy is implemented, legislation carries the most authority. However, regulations and published standards also carry substantial weight, especially as it relates to professional regulation (Walt 2006). Even though legislative control is less common in the healthcare environment, sometimes legislation may be necessary to ensure policy is implemented. For example, when the plan to introduce nurse practitioners (NPs) in Jamaica was decided in the 1970s, it was acknowledged that

legislation would be necessary. However, the plan and related policy were implemented without legislation leaving the NPs in a difficult position. Pharmacists would not accept their prescriptions without a physicians' countersignature. The pharmacists argued that the legal authority to prescribe had not been established, even though the medical profession and policymakers in the ministry of health at the time had agreed to it (Cumper 1986).

3.4.4 Walt's Strategy for Policy Implementation

What seems clear to Walt (2006) in the analysis of policy is that most thought is focused on the formulation of policy and related dialogue. There appears to be an assumption that good fortune or managers will carry out the desired changes proposed in policy and that there is little reason for a specific strategy for implementation. The implication is that policymakers do not engage much in assessment of the environment to determine if conditions for successful implementation exist.

Theoretically (Walt 2006) and based on the study done in Singapore, Schober (2013) suggests that with a pre-policy analysis, many later mistakes during implementation can be avoided (see Chap. 2, Conceptual Policy Framework for Advanced Practice Nursing). Walt (2006) further suggests that policy implementation is a complex interactive process in which those implementing policy affect the way policy is executed that results in change. However, in reality too often there is a major separation between policy development and implementation with little focus on putting policy into practice. The implication is that to avoid this gap, policymakers need to include strategies for implementation in the process of policy formulation. There is often an expectation from professionals and the public that policymakers have a plan in mind. In the Singapore context, study findings (Schober 2013) revealed that there was a belief that planning and coordination for APN implementation would be provided from the ministry of health. Managers and healthcare professionals were surprised when this did not happen.

3.5 A Comparison of Theories of the Policy Process

When considering strategic planning and/or strategic implementation of an ANP initiative, comparing policy theories provides an opportunity to combine the insights they provide (Sabatier 2007). In thinking strategically, some aspects or principles of theoretical constructs are accepted and others rejected as relevant or irrelevant to ANP and the inclusion of APN roles. Various policy theories contain different foci and concepts; however, the intent of the comparison of the policy theories described in this chapter is to understand and form an opinion on the usefulness of certain aspects of different approaches. Each of the theories described in this chapter has a relatively well-defined scope and provides a different lens on the policy process. All of the theories, to some degree, address questions related to policy formulation and change (see Table 3.1 for a brief comparison of foci and principles).

Table 3.1 Comparison of policy theories

Theory	Focus	Principles
Hall et al. (1975) Section 3.1	Agenda setting	Identifying legitimacy, feasibility, and support for an issue
Kingdon (2003) Section 3.2	Agenda setting, identification of issues, policy actors (decision-makers)	Three policy streams merge during windows of opportunity to cause major policy change
Lindblom (1979) Section 3.3	Incrementalism	Disjointed incrementalism trial and error unanticipated events
Walt (2006) Section 3.4	Policy implementation top-down/bottom approaches	Policy formulation to realization in practice Policymakers' spheres of influence

The intent of the author is to provide a brief comparison of theories as discussed in this chapter to raise awareness and understanding of philosophic underpinnings of each theory or overarching concept. It is hoped that the reader, in gaining understanding of theory, would find ideas that are applicable to their specific issue and/or country context. Not all theories focus on all aspects of the policy process; however, elements of different theories produce an explanation of a significant component of the policy process.

3.6 Commentary on the Relevance of Policy Theory for Nursing

Porche (2012) suggests that the discipline-specific knowledge and experience of nurses and other healthcare professionals provides them with a "unique knowledge and experiential base" from which to influence the policy process (pp. 114–115). Utilizing social and healthcare theories as guides, nurses as researchers, clinicians, and educators have the potential to assume a variety of roles in the policymaking process. Based on an understanding of the nuances and dynamics of how policy decisions are made, nurses are better positioned to participate in the development of policies that affect healthcare. In addition, the influence of nursing is possible with a socially relevant knowledge base within an environment that respects the nursing perspective (refer to Chap. 2, Sect. 2.3.3, for a description of how three policy theories plus evidence from the Singapore context were combined for development of the Conceptual Policy Framework for Advanced Practice Nursing).

When integrating theoretical knowledge of policy, nurses can assume a variety of roles in the policymaking process. These include the following roles (Porche 2012):

- Researcher in provision of evidence to support or challenge various elements of a proposed policy.
- Members or organizers of professional interest groups that focus on specific policy issues.

- Personal support and professional networks as legislative advocate collaborating with policymakers or policymaking bodies to influence policy development.
- Provision of expert testimony on policy issues. Professional experiences of nurses have the potential for reinforcing relevance to the policy issue.

Nurses may articulate what they want to happen in healthcare policy, and they may provide evidence to support their suppositions; however, they must engage in the policy process to ensure the changes they support are realized. In this effort, they must envision themselves as leaders in the process. The challenge is to motivate nurses to pursue leadership positions in the policymaking process (IOM 2011). Participation may be as simple as sharing research findings and personal experiences or as complex as aspiring for a political position at the government level. If nurses choose not to participate in the policy process, politicians and officials will listen to those who have a limited knowledge of nursing and the advancement of the profession.

Conclusion

The issues of health, healthcare services, and relevant policy impact the lives of all populations at diverse levels. If we, as healthcare professionals, do not feel that we have the power and ability to influence change that affects our lives and lives of those around us, why have we gained clinical and leadership expertise as advanced practice nurses? Advanced practice nurses can be instrumental in translating the intent of policy to the realities of implementation in practice. Planning that includes options for nursings' participation in the policy process includes insight, multiple strategies, and skillful techniques. This chapter suggests that there are various options for participation of nurses in the policy process. Understanding a context is always the first step. Through better understanding, there is a higher possibility of selecting appropriate strategies and actions.

Using a theoretical lens is essential to achieve this task. Understanding theory and thinking about the various factors that influence health policy development is a beginning in shaping change. This knowledge includes awareness of interactions among diverse individuals, unexpected events, and a complex mix of policies that span levels of governmental agencies along with contextual geographical and socioeconomic settings (Sabatier and Weible 2014).

The chapter also suggests that persons in positions of authority and power ultimately make pivotal decisions. If decision-makers with limited knowledge of nursing lack access to nursing representatives, they will likely resort to ill-informed or less-informed points of reference to guide their decisions. This calls for a transformation in nursing to become more visible and active leaders in the policy process. Policy associated with advanced nursing practice that proposes a new level of nursing and nursing roles requires a paradigm shift in thinking in the

provision of healthcare services. Advanced levels of autonomy, prescribing authority and referral patterns to other healthcare professional among other issues, often raise opposition to the advanced nursing practice concept. For this reason, the author emphasizes that APN leadership and participation is essential in policy development and implementation.

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Evidence-Based Policy Decisions

4

Evidence is the available body of facts or information about a topic or issue intended to make clear, prove, or disprove whether a proposal is accurate or valid. Integration of findings from formal, systematic research into the practice of evidence-based policy decisions identifies the best evidence in order to inform decision-making (Birkland 2005; Porche 2012). When an informed advanced practice nurse (APN) presents data and information along with a request for creation of or change in policy, the APN presents a stronger argument in support of the issue or agenda item (Duffy 2015, Tracy & Hanson 2014).

An ideal scenario suggests that evidence-based policy decision-making uses information derived from formal research and systematic investigation to identify programs and practices capable of supporting or improving policy-relevant outcomes. The concept of evidence-based policy decisions implies that a rational, rigorous, and systematic approach takes place when making policy decisions (Birkland 2005; Zahariadis 2014). The premise is that policy decisions are better informed by available evidence and rational analysis. Support for this view suggests that policy decisions based on empirical evidence produce better outcomes (Walt 2006).

This chapter explores and challenges the perception that policy decisions are a result of coordinated efforts based on evidence. In addition, the reality that policy decisions are often made in a precarious rather than a stable environment, not necessarily based on supportive data and evidence, is discussed. The concept of a policy agenda, introduced in Chap. 2, is revisited in the context of evidence-based policy decisions. This is followed by a discussion of the impact decision-makers with power and authority have in influencing policy decisions. The concept of direct and indirect participation in the policy process concludes the chapter.

4.1 Reality: Is Evidence Used to Make Policy Decisions?

Political strategies include the methods and processes to influence policy goals (Porche 2012). Policy decision-making can be viewed as a process where hope and desire for an identified outcome are ongoing. The future is uncertain as decision-makers progress

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through unpredictable and divergent scenarios related to policy decisions. In contrast, there is a perception that the policy process is a matter of political certainty and that policy decisions are coordinated efforts forming the basis of policy choices. Pawson (2006) suggests that the policy process is a balancing act between "hierarchical privilege, economic power, ideological standpoints and democratic mandates" (p. 2).

In some countries, key stakeholders and decision-makers are less inclined to develop professional views and make decisions based on trust and more often expect to be shown supporting evidence. In addition, the growth of knowledge management systems contributes to an expectation that information and evidence is available. Knowledge provides a perceived advantage for decision-making in an age of information systems and data banks. However, evidence-based policymaking uses hierarchies of evidence to evaluate potential interventions and to determine the strength of the evidence (Porche 2012).

The PEW-MacArthur Charitable Trust (2014) identified lack of a comprehensive guideline to provide clear direction for evidence-based policy decisions as a problem. Recognition of this gap led to the development of a framework by the PEW-MacArthur Results First Initiatives research project. Based on the literature and in-depth interviews of government officials, practitioners, and academic experts, the framework identifies the following five steps (PEW 2014, p. 1):

- Program assessment – Systemically review available evidence on the effectiveness of public programs
- Budget development – Incorporate evidence of program effectiveness into budget and policy decisions, giving funding priority to those that deliver a high return on investment of public funds
- Implementation oversight – Ensure that programs are effectively delivered and are faithful to their intended design
- Outcome monitoring – Routinely measure and report outcome data to determine whether programs are achieving desired results
- Targeted evaluation – Conduct rigorous evaluations of new and untested programs that warrant continued funding

The emphasis in this framework favors budgetary decisions with a focus on reduction of wasteful spending along with strengthened accountability and a somewhat inflexible view of progress toward expansion of innovative programs. This perspective is consistent with the concept of the New Public Management trend that suggests approaches used in the private sector can be successively applied in the public sector (Barzelay 2001). The identification of the PEW five-point path supportive of evidence-based policy seems appealing. However, the human and financial resources required of this type of rational approach would seem overwhelming and unobtainable within some country contexts (see Chap. 8 – Rational Policy Decision Making: Idealism Versus Realism – for further discussion on policymaking as a rational process).

There is an obvious point to be made that evidence should ideally and perhaps realistically inform policy decisions. In addition, it seems logical to think that research and empirical evidence should precede policy decisions (Pawson 2006).

This view counters the perspective of an evaluation that occurs after program design and implementation more specifically measuring outcomes.

Systematic reviews are proposed as a bridge to fully utilize research of anticipatory outcomes and evaluation research therefore taking a look at the evidence before making decisions that impact policy and practice. There is also an implication that the use of both evidence and implementation research requires a continuous feedback loop from past to present synthesizing findings for policy development (see Chap. 2, A Conceptual Policy Framework for Advanced Practice Nursing, for an example of this). Thus, the concept of evidence-based policy from this point of view can be seen as based on a cumulative and progressive body of knowledge.

In addition, the premise of selection bias in gaining attention for an issue or strategy suggests that the structure of policy networks includes manipulation strategies and skills of policymakers (Zahariadis 2014). If the reality of making decisions includes levels of political manipulation, there is a mandate that APNs learn how to penetrate this context effectively. With this in mind, the next section discusses the concept of a policy agenda and how this relates to policy decisions.

4.2 Policy Agenda Setting and Policy Decisions: Frameworks and Models

A policy agenda is a set of issues, problems, or topics that obtain the attention of or are viewed as significant by individuals involved in making policy decisions (e.g., legislators, government officials, key policy stakeholders). The concept of a policy agenda and agenda setting is first introduced in Chap. 2 – Section 2.2.1. This section continues the discussion of this topic.

In addressing the importance for APNs to participate in the policy process, Stewart (2014) emphasizes the need for healthcare professionals to understand the political process and policy directives in order to implement policy in practice. Suggesting that policy is born out of collective action within advocacy and lobbying groups or organizations, Stewart (2014) refers to the policy agenda as Stage 1 of five stages of policymaking as proposed by Anderson (2011). In this stage, the focus is on the issues that require the attention of public or governmental officials. Understanding the concept of a policy agenda provides APNs knowledge to use when identifying options to introduce proposed policy. Gaining the attention of policymakers and reaching priority status on the policy agenda can determine the success or failure of progressing to further stages of policy development (Hall et al. 1975; Kingdon 2003; Walt 2006).

In emphasizing that public policy starts with agenda setting, Kingdon (2003) describes three streams or Ps – problems, possible solutions, and political circumstances that are involved in setting the agenda. These three streams can be envisioned as free floating, waiting for a "window of opportunity" to open in order to progress in policy development. This perspective requires an alignment of at least two of the three streams for an issue to be considered (Porche 2012). The Kingdon

policy stream model proposes that for policy to change, policymakers must be convinced the issue is important. Identifying something as a significant issue is part of the debate (Birkland 2005). According to Kingdon's theory of policy windows (2003), when there is a recognized problem, a possible policy solution, and a favorable political environment, a policy window is open. When this happens, Kingdon proposes major policy decisions can be made. The initial stage in policy development for Kingdon is achieving a position on the policy agenda.

The Hall et al. (1975) agenda-setting conceptual framework proposes that an item emerges on the policy agenda when the three issues of legitimacy, feasibility, and support are met. It is only when an issue is high in relation to all three concepts that it becomes an agenda item (Walt 2006). This theoretical framework provides a simple and quick approach for analyzing what issues might be considered by decision-makers and policymakers. Theoretically, using these three conditions, policymakers, according to Hall et al. (1975), will calculate if the issue under consideration falls high or low on the continuum. If it has high legitimacy (e.g., the government has the right to intervene), high in feasibility (there are sufficient resources, personnel, infrastructure), and high support (important interest groups are at least positive or not negative), the issue might come onto the policy agenda.

Within healthcare environments, for example, the minister of health or director of a public health department, at any given time, will be considering a range of issues: effectiveness of hospital or community services, the rise in health risks to a population, access to medicines, and cost of healthcare in general. The agenda-setting process limits the possible items on the agenda that actually become the focus of attention. Ministries, such as the ministry of health, pursue their own interests. The ministry of health is itself a complex organization and one that has to relate to other departments and entities.

Policies often emerge from relatively specialized policy communities. Within healthcare, medical, dental, nursing, and pharmacy communities have official positions in the infrastructure and provide technical advice. It can happen that there is tension between heads of sectors representing the professional groups. In such an environment, it is increasingly important that issues such as inclusion of ANP in provision of healthcare services involve APN engagement in the process to catch the attention of those setting policy. A nurse's active engagement provides the nurse an opportunity to advocate for specific agenda items (Porche 2012).

There is a commonly held viewpoint that agenda setting is the most critical aspect of policy development and formulation (Porche 2012). As APNs define their scope of practice, level of autonomy, function within healthcare systems, and professional progression, these topics commonly fall under the jurisdiction of policy and professional regulation. Understanding the legislative, government and organization methods of making decisions such as reaching a place on the policy agenda can assist in removing barriers to an optimal practice environment by gaining the attention of policymakers (Stewart 2014; Harris 2014) (further in-depth discussion of social and healthcare theories can be found in Chap. 3).

4.2.1 Key Decision-Makers: Power and Authority

Policymaking is considered to be a complex, multidimensional, dynamic process that is influenced by the values of individuals who establish the policy agenda, determine the policy alternatives, and define the goals to be achieved by the policy, the implementation methods, and in the end the manner in which the policy is evaluated (Porche 2012; Walt 2006). In addition, their interpersonal and political networks influence what items or issues reach the policy agenda. Policymakers or decision-makers on policy include a variety of individuals who participate in the development and formulation of policy.

Political power is perceived as the ability of governments and institutions to reach collective decisions and put agreed policies into practice (Walt 2006). The range of policymakers contributing to the view of political power consists of legislators, government officials, and institutional and organizational administrators or leaders. Individuals in this capacity are in or have privileged access to an inner circle that can be viewed as the upper stratum of leadership sometimes referred to as the policy elites (Buse et al. 2005).

A democratic view of the policy process suggests that there are many ways individuals can participate in the policy process; however, this view is not universal. In contrast, the point is made that power is in the hands of a few and decided by a small group of individuals. Theorists, in describing policy processes, suggest that decisions are often made by this elite group of "actors"/individuals and their networks or spheres of influence that make up tight policy circles (Hall et al. 1975; Kingdon 2003; Walt 2006). Findings from a study conducted in Singapore (Schober 2013) demonstrated not only the presence of policy circles and the importance of pivotal persons in position of authority in policymaking but also their ability to network and communicate with other key decision-makers. As an example, once the ANP concept in Singapore caught the attention of top or elite decision-makers, their linkages to others in their networks were critical in launching the ANP initiative and graduate education program.

There may be an array of individuals who set the agenda, but one of the most important is the government, which has ultimate control over legislation and the policy process. At this level, governmental representatives clearly have control over what issues reach the policy agenda and may accept or reject specific issues. Throughout this publication, the author has emphasized that policymaking seldom proceeds as a rational linear process. In addition, it is worth noting key decision-makers "never start with blank sheets of infinite possibilities – previous decisions affect present policies" (Walt 2006, p. 41). Hogwood and Gunn (1984) make the case that governmental representatives consider some of the following factors in deciding what items reach the policy agenda:

- Where has the idea of initiative originated? Who identifies the issue as worthy of attention?
- Is it a legitimate problem for government intervention?
- Is there support or agreement for placement on the agenda?
- Is timing for policy action on the issue appropriate?
- Is the policy context correct? Are there alternative perspectives?

In constructing a comprehensive ANP initiative are the issues requiring legislation or regulations clearly identifiable so that it is easier to understand what actions are needed.
- Is the causal structure of the issue understood? For example, are the dynamics relevant to nurse prescribing understood?
- Can future implications be identified?

In the day-to-day affairs of policy and politics, reform and issues proposing change compete for policymakers' attention. Which one is actually considered seriously depends on various circumstances, some of which are discussed in this chapter.

