POLICY & POLITICS

in Nursing and Health Care

Eighth Edition

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Dr. Mason is a member of the Board of Directors of the Primary Care Development Corporation, a nonprofit Community Development Financial Institution focused on building the nation's capacity for primary care; and of Public Health Solutions, New York City's largest public health organization that focuses on improving the health of vulnerable families. She chairs the National Advisory Board of the Center for Health and Social Care Integration at Rush University Medical Center and is Facilitator and Co-Chair of the Catskills Addiction Coalition. She served as a member of the National Academies of Science, Engineering and Medicine Committee for the report on *Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health*, and she co-chaired the Josiah Macy Foundation invitational conference and report on *Registered Nurses: Partners in Transforming Primary Care*.

The recipient of numerous awards for leadership, dissemination of science, writing, education, policy, and advocacy, Dr. Mason is a fellow of the American Academy of Nursing and the New York Academy of Medicine, from which she received the Academy Medal for Distinguished Contributions in Health Policy in 2019. She received a BSN from West Virginia University, an MSN from St. Louis University, a PhD from New York University, an honorary Doctorate of Science from West Virginia University, and an honorary doctorate of humane letters from Long Island University.

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Dr. Dickson's program of research focuses on the intersection of adolescent health, health education, school health and education policy, and school nursing. She serves on the Board of Directors for the New Mexico Alliance for School Based Health Care and multiple state and local community advisory boards for projects focused on improving LGBTQ adolescent health and health education. Dr. Dickson testified before legislative health and education committees regarding her research on sexual health education in secondary schools. Her research collaboration includes the University of New Mexico Center for Participatory Research, where she serves as co-investigator for NIH/NINR-supported research exploring community-based participatory research within academic and community partnerships.

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UNIT 1 Introduction to Policy and Politics in Nursing and Health Care

UNIT 2 Health Care Delivery and Financing

Our nation has made great progress in improving the health of its people over the last century, as have other nations. Many people assume it's because we have built a highly technological health care system that is able to provide the latest in diagnostic and treatment services. However, since 2015, our rates of maternal mortality have increased while life expectancy at birth has decreased. Racial and ethnic health disparities persist and are reflected in these two indicators of the health of the nation.

We know that improvements in nutrition, sanitation, seatbelt use, vaccinations, and other factors have been drivers of improvements in the nation's health, and these factors are shaped by public policies. Social determinants of health are again receiving the attention they deserve from local communities and the nation. However, more needs to be done, and the nation's nurses can and must be leaders in calling for health and social policies that will promote the health of communities, whether through economic development; quality education; reduction of crime and trauma; access to affordable and nutritious foods; preventing addictions to nicotine, opioids, and other substances; prevention of the spread of infectious diseases, including HIV; or other "upstream" measures.

As the Principal Deputy Assistant Secretary for Health in the U.S. Public Health Service, after serving as Acting U.S. Surgeon General and Deputy U.S. Surgeon General, I'm keenly aware of the important role that nurses can play in promoting the health of our nation. You don't have to be Acting Surgeon General to do so! Even if you're working in acute care, you see the effects of unhealthy lifestyles and communities on the lives of individuals and families and can provide a voice to move organizations and communities to address social determinants. And how healthy is the community in which you live? Think about what would happen to this nation if every nurse became a local or regional leader in creating public policies that will foster health.

Policy & Politics in Nursing and Health Care is the classic book for helping nurses to understand how policymaking and politics work, to acquire tools for shaping these policies, and to learn about contemporary issues related to health and social policy. The importance of this book in developing the next generation of nurse leaders in policy cannot be overstated, but it's not the only tool you'll need. Honing your policy and political skills requires action. I'm doing what I can to be a leader and hope that you will join me in being the nurse leaders our nation needs.

Rear Admiral Sylvia Trent-Adams, PhD, RN, FAAN

Growing up in Naperville, Illinois, being a Girl Scout was part of my identity. I remember being a young girl and taking the pledge "to help people at all times." I couldn't have predicted how that would play out into a future career of service, continuing from a Girl Scout to a nurse, and then to serving my community as a member of the House of Representatives.

During a swimming lesson when I was 8 years old, I discovered I had a heart condition, supraventricular tachycardia, which occasionally prevents my heart from maintaining a normal rhythm. I saw my Girl Scout pledge come to life through the providers who helped me during my initial treatment. They made a lasting impression on me and inspired me to pursue nursing so I could help people too. I went to the University of Michigan for my nursing degree and completed a joint Master's degree in nursing and public health from Johns Hopkins University in Baltimore.

My path to policy was forged during my undergraduate years in nursing school when I took a course on nursing politics that changed my life and motivated me to engage in policy work. So, I took my personal experience as a patient as well as my nursing education and training to work for the Obama Administration as a Senior Advisor in the Department of Health and Human Services, assisting in public health emergencies like the Ebola epidemic in 2014 and the water crisis in Flint, Michigan in 2016.

Serving in the Obama Administration and later working to implement the Affordable Care Act helped solidify my values and fed my passion to make quality health care more affordable for American families. Shortly after I left the Administration, I knew I wanted to continue that work, and I decided to run for Congress. In January 2019, I was sworn in as the first woman and the first person of color to represent my community, and as one of only two nurses to serve in the 116th Congress. Since my very first day, I've been fighting to advance policies that expand access to health care and improve the health of individuals, families, and communities like the one I represent in Illinois.

Whether serving as health care providers, community leaders, or even policymakers, nurses across this country are in a position to boldly lead. In partnership with the Robert Wood Johnson Foundation, The National Academies of Science, Engineering, and Medicine (formerly the Institute of Medicine) will be launching a new study, *The Future of Nursing 2020-2030.* This groundbreaking publication will build on the first *Future of Nursing* report to outline the role of nurses in creating a culture of healthy people and neighborhoods. The new study will examine the role of nurses in building healthy communities through a holistic approach that considers issues like training, care delivery, and solutions to address disparities.

The country needs new leaders who can make progress on the issues that matter to our communities, and there is no one better than nurses to lead the way. Our patients, their families, and their communities are counting on us. This book serves as a guide to policy and politics in nursing and health care. I was proud to be one of the contributors in the sixth edition of this classic book, and I know that the eighth edition will inspire many nurses, nursing students, faculty, and researchers to develop their knowledge and skills in using policy to promote the nation's health.

Representative Lauren Underwood, MSN, MPH, RN

PREFACE

As the prior edition of *Policy & Politics in Nursing and Health Care* (seventh edition) was going to press, the Patient Protection and Affordable Care Act (ACA) had become the law of the land. Despite significant progress in reducing the nation's number of people who are uninsured or underinsured, subsequent changes in our political landscape brought changes to the ACA that have undermined, instead of strengthened, the law. Once again, our nation seems poised to have the worst record of any developed nation on access to health care, the quality of much of that care, and the health of the population.

The 2016 elections brought a significant change in federal leadership, followed by a midterm election that saw an unprecedented number of women running for office at local, state, and national levels. More women were elected to the House of Representatives than ever before, including a registered nurse, Lauren Underwood (see the Foreword by Representative Underwood). During a time when science is too easily dismissed or discounted, nurses' voices are crucial to shape evidence-based policies that improve the quality of health care, improve access to that care, and promote the health of individuals, families, and communities.

Because we live in politically polarizing times, we thought it important to be explicit with the values and assumptions that we shared in developing this edition:

1. *Health care is a right, not a privilege.* We know the scientific evidence and have witnessed firsthand what happens when people don't have access to health care. They die prematurely, are disabled unnecessarily, lose jobs, go into bankruptcy, and struggle to provide for themselves and their families. The United States is the only developed nation that fails to ensure that all of its people have access to health care, and our outcomes for the uninsured and the communities in which they live show it, including having a compromised workforce.
2. *Health disparities persist in American society and must be reduced.* The United States is the only developed nation in which longevity of the population is decreasing and maternal mortality is increasing. This is particularly true for people of color and those living in poverty. A healthy nation focuses on all of its people, not just on those already advantaged.
3. *Social factors play a larger role in shaping the health of families and communities.* Although the seventh edition of the book incorporated a focus on the social determinants of health, the current edition places an even stronger emphasis on them in recognition that social, economic, and environmental factors have a greater impact on health than health care. Health care's consumption of approximately 18% of the U.S. gross domestic product is undermining efforts to promote the health of families and communities rather than treating preventable illnesses—and at a very high price in humanistic and monetary terms. We believe that, regardless of where a nurse works (whether acute care, long-term care, school health, or other setting), all of us must be leaders in embracing a population health perspective that incorporates these other factors in our daily work.
4. *Nurses are the most trusted profession by the public and must live up to this honor by leading change in the communities where we live, work, play, and learn.* This is a value expressed by contributing authors throughout the current edition of *Policy & Politics in Nursing and Health Care.* There are myriad examples of nurses leading change in health and social policies to improve health, and we have incorporated some of them here. We encourage readers to seek out other examples in your own communities, health care settings, the policy world, and elsewhere. *The Future of Nursing 2020-2030* is underway as we go to press and is expected to highlight nurses' roles in building a culture of health and addressing social determinants of health, and recommend that more of us step up to be leaders in this space. Florence Nightingale, Harriet Tubman, and Lillian Wald are nurses from our history whose work illustrates that such leadership is part of our legacy. We issue the challenge to all readers to advance their work and continue in their footsteps.

This book reflects these assumptions in most chapters, but not all. We did not seek to invite only contributors who might agree with our assumptions. Rather, we expected them to provide the evidence for their positions and recommendations.

This eighth edition of *Policy & Politics in Nursing and Health Care* aims to help nurses explore the problems that impede health in our nation and globally, learn the best evidence available about policy options that are likely to successfully address these problems, and develop their political and policy acumen. As with prior editions, the book's target audience is novice to expert—whether

undergraduate, masters or doctoral students, or practicing nurses. Some chapters provide the basics of policymaking and politics, whereas others delve more deeply into the nuances of specific policy matters and political strategy. We have placed a stronger emphasis on the implications of the issues discussed for advanced practice nurses, including those pursuing or holding the doctorate of nursing practice (DNP). The DNP was designed to prepare nurses as clinical leaders who could develop evidence-based approaches to improving the health of specific populations, and policy *is* a population health intervention. However, we maintain that every nurse has a social responsibility to shape public and private policies to promote health.

Although the book is organized around a framework, it is not designed to be read only from start to finish. Rather, we encourage readers to explore the table of contents and search for those topics about which they want to learn more. We hope the book will guide nursing students and nurses who are policy novices throughout their journey of engagement in the world of policy and politics.

WHAT'S NEW IN THE EIGHTH EDITION?

This edition continues the almost 35-year approach of prior editions that have led others to describe the book as a "classic" in nursing literature. However, classics become stagnant if not refreshed. A new team of editors has brought a fresh perspective to this edition. The order of authorship on the cover does not reflect effort; rather, the editing of this book was truly a team effort.

Central to the changes in this edition are:

- Updates on the ACA and its implementation, its impact on nursing and the health of people, the role of politics in our health care system, and the need for further policy reforms.
- As noted previously, the importance of addressing upstream factors or social determinants of health is a major theme.
- In response to the mistrust of science and facts in some circles, authors have provided more depth and breadth to the evidence that undergirds policy issues and potential responses, with the understanding that evidence is necessary, but often not sufficient, for policy change.
- New and updated Taking Action chapters provide real-life examples of nurses' activism. For example, the Taking Action on Removing APRN Regulatory Barriers in West Virginia can serve as a case study on political strategy when in a polarized political environment.
- All of the chapters have been updated. For example, the chapter on media provides greater depth on the political context of media in our times to help readers to understand how to use media in credible ways. Other chapters have been significantly revised by new authors, with fresh perspectives on topics such as:
  - Primary care
  - Nursing education
  - Using research to advance health and social policies
  - Highlights of the ACA, with implications for nurses and other health professionals
  - The politics of advanced practice nursing
  - Ethical dimensions of policy and politics
  - Patient engagement
  - Overtreatment
  - Women's reproductive health
  - Public health
  - Emergency preparedness
  - Developing families
  - Nurses in boardrooms
  - Quality and safety in health care
  - Nurses' work environments
  - The intersection of technology and health care
  - Community-based organizations addressing health
  - School nursing
  - American Indian/Alaska Native policy issues

USING THE EIGHTH EDITION

Using the book as a course text. Faculty will find content in this book that will enhance learning experiences in policy, leadership, community activism, administration, research, health disparities, and other key issues and trends of importance to courses at every educational level. Many of the chapters will help students in clinical courses understand the dynamics of the health system. Students will find chapters that assist them in developing new skills, building a broader understanding of nursing leadership and influence, and making sense of the complex business and financial forces that drive many actions in the health system. In particular, the Taking Action chapters provide examples of nurses taking on real-world policy challenges. The book presents an in-depth view of the issues that impact nurses and suggests a variety of opportunities for nurses to engage in the policy issues about which they care deeply.

Using the book in government activities. The unit on policy and politics in the government includes content that will benefit nurses considering running for elective office, seeking a political appointment, and learning to lobby elective officials about health care issues.

Using the book in the workplace. Policy problems and political issues abound in nursing workplaces. This

book offers critical insights into how to effectively resolve problems and influence workplace policy as well as how to develop politically astute approaches to making changes in the workplace.

Using the book in professional organizations. Organizations use the power of numbers. The unit on associations and interest groups will help groups determine strategies for success and how to capitalize on working with other groups through coalitions.

Using the book in community activism. With an expanded focus on community advocacy and activism, readers will find information they need to effectively influence policy solutions to problems in their local communities, along with global perspectives.

ACKNOWLEDGMENTS

In every edition of this book, the co-editors have expressed their sincere gratitude to the many authors who have contributed their time and expertise to write a chapter out of a commitment to furthering the education of nurses and other health professionals on policy and politics. This edition is no exception. We are grateful for the thoughtful contributions of more than 120 authors and hope that readers will learn from them.

We are also grateful for the enduring contributions and imprint of the prior co-editors of this book that have made it the leading resource in its field. Susan Talbott was the co-editor on the first edition; Mary Chaffee on the fourth through sixth editions; Judith Leavitt on the second through sixth editions; and Frieda Outlaw, Eileen O'Grady, and Deborah Gardner on the seventh edition. We hope that they are pleased with the continued development of the book.

We owe a huge debt of thanks to Bryan Jackson, the book's editorial manager for this edition. He tracked our work, kept the co-editors moving along, coordinated our communications, and was simply amazingly organized. He did all of this while a student, working multiple jobs, and always being a supportive voice. Bryan, we are grateful for your superb work.

We also acknowledge the continuing support of Elsevier and the editorial team that worked with Sandra Clark and Lisa Newton. We are indebted to Clay Broeker, an extraordinary production manager who has worked on the last four editions of the book. Thank you, Clay, for your continued commitment to excellence in publishing.

Each of us has some special people to acknowledge.

Diana Mason

First, I am incredibly grateful to this new team of co-editors who as mid-career colleagues are unafraid to question the book's longstanding approaches and assumptions. They also worked superbly well as a team. This and their vision for nursing and health in our nation give me hope for nursing's future. I also want to acknowledge my husband, James Ware, for his continued support of my long days of work on this book and to my loving dog, Ricky, for his tolerance of walks delayed or missed.

Elizabeth Dickson

I would like to thank my husband, Jeff, and sons, T. and J., whose continued love, patience, and unconditional support leaves me speechless—words seem to fail me every time I try to express my gratitude. My deepest respect and thanks to our friends, family, and community that surround and support us. To Diana, thank you for opening this door for us to join you on this adventure; and to Monica, Adriana, and Bryan—this incredible group of colleagues—thank you for your hard work and dedication.

Monica R. McLemore

I would like to thank Diana Mason for the opportunity to work with these incredibly brilliant scholars and colleagues—it has been an experience of a lifetime. I also give thanks to the ancestors who make my existence possible. Finally, I am extremely thankful to my partner James and his careful support and stewardship of Aife (the dog) and Bella and Catness (the cats), as well as the kittens Brutus and Sirius, while I wrestled with fulfilling my tasks while standing on the shoulders of the previous editorial team.

G. Adriana Perez

I am honored to have worked with such dynamic scholars. Diana Mason, I appreciate you and the opportunity you have given us to learn from you and each other. I thank my family for inspiring me—my mother who came to this country as a young immigrant in pursuit of a better life and grandmother who was a nurse in Mexico. I am grateful to the love of my life, Nick, for always making me laugh. Gracias to my research participants, patients, and students for reminding me that in order to fully achieve a healthier future for all, we must link our research to practice and policy.

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Frameworks for Action in Policy and Politics

Diana J. Mason, Elizabeth Dickson, Monica R. McLemore, and G. Adriana Perez

"The most common way people give up their power is by thinking they don't have any."

Alice Walker

When Lauren Underwood was a young girl, she found out that she had supraventricular tachycardia for which she was treated. The health professionals who provided her initial treatment so inspired Underwood that she became a registered nurse. She is one of millions of Americans with a preexisting condition that made health insurance inaccessible for many people before the Affordable Care Act (ACA). Prior to that landmark legislation that reduced the number of people who were uninsured by 20 million (Kaiser Family Foundation [KFF], 2018), insurance companies could have either denied Underwood coverage or charged so much for a health plan that it would be unaffordable. After the 2016 elections, President Donald Trump and a Republican-controlled Congress renewed efforts to roll back the ACA under campaign promises to "repeal and replace Obamacare." A number of executive and legislative actions were taken to undo key features of the law, among them proposals to get rid of protections for people with preexisting conditions. At a community meeting hosted by the League of Women Voters, Congressman Randy Hultgren (R-IL), Underwood's congressional representative at the time, promised he would only support legislation repealing Obamacare that protected coverage for people with preexisting conditions. He then proceeded to vote for the 2017 American Healthcare Act that included ending the preexisting condition protections. Underwood was in the audience and decided to act. She ran for Congress.

As a Black nurse from Illinois who lived in a Republican-dominated congressional district, Underwood conducted a grassroots campaign that took her to some all-White neighborhoods and households that may never have considered voting for a person of color for their congressional representative. Underwood spoke directly to the benefits of the ACA, first as a nurse who had seen what happens to people who do not have health insurance and cannot afford care; and second, as a former special adviser to the U.S. Department of Health and Human Services during the Obama administration. She showed that she understood the issues that people cared about (health care, including mental health; jobs; and family) and was skilled in interacting with people.

Against the odds, Underwood defeated six Democratic men in the primary elections and then became the public face of the dramatic 2018 midterm elections in which Democrats took back control of the U.S. House of Representatives. She is regarded as one of the smart, new women leaders in our federal government and joins fellow nurses Eddie Bernice Johnson (D-TX), the first nurse to be elected to Congress; and Karen Bass (D-CA), a member of Congress since 2011. She follows another nurse, Diane Black (R-TN), who lost her bid for reelection in 2018.

These nurses are not alone in serving in important policymaking positions:

- Dawn Adams won another race-against-the-odds for Virginia's state assembly (see Chapter 43);
- Bethany Hall-Long became the Lieutenant-Governor of Delaware after serving for a number of years in the state's legislature (see Chapter 47);
- Rear Admiral Sylvia Trent-Adams served as the nation's Acting Surgeon General in the first year of the Trump Administration and then as Deputy Surgeon General (see Chapter 44 and the Foreword);
- Mary Wakefield was appointed by President Barak Obama to be the Acting Deputy Secretary of Health and Human Services after heading up its Health Resources and Services Administration;
- Erin Murphy has served in the Minnesota legislature and ran for Governor in 2018.

It seems that some nurses have awakened to their potential for shaping and leading the development of health and social policies in their own communities, states, and the nation. However, serving in an elected or appointed political office is not the only way to influence the development and implementation of health policy. The work that nurses do every day—the care and advocacy for patients, their families, and communities—and the lives we live, along with the places we work, play, and love, are shaped by local, state, and national policies. The forces of policy that form our lives as constituents and nurses are real—policy is being made around us constantly, in Washington, DC, in our state capitols, and in our local city halls. It is time for us to seize the opportunities for shaping our worlds. This chapter provides a foundation for learning how policy and its political context can be advanced to promote the health of individuals, families, communities, and nations.

FOCUS ON POLICY: WHAT POLICY?

Many nurses and others in health care often think of policy as "health policy" or "health care policy." The ACA is an example of a major federal policy that aimed to improve people's access to health care, particularly through providing affordable health coverage for essential services. However, access to coverage does not necessarily mean access to care, nor does it ensure a healthy population. Health care access means having the ability to receive the right type of care, when needed, at an affordable price.

The U.S. health care system is grounded in expensive, high-tech acute care that does not produce the desired health outcomes we ought to have and want and too often damages instead of heals. Despite spending more per person on health care than any other nation, the United States performs worse than other nations on most indicators of quality, efficiency, access, and other organizational performance measures (Papanicolas, Woskie, & Jha, 2018; Schneider, et al., 2017), and preventable medical errors are estimated to be the third leading cause of death in the country (Makary & Daniel, 2016). The nation also ranks at the bottom on certain health outcomes, including life expectancy at birth for both men and women, infant mortality rate, mortality rates for suicide and cardiovascular disease, and the prevalence of diabetes and obesity in children (National Research Council, 2013).

THE AFFORDABLE CARE ACT

The ACA included elements to change this picture by focusing on creating more value in health care, improving care coordination, expanding access to coverage or health insurance, and reforming how we pay for care. Fig. 1.1 illustrates these four cornerstones. The ACA aimed to move the health care system in the direction of keeping people out of hospitals, in their own homes and communities, with an emphasis on wellness, health promotion, and better management of chronic illnesses. In addition, it included provisions to hold hospitals and other health care organizations accountable for both their spending and outcomes.

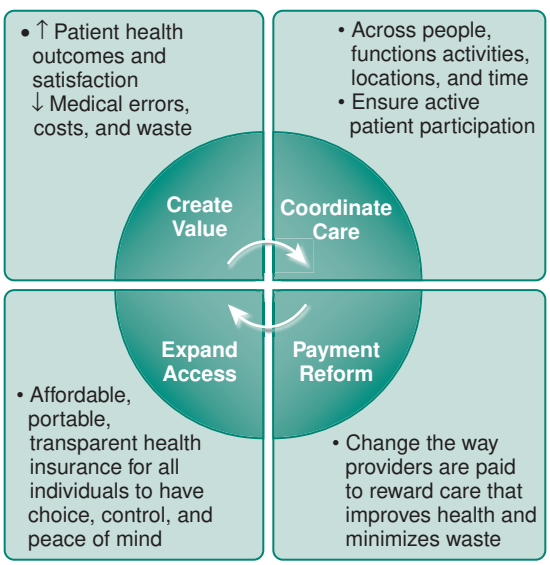

Fig. 1.1 Four cornerstones of reform. (From O'Grady, E. T., & Johnson, J. [2013]. Health policy issues in changing environments. In A. Hamric, C. Hanson, D. Way, & E. O'Grady [Eds.], *Advanced practice nursing: An integrative approach* [5th ed.]. St. Louis, MO: Elsevier Saunders.)

The ACA is arguably the most significant piece of social legislation passed in the United States since the enactment of Medicare and Medicaid in 1965 (see Chapter 18 for a detailed discussion of the ACA). Implementation continues to be a vexing process that requires tweaking, much as the Social Security Act did when it was passed in 1965 (Social Security Administration, n.d.). But the ACA became a political flashpoint, defining the ideologies of U.S. political parties. Democrats committed to the law but called for refining it, whereas Republicans overtook the House of Representatives in 2012 with calls for "repealing and replacing Obamacare." The public remained largely uninformed and misinformed about the legislation; 3 years after its passage, 4 out of 10 Americans were still unaware of many of its provisions and unsure that the ACA had become law (KFF, 2013). When the Trump Administration began to use executive orders to scale back and reverse regulations for implementing the ACA, the public became confused about whether the ACA and Obamacare were the same thing. Most of those who now had health coverage under the ACA wanted to keep their insurance but did not realize that this was Obamacare (Dropp & Nyhan, 2017). Confusion is likely to continue as attacks on the ACA persist. In 2018 a federal court in Texas ruled that the ACA was unconstitutional, a decision that was reviewed by the Fifth Circuit Court of Appeals and may go to the Supreme Court. In 2019, the U.S. Department of Justice said that it would support the Texas court's decision, despite the department's usual practice of defending federal laws.