4.2.2 Participation in the Policy Process: Direct and Indirect

Even though nurses are not usually viewed at the elite level of policy decision-making, the author proposes that participation in the policy process provides nurses an opportunity to advocate for specific policy agenda items and influence policy development. In describing a political influence model, Porche (2012) defines political influence as the ability of an individual or group to influence the policymaking process and proposes that nurses have the ability to influence the policy process within four spheres. The four spheres of influence identified by Porche (2012) are "government, workplace, organizations and community" (p. 16). Involvement of nurses in these settings provides an opportunity to advocate for specific policies from a nursing perspective.

Walt (2006) defines policymaking as a "series of more or less related activities and their intended and unintended consequences" (p. 41) rather than a distinct decision. In addition, the structure of the political system affects participation and the potential to influence policy decisions. The political system in a country encourages or discourages participation and results in significantly different healthcare politics. A great deal depends on the country context and the stability of its political structure. In addition, beliefs and attitudes about participation impact nurses' participation in public policymaking. Two types of participation are identified by Walt (2006): direct and indirect.

4.2.2.1 Direct Participation

Interest groups may try to lobby or influence policy and decision-makers at various stages of the policy process. Direct participation refers to those methods or techniques by which individuals or representatives of interest groups try to influence policy by relating to policymakers face to face (Walt 2006). For example, members of nursing associations or interest groups attempt to lobby decision-makers directly about their views on healthcare topics or, for example, specifically professional regulation of advanced nursing practice. Interest groups might also form alliances with other groups to propose or resist policies. The impact of these groups differs in how they are viewed by the government and official decision-making bodies. Some interest groups are

given insider status and more closely consulted (refer to Chap. 6, Sect. 6.1.3, for a discussion of a process for identifying stakeholders and their interests).

4.2.2.2 Indirect Participation

Indirect participation includes activities intended to more indirectly influence the selection of government representatives and the policies they are likely to support (Walt 2006). Indirect participation is voluntary engagement in activities and networks with political implications but without clearly defined political interests or political aims. It is difficult to grasp a clear definition for indirect participation as there may be implicit political influence without political ambition (Pausch 2012). Opportunities for indirect participation depend to a great extent on political systems. Political systems vary from so-called Western European liberal democracies with high levels of participation to postcolonial regimes in Africa that are seen as unstable to more authoritarian leadership (Blondel 1990; Walt 2006). Countries whose governments function within a stable framework offer more options for participation by having diverse interest groups that attempt to negotiate and influence policy to fulfill their own goals. Even in countries that appear to offer indirect participation, it is unclear to what extent the public can affect and influence policy decisions (Birch 1993).

The perspective of direct or indirect participation, as introduced in this chapter, includes nuances in definition and therefore is intended to present only a background for involvement in politics and policy. External or situational factors influencing decisions can be infinite and unanticipated. The subject of participation in policy and politics for APNs is picked up again in Chap. 5 with the delineation of stages of political engagement for nurses along with recommendations for acquiring necessary skills for leadership.

Conclusion

Healthcare reform and changes in healthcare sectors arise worldwide from different starting points. No matter where change or modification begins, there are complex layers of decision-making in the policy environment. This chapter explores the concept of evidence-based policy in the context of the reality of what factors actually influence policy decisions by identifying aspects of how health policies are made, who influences policy, and how. The power and authority of influential decision-makers and their spheres or networks of influence are emphasized.

Differences between countries such as shortage of funds, scarcity of information, personal values of administrators, lack of on-the-ground communication networks, and limited structures of accountability impact engagement in policy-making and vary significantly from country to country. Nevertheless, regardless of perceived constraints, there are opportunities for advanced practice nurses to become engaged at some level in the policy process. Options of direct and indirect means for participation are discussed to encourage nurses to have a voice in the policy environment. As healthcare professionals, advanced practice nurses can influence and promote policy change.

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Politics: The Art of Diplomacy and Negotiation

5

Politics is often a forbidden word in nursing; however, it is a process that every nurse is engaged in on a daily basis. When defined as the process of making decisions applying to members of a group, specifically to achieve and exercise positions of governance, politics involves all nurses. In addition, leadership is increasingly identified as an advanced practice nursing competency. Participation in policymaking is a core element of leadership. Leadership aptitude implicitly suggests obtaining expertise to navigate the sometimes murky and ill-defined atmosphere of politics and political negotiating. This chapter begins by suggesting stages of acquired levels of political engagement for nurses. Chapter content continues on to describe skills that nurses can achieve and use in the political process to become effective in influencing policy development and policy decisions.

5.1 Nurses' Stages of Political Engagement

Encouraging advanced practice nurses to participate in the world of policy and politics warrants clarification of terminology in reference to the health policy process. Policy usually refers to decisions resulting in a law or regulation. Politics most often refers to power relationships and to the process used to influence individuals who are making health policy decisions. Advocacy and lobbying can be seen as activities by groups such as the collective voice of APNs to influence policy decision-makers and in turn influence public policy (O'Grady and Johnson 2014).

Envisioning strategic thinking and policy development in healthcare environments is a task of unprecedented complexity for APNs, administrators, and policymakers (Tracy and Hanson 2014). The participation of nurses in the policy process offers an option for progress, opening access to opportunity for political action. However, "healthcare practitioners have a tendency to allow policy to happen around them not through them. To truly be an effective advocate, [knowledge of] policy must become a tool used to sharpen…practice" (Stewart 2014, p. 3). It is essential that APNs strengthen their leadership skills to become policy leaders based

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on an understanding of advocacy, policy, and politics. As healthcare professionals, policy for APNs may arise as professional regulatory mandates that directly impact practice and can be seen as part of everyday practice. However, the tedious nature of policymaking and/or political terminology at times serves to disengage the healthcare providers who need to understand and implement policy directives.

Knowing how the policy process works and identifying ways to participate allows APNs to engage in policymaking at numerous levels (Duffy 2015). To guide an understanding of the political process, Anderson (2011) proposes that there are five stages of policymaking: (1) the policy agenda, (2) policy formulation, (3) policy adoption, (4) policy implementation, and (5) policy evaluation. Easton's (1965) system model of the policy process is similar with the view of policymaking taking place in stages (see Fig. 5.1).

This is a simple linear approach to begin to think about policymaking. However, a critique of this view implies that policymaking takes place in stages with a clearly defined beginning and end. While this viewpoint is currently less commonly supported in the policy literature, the concepts and terminology that were originally developed continue to be used as a reference point (Birkland 2005). Refer to Chap. 3 for additional discussion of theories on social policy and factors that influence decision-making including the policy agenda and agenda setting.

The author proposes that nurses must be involved in policy development and emphasizes that without the participation of nursing in the policy process, decision-makers will formulate and enact policy that impacts the profession with limited knowledge of nursing and the advanced levels of practice. Four stages that characterize the political development of nursing are identified in Table 5.1. The proposed stages provide a reference point to consider as nurses in different countries and varied healthcare settings proceed to a level of maturity and leadership in the arena of politics and policymaking.

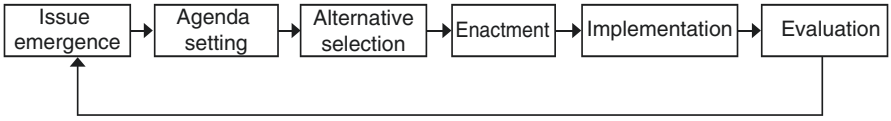

Fig. 5.1 The stage model of the policy process (Birkland 2005, p. 225)

Table 5.1 Nurses' stages of political engagement

First stage: buy-in
Nurses become reactive to an issue and gain an increased political sensitivity
Second stage: self-interest
Nurses develop a political voice characterized by organized political action, lobbying, and special interest groups
Third stage: political sophistication
Nurses become recognized as policymakers and leaders who have a valuable perspective and expertise in health policy
Fourth stage: leadership
Nursing leadership shapes and establishes policy agendas

Cohen et al. (1996), Mason et al. (2006)

The knowledge and experience that are specific to ANP and APNs place them in a unique position to influence policymaking. As a researcher, they can provide data and evidence. As a member of a special interest group, they can be instrumental in organizing members to focus on specific policy issues and lobby to influence policymakers. As an advocate supportive of an issue, APNs can collaborate with policymakers to gather support and influence policy development. Their expertise reinforces relevance to the policy issues (Porche 2012).

However, the ability of APNs to engage in political activities and policymaking is influenced by their resources and motivation to be involved in the process. The motivation to become involved is linked to political interest, view of personal effectiveness, and strong views on an issue. The opportunity to participate in the policy process can stimulate a nurse to consider political engagement. Resources that influence participation include nonwork-related time, available financial resources, and acquired skills (Porche 2012). The next section identifies the skills APNs should acquire to facilitate engagement in policymaking.

5.2 Acquiring the Necessary Skills

Advanced practice nurses provide first-rate healthcare to patients, families, and communities. In advocating for optimal healthcare options for their patient populations, they may not always see the link between advocating for health policy. Acquiring leadership competencies that influence policy in turn can influence quality provision of healthcare services. The practice experiences that APNs bring to policy discussions have the potential to personalize for decision-makers the impact of policies they create and develop (Duffy 2015).

5.2.1 Leadership Competencies

Progressing from clinical experts to leadership in health policy is not necessarily an obvious progression in skills. Not only do APNs need to obtain leadership skills, but they must also have the resources to stay informed and respond to changes in policies that will affect their clinical practice and the provision of healthcare services. Leadership has become a core competency for the APN; however, the concept includes some unique characteristics within the ANP context. These defining qualities according to Tracy and Hanson (2014) are mentoring, innovation, and activism. With this in mind, APNs as leaders are called upon to recognize the need for policy change as well as identify and implement strategies to achieve it.

The following APN competencies are identified as directly related to leadership in health policy (AACN 2006; Duffy 2015; NONPF 2012):

- Assumes complex and advanced leadership roles to initiate and guide change
- Provides leadership to facilitate alliances with multiple stakeholders to advance quality healthcare

- Advocates/lobbies for accessible healthcare services as well as quality and cost-effective care
- Participates in professional organizations and committees that influence APN practice and health outcomes of a population

In addition, nursing scholars suggest that nursing and politics actually complement each other (Leavitt et al. 2002). The nursing process includes assessment, planning, intervention, and evaluation. Theoretically, policymaking progresses from an identified problem to implementation of a solution, requiring the separation of one problem from another. Although the process may not always be straightforward, the APN must understand that various solutions exist, has to prioritize the options to interact and communicate with other interests, and be ready to respond to change. After acquiring more in-depth understanding of governance and legislative processes, the APN has the opportunity to apply that understanding to influence multiple levels of policy decision-making. When an informed APN requests a change in policy accompanied by evidence and data, this approach provides a stronger argument in support of change and/or policy (Duffy 2015).

Not all APNs are comfortable and confident in capacities of leadership, but Tracy and Hanson (2014) suggest that leadership is not an optional activity. Leadership competency can be viewed in four domains: clinical practice, professional organizations, healthcare systems, and the context of health policymaking. There is overlap in knowledge and skills across these domains. For example, the skills developed in clinical leadership can facilitate progress toward effectiveness in the policymaking context. The domain of health policy leadership is increasingly important as laws and regulation are enacted that have implications for APN practice.

5.2.1.1 Communication and Collaboration: A Beneficiary Policy Approach

There is an expectation, or at least a hope, that APNs will collaborate with other healthcare professionals in an effort to provide patient-centered care. Interprofessional models of care emphasize collaboration and an increased comprehension of the expertise each profession offers (Duffy 2015). It is equally important that the intersection of expertise between healthcare professionals works in partnership to communicate with key stakeholders and decision-makers to influence policy. As a component of the APN leadership competency, Tracy and Hanson 2014 recommend that refinement of communication skills, risk taking, interactions with leaders in positions of authority, and mentoring for active roles in policymaking should begin to take place during advanced graduate education.

Advanced practice nurses that are effective leaders are viewed as having identifiable attributes (see Table 5.2). The author emphasizes that not only are these wide-ranging qualities but valuable assets in the interdisciplinary contexts of healthcare systems and politics. Nursing leaders no longer have the luxury of utilizing leadership skills in only nursing environments but are called upon to demonstrate leadership beyond the jurisdictions of nursing education and practice.

Table 5.2 Attributes of advanced practice nurse leaders

Expert communication skills
Articulate in speaking and in writing
Able to communicate an important point
Outstanding listening skills
A desire to listen and try to understand alternative viewpoints
Maintains connections to other people and their expertise
Commitment – development of personal style
Engages in self-reflection
Thinks ahead, facilitates change
Participates and remains involved
Sets priorities
Proficient in use of technology
Risk taking
Leadership involvement at any level
Expresses self-confidence
Uses creative and strategic thinking
Willingness to make a mistake and begin again
Copes with change
Willingness to collaborate
Respects diverse perspectives
Desire to collaborate and develop alliances
Shares aspects of personal influence and networks
Willingness to mentor others

Adapted from Tracy and Hanson (2014) p. 281

Table 5.3 Strategies to develop political confidence and skill

Ability to provide policymakers substantive information in a simple but comprehensive format. Statistics and data are helpful
Be brief and focused in your discussions
Be specific in describing your intent and request
Consider compromise and know your limitations for negotiation
Establish who you represent and who your topic/issue will impact
Record notes of the conversation and follow up with information as the situation requires

Adapted from Porche (2012), p.177

Leadership strategies used by APNs in various political contexts include developing connections and influence with policymakers, motivating colleagues to stay informed of the status of current issues, and promoting links to other leaders who have access to additional and relevant resources.

Political confidence and good judgment are competencies that increase an individual's ability to influence others (Porche 2012). The knowledge, skill, intuitive thinking, and perception related to the politics of a given situation can be learned and developed with experience. Table 5.3 identifies strategies to develop political confidence and skill.

The proposed strategies build on learning and understanding the policymaking process and the significance of utilizing political strategies. In the process of developing these skills, it is important to identify key individuals and persons aligned with

the issue(s) for which you are seeking policy change or refinement. Use networks to obtain information and for communication. Political influence is cultivated over time; thus, persistence and perseverance are components in developing these skills.

Conclusion

The rationale for advanced practice nurses to participate in political activity is presented in this chapter by identifying stages for the political engagement of nurses. Encouragement of participation in politics and policymaking implies increasing levels of leadership and acquiring the skills needed to become an effective leader. This chapter proposes attributes of skilled nurse leaders and identifies advanced practice leadership competencies that relate specifically to policymaking.

Achieving diplomatic skills to navigate political environments is recognized as essential for the advanced practice nurse leader. Sensitivity and diplomacy are attributes that promote effective communication, especially during processes of negotiation when attempting to be persuasive in the political context of policymaking. Leadership skills of diplomacy have the potential to lead to improved relationships with others, more successful outcomes, and less stressful communications. The author suggests nurses are well positioned to integrate these traits based on their education and practice experiences and therefore are able to transfer this knowledge to politics.

Frameworks described in Chap. 2 and policy theory discussed in Chap. 3 highlight factors that are likely to influence policymaking and policy formulation. Content for this chapter builds on these prior discussions and continues to emphasize that features of policymaking do not occur in isolation. It is the combination of numerous elements that results in setting strategies for policy formulation and subsequent implementation. When advanced practice nurses understand the multiple and varied configurations of policymaking, they will be well prepared to be leaders actively engaged in politics. In addition, they will have acquired the skills applicable to strategic thinking and planning.

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Effective Change: A Strategic Approach

6

Many countries, whether developed or developing, are facing change or reform in the healthcare sector. Economics and shifting political ideologies are contributing to an alteration in the dynamics of access to and provision of healthcare services. Advanced practice nurses (APN) are being increasingly acknowledged as a component of this change. As healthcare professionals, APNs have some power to affect not only policy that impacts the profession but also that affects the populations who receive their care.

Thinking about a strategic approach when hoping to launch an advanced nursing practice (ANP) initiative is the first step in acting to influence restructuring of healthcare systems to promote the inclusion of advanced practice nurses (APNs). Progress is often not straightforward; however, this chapter offers tools, discussion, and country-specific examples to guide strategic thinking. The chapter begins by providing suggestions for assessing the healthcare environment followed by a discussion of the significance of regulation and governance issues to support advanced nursing practice. Country illustrations depict experiences with the processes of obtaining prescriptive authority and professional recognition. The chapter concludes by exploring the topic of influencing the process with debate, discussion, research, and dissemination of information.

6.1 Assessment of the Healthcare Environment

Assessment of the healthcare environment is a systematic process for determining the nature and extent of healthcare needs in a population, the causes and contributing factors to those needs, and the human, organizational, and community resources available to respond to these needs (Last 2001; Wright 2001). Assessment of the healthcare environment and the rationale for launching an ANP initiative is an early step in developing a strategic approach. Identification of population needs and the call for APN services can be accompanied by assessment of available resources for promoting the ANP concept. Conducting an environmental scan and/or a SWOT (strengths, weaknesses, opportunities, threats) analysis along with a guiding framework can bring focus to the receptivity for the ANP concept (see Chap. 2 "The

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PEPPA Framework and the Schober APN Conceptual Policy Framework"). The strategic tools of environmental scanning, SWOT analysis, and stakeholder analysis are discussed in the following sections and can be used to establish a level of understanding advantageous for strategic planning.

6.1.1 Scanning the Environment

Environmental scanning is a process that systemically collects and interprets relevant information and data to gain an understanding of a situation. In this case, it is a way to assess the interest and possibilities for the ANP concept and/or healthcare needs of the country or healthcare sector. An environmental scan assists in assessing internal needs and the external environment by collecting and interpreting data on events, trends, relationships, and expectations of different interest groups.

Doing an environment scan is commonly done when there is a high level of uncertainty in the environment and to evaluate long-term planning. A completed scan is a detailed and ultimately a continuous process. There are two ways scanning may be done (ICN 2005):

- Centralized scanning where specific components of the environment are analyzed. Only the significant issues likely to exert considerable impact on strategic planning (e.g., factors associated with the ANP concept) are evaluated. This is a more simple way to scan; however, it is not a comprehensive method.
- Comprehensive scanning analyzes all components of the environment in a detailed way. This method collects volumes of information and is time-consuming to collect and interpret the data.

Environmental scanning is a technique of detailed study of the environment. Sources of information that will be used should be determined. These sources can include secondary sources (newspapers, government publications, committee reports), mass media (radio, television, the Internet), internal/external agency or interest group reports, and formal research studies. Obviously, the volume of information can be enormous; thus, there is hesitancy to consider this approach given the human and financial resources required to conduct a scan. The three main approaches to environmental scanning are:

- Systematic approach with continuous collection of information. The environment is monitored in a recurring manner.
- Ad hoc approach with environmental components analyzed through survey and study for a specific initiative. This approach is useful when evaluating strategic alternatives and formulating strategies.
- Processed form approach collects information from internal and external sources, and the information is used after processing and analysis based on the requirements and criteria of the investigation.