UPSTREAM FACTORS: SOCIAL DETERMINANTS OF HEALTH

Promoting health requires more than a high-performing health care system (Tilden et al., 2018). First and foremost, health is created where people live, love, work, learn, worship, and play. It is becoming clear that one's health status may be more dependent on one's zip code than on one's genetic code (Graham, 2016). Geographic analyses of race and ethnicity, income, and health status repeatedly show that financial, racial, and ethnic inequities persist (Marmot & Allen, 2014). There are multiple ways in which exposure to structural racism has been shown to harm the physical, social, and economic health of individuals, families, and communities (Bailey et al., 2017). More so, the health of individuals and families is severely compromised in communities where good education, nutritious foods, safe places to exercise, and well-paying jobs are scarce (Artiga & Hinton, 2018). Creating a healthier nation requires that we address "upstream factors"—the broad range of issues, other than health care, that can undermine or promote health—also known as "social determinants of health" (World Health Organization [WHO], n.d.). Upstream factors promoting health include safe environments, adequate housing, economically thriving communities with employment opportunities, access to affordable and healthful foods, and models for addressing conflict through dialogue rather than violence (Fig. 1.2). The

Economic stability	Neighborhood and physical environment	Education	Food	Community and social context	Health care system
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code/ geography				

Health outcomes
Mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations

Fig. 1.2 Social determinants of health. (From Artiga, S., & Hinton, E. [2018]. *Beyond health care: The role of social determinants in promoting health and health equity. Henry J Kaiser Family Foundation.* Retrieved from www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.)

key to reducing and eliminating health disparities, which disproportionately affect racial and ethnic minorities, is to provide effective interventions that address upstream factors both from within and outside of health care systems.

There is growing recognition that even the health care system has to change its model from one that is strictly biomedical to one that recognizes that health is in large part determined by psychosocial factors (Adler et al., 2016). How does someone with diabetes successfully manage their condition if they are homeless, without refrigeration for insulin or access to healthy food or safe parks for physical activity? A focus on such factors is essential for economic and moral reasons. Even in the most affluent nations, those living in poverty have substantially shorter life expectancies and experience more illness than those who are wealthy, resulting in high costs in human and financial terms (Khullar & Chokshi, 2018). However, most of the focus on reducing disparities, including socioeconomic ones, has been on health policy that addresses access, coverage, cost, and quality of care once the individual has entered the health care system—despite the fact that most health care problems begin long before people seek medical care (Williams et al., 2008). Thus changing our nation's poor performance on health care and the health of its people requires knowledge about the political aspects of the social determinates of health. Political aspects of the social determinants of health appear in Box 1.1.

The ACA began to carve out a role for the health care system in addressing upstream factors. For example, the law requires that nonprofit hospitals do more to demonstrate a "community benefit" to maintain their federal tax breaks than they have had to do in the past. Hospitals must conduct a community health assessment, develop a community health improvement plan, and partner with others to implement it. This aligns with a growing emphasis on population health: the health of a group, whether defined by a common disease or health problem or by geographic or demographic characteristics (Felt-Lisk & Higgins, 2011). This focus on the health of populations within their respective communities is key for all health care organizations.

To improve the health of the U.S. population *and* reduce health care costs, we must build in to the health care system better ways to address social determinants of health and to enhance health promotion and wellness, disease prevention, and chronic care management—all essential components of primary care (Wagner, 1998; Starfield, 1998; Rowe et al., 2016). Nurses are critical to this shift from disease care to preventing illnesses, promoting health, and coordinating health care. A 2017 report by the Josiah Macy, Jr. Foundation called for a more robust, primary care system, one that builds its capacity by using registered nurses—and not just advanced practice registered nurses (APRNs)—as care team leaders who practice at the top of their education and training, with a responsibility for these foci (Bodenheimer & Mason, 2017).

For decades, nurses have led changes in health promotion and health care delivery but without naming or measuring their activities. However, there are notable exceptions to this invisibility. The American Academy of Nursing's *Raise the Voice Campaign* (American Academy of Nursing, n.d.) has identified nurses who have developed innovative models of care for which there are good clinical and financial outcome data. Known as "Edge Runners," these nurses have demonstrated that nursing's emphasis on care coordination, health promotion, patient- and family-centeredness, and the community context of care provides evidence-based models that can help to transform the

BOX 1.1 Political Aspects of the Social Determinants of Health

- The health of individuals and populations is determined significantly by social factors.
- The social determinants of health produce great inequities in health within and between societies.
- The poor and disadvantaged experience worse health than the rich, have less access to care, and die younger in all societies.
- The social determinants of health can be measured and described.
- The measurement of the social determinants provides evidence that can serve as the basis for political action.
- Evidence is generated and used in a continuous cycle of evidence production, policy development, implementation, and evaluation.
- Evidence of the effects of policies and programs on inequities can be measured and can provide data on the effectiveness of interventions.
- Evidence regarding the social determinants of health is insufficient to bring about change on its own; political will combined with evidence offers the most powerful strategy to address the negative effects of the social determinants.

Adapted from National Institute for Health and Clinical Excellence. (2007). *The social determinants of health: Developing an evidence base for political action. Final report to the World Health Organization Commission on the Social Determinants of Health.* Lead authors: J. Mackenbach, M. Exworthy, J. Popay, P. Tugwell, V. Robinson, S. Simpson, T. Narayan, L. Myer, T. Houweling, L. Jadue, and F. Florenza.

health care system (Mason, Jones, Roy, Sullivan, & Wood, 2015). Many also address social determinants of health (Martsolf, Sloan, Villarruel, Sullivan, & Mason, 2018). Some of these models of care were included as programs to scale up under the ACA: transitional care, the Living Independent for Elders; home visitation programs for high-risk pregnant women (Nurse-Family Partnership); and nurse-managed health centers (NMHCs).

Consider the 11th Street Family Health Services, a federally qualified NMHC located in an underserved neighborhood in North Philadelphia. Public health nurse Patricia Gerrity, a faculty member at Drexel University School of Nursing and founder of 11th Street, recognized that the leading health problems in this community were diabetes, obesity, heart failure, and depression. Working with a community advisory group, Gerrity focused on addressing access to nutrition as an "upstream factor" to improve the health of those living in the community. With no supermarket in the neighborhood until 2011, she invited area farmers to the neighborhood to provide a farmers' market, created a community vegetable garden maintained by the local youth, and invited area residents to attend nutrition classes on culturally relevant, healthy cooking. Subsequently under the leadership of nurse Roberta Waite and endowed as the Stephen and Sandra Sheller 11th Street Family Health Services, it is leading the way as one of more than 200 NMHCs in the United States that have improved clinical and financial outcomes by addressing the needs of individuals, families, and communities (American Academy of Nursing, n.d., b; Martsolf, Sloan, Mason, Sullivan, & Villarruel, 2017). Although the ACA authorized continued support for NMHCs, the law did not mandate funding and Congress did not appropriate funding for them (see Chapter 31 for a more detailed discussion of NMHCs and primary care.)

The ACA did not go far enough in shifting attention from acute care to promoting the health of communities and populations. Another approach to this shift is that of "health in all policies," the idea that policymakers consider the health implications of social and economic policies that focus on other sectors, such as education, community development, tax codes, and housing (Rudolph et al., 2013). As health professionals who focus on the family and community context of the patients they serve, nurses can raise questions about the potential health impact of public policies in every environment in which they work.

The Quadruple Aim

In 2008, Don Berwick and his colleagues at the Institute for Healthcare Improvement (IHI) first described the *Triple Aim* of a value-based health care system (Berwick, Nolan, & Whittington, 2008): (1) improving population health, (2) improving the patient experience of care, and (3) reducing per capita costs. This framework aligned with the ACA and later was modified to be the Quadruple Aim to include the dimension of clinician and staff satisfaction in recognition that "care of the patient requires care of the provider" (Bodenheimer & Sinsky, 2014).

The Quadruple Aim represents a balanced approach: by examining a health care delivery problem from all four dimensions, health care organizations and society can identify system problems and direct resources to activities that can have the greatest impact. Looking at each of these dimensions in isolation prevents organizations from discovering how a new objective—for instance, decreasing readmission rates to improve quality and reduce costs—could negatively impact the aim of population health, as scarce community resources are directed to acute care transitions and unintentionally shifted away from prevention activities. Solutions must also be evaluated from these four interdependent dimensions. The Quadruple Aim compels delivery systems and payers to broaden their focus on acute and highly specialized care toward more integrated care, including primary and preventive care (McCarthy & Klein, 2010).

The IHI (n.d.) identified these components of any approach seeking to achieve the Triple Aim:

- a focus on individuals and families
- a redesign of primary care services
- population health management
- a cost-control platform
- system integration and execution

Note that these address the goal of creating a high-performing health care system but do not focus on geographic communities or social determinants per se. However, these two concepts can be incorporated into the Quadruple Aim of improving the health of populations and reducing health care costs (Billioux, Verlander, Anthrony, & Alley, 2017).

The success of the nursing profession's continued evolution will hinge on its ability to address the Quadruple Aim by taking on new roles, more creatively engaging with patients, and stepping into executive and leadership roles in every sector of heath care, society, and government. Nurses must do this work from an interprofessional context, leading efforts to break down health professions' silos and hierarchies and keeping the patient and family at the center of care.

NURSING AND HEALTH AND SOCIAL POLICY

Health policy affects every nurse's daily practice. Indeed, health policy determines who gets what type of health care, when, how, from whom, and at what cost. The study of health policy is an indispensable component of

professional development in nursing, whether it is undertaken to advance a healthier society, promote a safer health care system, or support nursing's ability to care for people with equity and skill. Just as Florence Nightingale understood that health policy held the key to improving the health of the poor and the military, so are today's nurses needed to create compelling cases and actively influence better health policies at every level of governance—as Congresswoman Lauren Underwood understood. With national attention focused on how to transform health care in ways that produce better outcomes and reduce health care costs, nursing has an unprecedented opportunity to provide proactive and visionary leadership. But will we do so?

A 2018 study found that nurses were cited as sources in only 2% of health news stories and never in stories on policy (Mason et al., 2018). In a companion study, health journalists attributed this invisibility, in part, to nurses' reluctance to respond to requests for interviews, nursing journals' failure to promote the important research they publish, and nursing associations being largely invisible to newsrooms (Mason, Glickstein, & Westphaln, 2018). However, the journalists pointed out that they, their newsrooms, and the public relations staff in health care organizations and universities are biased about women, nurses, and positions of authority in health care. As the largest health care profession and one that remains comprised predominantly of women, nursing has great potential power but faces social barriers that persist amid societal inaccuracies about nurses' expertise and roles. The #MeToo movement may help to make such biases visible and help to ameliorate them, but nurses have to be proactive in changing them.

The Institute of Medicine's (IOM, now National Academy of Medicine) landmark report, *The Future of Nursing: Leading Change, Advancing Health* (2011), noted that nurses are essential for transforming health and health care in the nation. The report called for nurses to be leaders in redesigning health care and to be at all decision-making tables on health and health care. An interim evaluation of progress made on the report's recommendations found evidence of progress but noted that more attention needed to be given to developing nurses' leadership skills (National Academies of Science, Engineering, and Medicine, 2016). This is certainly the case in the policy arena, although the examples of nurse leaders in policy that we have cited provide encouragement and role models for us all.

POLICY AND THE POLICY PROCESS

What do we mean by policy? *Policy* has been defined as the authoritative decisions made in the legislative, executive, or judicial branches of government intended to influence the actions, behaviors, or decisions of citizens (Longest, 2010). However, that definition limits its application to sectors outside of government. For example, health care organizations set policy that affects employees, patients, and even surrounding communities (e.g., by closing a neighborhood clinic or buying property for hospital expansion). Thus a broader definition of *policy* is "a relatively stable, purposive course of action or inaction followed by an actor or set of actors in dealing with a problem or matter of concern" (Anderson, 2015, p. 6).

Public policy is policy crafted by governments. When the intent of a public policy is to influence health or health care, it is a *health policy*. *Social policies* identify courses of action to deal with social problems. All are made within a dynamic environment and a complex policymaking process. *Private policies* are those made by nongovernmental entities, whether health care organizations, insurers, or others. Indeed, there is growing recognition that policies set by health care organizations and insurers, for example, can limit APRN practice even in states that have removed laws requiring physician supervision or collaboration. A hospital can limit what registered nurses and APRNs do as long as the organization does not call for nurses to practice beyond the state's scope-of-practice policy.

Policies are crafted everywhere, from small towns to Capitol Hill. States use policies to specify requirements for health professions' licensure, to set criteria for Medicaid eligibility, and to require immunization for public university students, for example. Hospitals use policies to direct when visitors may visit patients, to manage staffing, and to respond to disasters. Public schools use state policies to specify who may administer medications to schoolchildren and what may be sold from a school vending machine. Towns, cities, and other municipalities use policies to manage public water, to define who may run for office, and to decide if residents may keep exotic pets.

In a capitalist economy such as that of the United States, private markets can control the production and consumption of goods and services, including health care. The government often "intervenes" with policies when private markets have failed to achieve desired public objectives. But when is it necessary for the government to intercede? Broadly speaking, in the current U.S. political system, the divide between liberal and conservative political parties is a fundamental disagreement about the degree to which government can and should solve problems (Kelly, 2004) in education, national security, the environment, and nearly every other aspect of public life (see Chapter 6 on Political Philosophy and Chapter 37 on Policy and Politics in Government). The American political landscape is

continuously shifting, as public mood shifts with new members of Congress being elected and senior members wanting to stay in office.

Longest (2010) describes two types of public policies the government develops:

- *Allocative policies* provide benefits to a distinct group of individuals or organizations, at the expense of others, to achieve a public objective (this is also referred to as the *redistribution of wealth*). The enactment of Medicare in 1965 was an allocative policy that provided health benefits to older adults using federal funds (largely from middle- and high-income taxpayers).
- *Regulatory policies* influence the actions, behavior, and decisions of individuals or groups to ensure that a public objective is met. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulates health care privacy or how individually identifiable health information is managed by users, as well as other aspects of health records.

Policymaking is an often-unpredictable dance that requires a high degree of political competence. Our system is based on continuous policy modification—incremental change is exceedingly more likely than revolutionary change. However, there are exceptions; once in a generation, a large social program is passed, such as Medicare and Medicaid in the 1960s and the ACA in 2010.

FORCES THAT SHAPE HEALTH AND SOCIAL POLICY

Some of the most prominent forces that shape health policy appear in Fig. 1.3.

Values

Values undergird proposed and adopted policies and influence all political and policymaking activities. Public policies reflect a society's values and also its conflicts in values. A policy reflects which values are given priority in a specific decision (Kraft & Furlong, 2017). Once framed, a policy reveals the underlying values that shaped it. Different people value different things, and when resources are finite, policy choices ultimately bring a disadvantage to some groups;

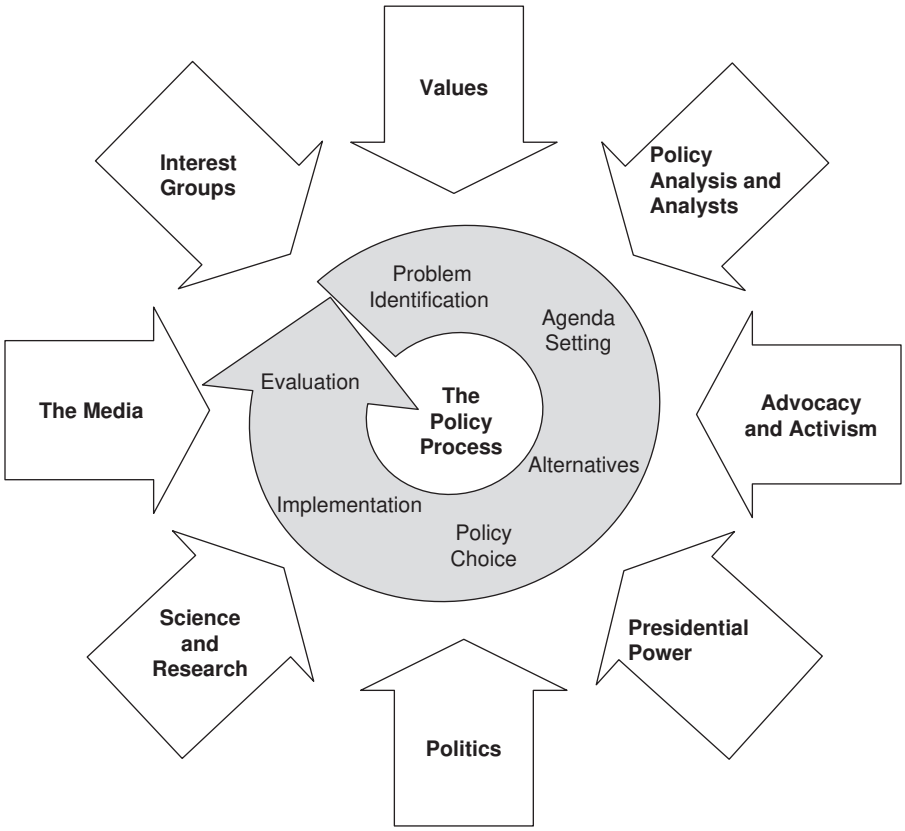

Fig. 1.3 The forces that shape policy.

some will gain something from the policy, and some will lose. To support or oppose a policy requires value judgments (Majone, 1992). Conflicts between values were apparent throughout the debates on the ACA. For example, despite a strong contingent of advocates for a government-run, nonprofit insurance option that would compete with private insurers, the insurance industry opposed it, as did others who saw it as an increase in government control, and it was not included in the law but continued to be discussed during the Democratic 2020 presidential campaign.

Politics

Politics is the use of relationships and power to gain ascendancy among competing stakeholders to influence policy and the allocation of scarce resources. Because inevitably there are competing interests for scarce resources, policymaking is done within a political context.

The definition of politics contains several important concepts. *Influencing* indicates that there are opportunities to shape the outcome of a process. *Allocation* means that decisions are being made about how to distribute resources. *Scarce* implies the limits to available resources and that all parties probably cannot have all they want. Finally, *resources* are usually considered to be financial but could also include human resources (personnel), time, or physical space such as offices.

Engaging in the political context of policymaking includes knowing the positions of key stakeholders and political parties, as well as the electoral process, public opinion, the influence of media coverage, and more (see Chapter 8 for a discussion of political analysis and strategies). Understanding politics is an invitation not to misuse power, people, or information but rather align the health of the public with the interest of the policymaker. For example, a congresswoman may have run her campaign focused on improving the economy. She may not have linked the rising obesity epidemic as a threat to the larger macroeconomy and American productivity. Nurses are able to link obesity to the economy by describing the catastrophic direct and indirect costs of the obesity epidemic and how it is making the United States less competitive in a global market. This is a way for nurses to use their power to create more urgency about the most pressing public health issues.

Science and Research

The information age has created an emphasis on evidence-based practice and policies, but we seem to be in danger of living in a world that eschews evidence. Scientific findings play a powerful role in the first step of the policy process: getting attention to particular problems and moving them to the policy agenda. Research can also be valuable in defining the size and scope of a problem and substantiating policy recommendations. This can help to obtain support for a proposed policy and in lobbying for support of it. Evidence should be used to inform policy debates and shape policy choices to help ensure that the solution will be effective.

The role of evidence in the policymaking process cannot be overstated, and it is not enough to determine if policies are supportive or punitive—it is necessary to understand policies in context. In other words, in some circumstances, policies may be supported by good evidence such as screening for alcohol and tobacco use during pregnancy, which could potentially mitigate poor outcomes; however, unintended consequences can result if not informed by context (Subbaraman et al., 2018). Pregnant people delay prenatal care if they believe screening for alcohol and tobacco will result in criminalization of themselves or loss of their children (Roberts et al., 2012). Thus it is important that both policies and their implementation be informed by rigorous evidence.

That said, evidence is essential but may not be sufficient to advance policies. As Haskins and Margolis (2014) note, when policy is made, politics and values often surpass rigorous, well-collected data, as well as dominate the conversations about what is considered evidence. This has been apparent in recent debates over two long-standing policy issues: climate change and childhood vaccinations. Despite evidence showing that humans are contributing to devastating changes in the earth's climate or that childhood vaccinations do not cause autism, debates about these issues continue to affect whether policies are or are not adopted to address the problems.

Policy Analysis and Analysts

Analysis is the examination of an object or a process to understand it better. Policy analysis uses various methods to assess a problem and determine possible solutions. This encourages deliberate critical thinking about the causes of problems, identifies the ways a government or other groups could respond, evaluates alternatives, and determines the most desirable policy choice (see Chapter 7 on The Policy Process). Policy analysts are individuals who, with professional training and experience, analyze problems and weigh potential solutions. Citizens can also use policy analysis to better understand a problem, alternatives, and potential implications of policy choices (Kraft & Furlong, 2017).

Advocacy and Activism

Patient advocacy has long been a central role for nurses. Nurses bring their expertise as advocates to a larger scale by working in policy and politics. Nursing's Social Policy Statement (American Nurses Association [ANA], 2010), a

document that defines nursing and its social contract, endorses advocacy through policy as a professional responsibility. Political activism may be associated with protests but has grown to include additional diverse and effective strategies such as blogging, arguing evidence to support policy choices, and garnering media attention in sophisticated ways. See Chapter 3 for more on advocacy.

Interest Groups and Lobbyists

Interest groups advocate for policies that are advantageous to their membership (see Chapter 66 on interest groups and Chapter 40 on lobbying). Groups often employ lobbyists to advocate on their behalf and their power cannot be underestimated. The Center for Responsive Politics tracks spending on campaigns and lobbying by individuals and organizations (www.opensecrets.org). Data from the center shows that, in 2018, $2.59 billion was spent lobbying in the United States, down from a high of $3.51 billion in 2010; and there were 11,272 registered lobbyists, down from a high of 14,826 in 2007. Of all industry sectors, health care ranked first in spending on lobbying, at $421.5 million. For organizations representing the health professions, the National Council of State Boards of Nursing spent more on lobbying than any other nursing organization ($555,000) in 2018 but ranked 30th overall. The ANA ranked fourth among nursing organizations ($333,676), although it spent $1.6 million in 2017. The American Medical Association spent more than $15 million in 2018 and ranked first among all health professions organizations.

The Media

The power of media is demonstrated in political and issue campaigns, whether through paid political advertisements or the "talking heads" on "news" programs that present polarized views. The aim is to deliver messages that resonate with the values and emotions of a target audience to support or oppose a candidate or proposed policy. The strategic use of media is imperative in today's cacophony of information. Gaining the attention of a target audience is power. Persuading that audience to behave the way you want is ultimate power.

In this information age, nurses must proactively use media to influence policy and make themselves available to speak with journalists about policy matters. However, as noted earlier, nurses have not always been eager to enter the media spotlight (see Chapter 12 on using media as a policy and political tool), particularly when it comes to talking with journalists. Social media is a tool for influencing policymakers and provides nurses with an opportunity to control their message.

The Power of Presidents and Other Leaders

The president embodies the power of the executive branch of government and is the only person elected to represent the entire nation within the federal government. As the most visible government official, the role of the president is able to propel issues to the top of the nation's policy agenda. Although the president and White House staff cannot introduce legislation, they can set policy agendas for Congress, working through the congressional representatives of their political party, as well as provide draft legislation and legislative guidance. Whether the president's legislative policy priorities are at the top of the congressional agenda will depend on whether the president's political party holds the majority of seats in Congress. The president can also issue executive orders when they do not have congressional support for policy change.

Theoretically, the three branches of government serve as a check-and-balance system to ensure the principles of democracy are upheld and that the interests of the citizens in the republic are equitably represented. For health policy, the role and power of the office of the president and the executive branch of the U.S. government cannot be overstated in terms of setting the tone, providing the vision, and engaging the public in determining effective health policies that ensure that all individuals can function as full citizens in society.

THE FRAMEWORK FOR ACTION

Nursing has a covenant with the public. The profession's practice laws, standards, and ethics have roots in its history of activism for social justice. A social contract with society demands professional responsibility. Thus every nurse must continuously consider the policy context of our daily practice in any setting. The solutions to today's most intractable health care problems, including perverse payment mechanisms, deeply disturbing social injustice, and shocking ethnic and racial disparities, are not simple to solve. However, according to the annual Gallup poll (Brenan, 2018), the public regards nurses' "honesty and ethical standards" more highly than those of any other profession. This public trust places a moral imperative on nurses to vigorously engage in influencing policy. Nurses work where policies are implemented; we see policies close up wherever we care for their patients and can actively work to change the unintended consequences we witness. This imperative requires us to expand our involvement in policy decisions at the institutional, community, state, federal, or international realm and is not restricted to any one setting.