The information gathered can identify the early signs of trends in the healthcare environment along with opportunities and threats. Conducting an environmental

scan along with a SWOT analysis identifies gaps that need to be addressed, thus contributing to strategic development. Information and trends discovered in the environmental scan provide a basis to also confirm findings from a SWOT analysis. For example, if the environmental scan identifies a scarcity of funding for healthcare professionals, this can be viewed as a threat to an ANP initiative. A prediction of a physician shortage can be seen as an opportunity for inclusion of APNs in the healthcare workforce (Schober 2016). For further guidance on doing an environmental scan refer to: http://www.who.int/workforcealliance/knowledge/toolkit/33/pdf for Part 2 of a World Health Organization's "Policy Toolkit for Strengthening Health Sector Reform."

6.1.2 SWOT (Strengths, Weaknesses, Opportunities, Threats) Analysis

A SWOT analysis is a process often used during strategic planning to assess a situation or context (see Appendices 6.1 and 6.2). It categorizes strengths, weaknesses, opportunities, and threats in order to identify challenges and opportunities when looking at a new initiative, identifying areas for change, and refining components already in place. Strengths are internal factors beneficial in achieving desired goals; weaknesses are internal factors that may impede achievement of objectives; opportunities are external factors that could be useful in accomplishing goals; and threats are external factors that may block achievement of objectives.

When preparing a SWOT analysis, typically a table is created, split into four columns in order to see each impacting element side-by-side for comparison (see Appendices 6.1 and 6.2). A completed SWOT matrix can be used to identify strategies to maximize strengths, defeat threats, overcome weaknesses, and take advantage of opportunities in order to set priorities for defining a strategic approach (Schober 2016). Strengths and weaknesses would not typically match listed opportunities and threats; however, in some way, they may correlate in identifying priorities for action.

Suggestions to strengthen the results of a SWOT analysis:

- Clarify what you are doing and why. For example, you may be conducting a SWOT analysis to define the national position on scope of practice for an APN and/or APN function in the healthcare workforce.
  - Select suitable individuals or experts who are knowledgeable and have expertise about the issues relevant to the SWOT topic.
  - Comments and information on strength and weaknesses should focus on the internal factors of skills, resources, and assets or lack of them. Opportunities and threats should focus on external factors over which there may be little or no control, such as social or economic issues. Weaknesses and threats restrict potential strategies and must be made explicit and addressed to facilitate action.
  - There may be an exploratory phase where participants in the SWOT are asked to gather data and information in specific areas. This is followed by regrouping participants to discuss the gathered information specific to the four SWOT categories that were identified at the initial meeting.

Schober and Affara (2006)

It is useful to identify the contrasts between an environmental scan and SWOT analysis to determine if one or both will be useful. The environmental scan collects information and data, especially on trends, to gain an understanding of the context, e.g., healthcare environment. The SWOT analysis categorizes the information into four compartments of strengths, weaknesses, opportunities, and threats in the present system and situation. Even though the techniques can be used independently, aspects of the findings from both when used together can assist in assessing the readiness of a country, institution, or agency for the ANP concept (Schober 2016).

6.1.3 Stakeholder Analysis

Stakeholders are individuals, interest groups, or organizations that can potentially have an influence on or be impacted by a proposal or initiative. The process of identifying stakeholders can include sorting them according to the impact they may potentially have on a strategy and the impact an action may have on them. Identifying interests of the stakeholders should be considered in strategic planning. In coordinating planning, it is helpful to identify (a) who the stakeholders are, (b) what their interest (or stake) is in the proposal, and (c) what related assumptions are associated with them. Stakeholders include not only those supportive of an initiative but also those who oppose it or are undecided (Schober and Affara 2006).

The degree of power and authority key stakeholders and decision-makers have to influence, control, or persuade others into making decisions can be pivotal to progress or lack of progress (see Chap. 4 for discussion of Key Decision Makers: Power and Authority). A stakeholder analysis seeks to:

- Identify and define the characteristics of potential stakeholders.
  - Assess the manner in which they might affect, or be affected by, the proposal related to advanced practice development.
  - Understand the relations between stakeholders including an assessment of the real or potential conflicts of interest and/or viewpoints of stakeholders.
  - Assess the capacity of different stakeholders to participate in or block the goal and objectives of the proposal.
  - Establish what resources the stakeholder will commit (or avoid committing) to the initiative.

(Schober and Affara 2006)

Persuasive stakeholders can take pivotal influential actions, facilitate policy formulation and/or role implementation, or exert influence that affects the evolution of an ANP initiative. Their power may be in the ability to direct and control decision-making, funding, or access to strategic resources. There will also be stakeholders with less influence but who are important to the development of an ANP initiative (e.g., citizen groups, peer associations).

A stakeholder analysis should do the following:

- Identify
  - Whom you want to recruit to assist and work with as a collaborator
  - Who you anticipate might block or impede the proposal and why
- Think about what strategic alliances need to be developed or if specific individuals need to be named to manage certain relationships

Identifying opponents to a proposal as well as supporters assists in responding to their concerns. In addition, supporters might be in an underserved population that will benefit from APN services, researchers with evidence to support the proposal, or a governmental entity seeking to reform healthcare services. Opponents may be other nursing groups, other healthcare professionals, a ministry of health unwilling to renegotiate levels of nursing practice, and sources unwilling to commit funding to the initiative (Schober and Affara 2006). Additional guidance on doing a stakeholder analysis can be found at: http://www.euforic.org/gb/stake1.htm *Guidance note on how to do stakeholder analysis of aid projects and programmes.*

6.2 Regulation

Professional regulation and policy that impact APN practice do not occur in a vacuum. Contextual influences play a significant role in shaping regulatory practices. The challenge for APNs is to acknowledge and understand factors that influence professional governance. To further understand the significance of regulation as it is relevant to the ANP topic, it is discussed here in the context of policy, public health policy, and the sociopolitical context.

Professional regulation for APNs is affected by public policy, and conversely public policy affects the nature of regulation taking place. According to Porche (2012, p. 5), "public health policy intersects policy that impacts the general population." Public policy is generally considered a product of some type of public request that generates a government-directed course of action aimed at resolving a problem or in response to public pressure about an issue. In addition, a distinctive purpose of public policy is to provide programs and services to meet the public needs. Procedural policy informs the process in which policymakers intend to implement changes (Porche 2012). For example, health-related issues that intersect with needs of the general population or public include ANP initiatives and governance that in turn require evaluation or investigation of applicable public health policy and regulation.

The World Health Organization (1998) considers healthy public policy as any course of action that can be expected to improve health and reduce inequities in health. Public health law and regulation are a form of policy. Policy with regulatory intent is designed to prescribe and direct the behavior of a particular group or population. Regulations define courses of action through influencing actions, behaviors, or resources within a

specific context (Porche 2012). Laws and regulation are normally regarded as consequences of policymaking. There is overlap in these processes and their implementation or lack thereof that might lead to a process of further policy development. Regulatory bodies are the last driving forces in health policy decision-making and include governments, legal systems, and special interest groups (Porche 2012).

6.2.1 SSPP Model (Scope, Standards, Policies, and Procedures)

Jhpiego, an affiliate of Johns Hopkins University, offers a healthcare professional and occupational regulation toolkit that provides a "comprehensive package of foundational regulatory information and tools that can guide stakeholders in processes such as task analysis or regulatory situational analysis in order to strengthen regulatory activities" (2013). The aim is to provide guidance to healthcare professional regulators and policymakers in the preparation of pivotal regulatory international documents and thus strengthen professional practice. The SSPP model (see Fig. 6.1) is a component of this package.

In the SSPP model (Fig. 6.1), scopes of practice, professional standards, policies, and procedures are related in a logical approach with one component the building block for another. Professional standards emerge from the definition of the profession's scope of practice. Competencies and standards result from a process of connecting a situational analysis, task analysis, and scope of practice definitions (see Fig. 6.2).

In the SSPP model, the setting of standards includes establishing procedures and policies that provide the basis of professional accountability and autonomy. Operationalizing the SSPP model is depicted in Fig. 6.2.

Professional organizations, regulatory bodies, and governmental agencies are central to standard setting and offer a profession such as ANP a process for role development (Schober 2016). The next section provides a country exemplar that identifies the significance and process of policy as it relates to prescriptive authority for nurses and advanced nurse practitioners in the United Kingdom.

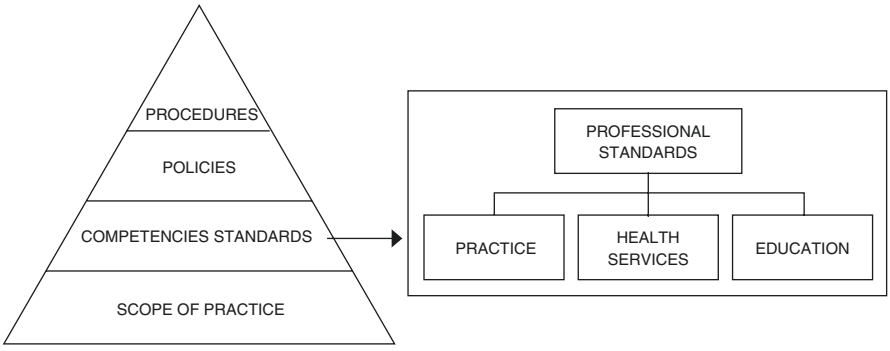


Fig. 6.1 SSPP Model (scope, standards, policies, and procedures) (http://reprolineplus.org/resources/health-care-professional-and-occupational-regulation-toolkit)

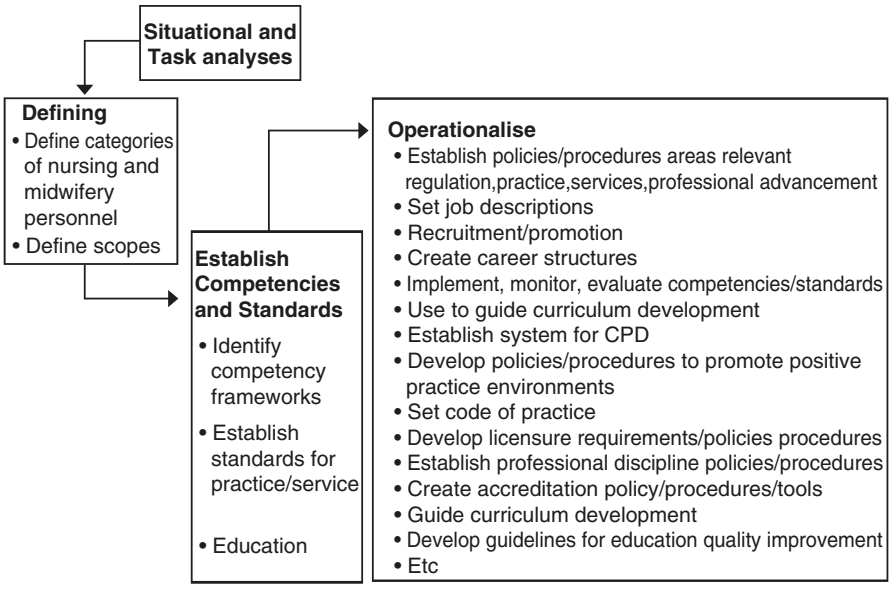


Fig. 6.2 Operationalizing the SSPP model (http://reprolineplus.org/resources/health-care-professional-and-occupational-regulation-toolkit)

6.2.2 Non-medical Prescribing in the United Kingdom (UK): Policy and Legal Strategy

The road to prescriptive authority for nurses in the United Kingdom has been a long and complicated one. This section will focus on non-medical prescribing for nurses and other non-medical prescribers in the United Kingdom. It will discuss the historical background to nurse/non-medical prescribing, regulation and policy, as well as the professional and legal and issues related to prescribing. The competencies for prescribing (RPS 2016) will be discussed, concluding with the impact of prescribing for modern day clinical practice.

The Department of Health (DH 2003a, 2006, 2012, 2013, 2016) has provided several changes to the Medicines Act (1968) to enable the prescribing of prescription-only medicines by professionals other than doctors and dentists. Some nurses have had the authority to prescribe from a limited nurse prescribers' formulary since 1994. However, since 2006, this has been extended to give independent prescribing rights to nurses, pharmacists, physiotherapists, podiatrists, and therapeutic radiographers and supplementary prescribing rights for diagnostic radiographers and dieticians (DH 2013, 2016), hence the title, *non-medical prescribing*.

Modern management of disease often involves drug treatments, and as a consequence, many healthcare professionals contribute to "medicine management." Medicine management is a broad concept described as "a system of processes and behaviours that determine how medicines are used by the health service and patients" (NPC 2001). If implemented correctly, this system enables patients to benefit from medicines that provide maximum benefit with minimal side effects (NMC 2015).

6.2.2.1 Non-medical Prescribing in the United Kingdom: The Origins

In 1986 a committee headed by Baroness Cumberlege stated "The Department of Health and Social Security (DHSS) should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme, and issue guidelines to enable nurses to control drug dosage in well-defined circumstances" (DHSS 1986). After 8 years of political and professional negotiation, district nurses (DNs) and health visitors (HVs) began prescribing in 1994. The Advisory Group on Nurse Prescribing made specific recommendations to the government on prescribing by DNs and HVs in 1989 (DH 1989, Crown Report I). The necessary legislation enabling nurse prescribing was provided in the Medicinal Products: Prescribing by Nurses etc. Act. This Act was passed in 1992 and was implemented in 1994. DNs and HVs have since been able to prescribe a limited range of products approved by the DHSS/DH and listed in the British National Formulary (BNF) as the Nurse Prescribers' Formulary (NPF). In developing the non-medical prescribing agenda, the government built on the prescribing experience acquired by nurses who possessed the DN and HV qualifications.

In 1997, under "new labor," the government's strategy document *The NHS Plan* (Department of Health 1997, 2000a) integrated the main principles of the modernization of the NHS. The principal aim of the reform was to provide high-quality, accessible healthcare, designed and delivered around the needs of its users. An important part of the reform, and one of the tools designed to achieve its aims, was the goal to redesign the NHS workforce to develop and utilize the skills and abilities of the NHS staff.

Within this document, the chief nursing officer defined ten key roles for the profession, one of which included prescribing (Department of Health 2000a). Following *The NHS Plan*, the Department of Health (DH), in collaboration with professional bodies, detailed changes to the NHS workforce in a range of specific documents (Department of Health 2000b, 2001, 2002); nurses and other allied health professionals were encouraged to expand their clinical roles, particularly in chronic disease management, and were empowered to prescribe medicines (Department of Health 2000c).

6.2.2.2 Toward Independent Prescribing

In developing the non-medical prescribing agenda, the Department of Health (2001) built on the prescribing experience acquired by nurses who possessed the district nurse (DN) and health visitor (HV) qualifications. However, the "Nurse Prescribers' Formulary (NPF) for DNs and HVs" or "limited" NPF was quickly criticized by nurses as being too limited, and despite having prescribing rights, very few nurses were actually prescribing (Luker 1997). These reactions led to the extension of prescribing rights (DH 1999), and following the second Crown Report (II) (DH 1999), recommendations were made to extend nurse prescribing. After a lengthy consultation process, a formulary was drawn up from four areas of clinical practice: minor injury, minor ailments, health promotion, and palliative care. Eighty medical conditions and 180 prescription-only medicines (POMs) were selected for nurses to prescribe from a nurse's formulary known as the *Nurse Prescribers' Extended Formulary*.

6.2.2.3 Nurse Prescribers' Extended Formulary

Following further public consultation, a proposal was made to introduce "supplementary" prescribing for nurses and pharmacists. In 2003 alterations were made to the NHS regulations and the prescription-only medicines order to allow implementation of supplementary prescribing by nurses and pharmacists (DH 2003a). Supplementary prescribing is based on a voluntary agreement between a medical independent prescriber (doctor/dentist), the patient, and the supplementary prescriber (nurse) (DH 2003a, b). This agreement is recorded as a clinical management plan (CMP). The CMP is a legal document that has to be complied, agreed, and signed by both the independent prescriber and the supplementary prescriber before supplementary prescribing can take place. Each patient for whom supplementary prescribing is used will have their own CMP, although each CMP can encompass a number of disease states.

Several key factors have to be incorporated into the CMP to fulfill the legal requirements. These include clinical outcomes, name(s) of the medication(s), when the patient should be referred back to the independent prescriber, and review dates and plan for reporting adverse drug reactions. The ideal CMP should consider evidence-based prescribing and clinical governance and reflect the supplementary prescribers' level of competency. The CMP can be cancelled at any time, either by the independent prescriber, by the supplementary prescriber, or by the patient. While giving the non-medical prescriber the opportunity to prescribe any medicine within their area of clinical competence, supplementary prescribing was viewed as being time-consuming and limited autonomy among nurses (Courtney et al. 2007).

From 1 May 2006, the Nurse Prescribers' Extended Formulary was discontinued, and all independent nurse prescribers received prescriptive authority to prescribe any drug from the BNF (including some controlled drugs), providing it was within their scope of professional practice (DH 2006). This development was welcomed by the nursing profession enabling nurses to become autonomous and responsible for their prescribing decisions and in many cases complete a package of care for the patient without having to liaise with a doctor. From this time, the only restrictions were schedule 4 and 5 controlled drugs.

From 23 April 2012, legislative changes to the Misuse of Drugs (amendment 2) (England, Wales, and Scotland) Regulations 2012 have enabled independent nurse and pharmacist prescribers to prescribe, administer, and give directions for the administration of schedule 2, 3, 4, and 5 controlled dugs (DH 2012). This means that all nurses with the appropriate prescribing qualification can now prescribe any medicines from the BNF on the same terms as a medical professional.

6.2.2.4 Regulation

All non-medical prescribers in the United Kingdom are required to undertake a specific educational program provided by approved universities and validated by the regulatory bodies: the Nursing Midwifery Council (NMC), General Pharmaceutical Council (GPhC), and Health Care Professional Council (HCPC). The NMC Standards of Proficiency for Nurse and Midwife Prescribers (NMC 2006) forms the

structure of this generic non-medical prescribing program, with the GPhC and HCPC requiring additional learning outcomes that are professional specific. Core standards for the educational program set by the regulatory bodies include entry requirements, core curriculum content, and core assessment criteria (NMC 2006; HCPC 2013). The program is offered by most universities as an integrated program with other non-medical prescribers such as pharmacists, physiotherapists, podiatrists, and radiographers.