The Framework for Action (Fig. 1.4) illustrates that nurses operate in four spheres: government, workplace,

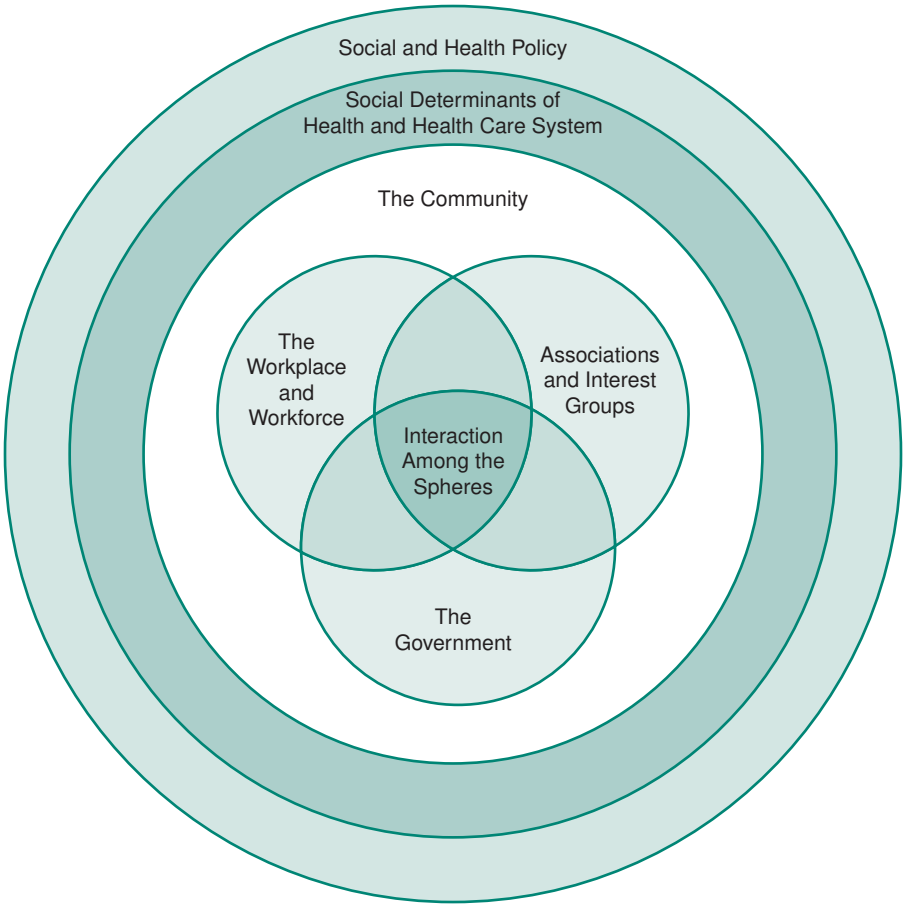

Fig. 1.4 A framework: Spheres of influence for action. Nurses need to work in multiple spheres of influence to shape health and social policy. Policies are designed to remedy problems in the health system and to address social determinants of health; both of which aim to improve health.

interest groups (including professional organizations), and community to influence policies that affect health and health care and core/social determinants of health. The focus in all spheres is on health, to represent that optimal health is viewed as the goal of nursing's policy efforts. Optimal health (whether for the individual patient, family, a population, or community) is the central focus of the political and policy activity described in this book. This focus makes it clear that the ultimate goal for advancing nursing's interests must be to promote the public's health.

Nursing embraces a broad definition of health that aligns with WHO (1948): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." It incorporates the concept of positive health, not just ill health. This definition requires a focus on social determinants of health and creating communities that thrive economically, have safe environments, and use resources to ensure that their members have access to good nutrition and other elements that can promote health.

The four spheres of influence provide a visual medium for understanding the policy arena but are not discrete silos. Policy can be shaped in more than one sphere at a time, and action in one sphere can influence others. For example, to achieve greater access to care for the uninsured, nurses may work in their own organization to alter policy to increase access to services. They may also use political strategies in the media, such as blogging or being interviewed on television, to express their support for better access to care. They may work with a professional

association or an interest group to communicate their views to policymakers. Additional context (the who, what, where, when, and why of nursing's policy influence) is provided in Fig. 1.5.

The Government

Government action and policy affect lives from birth until death. It funds prenatal care, inspects food, controls the safety of toys and cars, operates schools, builds highways, and regulates what is transmitted on airwaves. It provides for the common defense; supplies fire and police protection; and gives financial assistance to the poor, aged, and others who cannot maintain a minimal standard of living. The government responds to disaster, subsidizes agriculture, and licenses funeral homes.

Although most U.S. health care is provided in the private sector, much is paid for and regulated by the government. So, how the government crafts health policy is extremely important (Weissert & Weissert, 2019). Government plays a significant role in influencing nursing and nursing practice. States determine the scope of professional activities considered to be nursing, with notable exceptions of the military, veterans' administration, and Indian health service. Federal and state governments determine who is eligible for care under specific benefit programs and who can be reimbursed for providing care. Sometimes government provides leadership in defining problems for both the public and private sectors to address. There are more than a dozen House and Senate committees and subcommittees that shape policy on health, and many more committees address social problems that affect health. In the House of Representatives, the Congressional Nursing Caucus, an informal, bipartisan group of legislators who have declared their interest in helping nurses, lobbies for federal funding for nursing education.

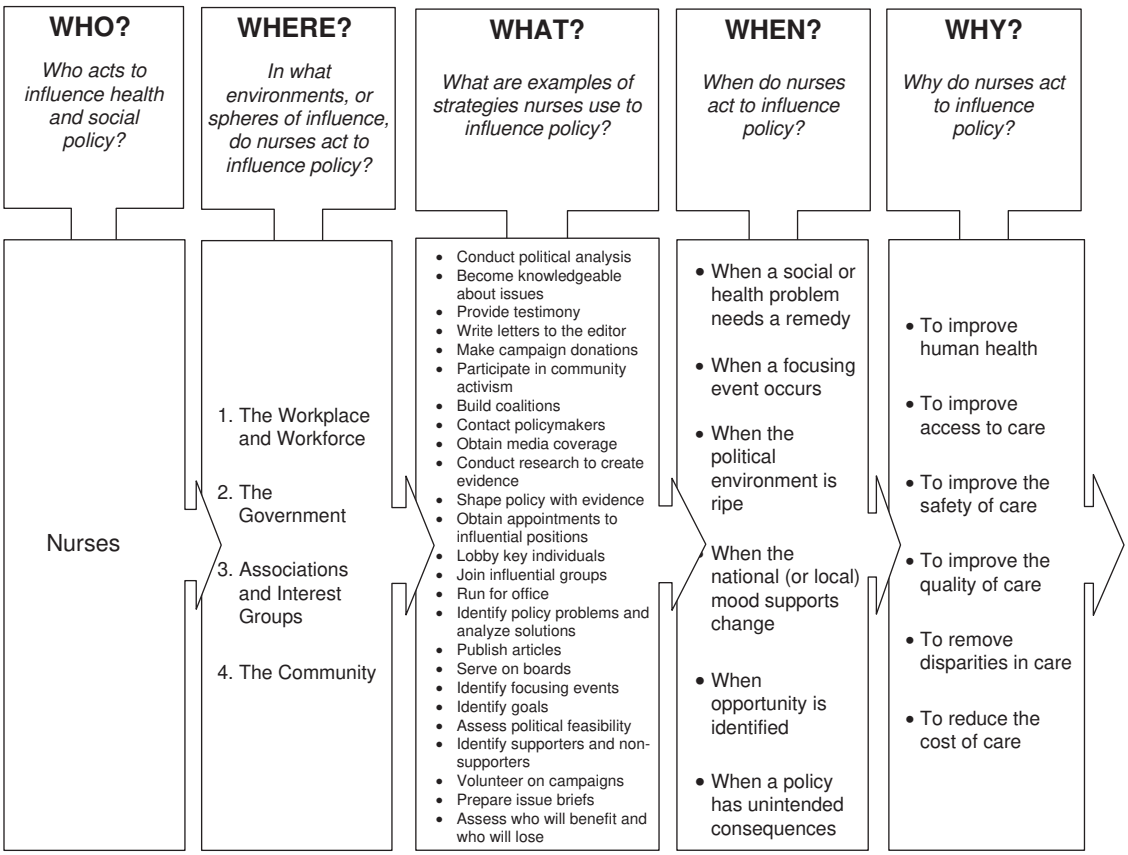

Fig. 1.5 The who, what, where, when, and why of nursing's policy influence.

Abraham Lincoln's description of a "government of the people, by the people, for the people" (Lincoln, 1863) captures the intricate nature of the relationship of government and its people. There are many ways nurses can influence policymaking in the government sphere at local, state, and federal levels of government. Examples include:

- Obtaining appointment to influential government positions
- Serving in federal, state, and local agencies
- Serving as elected officials
- Working as paid lobbyists
- Communicating positions to policymakers
- Providing testimony at government hearings
- Participating in grassroots efforts, such as rallies, to draw attention to problems

The Workforce and Workplace

Nurses work in a variety of settings: hospitals, clinics, schools, private sector firms, government agencies, military services, research centers, nursing homes, and home health agencies. All of these environments are political ones; resources are finite, and nurses must work in each to influence the allocation of organizational resources. Policies guide many activities in the health care workplaces where nurses are employed. Many that affect nursing and patient care are internal organizational policies such as staffing policies, clinical procedures, and patient care guidelines. External policies are operative in the health care workplace also; for example, state laws regulating nursing licensure. Federal laws and regulations are evident in the nursing workplace such as Occupational Health and Safety Administration regulations regarding worker protection from bloodborne pathogens.

Policy influences the size and composition of the nursing workforce. The ACA authorized increased funding for scholarships and loans for nursing education, potentially augmenting existing workforce programs funded under Title VII and Title VIII of the Public Health Service Act. The nongovernmental Commission on Graduates of Foreign Nursing Schools is authorized by the federal government to protect the public by ensuring that nurses and other health care professionals educated outside the United States are eligible and qualified to meet U.S. licensure, immigration, and other practice requirements (Commission on Graduates of Foreign Nursing Schools, 2009). The National Council of State Boards of Nursing is a not-for-profit organization that brings together state boards of nursing to act on matters of common interest affecting the public's health, safety, and welfare, including the development of licensing examinations in nursing (National Council of State Boards of Nursing, 2009). These are just a few examples of the external forces that shape workforce and workplace policy.

Associations and Interest Groups

Professional nursing associations have played a significant role in influencing practice. Many associations have legislative or policy committees that advocate policies supporting their members' practice and advance the interests of their patient populations. Working with a group increases the effectiveness of advocacy, provides for the sharing of resources, and enhances networking and learning. In fact, these associations can be excellent training grounds for novice nurses to learn about policy and political action (see Chapter 4).

When nursing organizations join forces through coalitions, their influence can be multiplied. For example, the Nurses on Boards Coalition (www.nursesonboardscoalition.org) is a group of national nursing organizations, schools of nursing, health care organizations, and other strategic partners to work on *The Future of Nursing* report's recommendation to increase nurse appointments to commissions, task forces, boards, and other entities. See Chapter 49 for more on the Coalition.

Nurses can be influential, not just in nursing associations, but by working with other interest groups such as the American Public Health Association or the Sierra Club. Some interest groups have a broad portfolio of policy interests, whereas others focus on one disease (e.g., National Breast Cancer Coalition) or one issue (e.g., driving while intoxicated, the primary focus of Mothers Against Drunk Driving). Interest groups have become powerful players in policy debates; those with large funding streams are able to shape public opinion with media advertisements.

The Community

A limited number of nurses will have the opportunity to influence policy at the highest levels of government, but extensive opportunities exist for nurses to influence health and social policy in communities. Nursing has a rich history of community activism with remarkable examples provided by leaders such as Lillian Wald, Harriet Tubman, and Ruth Lubic. This legacy continues today with the community advocacy efforts of nurses such as Lucia Alfano, Gina Miranda-Diaz, Danielle Pendergrass, and one of this book's editors (McLemore) who were designated by the Campaign for Action as "Breakthrough Leaders in Nursing" (see Chapters 78, 29, and 13 for the stories of Alfano, Miranda-Diaz, and McLemore). Others stories throughout this book highlight the leadership of nurses in their communities (for example, see Chapters 75 and 76).

A community is a group of people who share something in common and interact with one another, who may exhibit a commitment to one another or share a geographic boundary (see Chapter 73). A community may be

a neighborhood, a city, an online group with a common interest, or a faith-based network. Nurses can be influential in communities by identifying problems, strategizing with others, mobilizing support, and advocating change. In residential communities (such as towns, villages, and urban districts), there are opportunities to serve in positions that influence policy, whether planning boards, civic organizations, and parent-teacher associations, or other group.