The Department of Health (2006) also specified specific entry criteria for health professionals wishing to undertake the non-medical prescribing programs, which include:

- Recent educational study to at least at degree level
- Three years post-registration experience, working for at least 1 year in the area in which prescribing is intended
- Competent to undertake a history/clinical assessment/make a diagnosis
- Identify a designated medical practitioner (DMP, doctor) willing to supervise specific learning in practice
- An identified need for prescribing within the workplace
- Access to a budget to meet the cost of prescriptions
- Access to CPD for prescribing
- A robust clinical governance framework

Key principles should be considered when selecting students to undertake the non-medical prescribing program and include patient safety, benefit to the patient in terms of quicker and more efficient access to medicines, and a better use of skills (DH 2004a). Throughout the program, all students are required to apply the principles of prescribing to their practice and reflect on this through a learning log or portfolio. However, they may not prescribe until they have successfully completed the program and the relevant qualification has been recorded with the regulatory body.

6.2.2.5 Supervision in Practice as Part of Education

Supervised clinical practice is a crucial element of the non-medical prescribing educational program. Each student is required to identify a designated medical practitioner (DMP), (a doctor), who will provide the student with supervision, support, and the opportunities to develop the competencies required to become a safe, cost-effective, and competent prescriber. The time spent with the DMP and the range of activities undertaken within the supervised clinical practice will depend on the individual student and their clinical relevant experience. However, as guidance, time should be spent observing consultations with patients, discussion of differential diagnoses, clinical reasoning in relation to the patient presentation, and discussion and analysis of the patient treatment/management plan. Non-medical prescribers who have achieved prescriptive authority as a result of successfully completing the non-medical prescribing program must aim to maintain their standard of competence through regular CPD.

6.2.2.6 Regulatory Standards

The NMC (2006) (due for revision in 2017) and HCPC (2013) have both published standards for prescribing. Although the GPhC does not have specific standards for prescribing in England, the Pharmaceutical Society of Northern Ireland has published standards and guidance for pharmacist prescribers, which are widely used in England. Each of these regulatory standards for prescribing has documented core learning outcomes for the educational programs for non-medical prescribing and specific standards of professional conduct that non-medical prescribers must adhere to ensure integrity. It is important that the standards are adhered to and practitioners practice lawfully, safely, and effectively. Although worded differently, the core standards for prescribing include (NMC 2006; HCPC 2013):

*The following standards have been taken from the NMC (2006) Standards of Proficiency for Nurse and Midwife Prescribers

1. Licensed as a prescriber – Non-medical prescribers must have successfully completed a program of education and be registered with the appropriate regulatory body as an independent/supplementary prescriber.
2. Accountability – The non-medical prescriber is accountable for all prescribing decisions and must only prescribe within an agreed level of experience and competence.
3. Assessment – Non-medical prescribers must be able to take a thorough detailed holistic history from the patient including a detailed medication history.
4. Need – Non-medical prescribers must only prescribe medication for a patient where there is genuine need.
5. Consent – Patients must consent to their treatment and made aware that any prescribing decision will be communicated to other appropriate health professionals.
6. Communication – There must be clear communication with other health professionals in relation to referrals.
7. Record keeping – All records should be accurate, comprehensive, contemporaneous, and accessible by all members of the prescribing team.
8. Clinical management plans (supplementary prescribing) – Supplementary prescribers must only prescribe within the accordance of the clinical management plan.
9. Prescribing and administration/supply – Prescribing and administration activities should be kept separate whenever possible.
10. Prescribing and dispensing – Prescribing and dispensing should be kept separate whenever possible.
11. Prescribing for family and others (excluding controlled drugs) – A prescriber must not prescribe for themselves. A prescriber must not prescribe for someone that they have a close personal relationship with.
12. Computer-generated prescriptions – Computer-generated prescriptions must be supported by the relevant software. A visible audit trail must be available. Prescribing details must not be altered. Prescription must be signed immediately after printing.

13. Evidenced-based prescribing – Prescribing practice must be evidence based and respond to local/national guidelines.
14. Delegation – A prescriber can delegate the administration of medication to another, providing the delegate is competent.
15. Continuing professional development – It is the prescriber's responsibility to remain up to date with the knowledge and skills needed to prescribe.
16. Prescribing controlled drugs – Since 2012 nurses and pharmacist may prescribe controlled drugs. Physiotherapist and podiatrist may only prescribe controlled drugs from a specific list. Therapeutic radiographers may not prescribe controlled drugs (subject to change in legislation).
17. Prescribing unlicensed medicines – Since 2010 nurses and pharmacist may prescribe unlicensed medicines. Physiotherapist, podiatrist, and therapeutic radiographers cannot prescribe unlicensed medicines.
18. Prescribing "off-label" medicines – All non-medical prescribers may prescribe "off-label" medicines, providing this is within their scope of clinical practice.
19. Repeat prescribing – Non-medical prescribers can issue repeat prescriptions in the knowledge that they are accountable as the signatory on the prescription.
20. Remote prescribing – Remote prescribing can be undertaken providing the patient is known to the prescriber, and there is an up-to-date medical history.

6.2.2.7 Prescribing Accountability

There are several components to the English legal system that must be understood as all non-medical prescribers are accountable for their prescribing decisions. All prescribers are accountable to the public through criminal law, the patient through civil law, the employer through your contract of employment, and your profession through the professional code of conduct (Armstrong 2011)

6.2.2.8 Prescribing Within the Area of Competence

All non-medical prescribers are accountable to civil law with regard to the scope of their practice and must prescribe only in areas that they are deemed to be competent. In cases where a non-medical prescriber may want to expand the scope of clinical practice by increasing his/her area of competence, it is important that this is done within the framework of clinical governance.

6.2.2.9 Consent

Patient consent is a fundamental principle of healthcare law and is based on the legal and ethical principle that a patient has a right to decide what will happen to their body. Provision of information is core to the consent process, and it is the non-medical prescriber's responsibility to provide the patient with correct information regarding any treatment that is prescribed (Dimond 2009). Non-medical prescribers should confirm that their patients know and understand what their treatment is for, how it works, and any risks or possible adverse reactions. Patients should also be given advice as to what to do if they experience any adverse reactions.

6.2.2.10 Record Keeping

Non-medical prescribers are encouraged to adopt good record keeping practice and maintain records that are "unambiguous and legible" (DH 2006). Records should contain details of the prescription as well as a documented record of the consultation. Ideally, any information given to the patient should be documented in the patients' notes. Neighbour (1987) described this as "safety netting" and considers it to be an integral part of the consultation process. This should include advice given to patients about when and how to seek further medical attention if symptoms deteriorate. Records should be written immediately after the consultation or as soon as possible afterwards (NMC 2015).

6.2.2.11 Professional Indemnity

In the United Kingdom, vicarious liability in healthcare means that healthcare professionals have legal exemption from liability for damages or claims made by patients and resulting from performing duties specified in their job description. However, despite this, many professional organizations now insist that practitioners have their own professional indemnity insurance. The NMC (2015) code of professional standards of practice and behavior for nurses and midwives suggests that while employers have vicarious liability for acts of omission/negligence of their employees, this would not cover independent practice and some areas of advanced practice. It is the individual's responsibility to establish their insurance status and take appropriate action. All non-medical prescribers should ensure that they have personal professional indemnity insurance through professional organizations such as the Royal College of Nursing, Pharmacist Defence Association, and Chartered Society of Physiotherapist. All non-medical prescribers must ensure that their job description reflects any extended role, including prescribing.

Although indemnity protects the prescriber in case of patient legal claims, any claims would be reviewed with respect to contractual law. This demands that practitioners adhere to all policies and procedures laid down by their employer. Practitioners must then act within the context of these policies and within the parameters of their employment contract and job description. Prescriptive authority is a good example of how advanced practice is developing. However, through expansion of responsibility, there is also the risk of the expansion of liability.

6.2.2.12 Maintaining Competence in Practice and CPD

Healthcare professionals have a duty of care and are responsible for the well-being of their patients. Clinical governance is a well-embedded tool, which can be used to achieve this and to provide safe, effective, and high-quality patient-centered care (DH 2004b). Organizations and their employees are responsible for ensuring that their work conforms to principles of clinical governance. This has clear implications for non-medical prescribing practice. Non-medical prescribing practice should be subjected to regular audits and evaluations and be part of risk assessment frameworks established by employer organizations (DH 2004a). In order to maintain competence and keep abreast of current research, practitioners should implement the skills acquired during their prescribing course. Critical appraisal skills are

particularly useful in evaluating the validity and usefulness of newly published research before considering its implementation. It is important to join with other practitioners in prescribing forums, study groups, and professional teams to assess evidence also. Developing critical appraisal skills comes with practice and peer support is also valuable. Sharing opinions and experience is invaluable.

A variety of evidence-based resources exist for prescribers to use, including a range of national service frameworks which all support good practice. The National Institute for Health and Clinical Excellence (NICE) produces evidence-based guidelines for use by prescribers on a regular basis. On a more local level, health Trusts produce formularies and clinical guidelines for practitioners to use. Once they become confident, non-medical prescribers can participate in the development of such tools as clinical guidelines (Chapman 2008). A pharmacy lead in a primary care or an acute trust can be very helpful in offering guidance on local prescribing issues, especially around local formulary usage.

6.2.2.13 Competency Framework for All Prescribers

Developed by the National Prescribing Centre in 2012, the single competency framework provided an outline of common prescribing competencies to enable all prescribers to become and remain effective prescribers in their area of practice (NPC 2012). The competency framework (see Fig. 6.3 and Table 6.1) has been updated by the Royal Pharmaceutical Society (RPS) in 2016. The competency framework (see Fig. 6.3) sets out what good prescribing looks like. There are ten competencies split into two domains (see Table 6.1). Within each of the ten

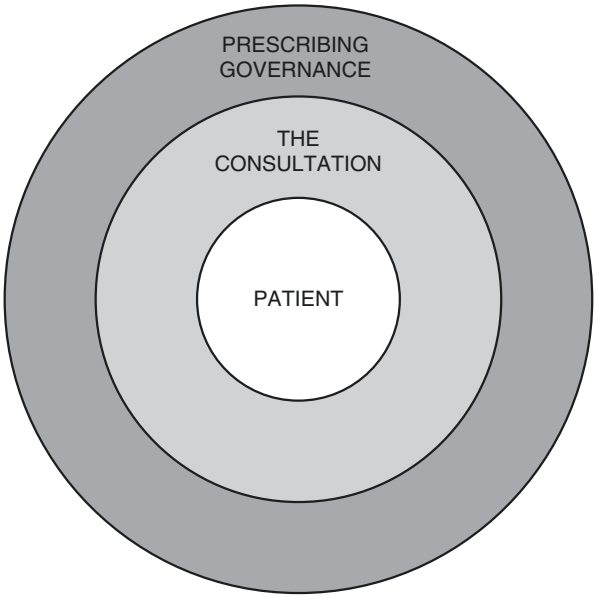


Fig. 6.3 The competency framework for all prescribers in the United Kingdom (RPS 2016)

Table 6.1 The prescribing competency framework for UK prescribers (RPS 2016)

The consultation	Prescribing governance
1: Assess the patient	7: Prescribe safely
2: Consider the options	8: Prescribe professionally
3: Reach a shared decision	9: Improve prescribing practice
4: Prescribe	10: Prescribe as part of a team
5: Provide information	
6: Monitor and review	

competency dimensions, there are statements, which describe the activity, or outcomes prescribers should be able to demonstrate. All of these statements MUST be completed and signed off to pass the portfolio.

6.2.2.14 Impact of Prescribing on Clinical Practice in the United Kingdom

Since 1994 the scope and practice of nurse prescribing have steadily grown (NPC 2012). Advances in prescriptive authority may have seemed slow and frustrating at times, but by 2012 legislation had been amended to enable independent nurse and pharmacist prescribers to prescribe all medicines the same as doctors (DH 2012) and other non-medical prescribers (the exception being controlled drugs and unlicensed drugs). It is now widely accepted that prescribing is a core component of the advanced practice role. With the advent of independent non-medical prescribing, the principles for NHS reform set out in the NHS plan of 2000 (DH 2000a, b, c), to improve patient care, choice and access to health professionals, patient safety, better use of health professional's skills, and more flexible working, have been fulfilled. However, Anguita (2012), discussing the evidence for non-medical prescribing, suggests that although the published literature concludes a high level of patient satisfaction from nurse prescribers, the evidence for nurse prescribing must increase and focus on clinical, economic, and humanistic outcomes. Cope et al. (2016) conclude that nurse and pharmacist independent prescribing is becoming well-integrated and an established component of patient management. Latter et al. (2011) also suggest that education for non-medical prescribing is fit for purpose and prescribing by nurses is safe and clinically appropriate with most Trusts having core clinical governance and strategies for prescribing. The numbers of registered nurse independent/supplementary prescribers has been rising steadily and, by February 2016, was approximately 28,000. Latter et al. (2011) found that the majority of nurse independent prescribers had used their prescribing qualification and that most were currently prescribing. At the time of this evaluation, the majority of independent nurse prescribers were working in primary care; however, more recently nurses working in all areas of clinical practice are undertaking the non-medical prescribing programs.

6.2.2.15 Conclusion

This section on non-medical prescribing for nurses in the United Kingdom has explored the history, legislation, education, legal, and professional issues that surround the complexity of nurse prescribing in the twenty-first century. The road to full prescribing rights for nurses has been a long and arduous one. Although

prescribing is firmly embedded within the advanced practice role, the future may see prescribing as an integral component of preregistration nursing and become the norm for routine nursing practice. However, before this can be achieved, the pioneers of nurse prescribing will need to have their prescribing habits evaluated and audited to ensure that nurse prescribing is improving the health outcomes and meeting the needs of the patients (Anguita 2012; Cope et al. 2016).

Nurses have always been responsible for the administration of medicines, but it is the new role of nurse prescribing that is challenging. The different programs and formularies that encompass non-medical prescribing are complex and have the potential to be very confusing for the patient. The added accountability and responsibility that non-medical prescribers have can be daunting at first. However, with confidence develops competence and as the numbers of non-medical prescribers increase, attitudes toward non-medical prescribing will become more positive.

This is an exciting time for all non-medical health professionals. As advanced practice roles develop in response to patient need, the ability to prescribe safely and effectively is becoming more and more important. New advanced practice roles will require the advanced practice nurse to have a registered prescribing qualification. These roles have clearly benefited patients and contributed significantly to the expanded role of the nurse and promoted the image of nursing as a primary profession (DH 2012). Healthcare professionals other than doctors in the United Kingdom now have the most comprehensive prescribing authority in the world (H Ward, London South Bank University, 14 November 2016, personal communication).

Prescriptive authority for nurses varies significantly from country to country. The next section presents a global profile of the variance in nurse prescribing worldwide.

6.2.3 Nurse Prescribing: A Global Role Analysis

Prescribing of medicines by nurses around the world has been practiced formally, to varying degrees and for varying purposes, over the past 50 years. The earliest reports in the medical literature that describe the provision of medicines by nurses came in the 1970s, which explored the prescription of contraceptives, both in the Philippines and the United States (Galang 1975; Sorely 1975). During the 1980s and the 1990s, prescribing by nurses accelerated rapidly with the expansion of nurse practitioner scope of practice in the United States and the implementation in the United Kingdom of the *Medicinal Products: Prescription by Nurses Act of 1992* (RCN 2013). The turn of the twenty-first century brought further expansion of nurse prescribing in Canada, Europe, and Australia and was authorized by national regulations that required varying degrees of education, experience, and expertise. Also, importantly, prescribing by nurses accelerated broadly in Africa in response to the widespread rollout of affordable antiretroviral drugs for the treatment of HIV/AIDs (Miles et al. 2007; Zachariah et al. 2009).

The regulations that authorize nurse prescribing vary widely around the globe. In some countries, primarily in Western industrialized nations, nurse prescribing is authorized based on scope of practice statutes or other regulatory mechanisms that

grant the authority to prescribe medications (Kroezen et al. 2011). In contrast, in some low- to middle-income countries, especially in Africa, nurse prescribing is authorized via a variety of mechanisms, e.g., registration, licensure, scope of practice, continuing professional development, or accreditation of pre-licensure education (Dynes et al. 2016). Or, formal authorization, despite active practice, may not exist at all (Ladd et al. 2016; Maier and Aiken 2016).

Nurses are moving into roles that have heretofore been considered the sole domain of medicine. The question naturally arises around whether these practices constitute tasks that are shifting away from medicine or are tasks that are shared or are wholly incorporated into the role of nurses at varying levels. There has been significant research that identifies the role and scope of nurse prescribers from the vantage point of Western industrialized nations (Maier and Aiken 2016; Kroezen et al. 2011; Kroezen 2014). However, the following commentary will offer an analysis of predominant role descriptors that are applied to the practice of nurse prescribing from the perspective of high- as well as low- to middle-income countries.

6.2.3.1 Advanced Practice Nursing, Advanced Nursing, and Task Shifting/Sharing

The term "advanced practice nurse" has been described by a number of national and international organizations. The advanced practice nurse, as defined by the International Council of Nurses (ICN), is:

> a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level. (ICN 2008)

Both the ICN and the Institute of Medicine (2010) describe the role of the advanced practice nurse that includes advanced clinical competencies such as advanced health assessment, ordering and evaluating diagnostic tests, and the prescription of treatments which includes pharmaceutical agents (country specific) (ICN 2008; IOM 2010).

The definition of advanced level nursing, in contrast, was formally clarified in 2010 by the Department of Health in the United Kingdom in the *Advanced Level Nursing Position Statement* (United Kingdom Department of Health 2010). The purpose of this statement was to provide a standard for the delivery of high-quality care, to improve patient safety, and to encourage concordance in the development of roles and positions for nurses in the United Kingdom. In general, the requirements for advanced level nursing are more flexible and lenient and do not carry the same requirements around education and scope that exist in other countries such as the United States. For example, advanced level nursing is practiced in the United Kingdom in the capacity of basic registration or in the post-professional arena (East et al. 2014).

The World Health Organization (WHO) (2008) in their seminal guideline Task Shifting: *Rational Redistribution of Tasks Among Health Workforce Teams* first comprehensively described task shifting. This document describes the concept of task shifting as the "rational redistribution of tasks among health workforce teams" (p. 2). While the

WHO acknowledged that this practice has been adopted to address human resource needs throughout history, it sought to specifically address shortages of health workers in countries that are experiencing high levels of disease burden related to HIV and AIDs. The Institute of Medicine (IOM) in 2011 reinforced the practice of task shifting as a cost-effective, sustainable strategy to mitigate the burden of HIV in African countries. However, the IOM chose instead to utilize the term "task sharing" as it represents a process that is neither hierarchical nor confined and allows for practices that expand or contract based on local health needs in low-resource settings (IOM 2011). Correspondingly, the term task sharing will be used in place of task shifting in this section. This is in pursuance of a term that represents a more inclusive, team based approach.

6.2.3.2 Global Nurse Prescribing by Role Descriptor

The following sections describe nurse prescribing as associated with role descriptors. Refer to Appendix 6.3 for a world map identifying global nurse prescribing by country and role descriptors.

Advanced Practice Nursing There are commonalities and differences between these three models of care delivery. Advanced practice nurses, who most closely adhere to the ICN (2008) definition, are a cadre of nursing professionals that have the authority to initiate and manage pharmaceutical treatments in most countries that define the role (Maier and Aiken 2016). While there is some variation in the level of preparation and regulation for the advance practice nurse or nurse practitioner based on jurisdiction, in general, the advanced practice nurse prescriber is educated at the master's level (Ladd et al. 2016). The role of the advanced practice nurse with its associated prescriptive authorization is now firmly entrenched, based on statutory authority and scope of practice in a number of Western nations in North America, Western Europe, and Oceana (Kroezen et al. 2011; Kroezen 2014; Ladd et al. 2016) (see Appendix 6.3). However, there are only two countries in the world that currently authorize nurse prescribing at the advanced practice level only, the Unites States and Montserrat in the Caribbean (Ladd et al. 2016).

Advanced Level Nursing Nurse prescribing at the advanced level (as described by the UK Department of Health) is found extensively throughout the world. This type of prescribing is practiced by nurses at the post-professional level and may or may not be integrated via statute or regulation. Previous reports have pointed to the expansion of this model of nurse prescribing, particularly in Western European and the Anglo-Saxon countries (Kroezen et al. 2011). However, this data primarily documents nurse prescribing that occurs in these geographic jurisdictions by a population of nurses that are educated and practice in a variety of role designations, i.e., post-professional nurse and advanced practice nurse. Differentiated role designations based on professional training and education are more difficult to ascertain because of the wide variation of country level scope of practice regulations. For example, a number of countries in Western Europe, North America, and Oceana allow nurse prescribing at both the advanced level (post-professional) and the advanced practice level (see Appendix 6.3).

Therefore, in these countries, prescribing by nurses is an authorization that is not necessarily based on a strict role designation but more likely a result of incremental policy changes that reflect healthcare practices in each country.

Task Sharing Nurse prescribing that occurs within the framework of task sharing may not carry the same regulatory requirements, especially in low-middle-income countries. However, it is extensively practiced, mostly based on the needs that arise in settings where there are shortages of physicians. Task sharing that occurs between physicians and nurses is the predominant model worldwide (Lewin et al. 2010). Nurses play a key role in the sharing of responsibilities, especially in Africa, where qualified nurses, mostly at the post-professional level, prescribe and manage antiretroviral therapies in settings where physicians are scarce. This model of nurse prescribing has arisen from the exigencies related to the provision of care for patients with HIV/AIDS in Africa and has most prominently been implemented as nurse initiated and managed antiretroviral therapy (NIMART) (Zuber et al. 2014). NIMART has been widely recognized as an explicit example of effective task sharing. Numerous studies have demonstrated the equivalence of NIMART and physician led care regarding outcomes and quality (Chimbwandira et al. 2013; Fairall et al. 2012; Kiweewa et al. 2013).

The regulatory environment that frames this type of nurse prescribing, especially in Africa, is developing rapidly. In 2011, the African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC), with support from the US Center for Disease Control and the President's Emergency Plan for AIDS Relief (PEPFAR), was initiated to strengthen nursing regulation, primarily in East, Central, and Southern Africa. The program was designed to provide technical support for nurse and midwifery leaders, as well as representatives for ministries of health, academia, professional regulatory bodies, and national nursing associations. After 3 years, significant advancement has occurred in regulatory function in over 11 countries, with positive impacts on the quantity and quality of national HIV programs (Dynes et al. 2016).

Finally, prescribing within the context of task sharing occurs extensively in a more basic, nonregulated environment. For example, many countries throughout the world allow nurses to prescribe or refill drugs based on policies that are promulgated by ministries of health or through national drug policies. There are a number of countries that authorize nurses to prescribe contraceptives and psychotropic medications with restrictions or to prescribe or refill opioids for palliative care or emergency situations (Ladd, et al. 2016). These policies appear to arise from the substantial workforce shortages that exist in primary care and psychiatry and/or palliative care (WHO 2011; Lynch et al. 2013).

6.2.3.3 Conclusion

The provision of pharmaceuticals by nurses is a function that is increasingly aligned to nursing, but is not standardized globally. The role of nurse prescribing is not part of a shared framework of practice like that of medicine. Instead, like advanced practice and advanced level nursing, it is growing in a more organic fashion, based on the need to assuage shortages in the healthcare workforce or to improve efficiencies in systems that face increasing rates of chronic illness in progressively aging populations.

Significant challenges remain for nurse prescribing in the regulatory space around the world. Historically in nursing, regulations are implemented in response to already existing practices or roles (Delamaire and Lafortune 2010; Carney 2016). For some jurisdictions, this may represent national values that promote safety and clarity in the delivery of healthcare. However, others may consider added regulation to be a restraint on the practice of nurses who do not meet the stipulated requirements, a restriction on competition, or a restriction to access of much needed healthcare services (RCN 2012; FTC 2014; IOM 2011).

Regulation of nurse prescribing in Africa is a noteworthy example of how the development of a regulatory framework can both enhance quality and expand access to essential medicines. The African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC) has worked to move a practice that incorporates nurse prescribing, NIMART, into the regulatory mainstream. It has done so by strengthening preservice education, supporting the development of continuing professional development programs, expanding scopes of practice, and addressing other regulatory priorities. It may also be contributing to a move from "task sharing" to the more codified roles of advanced level nursing and/or advanced practice nursing. The United Nations in 2015 launched their ambitious set of sustainable development goals (SDGs), goals that seek to address the most daunting and intractable development/health goals of the twenty-first century (United Nations 2015). Considering that nurses remain the largest segment of the healthcare workforce worldwide, enhancing capacitance via role or regulation can only serve to move forward the agenda of the sustainable development goals, especially in the nations that face the greatest burden of disease in the context of severely constrained resources (E Ladd, MGH Institute of Health Professions, 22 November 2016, personal communication).

Prescriptive authority is only one component that requires attention and policy for nurses and advanced nursing practice. The following exemplar from New Zealand portrays a comprehensive view of the process associated with inclusion of nurse practitioners in the healthcare system of the country.

6.3 Introducing Advanced Practice Nurses: A Process

Consideration of integrating the ANP concept into the delivery of healthcare services mandates a paradigm shift in thinking. Repeatedly the author has tried to emphasize that this process requires change at numerous levels. The following country exemplar describes the processes of change that have taken place in New Zealand as the country responded to healthcare reform and developed advanced nursing practice.

6.3.1 The Nurse Practitioner in New Zealand: Legislation and Process

The New Zealand (NZ) nurse practitioner (NP) was approved by the ministry of health and New Zealand Nursing Council in 2001, with the first NP registered later

that year. The number of NP registrations has grown at an accelerating pace since. It took 10 years to register 100 NPs (2011), but only 5 years to register the next 100 NPs (2016). NZ is on track to register the next 100 NPs in a short 2–3-year period. The NP development pathway in New Zealand has been full of twists and turns, leaping forward at times as well as encountering unforeseen obstacles. As in many countries, the NP role confronts established medical hegemony and healthcare bureaucracies and also challenges the nursing profession itself. There are many lessons that have been learned since the inception of the NZ NP over 15 years ago.

6.3.1.1 Nurse Practitioner Registration, Legislation, and Processes

In 1998 the NZ Ministerial Taskforce on Nursing recommended the development of the NP role. The purpose was to expand the workforce available to care for the growing chronically ill population and to ameliorate medical provider shortages Ministerial Taskforce on Nursing (1998). Unlike some other countries, the NZ NP title is protected by clearly defined legislation and regulation. The legislative process was simplified in NZ because of the country's relatively small population (4.5 million) and a single national ministry of health. Unlike the United States or Australia, no regulatory reconciliation is required across individual states. Early on, one of the most important decisions was to ensure NPs were licensed to practice independently with no legal requirement for medical oversight.

An approved clinical master's degree is required for NP registration, as well as 4 years of practice within a specific area of practice. The NP candidate must show competency in diagnosis and treatment, medication prescribing, cultural competency, leadership, quality assurance activity, and evidence-based practice. In the beginning, there were six NP competency domains creating almost impossible expectations for practicing NPs. However, in 2014 Nursing Council New Zealand (2015a) competencies were reconciled to four domains that focus mainly on advanced clinical practice and less on leadership, teaching, and research.

A portfolio that demonstrates NP practice competency is required for registration by the Nursing Council. In the beginning, there was very little direction about how to complete this document. This resulted in larger and larger portfolios over the years due to candidates' anxiety that they had not included enough information to satisfy Nursing Council requirements. As a result, this created a barrier for many potential NPs. It was common for NP candidates to finish their clinical master's degree and then spend years putting together their NP registration portfolio. In 2015, the Nursing Council, in collaboration with practicing NPs, created a clear guideline for portfolios. Importantly, this included page limits for each section. The number of NP registration applications surged in 2016 following the publication of the portfolio guidelines indicating that this did indeed decrease a barrier to seeking NP registration.

New Zealand NP applicants are required to successfully pass a panel interview. In the early years, the panels consisted of medical doctors, advanced practice nurses (clinical nurse specialists were used if an NP in the candidates' practice area was unavailable), and a nurse leader. A staff member from the Nursing Council facilitated the process. The panel interview began as an all-day event that included not only assessment of the candidate's clinical competence but also cultural, leadership, and quality assurance

competencies. Over time, the panel interview process has evolved and now focuses only on clinical practice competencies via oral case studies. The process currently lasts about 2 h. Panel members include two practicing NPs and a Nursing Council facilitator.

The NP scope of practice in the beginning was restricted to a specific practice area or specialty. Some were generalist scopes of practice such as primary healthcare across the life span or older adult care. Others were very specialized such as wound care, diabetes, or respiratory care. Each NP defined their scope of practice and was registered to practice only within that narrow scope. Additionally, NPs could be registered with or without the ability to prescribe medications.

Over time, these narrow scopes of practice became problematic as NPs moved to other roles and/or workplace settings. This meant that an NP employed in a different area of practice had to be reregistered by the Nursing Council in that area and proved to be cumbersome for regulators and NPs alike. In 2014, after extensive national consultation, the NZ Nursing Council broadened the NP scope of practice to a generic definition that applied to all registered NPs and required that they all be competent to prescribe medications. Although each NP has an "area" of practice, it can now be more easily changed if she/he demonstrates the experience and education needed to practice in a particular area (Nursing Council New Zealand 2015b).

6.3.1.2 Nurse Practitioner Prescribing Legislation

In 1998 the ministry of health introduced legislation to extend prescribing rights to nurses and other healthcare professionals (Jacobs and Boddy 2008). It was not clear in the beginning whether nurse prescribing would be linked to the NP scope of practice alone; however, this was made clear in the 2001 NP legislation Nursing Council New Zealand (2015a). NPs were allowed restricted prescribing rights known as "designated" prescribing rather than the "authorized" prescribing granted to medicine, dentistry, and midwifery. The main difference was that designated prescribers were only allowed to prescribe from a short list of medicines within their NP scope of practice. At the time of the first NP registration in 2001, there were only two areas of limited nurse prescribing: child family health and aged care. These areas were chosen because they reflected the greatest healthcare consumer need.

The original lists of drugs included many over-the-counter or "pharmacist-only" medications, with very few actual prescription medicines. The list included categories such as respiratory inhalers, antibiotics, antiviral and antifungal medications, and selected prescription NSAIDs. Controlled drugs such as morphine and diazepam were included but were restricted to a 3-day prescription for emergency situations. There were no cardiac, psychotropic, or many other commonly used medicines. This greatly restricted independent NP practice.

The designated prescribing "lists" quickly became problematic as some critics had predicted. A legislative process was required to change or add to the "list" which was slow and burdensome. Consequently, the lists could not be easily changed in response to constantly evolving guidelines or as new research was translated into practice. These concerns were recognized by the ministry of health, and in 2005 legislation was enacted that greatly expanded the list to over 1500 medications (Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005). A

greatly expanded list of controlled drugs was also included, although designated NP prescribers were still only allowed 3-day prescriptions for emergencies thus greatly restricting the practice of some NPs, particularly those working in palliative care and aged care.

In 2014, prescribing rights were expanded once again and NPs became "authorized" prescribers rather than "designated" prescribers. NPs now have the same prescribing rights as medical doctors, dentists, and midwives. The change to authorized prescribing met little resistance mainly because NPs had never required medical oversight of their practice and had been safely prescribing medications for over a decade by this time. Independent authorized prescribing rights have greatly enhanced the reach of NP practice. This is particularly true for those working in generalist areas of practice such as primary healthcare, aged residential care, palliative care, and child and youth health.

6.3.1.3 Nurse Practitioner Education

All NPs must successfully complete a NZ Nursing Council-approved clinical master's program (or educational equivalent) in order to apply for registration. When the NP began in 2001, the "taught" clinical master's was new to New Zealand. Prior to this time, most nursing master's degrees were research based. The potential NZ NP was seen as an expert within their clinical field and within the wider nursing profession. Due to this assumed clinical expertise, initially there were no clinical practicum "hours" stipulated by the NZ Nursing Council or by educational institutions. In the beginning, some clinical master's programs had as little as 150 h clinical education in the practice setting. Much of the advanced practice clinical experience relied on the nurses' current workplace experience, and in essence, they were asked to expand their practice to NP level while working in their current registered nurse role. This often created "role confusion" for nurses and difficulty acquiring the advanced practice experience they needed.

While a great many nurses completed the required prescribing practicum and master's degree, relatively few progressed to NP registration. This was due to several factors that developed along the NZ NP evolution path. There was no formal connection between NP training processes and a specific NP master's program that included protected supervised clinical training hours outside the nurse's usual clinical practice. Overall, there was little integration of NP education, registration or employment processes, which resulted in delays and barriers for preparation, and employment of potential NPs.

In 2016, the Nurse Practitioner Training Programme (NPTP) pilot was funded by the Health Workforce New Zealand (a government agency) to integrate NP education, registration, and employment processes. NPTP leaders collaborated with the Office of the Chief Nurse and the National Nurse Leaders Group to ensure national consistency of the NPTP Programme. The NPTP Programme includes 500 h of clinical practice that is outside the nurses' usual employment time. The Health Workforce New Zealand provided funding for education costs and also funded employers for NPTP clinical practicum time. A more robust process for NP academic mentor and clinical supervision oversight was developed. The NPTP leadership collaborated

with the NZ Nursing Council to align NP registration with NP education processes. This alignment promoted earlier completion of the NP portfolio and increased the percentage of prescribing practicum students who successfully passed NP registration within a year of graduation from approximately 20% to 80%.

An important component of the NPTP was employer engagement to identify potential NP positions. Under the usual funding scheme, employers had no obligation to hire the newly registered NPs for whom they had received significant education funding. As a way to increase employer commitment to their potential NPs, all NPTP recipients of clinical training funding must now agree to employ the NP upon registration. The first cohort of 20 NPTP students will be complete in the late 2016 and are scheduled for NP panel interviews in March 2017. All have employment agreements after successful NP registration.

6.3.1.4 Conclusion

The journey of the NP development in New Zealand has been a somewhat convoluted pathway. However, the number of NP registrations and NPs in practice is now growing faster than ever before. Key aspects that have enhanced the growth and utilization of NPs are independent authorized prescribing and the consolidation and the clarification of registration policies and procedures. The evolution of clinical master's funding specifically for NP practice and the integration of NP education, registration, and employment processes have also been contributed to the success of the role. Further development is needed to ensure that NPs have a clear and secure funding stream for future employment. The NZ NP is continuing to develop as a key member of the healthcare workforce and is making a vital contribution to meeting the changing healthcare needs of the population in New Zealand (M Boyd, University of Auckland, 14 November 2016, personal communication).

The processes for the evolving level and role of advanced nursing practice are not without its challenges. The following exemplar from Australia describes difficulties in transition from capacity as a general nurse to that of a nurse practitioner.

6.3.2 Transition Experiences of Nurse Practitioners in Australia

The diversity of factors that have to be considered in coordinating an advanced nursing practice initiative is extensive. This depiction of experiences of newly endorsed nurse practitioners in Australia increases awareness of the complexities of introducing a new nursing role and suggests that various levels of preparation and planning could ease the integration of nurse practitioners into the healthcare workforce.

6.3.2.1 Nurse Practitioner Implementation in Australia

The findings from a doctoral study conducted in Australia revealed the social, political, and organizational issues often challenged nurse practitioner (NP) transition to practice and their capacity to respond to change. It is important to note that the study was undertaken between 2010 and 2012 that was a critical time for the nursing profession in Australia with the move from state and territory to national registration

for all health professionals. In particular, there were significant changes to the requirements and processes for endorsement, which had a negative impact on many of the study participants. Participants shared details of the challenges they encountered due to lack of understanding and support by nursing organizations.

Despite very sound reasons for implementing the NP role in Australia, the findings from this study indicate that in some contexts, there was little strategic planning for the NP positions. The authors recommended that NP positions should be based on service needs and/or gaps in services. In the country, consistent and equitable recruitment processes should be transparent and advertised nationally so that NP candidates are selected to address the strategically identified service gaps. Several of the participants in the study were *tapped on the shoulder* and encouraged to undertake the required educational program to be eligible for endorsement. This practice of "promising" positions to nurses aspiring to become an NP, rather than recruiting through competitive and transparent processes, was felt to be a questionable practice. Many of these promised positions did not occur once the candidate was endorsed, resulting in some of them leaving their place of employment to find an NP position elsewhere. Their determination, personal strength, drive, tenacity, and resilience often resulted in the NPs having to uproot their families to achieve their goal of becoming an NP (MacLellan et al. 2016b).

Findings from this study also highlighted that for those participants who had secured an NP position, the workload expectations relating to the higher grade position and the higher level of pay were a source of concern. The pressure of seemingly unattainable workloads and of excessive travel expectations was overwhelming for some participants who reported high levels of anxiety, frustration, stress, exhaustion, and burnout. Delays and cumbersome processes for gaining approval for clinical practice protocols held many of the new NPs back (MacLellan et al. 2015c).