POLICY AND POLITICAL COMPETENCE

Competence is being adequately prepared or qualified to perform a specific role. It encompasses a combination of knowledge, skills, and behaviors that improve performance. Nurses are often reluctant to become involved in policy because of the "politics." Political skill has a bad reputation; for some, it conjures up thoughts of manipulation, self-interested behavior, and favoritism. Although "playing politics" is not generally considered to be a compliment, true political skill is critical in health care leadership, advocating for others, and shaping policy. It is simply not possible to succeed in any decision-making arena by ignoring the political realm. Ferris, Davidson, and Perrewe (2010) consider political skill to be the ability to understand others and to use that knowledge to influence others to act in a way that supports one's objectives. They identify political skill in four components:

1. *Social astuteness:* Skill at being attuned to others and social situations; ability to interpret one's own behaviors and the behavior of others.
2. *Interpersonal influence:* Convincing personal style that influences others featuring the ability to adapt behavior to situations and be pleasant and productive to work with.
3. *Networking ability:* The ability to develop diverse networks of people and position oneself to create and take advantage of opportunities.
4. *Apparent sincerity:* The display of high levels of integrity, authenticity, sincerity, and genuineness (pp. 9–12).

In most cases, policymakers are generalists who make decisions on a broad range of issues. Nurses can have a profound impact on policymaking by using their knowledge to frame and define health policy alternatives. Influencing policy at all levels requires a strong set of interpersonal skills, integrity, and knowledge. Political competency, at either the individual or the organizational level, can be defined by three main elements: deep knowledge, political antennae, and power (O'Grady & Johnson, 2013) (Fig. 1.6).

- *Deep knowledge* requires freely sharing expertise and gaining the knowledge you need from others. Subject-matter expertise without knowledge of policy and its processes is a doomed strategy. Deep knowledge involves knowing the viewpoints of others, including the opposition, and having a clear message and data ready to support your position and neutralize opposition.
- *Political antennae* means the ability to scan the environment and identify opportunities to offer solutions to policy problems. These problems should focus not just on nursing but on broader health and health care issues. Having political antennae requires active listening to

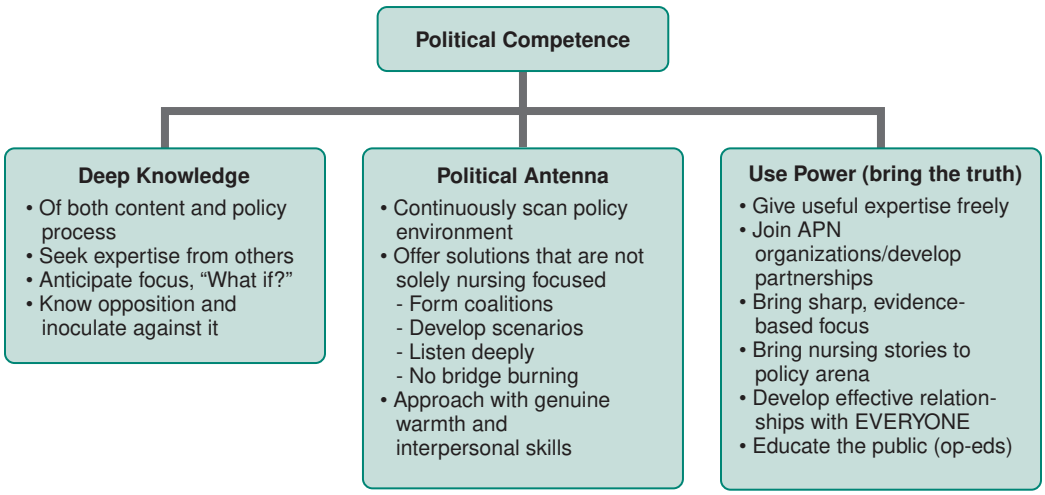

Fig. 1.6 Political competencies. *APN*, Advanced practice nursing. (From O'Grady, E. T., & Johnson, J. [2013]. Health policy issues in changing environments. In A. Hamric, C. Hanson, D. Way, & E. O'Grady [Eds.], *Advanced practice nursing: An integrative approach* [5th ed.]. St. Louis, MO: Elsevier Saunders.)

understand policymaker's values and motives, and compose messages and responses to fit their political objectives. It also requires avoiding bridge-burning in relationships. Political and policy disagreements require a response of genuine warmth, a quality that can go a long way in building trust. Learning how to navigate differences and agreeing to disagree without being disagreeable are important political skills.

- *Power* is the ability to act to achieve a goal. In the policy process, this means recognizing the policymakers with power, who is on which congressional committee, and who are the thought-leaders in the community. Creating coalitions with individuals and groups with similar goals is an important way nurses can augment their policymaking power. Most importantly, an individual nurse can claim power by being knowledgeable, articulate, and having an "elevator speech" that can spark interest in a policymaker or staff member.

Application of power requires raising one's awareness about what is true and what is false. Being grounded in truth, such as knowing the value of human caring and the role that nursing can have on individuals and populations, is a form of personal integrity that leads to power. To be effective in the policy arena, nurses must have a sharp focus on the evidence, not emotion. Advancing nursing's policy agenda through such a use of power demands that we drop nursing parochialism and focus on problem solving. Nursing *parochialism* is when a nurse is in a problem-solving context (policy meeting) and offers up only the solution of "nurses" as the remedy to every problem. Parochialism is an approach that narrows options and interests and appears self-serving. However, bringing nurses' stories to the policy arena is a powerful way to pair the human story to the scientific evidence.

NURSING ESSENTIALS

To ensure policy competency, the American Association of Colleges of Nursing (AACN) publishes the necessary curriculum content and expected competencies of all nursing school graduates from baccalaureate, master's, doctor of nursing practice, and research doctorate (PhD) programs they credential. These documents serve as a framework for 21st century nursing practice in care of individuals, families, communities, and populations. The content builds on nursing knowledge, theory, and research, from a wide array of fields and professions.

A study by Byrd and colleagues (2012) found that undergraduate nursing students are largely unaware of the importance of political activity for nurses. After participating in a robust and active public policy learning activity, students measured high on a political astuteness scale. This study suggests that political skills can be learned when presented with relevance to nursing and used to hone skills such as inquiry, critical thinking, and complex problem solving. These results highlight the importance of increasing students' awareness of how to participate in the political process, as well as encouraging their participation in student and professional organizations.

For each level of nursing education—bachelors, master's, and doctorate (DNP and PhD)—there are clear expectations that nursing graduates will have policy competency (AACN, n.d.; 2010). It is expected that DNP graduates are able to design, implement, and advocate health policies that improve the health of populations. In addition, a DNP graduate integrates these practice experiences with two additional skill sets: the ability to analyze the policy process and the ability to engage in politically competent action (AACN, 2006).

CONCLUSION

Corralling the political power of the 4 million registered nurses in the United States (ANA, 2018) can occur when individual nurses join, support, and fully engage with their professional nursing organizations. More than any other effort to date, *The Future of Nursing* report (IOM, 2011) brought nurses together to engage across associations and educational institutions and, with new community partners, to change policy such as state laws and regulations that limit full practice authority for APRNs. Many of the recommendations direct policy changes resonant with nurses and a new *The Future of Nursing 2030* report by the National Academy of Medicine promises to broaden the recommendations to incorporate how nurses can build a culture of health in our communities and our nation.

Nurses who effectively use power are a sought-after and valued asset. They are invited to the table and are not only asked back but invited to more tables with ever-expanding influence. This requires a great degree of knowledge, along with humility, a problem-solving attitude, and a patient-centered lens. Such activities and attitudes strengthen an individual's interpersonal power and integrity, which can inspire others. Together, we can improve health care and the health of our communities, locally and globally.

DISCUSSION QUESTIONS

1. What are the most pressing health care problems you see in your community? How can you frame that issue in a health policy context?
2. Can you identify areas in your own political competence that require growth? What do you need to learn to be more effective?

3. Why has nursing made policy and political competence such a strong part of the nursing curriculum and role development?

REFERENCES

Adler, N., Cutler, D., Fielding, J.E., Galea, S., Glymour, M.M., Koh, H.K., & Satcher, D. (2016). *Addressing social determinants of health and health disparities: A vital direction for health and health care.* NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. Retrieved from https://nam.edu/wp-content/uploads/2016/09/Addressing-Social-Determinants-of-Health-and-Health-Disparities.pdf.

American Academy of Nursing. (n.d., a). *Raise the voice.* Retrieved from www.aannet.org/raisethevoice.

American Academy of Nursing. (n.d., b). *Edge runners: The eleventh street family health service.* Retrieved from www.aannet.org/edge-runners–eleventh-street-family-health-services.

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice.* Retrieved from www.aacn.nche.edu/publications/position/DNPEssentials.pdf.

American Association of Colleges of Nursing [AACN]. (2010). *The research-focused doctoral program in nursing: Pathways to excellence.* Retrieved from www.aacnnursing.org/Portals/42/Publications/PhDPosition.pdf.

American Association of Colleges of Nursing [AACN]. (n.d.). *Essentials.* Retrieved from www.aacnnursing.org/Education-Resources/AACN-Essentials.

American Nurses Association [ANA]. (2010). *Nursing's social policy statement: The essence of the profession.* (3rd ed.) Washington, DC: American Nurses Association.

American Nurses Association. (2018). *About ANA*. Retrieved from www.nursingworld.org/ana/about-ana/.

Anderson, J. E. (2015). *Public policymaking* (8th ed.). Farmington Hills, MI: Cengage Learning.

Artiga, S. & Hinton, E. (2018). *Beyond health care: The role of social determinants in promoting health and health equity.* Retrieved from www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, *389*(10077), 1453-1463.

Berwick, D., Nolan, T., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. *Health Affairs, 27*(3), 759–769. Retrieved from content.healthaffairs.org/content/27/3/759.full.

Billioux, A., Verlander, K., Anthrony, S., & Alley, D. (2017). *Discussion paper: Standardized screening for health-related needs in clinical settings: The Accountable Health Communities Screening Tool.* National Academy of Medicine. Retrieved from https://nam.edu/standardized-screening-for-health-related-social-needs-in-clinical-settings-the-accountable-health-communities-screening-tool.

Bodenheimer, T. & Mason, D.J. (2017). *Registered nurses: Partners in transforming primary care: Proceedings of a conference on preparing registered nurses for enhanced roles in primary care.* New York: Josiah Macy, Jr. Foundation. Retrieved from http://macyfoundation.org/docs/macy_pubs/Macy_Monograph_Nurses_2016_webPDF.pdf.

Bodenheimer, T. & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*(6), 573-576. Retrieved from www.annfammed.org/content/12/6/573.full.

Brenan, M. (2018). *Nurses again outpace other professions for honesty, ethics.* Retrieved from https://news.gallup.com/poll/245597/nurses-again-outpace-professions-honesty-ethics.aspx.

Byrd, M.E., Costello, J., Gremel, K., Schwager, J., Blanchette, L., & Malloy, T.E. (2012). Political astuteness of baccalaureate nursing students following an active learning experience in health policy. *Public Health Nursing, 29*(5), 433–443.

Commission on Graduates of Foreign Nursing Schools. (2009). *Commission on graduates of foreign nursing schools: Mission and history.* Retrieved from www.cgfns.org.

Dropp, K., & Nyhan, B. (2017). *One third don't know that Obamacare is the ACA.* Retrieved from www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html.

Felt-Lisk, S., & Higgins, T. (2011). *Exploring the promise of population health management programs to improve health: Mathematica policy research issue brief.* Retrieved from www.mathematica-mpr.com/publications/PDFs/health/PHM_brief.pdf.

Ferris, G., Davidson, S., & Perrewe, P. (2010). *Political skill at work: Impact on work effectiveness.* Boston, MA: Nicholas Brealey Publishing.

Haskins, R., & Margolis, G. (2014). *Show me the evidence: Obama's fight for rigor and results in social policy*. Washington, DC: Brookings Institution Press.

Institute for Healthcare Improvement. (n.d.). *The Triple Aim: IHI Triple Aim initiative.* Retrieved from www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press. Retrieved from www.iom.edu/nursing.

Kaiser Family Foundation. (2018). *Key facts about the uninsured population.* Retrieved from www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

Kaiser Family Foundation [KFF]. (2013). *Kaiser health tracking poll: August 2013.* Retrieved from kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-august-2013.

Kelly, N. (2004). Does politics really matter? Policy and government's equalizing influence in the United States. *American Politics Research, 32*(3), 264–284.

Khullar, D., & Chokshi, D.A. (2018). Health, income, & poverty: Where we are and what could help. *Health Affairs.* Retrieved from www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/.

Kraft, M., & Furlong, S. (2017). *Public policy: Politics, analysis, and alternatives* (6th ed.). Washington, DC: CQ Press.