In addition, research findings illustrate some major concerns related to the practices of some senior managers and healthcare organizations at the time of the conduct of the study. Study participants felt that these problems were insurmountable as they were totally isolated and unsupported by their managers, nursing peers, and other NPs. These issues need to be addressed and thought to be a matter of urgency so that the sustainability of the NP role in Australia is not jeopardized (MacLellan et al. 2016a)

6.3.2.2 The Importance of Intraprofessional Support

A successful transition will only occur if there is a genuine commitment from both the nursing profession and healthcare organizations (MacLellan et al. 2015b). The provision of workplace environments where NPs are supported and empowered to reach their full potential is likely to have a positive impact, not only for the individual but also on the organizational culture and ultimately patient outcomes. In contrast to the anticipation one would expect with the introduction of new NP roles, this study revealed that many senior nurses displayed covert and overt resistance to the NP concept. Instead of collegiality, mentorship, and support, many nurses in positions of power withheld information, created impediments, scrutinized the NPs' practice, and sabotaged their transition to such an extent that many felt disempowered, demoralized, and isolated (MacLellan et al. 2016a).

This resistance and the lack of support from senior nursing leaders and peers are seen as barriers to transition to NP roles, as horizontal violence and a misuse of power have been demonstrated to undermine the NPs' confidence and negatively impact retention. It is felt that this is possibly one of the reasons for the slow growth in NP numbers in Australia (MacLellan et al. 2016a).

Future success and sustainability of NP roles require a greater awareness by nursing leaders of the influence they exert over NP transition. Provision of supportive and structured orientation programs is needed to facilitate effective transition to these diverse, complex, and challenging NP roles. Clarity of expectations and a gradual increase in responsibilities are likely to optimize adjustment to the NP role. It is felt that nursing organizations must work together to provide an online community of practice for NPs. Such an initiative is envisioned to provide positive and professional support, career advice, and opportunities for continuing professional development along with strategies that are likely to enhance longevity and workplace satisfaction. One-to-one mentorship is not only encouraged but considered vital to reduce isolation and provide a support network for new NPs (MacLellan et al. 2016a).

6.3.2.3 The Importance of Interprofessional Support

In the early days of the introduction of NPs in Australia, several medical organizations voiced strong opposition to the role. The extent to which the actual membership of the medical associations supported or rejected the implementation of the NP role has always been a topic of debate. However, medical resistance was not evident in this study (MacLellan et al. 2015a).

The participants revealed changing attitudes among medical and allied health colleagues. Their interprofessional relationships were characterized by mutual respect and effective communication that resulted in positive patient outcomes. The study findings indicated that most NPs were well known to their medical colleagues based on a history of working together previously. As a result, the NPs were able to more easily negotiate a position for themselves within the healthcare team. New NPs made significant efforts to develop strong and mutually beneficial relationships with medical staff and shared stories of successful collaboration with general practitioners as well as examples of effective mentoring and clinical supervision.

Based on study findings, it is evident that ensuring that members of the healthcare team are cognizant of the scope, role, and responsibilities of NPs, as well as their value to patient outcomes, is vital to successful implementation of NP roles (MacLellan et al. 2015c). Study findings suggest that interprofessional collaboration, support, and mentorship were critical factors without which it is very difficult to succeed as a new NP. This study is the first to report a change in attitudes and growing acceptance of NPs by the medical profession in Australia. Narratives suggest that medical colleagues may be the NPs' greatest allies and strongest supporters (MacLellan et al. 2015a). Although medical and allied health support has been shown in this study to be necessary, the support of healthcare and nursing organizations is also critical (L MacLellan, I Higgins, T Levett-Jones, The University of Newcastle Australia, 20 November 2016, personal communication).

Most countries worldwide are in initial phases of considering ANP as an option in healthcare provision. The following exemplar from Germany offers a description of the country initiative as it evolves in its early stages.

6.3.3 Advanced Nursing Practice Strategy and Policy in Germany

As described in Volume 1 of this monograph series (Introduction to Advanced Nursing Practice: An International Focus), ANP is an emerging concept in Germany. There are reports of small numbers of APNs practicing across a number of hospital settings (Boeckler and Dorgerloh 2014; Krotsetis et al. 2014; Teigeler 2015; Weskamm 2016). The number of APNs practicing across Germany might be higher than the numbers of APNs (up to 17) reported in the published articles. The exact figures for ANP posts, however, are unknown. One of the issues with regard to the strategic development of ANP in Germany is that nursing on the whole lacks self-regulation (DeJong 2006). Non-nursing professionals by and large guide ANP decision-making at policy level. The establishment of nursing boards in Germany seems to be fundamental in order to develop the political momentum required for the development of ANP at a national level. This side of political development is in its infancy in the country compared to other international settings. At the time of writing, there is one (out of 16) federal state in Germany that has a nursing board. Two other states (Bundesländer) are due to follow with the establishment of a nursing board in 2017 (DBfK 2016).

Credentialing for APNs is another policy issue. Despite the ambiguity surrounding it (Mendel and Feuchtinger 2015), the title "Pflegeexpertin APN" (translated "nursing expert APN") is gaining popularity in Germany (DBfK, ÖGKV & SBK 2013; Weskamm 2016). Nursing titles protected by law in Germany relate to the ones awarded at initial qualification such as "Gesundheits-und Krankenpflege" (general nursing), "Gesundheits-und Kinderkrankenpflege" (children's nursing), and "Altenpflege" (care of the elderly) (Ullmann and Ullmann 2011). Another protected title is "Fachgesundheits-und Krankenpflege," which describes specialist qualification following initial nursing qualification (Ullmann and Ullmann 2011). The title "Pflegeexpertin APN" is not protected in law nor is it widely established what the requirements for the title entail.

The core concepts for "Pflegeexpertinnen APN," as described in various case-based papers, include (a) direct patient care, (b) patient education, (c) nursing staff development, and (d) research (Krotsetis et al. 2014; Teigeler 2015; Weskamm 2016). The Mendel and Feuchtinger (2015) report, based on a Delphi study with 66 nurse experts, managers, and team leaders in one university teaching hospital in Germany, that "Pflegeexpertinnen APNs" show core concepts comparable to the role of a "clinical nurse specialist." Core concepts comparable to the role of the "nurse practitioner" were by and large not identified. The percentages of time reported for each core concept for APNs (direct patient care, patient education, nursing staff development, and research) vary across cases. Nydal (2016) describes two advanced level nurses in one university

hospital group in Northern Germany who are practicing 25% of their time in direct patient care. Teigeler (2015) reports that the aim within this university teaching hospital is that "Pflegeexpertinnen APNs" spend approximately 50% of their working time in direct patient care. Based on these reports, it appears as if there is a need to be more strategic in regard to the percentage of APN time that is directed toward patient care.

There are a number of nursing associations in Germany, including the Deutscher Pflegerat (DPR) and the Deutscher Berufsverband für Pflegeberufe (DBfK), who support the concept of ANP. The DBfK published some reports including one in 2007 and another in 2013 that outline the potential of ANP within German healthcare settings. The Deutsches Netzwerk for APN and ANP g.e.V. (DN APN and ANP) is a networking group for people with a specific interest in the field of ANP. The Netzwerk published their position in 2011 (Ullmann et al. 2011). The associations and networks offer ways in which nurses can share ideas and experiences and where they can contribute to the German ANP policy arena. The statement papers and reports published by any of the groups supporting ANP in Germany do have an essential recommendation character, but they are not in any way obligatory.

In other European countries such as the Republic of Ireland, there is a national framework including ANP core concepts and a mandatory process for establishing ANP post (NCNM 2008; NMBI 2016). A national framework and a mandatory process for the establishment of ANP posts have yet to be developed in Germany. There are country-specific aspects that need to be considered during the development of ANP posts (ICN 2001–2016). International research such as the MUNROS project compare advanced nursing roles such as ANP posts across nine European countries (De Bont et al. 2016), a project that includes Germany. Advanced nursing practice in Germany is an emerging concept. There are policy challenges relating to self-regulation, ANP credentialing, and requirements. It is noteworthy that research and empirical evidence is available to assist the strategic development of ANP in Germany (D Lehwaldt and S Krotsetis, The Deutches Netzwerk for ANP and ANP g.e.V, 25 November 2016, personal communication).

The growing presence of ANP globally confirms an increasing presence of success stories with advanced nursing practice. The following exemplar presents the 20 years of experience in the Netherlands with ANP development.

6.3.4 The Netherlands: Process, Legislation, and Evaluation

The following narrative describes the evolving nature of the nurse practitioner role (in Dutch the title is nurse specialist) as it emerged beginning with an initiative in Groningen, the Netherlands, and spreading to other areas of the country.

6.3.4.1 Introduction

In 1997 the nurse practitioner (NP) role was introduced in the Netherlands. In contrast to other initiatives, it was an initiative of a hospital, the University Medical Center in Groningen. The board of directors appointed a project leader who was familiar with the function of NPs in the United States. The aim was to improve

nursing care to an advanced level using the experiences and competencies of nurses. A new healthcare act ended the act that forbade medical care by nonphysicians. This opened the possibilities to create a position for nurses with integrated routine cure and complex care for a well-defined group of patients. The concept of the function of an NP was introduced during a 2-day conference for stakeholders such as policymakers, insurance companies, and healthcare professionals such as nurses and physicians. During that time, there was no general professional organization for nurses. Each nursing specialty had separate organizations, with more than 60 organizations representing nursing. There were also some initiatives to improve the nursing organization structure, and these representative persons were invited to the conference as well.

The conference was a great success. Invited speakers from the United States and United Kingdom did excellent work with informing the public what the advantages and challenges of the APN function were including legal, regulation, and educational requirements. It was like a bombshell. The press paid very much attention to this development. The minister of health (MOH) had a very supportive attitude and attended the conference. As a former physician, the MOH was very well informed about the know-how of nurses and the important role they play in healthcare. In addition, the MOH knew very well that experienced nurses are indispensable for physicians with their advice and suggestions for diagnostic procedures, interventions, complications, and so on. However, some key figures in nursing were less pleased. Although they had a podium presentation during the conference and were enthusiastic about the conference, they found it not appropriate to start a new function without asking permission and sent a letter of objection to the project leader. The criticism from nursing representatives was temporary as they saw the enthusiasm of the MOH. As a result, the nursing leaders adopted the nurse practitioner concept and started to proceed to develop policy and legalization as if it was their own creation.

6.3.4.2 Motivation

The board of directors of the University Medical Center in Groningen (UMCG) were interested in the NP function to improve continuity of (medical) care. There were shortages of medical specialists and physicians. The shortage of the physicians was relative to the healthcare environment. The physicians had been available for 60 h a week but improvement of their theoretical education, supported by official regulations, decreased their working hours. The young doctors were used to being the pillars for the continuity of care for patients. However, working in shifts on different wards, in outpatient clinics, and in surgery, combined with the decreased availability, was not realistic any more. As a result, the first six nurse practitioners in the UMCG had a more or less medical profile.

Experience working with nurse practitioners was not required in the hospital. The hospital with 1300 beds was divided in 21 medical specialties and subspecialties such as orthopedics, pediatrics, and surgery – with different numbers of professionals and providing their own management. When the hospital divisions were given the choice to work with an NP, it was supported and funded by the UMCG board. Medical specialists, who were familiar with the NP role by experiences in the United States, were enthusiastic to work with an NP. However, young doctors were skeptical. They did not understand

why an NP could do the same work as they did without the same education. Nurses were cautious. It was easy to find candidates for the NP function but there was resistance as well, mainly emotional. Nurses voiced comments such as "Physicians need to solve their own problems like we do" and "Who is taking our job?" However, nurses also saw the opportunity for career changes and for a development in a career in clinical patient care instead of the only other chance in management. Details of the experiences were spread through many conferences for medical specialists and nurses. Other healthcare facilities, not only hospitals, became interested also in the development of the NP.

6.3.4.3 Educational Program

The first master's program at the Hanze University of Applied Science started at the end of 1997 with 16 students. From the very beginning, the intent was to offer a program on the master's level, which was made possible by the process of the Declaration of Bologna that was adopted by 29 European countries in support of the bachelor/master system. This made it possible for the universities of applied science to offer master's programs, which was not possible before. A program of advanced nursing practice seemed a fruitful opportunity. The Hanze University of Groningen, University of Applied Sciences, developed a master program for advanced nursing practice, with a US program as an example. From the very beginning, only bachelor-educated nurses were admitted with a function in practice as a student nurse practitioner. It was a combined program with general theory (1120 h in total) of advanced practice, combined with working and learning in (sub)specialty (2240 h). Nurse practitioner students, at least 30 years old, kept their salary as an experienced RN. The National Accreditation Body (NVAO) accredited the master's program. For clinical practice, teaching was done by a preceptor, most of the time, a physician. The physician had to develop a teaching program for the specific specialty of the NP, and this was approved by the University of Applied Science. The involvement of the physician had an advantage in that he had commitment with the implementation of an NP and knew exactly how capable the NP student was.

This model worked very well, although the focus of the NP was medical. It was thought that this was temporary because the starting NPs were very experienced nurses, and the care side would automatically be integrated in their role, even when the medical procedures were not new anymore. For some NPs, this became true, but a few of the first NPs kept a medical focus. This was characterized by the change of the uniform by NP candidates. As an unwritten rule, they started wearing a doctors' coat as soon as they applied as student NP.

During this time, as the vision of the NP gained strength, nurse practitioners became preceptors. The function developed more effectively in a combination of cure and care like as it was intended; however, the focus is still medical.

Although the NP concept started on a small scale, 16 students with a nursing population of 200,000, the 18 universities of applied science with a bachelor of nursing in the country saw the benefits of an ANP master's program to strengthen their position and increase their status in competition with the scientific universities. Within a few years, there were nine universities of applied science that offered this master's program. There were differences in the program, but the terms were comparable. They all were based on the same idea of combining theory and practice.

With only one organization for accreditation, they were comparable with each other in recognition. Without recognition there was no funding.

The development of the NP was fast. A national profile for the NP role was written. During the same time, all the different professional organizations were merging, and one strong professional organization was born. The nurse practitioners had their own organization with support of the MOH, but they became a special part of the unified nursing organization. The nursing organization had power and was important in politics as a representative of all nurses. A small organization of nurse practitioners had no chance to survive and being political involved thus the link with the new nursing organization was beneficial for the NPs.

It was not difficult to find candidates for the function of NP. Although there was some resistance in the beginning from RNs (registered nurses), they saw the benefits of the NP. The perceived status of NPs by doctors increased with their function, and RNs saw changes of the change for themselves. The new nursing organization was active with legislation for the NP. From 2004 the educational program was funded, the preceptors received financial incentives, and the employers received compensation for the absence of the NP 1 day a week during their educational period.

6.3.4.4 Legislation

It was complicated to get legislation for the NP function in the existing laws. Although NP is hard to pronounce in Dutch, internationally it is an understandable concept. In the Netherlands, the title NP was not protected. The only possibility in the law was to use the rules for specialization. For example, physicians can specialize and be registered as a medical specialist. The same rules existed for the RN. The only disadvantage was that the title would be nursing specialist. Internationally, this is another concept, but in the Netherlands, a nurse specialist is the equivalent of an NP.

With the legislation of the NP as nurse specialist, it became possible to protect the title and start with registration and reregistration. A special board was developed. The board increased the requirements for registration on a higher level than the educational program before 2006.Consequently, all the NPs who received a diploma before 2006 had to complete extra learning activities for registration, such as pharmacology as a preparation for prescribing. Registration gave them rights for independence practice, to do some medical procedures and intervention. Only registered NPs (in Dutch officially nursing specialist) were allowed to practice. Reregistration is required every 5 years. The highest penalty as consequence of malpractice is removing the NP from the register with no possibilities to practice anymore.

In 2015 the last adjustment of the law was realized and that was reimbursement. From January 2015, the nurse specialist is firmly anchored in the Dutch healthcare system, with 2890 official registrations and 777 student nurse specialists. They work in all areas of practice. The lowest number is still in primary care, although the number is rising as well. General practitioners were at the beginning restricted in working with the NP. Primary care is important in the Netherlands as everybody is required to have a general practitioner. There was no formal expectation that the relation between the general practitioner and the patients was more or less personalized; the general practitioners assumed to take care for the entire family. This was a myth, but it was one of the reasons that general

practitioners were restricted. On the other hand, nurse specialists found it hard to work in primary care because they had to see so many patients and need to make many high-level decisions with risks for malpractice. But the trust in the nurse specialist is growing, also in primary care. General practitioners are now working in groups and not in a solo practice with room for other healthcare professionals, such as nurse specialists.

6.3.4.5 Opportunities

Since the beginning of 2015, it is possible for nursing specialists in the Netherlands to start their own practice. There are some small-scale initiatives mainly in the specialties of wound care and elderly care, but this is expected to grow. The demand for care is changing. Dutch people live longer, are aging, and often have numerous chronic disorders. At the same time, they want to have more say to increasingly retain control over their health and care. The political and social debate invariably presents aging as a problem with major implications for the affordability of healthcare. This is due to the current attitude about aging and health. "Aging means diseases and diseases need to be treated by a doctor." But is that the right paradigm? The elderly need help to stay independent, to stimulate their wellness, and to participate in society. This may negatively be influenced by diseases but also by the iatrogenic effects of treatments. For the elderly, the fight against the disease is not always the right answer.

That is why advanced practice nurses (nurse specialists) with their broad scope in cure and care are challenged to play an important role in the healthcare for the elderly. Medical treatment is not always the right answer but is stimulated by the fact that insurance companies only pay for this treatment. There is a need for another way of financing and a paradigm shift from a medical model to a biopsychosocial model in healthcare with shared decision-making taking into account the wishes of the patients' personal and environmental factors.

But a main condition for the involvement of nurses such as nurse specialists is a clear definition of advanced nursing practice, legal registration, and credentialing to offer safe and responsible care and cure.

6.3.4.6 Evaluation

The way nurse practitioners were implemented in the Netherlands is unusual. It was more or less an individual initiative at one medical center with support of the government but not from the professional nursing organization. Without such an initiative and process, it would have taken many more years before the decision to work with nurse practitioners was made. The country relied on consultation and the involvement in decision-making of as many people as possible. Consensus has been institutionalized in the Netherlands, where the national identity is reflected in countless advisory and consultative bodies. This way of implementation had consequences for the first nurse practitioners with a mainly medical profile. Later on the profile became more of a combination of cure and care and as a consequence was diverse. Their practice continues to be varied, and, in fact, a nurse specialist is an individual function influenced by the conditions and circumstances in the environment.