Lincoln, A. (1863). *Gettysburg Address.* Retrieved from www.ourdocuments.gov/doc.php?flash=old&doc=36.

Longest, B. (2010). *Health policymaking in the United States* (5th ed.). Chicago, IL: Health Administration Press.

Majone, G. (1992). *Evidence, argument, and persuasion in the policy process.* New Haven, CT: Yale University Press.

Makary, M. & Daniels, M. (2016). Medical error—The third leading cause of death in the U.S. *British Medical Journal,* 353, i2139. Retrieved from www.bmj.com/content/353/bmj.i2139.

Marmot, M. & Allen, J. (2014). Social determinants of health equity. *American Journal of Public Health,* 104(Suppl 4), S517-S519.

Martsolf, G., Sloan, J., Mason, D.J., Sullivan, C., & Villarruel, A. (2017). *RAND Report: Nurse-designed models of care and culture of health: Three case studies.* Santa Monica, CA: RAND Corporation.

Martsolf, G., Sloan, J., Villarruel, A., Sullivan, C., & Mason, D.J. (2018). Promoting a culture of health through cross-sector collaborations. *Health Promotion Practice*, *19*(5), 784-791.

Mason, D.J., Jones, D., Roy, C., Sullivan, C., & Wood, L. (2015). Commonalities of nurse-designed models of health care. *Nursing Outlook, 63*(2015), 540-553.

Mason, D.J., Glickstein, B., & Westphaln, K. (2018). Journalists' experiences with using nurses as sources in health news stories. *American Journal of Nursing, 118*(10), 42-50.

Mason, D.J., Nixon, L., Glickstein, B. Han, S., Westphaln, K., & Carter, L. (2018). The Woodhull study revisited: Nurses' representation in health news media twenty years later. *Journal of Nursing Scholarship, 50*(6), 695-704.

McCarthy, D., & Klein, S. (2010). *The Triple Aim journey: Improving population health and patients' experience of care, while reducing costs.* Retrieved from www.commonwealthfund.org/Publications/Case-Studies/2010/Jul/Triple-Aim-Improving-Population-Health.aspx.

National Academies of Sciences, Engineering, and Medicine. (2016). *Assessing progress on the Institute of Medicine report: The future of nursing.* Washington, DC: The National Academies Press. Retrieved from www.nap.edu/download/21838.

National Council of State Boards of Nursing. (2009). *National Council of State Boards of Nursing—About NCSBN*. Retrieved from www.ncsbn.org/about.htm.

National Research Council. (2013). *U.S. health in international perspective: Shorter lives, poorer health.* Retrieved from www.nap.edu/catalog.php?record_id=13497.

O'Grady, E.T., & Johnson, J. (2013). Health policy issues in changing environments. In A. Hamric, C. Hanson, D. Way, & E. O'Grady (Eds.), *Advanced practice nursing: An integrative approach* (5th ed.). St. Louis, MO: Elsevier Saunders.

Papanicolas, I., Woskie, L.R., & Jha, A.K. (2018). Health care spending in the United States and other high-income countries. *JAMA.* 319(10), 1024-1039.

Roberts, S. & Nuru-Jeter, A. (2012). Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *Journal of Behavioral Health Services Research,* 39(1):3-16.

Rowe, J., Rizzo, V., Kricke, G.S., Krajci, K., Rodriguez-Morales, G., Newman, M., & Golden, R. (2016). The ambulatory integration of the Medical and Social (AIMS) model: A retrospective evaluation. *Social Work in Health Care, 55*(5), 347-361.

Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in all policies: A guide for state and local governments.* Retrieved from www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf.

Schneider, E.C., Sarnak, D.O., Squires, D., Shah, A., & Doty, M.M. (2017). *Mirror, mirror: International comparisons reflect flaws and opportunities for better U.S. health care.* Retrieved from https://interactives.commonwealthfund.org/2017/july/mirror-mirror/.

Social Security Administration. (n.d.). *Legislative history*. Retrieved from www.ssa.gov/history/law.html.

Starfield, B. (1998). *Primary care: Balancing health needs, services, and technology*. New York: Oxford University Press.

Subbaraman, M.S., Thomas, S., Treffers, R., Delucchi, K., Kerr, W.C., Martinez, P., & Roberts, S. (2018). Associations between state-level policies regarding alcohol use among pregnant women, adverse birth outcomes, and prenatal care utilization: Results from 1972 to 2013 Vital Statistics. *Alcoholism: Clinical and Experimental Research.* [Epub ahead of print].

Tilden, V., Cox, K., Moore, J., & Naylor, M. (2018). Strategic partnerships to address adverse social determinants of health: Redefining health care. *Nursing Outlook,* 66(3), 233–236.

Wagner, E.H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice, 1*(1), 2–4.

Weissert, C., & Weissert, W. (2019). *Governing health—The politics of health policy* (5th ed.). Baltimore, MD: Johns Hopkins University Press.

Williams, D.R., Costa, M.V., Odunlami, A.O., & Mohammed, S.A. (2008). Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *Journal of Public Health Management and Practice, 14*(Suppl.), S8–S17.

World Health Organization. (1948). *Preamble to the Constitution of the World Health Organization*. Retrieved from www.who.int/about/definition/en/print.html.

World Health Organization. (n.d.). *Social determinants of health.* Retrieved from www.who.int/social_determinants/en/.

2

Historical Perspective on Policy, Politics, and Nursing

Patricia D'Antonio, Julie Fairman, and Sandra B. Lewenson

"Reform can be accomplished only when attitudes are changed."

Lillian Wald

In 1893, Lillian Wald, then a young medical student, visits the sick mother of a poor and vulnerable New York City family. What she sees—a young mother struggling to recover in a ramshackle tenement, with little access to fresh air and healthy food—and what she does—leaving medical school and returning to nursing because she believed nurses could have a greater impact—changes her life (Wald, 1915). She and her nursing school colleague, Mary Brewster, establish the Henry Street Settlement House in New York City's lower east side. Like many reformers in the late 19th century, Wald and Brewster believed that only by living in impoverished, immigrant communities could they effect meaningful change in the city's housing, sanitation, nutrition, and educational policies. However, Wald takes her vision one step further. She establishes the Visiting Nurse Service at the Henry Street Settlement (D'Antonio, 2010). At a time when the best in health care centered on the home, she decides that those most vulnerable would have the best in nursing care when ill at home and they would also have the best in health promotion and disease prevention; these families would learn from visiting nurses how to keep themselves healthy in the face of the infectious diseases rampant at the time. In addition, these visiting nurses would respond to calls from the families in the community just as she would respond to the calls from physicians. Turning her vision into a reality took hard work and strategic partnerships with insurance companies, donors, schools, and the New York City's Department of Health. However, she prevails—and changes the structure of the U.S. health care system. What come to be known as public health nurses remain central to developing programs addressing public health efforts to promote health and prevent disease. Wald's skill lay in her ability to harness the support of those in power.

Recognizing the strength of coalitions to enact change, Wald, along with her colleagues at the settlement house and other nurse leaders, participated in the establishment of the National Organization of Public Health Nursing in 1912, creating an organization to control the standards and practice of public health nurses. She created coalitions, such as that with the American Red Cross, when concerned about the need for access of care in rural communities (Lewenson, 2015), and she knew how to procure the financial resources from private foundations and donors to support many of her public health initiatives. Her success lay in creating coalitions that first identified problems, then found the right resources, and effected successful solutions by making the issues ones that the public "owns."

Why should anyone care about one story about one famous nurse? Because the issues that Wald and her colleagues set out to address remain central to the current debates about how to get the best in health care to vulnerable and dispossessed individuals, families, communities, and populations. Rates of infectious diseases are again climbing in the United States and across the globe, adding to the increasingly recognized and growing burden of noninfectious diseases. Even though its fate is uncertain at the time of this writing and it was an imperfect vehicle, major policy initiatives such as the Affordable Care Act (ACA) promised and did increase access to health care, improved quality, and attempted to contain costs by shifting the focus from acute care hospitals to homes, communities, and primary care sites. The ACA privileged health promotion and disease prevention in ways unprecedented since the early 1920s, but as is wont to happen, politics, rather than evidence, reshaped the debate after the 2016 election. Remembering Wald's story shows that nurses have been, and

will continue to be, active participants in health policy debates from the home to the national level and in turning ideas into reality but that their actions will always be part and process of the political system.

Stories create the foundation upon which policies move forward or fail, but the reason for exploring the intersections of history and health policy transcends simply knowing stories. Examining points at these intersections allows for a richer understanding of the possibilities and the problems that resonate in health policy deliberations. The distance of time as one studies change over time, the core of historical methods, allows a different view of the tensions existing between public and private spheres of influence, community needs and professional prerogatives, best evidence, and political power. This chapter uses historical case studies, looking to the past to find themes, ideas, and actions that can provide tools for considering future policy deliberations and actions.

"NOT ENOUGH TO BE A MESSENGER"

Buoyed by the success of public health initiatives like Wald's, public health officials returned from rebuilding post–World War I Europe to implement a bold new vision in the United States. The turn toward health care, in addition to illness care, was one of the hallmark characteristics of the "new public health" of the 1920s. If the prewar public health agenda of reformers like Wald focused on the ill individual and environment, then the postwar agenda would focus on the individual alone and how that individual could experience even greater health through the practices of personal hygiene, mental hygiene, and social hygiene. Its centerpiece was the "periodic medical examination"—now being urged for women as well as children. Public health leadership was well aware that cancer and degenerative heart disease were emerging as leading causes of death, and they urged nurses to preach to patients to demand, and physicians to provide, examinations that would detect susceptibility to these diseases or identify them when there were still treatment options. They also recognized that routine prenatal examinations that identified and treated medical problems offered the best hope of decreasing appallingly high rates of maternal mortality and launched campaigns that urged mothers and fathers to see pregnancy as akin to a disease and not as a normal phenomenon (D'Antonio, 2014). The problem lay in convincing the public.

In New York City, the focus of this section and the epicenter of both the public health and nursing worlds, public health leadership in the city turned to nurses to deliver this message. This decision seemed self-evident. Public health nurses had long considered themselves and had been considered by others as the "connecting link" between patients and physicians, between and among institutions, and between scientific knowledge and its implementation in the homes they visited. They became the centerpiece of the city's "demonstration projects," an envisioned mix of different types of public and private partnerships that would test ways of delivering this message that were carefully coordinated for efficiencies, cost-effectiveness, and high quality.

Public health nursing leaders in New York City believed that the turn toward health, particularly that of mothers and young children, would define their professional identity and disciplinary independence to a broader community. Health work with mothers and young children had been part of their traditional practices; and, as men were more likely to have periodic medical examinations associated with the purchase of life insurance policies and employment, women and young children seemed particularly vulnerable. In 1921, with funds from an anonymous donor, a small group of White New York City public health nurses, some also involved in the demonstration projects, launched The Citizen's Health Protective Society in the middle-class Manhattanville section of the city. This would be a self-sustaining insurance program that promised prenatal care for mothers, attendance at a medically supervised childbirth if delivered at home, and nine visits for all mothers in the postpartum period. It also promised health supervision of babies and preschool children and bedside nursing if sick at home. Do you want, it queried in handouts to families in Manhattanville, a carefully selected White, middle-class community, a self-supporting nursing and health service for $6 per year for an individual and $16 per year for families of three or more? Manhattanville did not. The Society moved to a more promising location at 134 Street and Amsterdam Avenue. This community remained uninterested as well. The Society closed in 1924. Families appreciated health work, but they would pay only for illness care. They would not pay for nursing health care (Maternity Center Association, 1924).

Public health nurses in the city's demonstration projects had more success. These nurses, similar to progressive urban colleagues throughout the country, went one step farther than their health education mandate. They used their experiences in the demonstration projects to move to identifying families as their practice domain. They built knowledge that bridged the biologic sciences that supported their public health practices with the new social sciences that buttressed their work with families. However, this practice brought them out of bounded disciplinary interests and into a place at the center of not only their own but also others' agendas. Foundations, families, physicians, and other public health workers all had particular ideas

about what nurses should and could do as they delivered their messages of health.