The support of the MOH in the beginning of the process was crucial, strengthened by the fact that as physician, the MOH was an insider in the healthcare system. The shortage of physicians was favorable but only because the nurses were so

experienced that they could take over medical tasks. The support of additional ministers of healthcare appeared to be sustainable. Healthcare politics are difficult, costs are rising, and healthcare professionals are challenging to influence.

The availability of many educational programs for nurse specialists stimulated their growth. This is favorable for growth in the number of nurse specialists and, with their growing number, favorable for their power. After several years of light competition, the schools joined each other and made a coherent curriculum. It is still a pity that the number of specializations is low and that still a big part of the theory needs to be given by the preceptor. The change of the title was problematic to explain, especially abroad. It is still confusing, but it was the only way for fast legalization of a function that has proven to have the right to exist within the healthcare system in the Netherlands. The results are good (PF Roodbol, University Medical Center, 28 November 2016, personal communication).

6.4 Influencing the Process: Beneficial Debate and Discussion

At times, in working to promote policy and strategies supportive of ANP, the challenges may seem overwhelming. From a positive perspective, the opportunities for participation in a strategic approach and policy development do exist. The ability to identify overlapping communities that exchange ideas can highlight issues for a policy agenda or for options of implementation of an ANP initiative. In most countries, especially in the case of healthcare concerns of an entire population, there is often room for wider consultation between groups. However, even in countries where mechanisms for participation and public consultation exist, they are often not used. Philosophical "armchair" discussion without action and visibility will not contribute to change.

Most countries are facing some type of healthcare reform and change in the healthcare sector. Although dominant in different ways, economic constraints and political change have forced a change in thinking on many levels with countries exploring different and new options, including what category of healthcare professional provides healthcare services to the country's population. This may seem frightening to some; nevertheless, it also provides opportunities for inclusion of APNs. Promotions of ANP to fill the service gaps, task reallocation, and skill mix in the healthcare workforce may be topics driving the launching of a new initiative in some countries. For other countries, ANP initiatives may be grounded in increased autonomy, recognition, and professional progression for nurses. While not universal, opportunities are there even though options and strategies are extremely sensitive to country context and the healthcare environment.

Whether at the phase of problem identification, policy formulation, or implementation, the extent of participation by nurses and APNs may be constrained by scarcity of funds, lack of information, lack of managerial/administrative skills, and poor or limited communication networks that lack structures of accountability. However, at some level, there are opportunities to shape change. As healthcare professionals and leaders, APNs can draw attention to identify agenda items, facilitate discussion, and provide information based on their experiences and research.

Understanding the policy and political environment facilitates APNs to function effectively in the promotion of policy change and in strategic planning.

6.5 Research and Evaluation

Evaluation is both the end of the policy process (is the policy/strategy effective?) and the beginning (what should be changed?) (Walt 2006). Policymakers, decision-makers, and key stakeholders depend on information from multiple sources. In exploring the relationship between policymaking and consideration of a strategic approach, Walt (2006) proposes the following questions:

- Do policymakers/decision-makers introduce new policies because their attention is drawn to evaluation reports or research?
- Do policymakers/decision-makers commission research because they lack information or because they want confirmation for predetermined positions?
- Are there actions researchers should take to ensure research findings are disseminated to policymakers/decision-makers?
- Or, should researchers maintain an objective distance only communicating research results for peer group review?
- What role should media play in dissemination of research and evaluation reports?

Research is generally understood as a systematic process of generating new knowledge. The distinction between research and evaluation is not entirely clear and sometimes the term "evaluative research" is used. Evaluations do use research methods and may be as time-consuming as conduct of research studies. Evaluations or assessments of some topic are often seen as relevant to providing decision-makers' direct feedback on the value of a specific policy, scheme, or program and most often seen as auditing or monitoring. An audit looks at or appraises to what extent a process or performance conforms to predetermined criteria. Monitoring pertains to continuous oversight of the implementation of an activity or action. Although potentially useful, research is not always perceived as policy or strategy relevant. However, auditing and monitoring are commonly seen as policy-relevant research, seeking to understand various components of change and the impact of policies/strategies.

There are very few instances that show a direct link between research results and policymaking. Contrasting opinions suggest that new knowledge seeps into the political environment and does at various points influence thinking of decision-makers but not in a linear manner. Just as people aspire for a rational approach to policy and strategic planning, this is an ideal but unrealistic; the research-policy connection is extremely complex and cannot be seen as progressing from one step to another along a straight line. It is more realistic to think of research influencing policy development and strategic planning by drawing on knowledge from different, overlapping networks and sources while participating in some form of information exchange and communication. Rather than having an immediate and direct

influence on healthcare policy decisions, research is more likely to have a cumulative effect.

6.5.1 Dissemination of Empirical Findings and Information

Communities of individuals developing policy or creating strategies may include civil servants, academics, publishers/editors of professional journals, journalists, elected officials, members of government agencies, professional associations, interest groups, among others. Through a common interest in policy issues, there is an ongoing exchange of information discussing or describing activities and ideas. Some of this is done to gain acknowledgment from other members of the community of experts thus hoping to be rewarded with esteem and recognition (Walker 1981).

The process of dissemination of information can be described as deliberate or diffused (Walt 2006). Decision-makers may actively request information on a specific topic or to confirm a particular position. Alternatively, decision-makers may become aware of and pay attention to information through professional conferences and participation in grant-giving bodies or through publications. Research is not commonly reported in the mass media; thus, it may take time to reach the attention of policymakers and key stakeholders. It may take years for reported research to permeate the consciousness of policymakers in the international or national levels.

To assess to what extent decisions are affected by research, Weiss (1991) suggests that it is key to define what form of information comes in: data and findings, ideas and criticism, or briefs and advice for action. Each form has its strengths and weaknesses with one form of information being more useful than the other depending on the situation and topic. Decision-makers will likely choose and remember information selectively. It may be difficult to pinpoint what links any kind of information directly to policy and strategy. Interpreting reports or research findings may be problematical if the original policies/schemes were vague, offering robust promises resulting in ineffectual results. Scientific uncertainty can lead to distortion and lack of clarity. Confused and frustrated decision-makers will likely be immobilized.

Clear communication and active dissemination of evidence to all relevant decision-makers in easy-to-understand formats are critical to increasing awareness, consideration of the information, and adoption and use of evidence. Communication strategies should concentrate on making evidence interpretable, persuasive, and actionable. Core constructs for communication include (McCormack et al. 2013):

- Adapting and focusing the message so that communication designed for a particular stakeholder is to the point based on information known about or received from the stakeholder relevant to the issue under discussion.
- Target the message to the relevant entity or organization that the stakeholder represents (e.g., knowledge of the person's attitudes about subjects such as academic education for nurses or prescribing for nurses if the person is an educator or chief nursing officer, awareness of a stakeholder's opinion of liability

coverage/indemnity for advanced practice nurses if the audience is an insurer or legal counsel).
- Utilize narrative communication – Communicate the evidence in the form of a story or account related to actual experiences or events (e.g., recount how a day-to-day problem occurs in primary care of the elderly or emergency care in mental health situations). Tell the story as it relates to the collected information or evidence.
- Communicate the same or similar message in alternative ways (e.g., emphasize what is gained or what is lost by taking action or making a choice).

Findings from studies and research, especially systematic reviews and similar documents, need to be communicated effectively to influence optimal development of policies. Complicated research and reviews are inherently complex. Subtle differences in explaining the findings from evidence reports make it difficult for the intended audience or stakeholder to understand and use in decision-making if information is not communicated clearly.

Conclusion

Integrating advanced practice nurses into the skill mix of healthcare providers in and of itself requires an adjustment in thinking and organization of healthcare systems. In essence, the concept of a strategic approach suggests a process that shapes or reshapes what has been thought to be customary in identifying professionals and healthcare services. Previous chapters have introduced theories and frameworks that serve as guides for strategic thinking. This chapter offers ideas for assessing the healthcare environment and introduces a process for identifying key stakeholders according to the impact they may potentially have on strategy planning and policy development.

Regulation is discussed based on a model that includes aspects of scope of practice, standards, policies, and procedures. This model offers a regulation toolkit to guide stakeholders in the processes of regulatory activities for healthcare professional. A global overview of nurse prescribing and in-depth country exemplars portray developmental processes related to the introduction of advanced levels of nursing practice. The chapter explores the benefit of debate and discussion in promoting the advancement of nursing. There is controversy as to what extent research and empirical evidence informs policy and decision-making; therefore, the significance of evaluation, research, and dissemination of the information is discussed.

Policy decisions can be influenced in multiple ways; however, the extent of the influence of evidence may not be seen directly. It is more likely to be a process of exposure and revelation over a period of time depending on the mode of communication. Impediments to a clear understanding of the influence of information include political or ideological factors, conceptual confusion and uncertainty regarding empirical findings, and uncertainty about the usefulness of the information, timing, and communication. Research and evaluation may not be a central point to making policy and developing strategy, but it is useful even if the depth of influence is imprecise.

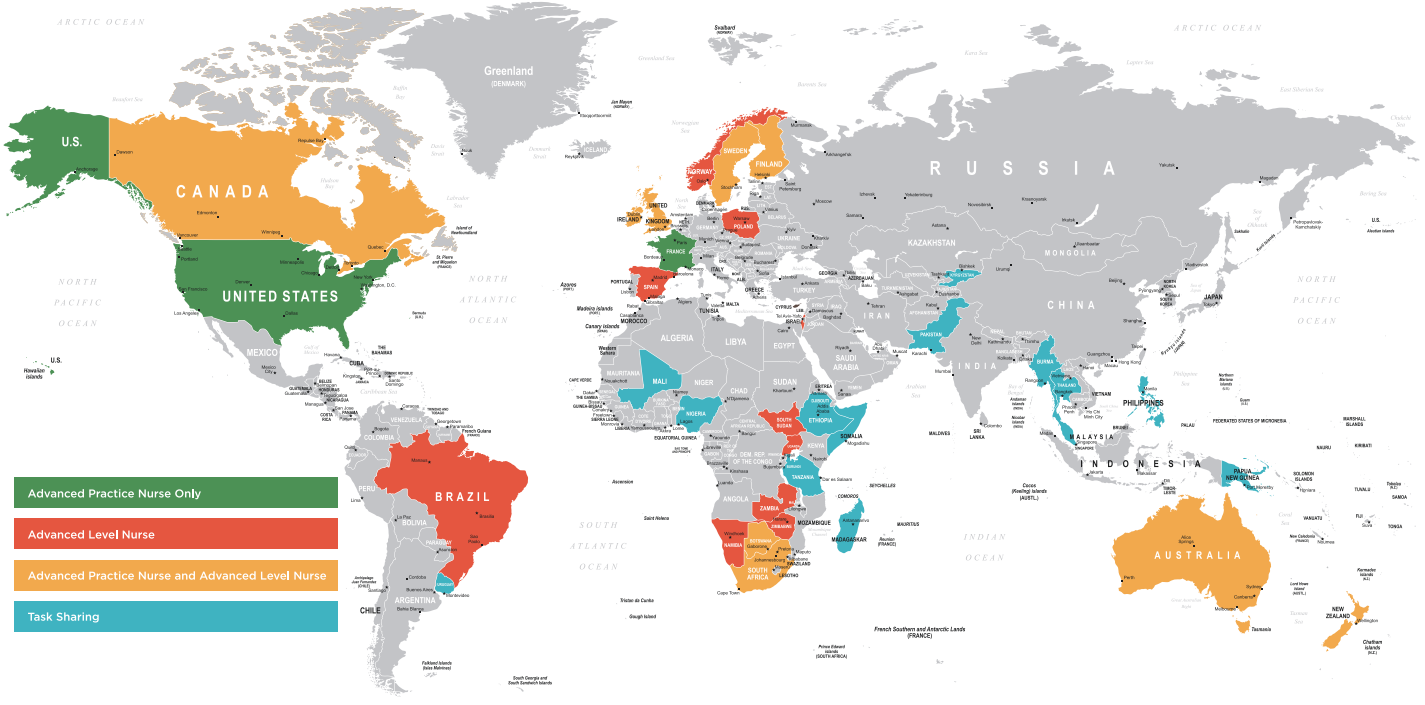
Appendix 6.1: SWOT Analysis Matrix Template (Schober 2016)

INTERNAL FACTORS	STRENGTHS	WEAKNESSES
EXTERNAL FACTORS	OPPORTUNITIES	THREATS

Appendix 6.2: SWOT Analysis Matrix Illustration (Schober 2016)

	STRENGTHS	WEAKNESSES
INTERNAL FACTORS	• Observable presence of nurses working APN roles • Confirmed acceptance by the public • Commitment by nursing to develop advanced clinical roles • Respected status of nurses • Accessible advanced nursing education • Funding available for education and positions for an APN	• Poor role defibition/Role ambiguity • Multiple titles to define the same role • Variability in standards of educational programs for advanced nursing • No role models for advanced practice • Regulations lag behind actual practice • Polocoes limiting advanced practice • Resistance by doctors of APN roles
	OPPORTUNITIES	THREATS
EXTERNAL FACTORS	• Increasing educational levels for nursing • Move to university based nursing education • Growing demand of healthcare dervices for chronic/long term illness • Healthcare reform & governmental desire to improvr care • Shortage of doctors • Interest in new models of healthcare provision, e.g. collaborative, multidisciplinary teams	• Identification of new categories of healthcare professionals viewed as a possible threat to APN development, e.g. physician assistants • Medical dominance • Absence of professional development/career pathways • Lack of qualified faculty to prepare APNs • Lack of defined scopes of practice or approved posts/positions for the APN • Inadequate funding for education an

Appendix 6.3: Global Nurse Prescribing by Role Descriptor



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Policy Analysis

7

Policy analysis is comprised of a technique or process used to determine what a policy will achieve or has achieved relevant to an aspiration or purpose. Analysis can be descriptive in attempting to explain existing policy and its development or prescriptive when the analysis is used in formulating new policies and proposals. Policies that have been developed and implemented should be analyzed periodically for general acceptance and consistency with the current political environment and social and healthcare issues. Review and analysis of policies provide the opportunity for modifications as well as offering a perspective of the world of politics (Dye 2010; Longest 2005; Porche 2012). This chapter explores policy analysis and evaluation focusing on the consideration of what facilitates or impedes formulation and realization of policy. Policy analysis models are discussed. An evaluation process that includes reflexive response and adaptation in development of strategies is proposed. This chapter concludes by urging nurses, especially those leading advanced nursing practice initiatives, to become engaged in interactive policy communication to further ensure evaluation of the impact and outcomes of policy directives.

7.1 Process and Models

Policy analysis consists of a systematic evaluation of the technical and political implications of alternatives proposed to solve public problems (Birkland 2005; Porche 2012). Policy analysis refers to both the process of assessing policies or programs and the product of that analysis using qualitative and quantitative data and a variety of approaches to assess the situation. Results of analysis can facilitate discussion and debate on policy as well as provide evidence for decision-making and/or adaptations.

The context in which an issue arises or policy exists is assessed in the process of policy analysis through interpretative analysis of the policy and an evaluation of the historical context of the policy. This process may produce details regarding the association between current policy along with past and present political, social, and

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healthcare contexts. If there is a disconnect between current policy and the present context, either a further in-depth policy evaluation may be warranted. The initial policy analysis could simply lead to a recommendation for policy modification.

According to Porche (2012), there are two foci for policy analysis:

- Analysis *of* policy
- Analysis *for* policy

Analysis *of* policy can be viewed as a retrospective process that explores the purpose of the policy and what comprised and established the policy. This analysis of policy studies how policy evolved onto the policy agenda and the process of formulation of the policy. In contrast, analysis *for* policy is prospective and explores potential outcomes if a specific policy is developed and implemented (Buse et al. 2005). Policy analysis is dependent upon access to data sources such as valid and reliable documents, interviews, focus groups, and government or agency reports (Porche 2012)

The product of the policy analysis is a clear description of the issue, identification of policy solutions, courses of action with expected outcomes along with a contextual, and comprehensive understanding of the policy. In addition to creating policy or assessing the need for modification of current policy, analysis can be done during all phases of policymaking from agenda setting to policy formulation to implementation (Porche 2012).

However, Birkland (2005) comments that frequently debate on policy is based on anecdotal evidence rather than scientific policy analysis. In comparing these two approaches, anecdotal evidence provides easily understood stories, while scientifically sound evidence from a study is based on factual data. Evidence may contrast with anecdotes or "common wisdom" (p. 11), and even though data are based on scientific findings, it may prove to be unpopular.

The policy feedback theory proposed by Mettler and Sorelle (2014) adds another dimension to the concept of policy analysis. Policy feedback refers to the potential for policies to transform politics and, as a result, influence future development of policy and thus transform the political landscape. The field of policy analysis, which endeavors to predict the most valuable approaches to solving social problems or to evaluate the capacity of existing policies to do so, often focuses on issues of economic value or social well-being. Policy feedback theory proposes to assess how policies affect decisive aspects of governance, such as whether policy promotes public and citizen participation or deters it, whether policy promotes development of powerful interest groups, and how they affect governing capacity. This approach attempts to clarify the impact of policies and assist in avoiding unintended consequences.

Ideally, evaluation and analysis of policy should be based on sophisticated research conducted by objective researchers. In the real world, data are at times difficult to find or do not exist and are too time-consuming to obtain, or results may be withheld due to personal reasons by the researcher (Birkland 2005). Unfortunately, due to diverse interests related to a particular issue such as a controversial topic,

empirical results may be labeled as preliminary or inconclusive to impede decision-making. As a consequence the issue disappears from the policy agenda. It is important to bear in mind that even though policy analysis appears sound and logical, by itself, it is unlikely to make a difference in a heated policy debate. Birkland (2005) suggests that ideological agreements on an issue may play a more significant part in making decisions than sound evidence. In spite of this, policy analysis can still be seen to have a role in the policy process if the empirical evidence is accurate and thorough.

7.1.1 Policy Analysis Models

It is not the aim of this publication to provide an in-depth discussion of policy analysis models but to offer an introduction to several examples of approaches that can be considered when thinking about doing a policy analysis. The following sections provide brief synopses of these models.

7.1.1.1 Process Model

The process model identifies policymaking stages and analyzes the factors associated with each of the stages including stakeholders and policymakers. The person(s) conducting the analysis uses any policymaking model as the framework to conduct the policy analysis (Lester and Stewart 2000). This model is flexible when considering its use but has been critiqued as being too simplistic, failing to take into account the multiple factors that influence the policy process.

7.1.1.2 Substantive Model

The substantive model analyzes the policy from the perspective of the policy issue. Policy content experts typically conduct the analysis and must be familiar not only with the content but with political bodies and identified strategies used in policymaking associated with the focus area (Porche 2012).

7.1.1.3 Eightfold Path

This problem-solving process is used to clarify the policy issue and determine policy solutions (Bardach 2005). The eight steps in this model are:

- Defining the issue/problem
- Collecting the evidence/data
- Constructing policy options
- Selecting the criteria for a policy alternative
- Projecting the outcomes: anticipated and unanticipated
- Come to terms with any points of negotiation or compromise
- Deciding among the various options
- Communicating the narrative: redefining the issue, reconceptualizing the options, reconsidering the criteria, rethinking the outcomes, and reevaluating possible compromises from the perspective of the identified best policy option

The steps do not need to be pursued in the order in which they have been listed. This brief description is simply an effort to describe a process with definition of the issue or problem as the beginning and relating the story or narrative usually identified as the ending point.

7.1.1.4 Logical-Positivist Model

This model is also identified as the behavioral or scientific approach. The logical-positivist model starts with a theory or theoretical framework using deductive reasoning to guide the policy analysis process. Data is collected and analyzed using either comparative or correlative measures resulting in a final report (Lester and Stewart 2000).

7.1.1.5 Participatory Policy Analysis (PPA)

This model seeks input from additional participants to ensure that principles valued by the public are included in the formulation of policy alternatives. This policy analysis model aims to directly engage citizens of the country or locale in the policymaking and analysis processes (Smith and Larimer 2009).

The introduction of models of policy analysis is intended to suggest the diversity of approaches that can be considered if policy analysis is desired when developing strategies for an ANP initiative. This is not an exhaustive presentation of policy analysis models nor is it meant to imply that doing an analysis of policy is a path to success or even required. However, policy analysis can critically appraise the extent to which a policy is a feasible and implementable option to the identified topic or issue.

7.2 Indicators and Outcomes

Indicators provide evidence that a certain condition exists or certain results have or have not been achieved and therefore can enable decision-makers to assess progress toward the achievement of intended outcomes, goals, and objectives.

Outcome indicators associated with healthcare tend to measure the broader results achieved through the provision of services. These indicators can exist at various levels: population, agency, and program. An aspect of policy evaluation is to measure the overall effectiveness and extent to which a policy has achieved its objectives, paying attention to impact and outcome.

Indicators are most often seen as quantitative measures that express the status and trends of complex phenomena based on monitoring data and that resonate with the interests of relevant audiences (Pinter and Swanson 2006). Consider the following assumptions (Hezri 2003):

- Indicators will provide clear answers to questions about environmental change and sustainability
- Indicators will help to explain how decisions and decision outcomes are linked
- Having the right indicators will result in better decisions.

These assumptions tend to be widely accepted; however, examination and review of the use of indicators reveal that these assumptions cannot be taken for granted.

Ideally, indicators should inform decision-making by helping to understand an issue and to make a direct relationship between indicators and decision outcomes. For example, indicators can be used to measure the impact of specific decisions or to measure effectiveness. The reality is that indicators or indicator sets do not readily or automatically lead to change in policymaking. Instead, indicators are often used for ulterior motives such as (Hezri 2003):

- To support a predetermined position
- To give performa assurance about appropriate decisions
- As a delaying tactic or substitute for action by stating a decision can be taken once there are demonstrated indicators

Defining, selecting, and promoting knowledge in policymaking are highly variable processes concerned not only with rational debate and decision-making but also with power and politics. Jones et al. (2012) comment that understanding the prevailing political context and how to navigate the many choices and conflicting perspectives on an issue offer insight and entry points to engage in the process.

7.3 Evaluation and Adaptation: Population Indicators

Population-level indicators measure changes in the condition or well-being of children, families, or communities (i.e., teen pregnancy rate, infant mortality rate). Changes in population-level indicators are often long-term results of the efforts of a number of different programs, agencies, and initiatives. In some cases, rather than providing information about the results achieved by interventions, population-level indicators may provide information about the context in or assumptions under which these interventions operate. For example, the overall level of unemployment provides important contextual information for job placement programs. In this case, monitoring the unemployment rate allows stakeholders to correctly interpret program results.

Agency-level indicators measure results for which an agency is responsible; program-level indicators measure the results for which a program or subprogram is responsible. Agency- and program-level outcome indicators are often defined more narrowly than those pertaining to the population as a whole; for example, they may measure pregnancy rates among teenage girls in a given county or among girls receiving a given set of services. Identification of appropriate indicator levels ensures that expectations are not set unrealistically high.

7.4 Determining the Correct Path to Follow

Historically, multiple theories have provided significant insights into the idea of translating knowledge to the policy process or to the realization of policy in actual practice. In various ways, all of these theories offer insights into the importance of understanding the political context surrounding policymaking and the power

relations among decision-makers (Jones et al. 2012). The author has attempted in various ways to underscore the need for nurses and proponents of advanced nursing practice to develop an interactive process between knowledge conducive to policy-making and the policy process. This emphasis includes (Jones et al. 2012):

- Developing a shared understanding of what questions to ask
- How to go about answering them
- How best to interpret responses

Reviewing a range of theories and concepts contributes to an awareness of the many levels of nuance associated with policy decisions and policymaking. As a result, is it not possible to construct a one-size-fits-all model for analysis of the success of a policy or action. Defining, selecting, and promoting knowledge relevant to the policy process and strategic thinking are highly variable, based as much on matters of politics and power as with rational discussion and problem-solving. The complex nature of interactions between decision-makers will depend on the nature and timing of interventions by various stakeholders, "creating windows of opportunity or tipping points" (Jones et al. 2012, p. 6).

The challenge when trying to identify the correct path for developing policy is to think pragmatically about theoretical principles in light of what can be gained to promote better understanding as it relates to policy and developing strategies for ANP. The ability to do this requires the reader to think systematically about the context in which they work, the dynamics of the processes they face, the array of decision-makers who influence policy, how any of the issues are currently being addressed (or not), and strategies that might be linked more effectively to the policy processes.

Conclusion

"It is rarely the case that there is simply a gap between knowledge and policy that requires bridging" (Jones et al. 2012, p. 120). The link between knowledge and policy differs depending on the policy issue. Policy analysis is explored in this chapter as a technique that can be used to identify current policy issues and to facilitate formulation and/or modification of policy. Ideally, the outcome of policy analysis includes a description of the issue, identification of policy solutions or alternatives, and courses of actions with expected outcomes along with a contextual and comprehensive understanding of the policy. This chapter introduces several models to consider when using policy analyses in policy refinement and adaptation. The significance of evaluation indicators and outcomes is explored. By now, following discussion of strategic planning and the policy processes in prior chapters, it should be well established that these processes do not necessarily proceed along an orderly path. Determining the diverse aspects of strategic thinking is a complex process. This chapter builds on prior chapters in trying to disentangle different perspectives in order to improve an understanding of what it takes to launch a context-specific advanced nursing practice initiative.

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Rational Policy Decision-Making: Idealism Versus Realism

8

As a concept, rational decision-making can be viewed as a multi-step process, from problem identification through solution, for making logically sound decisions (Porche 2012; Walt 2006). Rational decision-making favors objective data and a formal process over subjectivity and insight, making an assumption that the decision-maker has all relevant data about alternative choices and solutions. This concept also assumes that decision-makers have the time, intellectual ability, and resources to evaluate each choice against others. This chapter discusses the characteristics of a rational approach to policy decision-making and identifies a rational approach model in making policy decisions. The rational approach to making decisions is compared to the theory of step-by-step or incremental decision-making. In addition, disjointed incrementalism is discussed in exploring the perspective of what influence unexpected or unforeseen events may have on the policymaking process.

8.1 Policy-Making: A Rational Process

Is policy-making a rational process? Is strategic planning beneficial? Are communication and collaboration advantageous? How does reality intersect with idealism?

Various perspectives and theories that suggest policies or policy decisions can be made in a rational way have been discussed in earlier chapters. In theory, this view suggests that rational thinking in making policy decisions is the approach policymakers ought to take in making decisions. The rational model of making policy decisions proposes that policymakers go through certain stages logically to achieve the best possible policy decisions. Key points of a rational model include the following assumptions (Kingdon 2003; Walt 2006):

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- Policymakers can identify or define a specific problem and are able to separate it out from other similar problems (e.g., limited access to healthcare professionals to provide quality primary healthcare services).
- Principles that guide policymakers are ranked according to their importance (e.g., providing quality healthcare services may be secondary to providing services at the least cost or more efficiently).
- That various alternatives are being considered.
- The pros and cons of each alternative are assessed systematically.
- Each alternative and its advantage or disadvantage are being compared.
- The policymaker chooses the optimal alternative at the least cost.

Assumptions of the rational model imply that the result of this process is a rational decision that most effectively achieves an anticipated conclusion. For various reasons, such a model does not describe reality. Those that question that a rational model accurately describes the policymaking process point out the following (Cairney and Heikkila 2014; Kingdon 2003; Walt 2006):

- Policymakers do not always face well-defined problems.
- Defining the issue, topic, or problem may be difficult and complicated.
- It is unrealistic to think policymakers have the time, imagination, and information to assess the pros and cons of various alternatives.
- Unanticipated consequences, by definition, cannot be anticipated.
- Policymakers are not objective or value-free. They have preferred ways of thinking or resolving issues.
- Past policy heavily influences present policy.
- The ability of individuals to process information is more limited than a comprehensive approach would require.

The rational view of policymaking may be an ideal to strive for when providing a theory of the way policymakers ought to act in making decisions. However, the author proposes that the idea of a rational process is unrealistic. While there is little disagreement in identifying different stages of the policy process, there is a great deal of dissension as to how far policymaking follows a rational or logical process from problem identification to evaluation (Kingdon 2003; Walt 2006). Precise and sequential stages do not describe these processes accurately. While there are identifiable processes, they do not necessarily follow one another through time in any ordered pattern.

Policy models or frameworks may give a false impression of rationality by implying that policymaking follows a linear process through chronological phases. This chapter and topics discussed in Chap. 4 propose that policymaking is not a fully rational process. For example, policies may remain intentions that are never put into practice or may be implemented in ways that misrepresent the original intention of the policymakers. A rational approach prescribes how policy ought to be made; however, unexpected and unanticipated events or actions are more likely to define reality and shape the policy process. The next section

discusses how incrementalism in relationship to policy development contrasts with the rational model.

8.2 Incrementalism and Policy Decisions

The concept of incrementalism proposes that policy change occurs using small incremental steps rather than a few (extensively planned) large steps (Kingdon 2003; Lindblom 1979; Porche 2012; Walt 2006). This theory suggests that in public policy, the method of change is with many small policy changes enacted over time in order to create a larger broad-based policy change. Walt (2006) suggests that incrementalism is more descriptive of the way policy is actually made as apposed to a rational process. The main assumptions of incrementalism are as follows:

- Policymakers usually do not think through or spell out their objectives.
- Policymakers identify a small number of alternatives and tend to choose options similar to existing policies.
- For each alternative only the most important outcomes are considered.
- There is no optimal policy option. There is consensus among policymakers about the decision that was chosen, but it is not necessarily the "best" decision.
- Incremental policymaking focuses on small changes to existing policies. Policymaking is sequential – it involves a return to a problem or concern as mistakes are corrected and new decisions or strategies are developed.

The best known of the incrementalist theorists is Lindblom (1959) who argues that usually what is politically feasible is only slightly different from existing policies. On a positive note, Lindblom (1979) suggests that this is good because:

- It focuses the policymaker's assessment of the issue on familiar, better known experience.
- It reduces the number of different alternative policies to be explored.
- It reduces the number and complexity of factors policymakers have to analyze.

The incremental approach proposed by Lindblom (1959) is based on the premise that policymakers are required to make decisions in a political world with many limitations in the process. As a result, smaller changes are easier to get agreement on than trying to overcome major obstacles unless there is a crises situation. A criticism of incrementalism is that this approach is too conservative and that in countries where high social stability does not exist and where significant social change is needed, incrementalism would possibly be inappropriate and that change would be too slow (Dror 1989). However, Lindblom (McGrew and Wilson 1982) suggests that it is possible for incremental steps to be made quickly because they are only incremental and do not provoke strong opposition as do proposals for extreme change.

8.3 A Debate: Rational Change Versus Disjointed Incrementalism

In Chap. 1 policy theory is defined as a scholarly or academic attempt at seeking to explain and generalize the policy process. The dialogue of a rational process versus incremental change in policy development is essentially an artificial debate (Mason et al. 2007; Porche 2012). There are widely held images, and perhaps hope, that policymaking is based on rational and informed processes. However, criticism of rational models suggests that this is unrealistic.

Broad support exists for incremental change, or some variation of incrementalism, as more realistic. In addition, Porche (2012) comments that most policymaking is incremental. However, as noted earlier, critics of the incremental approach point out that this perspective, albeit more based in reality, is not the way things should be or are actually done (Porche 2012; Walt 2006).

A line of reasoning follows that the rational approach describes an ideal model of policymaking, and incremental change describes what actually happens in the policy process. Both accurately describe aspects of policymaking but should be explored separately: one is a normative/prescriptive approach (rational approach); the other is an explanatory/descriptive model (incrementalism). There is an identifiable disparity between the two perspectives. The usefulness of analysis of the ideal model versus what mostly happens in practice offers the reader an awareness of this gap. This understanding allows exploration of the dynamics of a systematic approach to solving problems while also recognizing that different interests and events influence the policymaking process (Mason et al. 2007). In providing a debate format of the two perspectives, first assumptions of rational decision-making are reviewed followed by key principles of the theory of incrementalism/disjointed incrementalism.

8.3.1 Assumptions of the Rational Decision-Making Model

Theoretically, as suggested earlier in this chapter, the rational decision-making model follows a formal path of actions that include (Boundless 2016):

- Formulating a goal(s)
- Identifying the criteria for making the decision
- Identifying alternatives
- Performing analysis
- Making a final decision

The rational model of decision-making assumes that decision-makers will make choices that maximize benefits and minimize any costs. The idea of rational choice is easy to see in relation to economic theory. For example, there may be interest in utilizing APNs to enhance healthcare services in the most cost-effective manner. However, the rational decision-making model does not take into consideration

factors that cannot be quantified, such as ethical concerns, qualitative cultural aspects, or consumer acceptance. Its objectivity creates a bias toward the preference for facts, data, and analysis (Boundless 2016).

Early theories of policy decision-making focused on producing descriptive theories for which all observed decision-making could be described as making rational choices based on the expectations about the consequences that are informed by prior objectives and/or experiences. Therefore, rational choice assumes that policymakers pay attention to problems or issues first and then develop policies next (Zahariadis 2014). It is increasingly acknowledged, and the case is made in this chapter that the vast array of decision-making styles and environments make developing such a prescriptive theory as unachievable. The gap between descriptive (what is actually done) and normative (what should be done) in decision-making is extensive (Boundless 2016). "Ambiguity is a fact of political life and makes policymaking messy, complex, costly and less coherent" (Zahariadis 2014, p. 50). At the same time uncertainty can promote innovation and disperse political conflict by stirring the imagination and facilitating possible options (Sharkansky 2002).

8.3.2 Incrementalism and Disjointed Incrementalism

Theoretically, the incremental approach begins with the current existing state of affairs and alters current policy through a series of small, step-by-step incremental changes in relation to the articulated aim or objective. Incrementalism proposes to permit greater involvement and access between the various policy arenas and political systems over time. Similar to the rational approach, policy formulation is also dependent on a policy agenda, culture of the political environment, and the policy issue being considered (Porche 2012).

However, incremental policymaking, in essence, describes a progression using existing policies as a foundation. As a result, a new policy may be achieved over time as an expansion of the original intent of a policy that is already in place. However, incremental policymaking may result in a disjointed approach that produces confusing and contradictory policies.

Lindblom (1979) proposes that disjointed incrementalism is a variation of incrementalism. Based on the concept that all analysis is incomplete and all incomplete analysis may fail to represent what may be critical to good policy, disjointed incrementalism attempts to make the most of limited policymakers' abilities to understand all aspects of the situation. As a result, some events or decisions are dealt with in an ad hoc manner using whatever analysis is convenient without comprehensive review of all associated dimensions or issues. Theoretically, disjointed incrementalism presents the idea that complex problems and issues, realistically, cannot be completely analyzed and, therefore, require strategies for skillful navigation of the incompleteness of what is known. Disjointed incrementalism speaks to the fragmentation of policymaking and consequent political interaction of participants (see Chap. 3 for further in-depth discussion of Lindblom's theory of incrementalism).

Is it realistic to propose that a more comprehensive plan could prevent disjointed policymaking? According to Porche (2012, p. 120), an attempt at such an approach includes:

- A comprehensive policymaking goal that describes the desired policymaking intent
- An agenda-setting plan that describes what policies will be developed and a timeline for placement on the action policy agenda
- Identified policy modifications with a timeline for policymaking
- Development of a long-term political strategy for each policy modification that will occur over time
- Development of policy evaluation plans to provide data that support each successive policy modification

Repeatedly throughout this publication, a perspective is offered that the policy process is neither logical nor rational. No matter what the approach to policymaking and strategic decisions that is chosen, the debate continues and the indication is that there is no straightforward approach and there are no simple answers to either strategic planning or policy decision-making.

Conclusion

Strategic thinking regarding the initiation or refinement of an advanced nursing practice plan requires knowledge of the policy process and policymaking. The policy process is best envisaged as a complex phenomenon of continuous interactions including public policy and its contexts, events, decision-makers, and outcomes (Weible 2014). Diverse questions arise in attempting to pragmatically define decision-making theory or any aspect of it. No single theory provides a comprehensive description or explanation of policy processes.

For anyone trying to comprehend and use theory for the first time, a policy process theory may seem a bit of a mystery. This chapter introduces some selected principles of commonly held theories relevant to rational and incremental decision-making; however, the field of public policy is more comprehensive than represented in this chapter and requires additional investigation, especially as it relates to healthcare settings. In addition, theoretical viewpoints on policymaking are usually published in non-nursing literature and may not catch the attention of nursing leaders. The author has identified concepts that appear to be usable in the context of strategic planning and policymaking for advanced nursing practice; however, research is needed to investigate if the linkages proposed in this chapter and earlier chapters in this publication are applicable outside of their original scope.

When new to the field of theory of the policy process, one way to become at ease with a theory is to use it to portray the context of an issue and proceed to attempt to apply the theoretical premises to the situation. An example of this method can be found in Chap. 2 with the description of three policy theories that were utilized in the development of the Conceptual Policy Framework for advanced practice nursing and linked to empirical findings from a research study.

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