This placed the demonstration project nurses squarely in the middle of escalating tensions among New York City's Department of Health, the private agencies who delivered home health care, and the Rockefeller Foundation and Milbank Memorial Fund who provided the financing, over who controlled the public health agenda. The private or (as they referred to themselves) voluntary agencies and philanthropies publicly ceded control to the official agency that the Departments of Health represented, but privately they constantly sought ways to turn the Department of Health toward their priorities. In New York City, both the private agencies and Rockefeller Foundation and the Milbank Memorial Fund believed public health nurses were key to this process. Indeed, the involvement of the city's public health nurses in the demonstration projects operating in the East Harlem section of the city had been a central element in the Rockefeller Foundation's support. It could not be a true demonstration of care control, the Foundation believed, unless it involved the city's own public health nurses who ran clean milk and infant welfare stations and who implemented programs of case finding, case holding, and case control of tuberculosis and other infectious diseases. In addition, it could not be a true maternal-child nursing service without the support of the city's school nurses who worked with those older than 6 years. The Foundation's policy, in the United States and abroad, was one of working only through governmental public health authorities to ensure the sustainability of its initiatives. It hoped to use a consolidated private and public health nursing system in East Harlem to ultimately do the same in New York City (D'Antonio, 2014).

However, the public health nursing leaders of the city's demonstration projects never persuaded the various heads of the New York City's Department of Health to let its nurses join any of their projects. The Department of Health maintained that its nurses were official agents of the city with real police power that it hoped they would rarely use; it needed to maintain control of their practices. The Department of Health had its own agenda for its nurses. It wanted to position them as representatives of a new public health message clothed in tact and sympathy rather than, as in the past, the bearer of quarantine placards and sanitary citations.

More importantly, the nurses involved in the health demonstration projects had shared no investment with their supporting philanthropies in involving the city's own public health nurses. Because, in the end, they won what they themselves wanted. By the end of the formal demonstration period in 1928, both private and public health nurses in New York City—not the physicians who had done so in the past—supervised the independent practices of other public health nurses. This was a substantive achievement. Public health nurses employed by New York City finally gained control of their own nursing practices.

At the same time, nurses in the demonstration projects thrived in their missions of service to mothers and young children and of research on the most pressing issues in public health nursing. It launched a program that continued a long-standing nursing mission to provide bedside nursing to sick residents in their own homes. It also strengthened its outreach to pregnant women, encouraging medically supervised births preferably in hospitals and providing both prenatal and postpartum care in homes. It started new health education services for preschool children. It also began sustained research projects about the organization of public health nursing work, particularly that situating generalized nursing as the standard for urban public health nursing. In addition, in 1928, in response to the needs of the discipline for more advanced clinical education, it recast itself as a postgraduate training site for public health nursing students in New York, from around the nation and from international sites of Rockefeller Foundation philanthropy (D'Antonio, 2013).

New York City's health demonstration projects eventually established what are currently the norms for primary, pregnancy, dental, and pediatric care. However, this change came almost painfully slowly through the day-to-day work of public health nurses going door to door, street to street, school to school, and neighborhood to neighborhood preaching the gospel of good health to those without access to the resources that class, race, ethnicity, and financial stability provided to others. As importantly, however, it came through the efforts of families to first incorporate and then to normalize these messages of health by removing them from stigmatizing sites of health and social welfare (in which the public health nurses were located) and placing them within the schools that the community embraced. The nurses in New York City's health demonstration projects slowly moved from understanding their role as bringing "medicine and a message" of middle-class values to immigrant families they wished to assimilate, to conceiving it as one of being "more than just a messenger" as they sought to serve as embodiments of a new emphasis on sound mental and physical health. Support for public health nursing did decline in the 1930s as nurses painfully realized that it was "not enough to be a messenger," but the decline was less about no longer serving families who needed to assimilate, as other historians have suggested. The decline was as much about families taking responsibility for their health (D'Antonio, 2014).

New York City's public health nurses were also working in a context increasingly dominated by the rise in hospitals

and their outpatient clinics where families increasingly sought health care. However, the nurses in New York City's demonstration projects paid little attention to warnings about the implications of these new clinical sites for public health practice. They steadfastly maintained the site of their practices to that place where it could be most effectively and independently exercised: with cooperative families in their own homes, in the clinics the nurses controlled, and in the classrooms they created. Despite their commitment to maternal-child health initiatives, this narrow focus allowed them to professionally ignore one of the most pressing public health issues in the city—and indeed the United States—in the early 1930s: the newly rising rates of maternal mortality attributed by both the New York Academy of Medicine and the Maternity Center Association to poor obstetric practices in hospitals that women were increasingly choosing as sites of their infants' births. These nurses could not see or take responsibility for solving problems that lay inside public health policies but outside of their defined disciplinary purviews and sites of practice (D'Antonio, 2014).

BRINGING TOGETHER THE PAST FOR THE PRESENT: WHAT WE LEARNED FROM HISTORY

Generations later, a different group of constituents gathered to consider a new agenda for nursing in the 21st century that would situate patient care, rather than professional self-interest, at the forefront. In 2009 the Robert Wood Johnson Foundation (RWJF) in collaboration with the then Institute of Medicine (IOM) (currently the National Academy of Medicine) commissioned a new study charged with developing recommendations for reconceptualizing nursing practice and education (see Chapter 71). The committee appointed by the IOM was indicative of the changing health care political landscape and reflected the multiple stakeholders and thought leaders who were or would be partners with nurses to improve patient care. The committee was very diverse in age, profession, political leanings, and race/ethnicity and included consumer representation. The 6 nurses on the 18-member committee all came from diverse backgrounds and served as a contrast to the dominance of White women in the profession seen in the demonstration projects and public health leadership of the 1920s and 1930s. The pivotal role of foundations had changed: they now shared influence with multiple stakeholders such as the federal government, pharmaceutical corporations, consumer groups, and the insurance industry. These groups were now critical players in shaping the scope of nursing practice. In ways unthinkable in the 1920s and 1930s, consumers of nursing care played pivotal roles.

The final report, *The Future of Nursing: Leading Change, Advancing Health*, and its recommendations reflected the diversity of the committee and the stakeholders as well as the political landscape of health reform being debated as the committee deliberated (IOM, 2011). The report and the actions taken since, particularly by the Campaign for Action (https://campaignforaction.org), an initiative of the AARP and the RWJF, have provided the foundation for policy change through the development of state action coalitions and nationally based coalitions such as Nurses on Boards (https://campaignforaction.org/issue/promoting-nursing-leadership/). This national and state-based call for action, rather than the small demonstration projects of the early 20th century, may also reflect the changing role of philanthropies, as well as the power of new media to shape the policy message.

The first recommendation that nurses should practice to the fullest extent of their knowledge and skills links the story of the New York public health nurses to the nurses of the present. The conceptualization of the role of the public health nurses with families and communities, as well as their aims and efforts to fully incorporate their skills and knowledge into their practice, reflects historic continuities of nursing practice over the past century. This continuity resonated strongly with the public, professional organizations, and federal and state governments. Since the report was issued, nine states have removed practice barriers to allow nurse practitioners to practice independently and numerous other states are expanding their practice acts (https://campaignforaction.org). At the national level, retail clinics, health care service sites in drug stores, and big box stores typically staffed with nurse practitioners are growing in number and popularity, and nurse-managed health centers are recognized by many health systems as a practice model that can provide access to high-value care for people with limited resources (Brooks Carthon et al., 2016; Fairman et al., 2011). In general, policymakers and the public still see nurses—but now nurse practitioners rather than, as in the past, public health nurses—as a viable and valuable policy solution to the current primary care provider shortage and misdistribution. However, this recognition does not always translate to policy change.

Health policy researcher Debra Stone notes that there is no strict dichotomy between reason and power and between policy and politics (Stone, 2001). The IOM's *The Future of Nursing* report placed nurses at the center of a perfect storm of these forces and reflected the political, economic, and social context that propelled both professional and public interests (IOM, 2011). The report recommendations were also strategically shaped to position the patient as the focus of care within a reformed health system,

and the history of both public health nurses and nurse practitioners is a reminder of the importance of public need when public disciplinary interests are articulated. History is also a reminder that sometimes small, piecemeal changes or events can be the springboard for larger policy issues at the right time and place.

When thinking about the policy levers that drive our health care system, we can look to history as a way of providing perspective and for pulling apart the power dynamics that drive policymaking. Our examples demonstrate how the IOM report placed nurse practitioners, just as the Public Health Department and the Rockefeller Foundation situated the earlier public health nurses, as policy solutions for improving the health care of the nation at a particular time and place. Our histories show that policymaking is untidy; we want it to be rational, but "reasoned analysis is necessarily political. It always involves choices to include things and exclude others and to view the world in a particular way when other visions are possible" (Stone, 2001, p. 378). The public health nurses of the 1920s and 1930s were perhaps not as facile at understanding this reality or not as skilled at thriving within an environment when the political alliances were flexible and shifting, but they did adjust. These are important lessons to learn and remember. Currently, as we try to reformulate our health care system to be more accessible, efficient, and inclusive, policymakers are making choices about providers and services. Nurse practitioners are part of policy solutions as seen through the norming of retail clinics and nurse-managed health centers. However, they need to remember that strategic alliances shift, that new stakeholders emerge, and that future policy decisions may not always be rational, but they will always be political. New political stakeholders, as we have seen since the 2016 election, will have the power to reshape health care according to their own alliances. Nurses will have to necessarily develop strategies to be part of the process in a very different policy environment. How nurses and their organizations are able to influence and challenge new directions will have a critical impact on the health of individuals, families, and communities.

There are both historical continuities and differences in the stories of public health nurses of the 1920s and 1930s and the growing appeal of nurse practitioners nowadays to policymakers and stakeholders. The ability to build coalitions and partnerships is as critical nowadays as it was in the 1920s and 1930s. In the early 1960s, when nurse Loretta Ford and physician Henry Silver serendipitously found they shared common interests of providing better care to rural poor families, they knew physician manpower was unavailable and that the nurse with additional skills and knowledge could provide the needed level of care. The United States was suffering from a primary care shortage similar to the current shortage. Although they published their model early, they were not alone in coming to these conclusions. Nurse Barbara Resnick and physician Charles Lewis in Kansas City in the mid-1960s were also situating nurses as the solution to patient dissatisfaction with the lack of continuity of care in their university outpatient clinics. Although models like these were part of larger changes occurring where physicians were in short supply or nurses initiated their own practices, individual and sporadic efforts such as these were not enough to drive changes in policy even when analytic reasoning indicated their effectiveness. Nurse practitioners lacked a unified coalition to move their interest forward (e.g., to change restrictive state practice regulations and payment structures), and they lacked interested groups and partners outside of nursing to help broaden their appeal. Although individual physicians were supportive, organized medicine was not (Fairman, 2011).

Having data is important, as the public health nurses understood, but, as Stone (2001) also argued, politics may trump data. Data supporting the value and quality of nurse practitioner services began appearing in the early 1970s. A meta-analysis of 1970s-era studies of nurse practitioner effectiveness done by the Congressional Office of Technology Assessment documented their effectiveness in 1984. Although powerful in its scope and innovation, this study did not stimulate the interests of lawmakers at the state and federal levels, who could have used the data to develop a reasoned policy analysis. Although professional nursing did have lobbyists working on professional issues, the organizations were more focused on workplace issues than broader policies and were not mature or flexible enough to work together as a larger, powerful group until the late 1970s. Organized medicine was indeed "organized" and had powerful lobbies and leadership that kept its message simple and consistent and one that would be replayed for decades. The message was that physicians were the only safe providers because of their longer and more intensive education; yet, their position actually lacked data. This message, particularly from the American Medical Association, continues.

Another lesson learned from the public health nurse narrative that resonates nowadays is the importance of the creation of bridges between the community and the health system. In the late 1970s, professional nursing organizations such as the American Nurses Association (ANA) seized a strategic opportunity to reformulate their policy agenda. Building on the growing body of studies that indicated high patient satisfaction and clinical effectiveness of nurse practitioners as providers, and a growing strategic and political movement that situated the patient as the focus of professional legitimacy, the ANA built policy

positions that situated nurse practitioners as normative providers for groups of patients such as older adults, children, and healthy adults. A deceptively strong and influential patient movement was also beginning to support nurse practitioner–provided care. Although patient support was unorganized and lacked a single leader, patients across the country showed their appreciation by returning for follow-up visits and bringing in their family and neighbors. The ANA effectively built upon the momentum patients provided to begin to form coalitions and work more effectively with the nascent nurse practitioner organizations to generate more powerful policy positions and partnerships.

We also learn from history that sometimes coalitions are not enough to move the policy levers. Even as nurses built coalitions and patients became their advocates through the 1980s and 1990s, there were pieces missing. For example, medical organizations influential in the policy arena did not offer nurses large-scale support. Most physician organizations were not interested in partnerships and still held strong political capital at the state and national levels. Individual physicians certainly supported nurse practitioners in their own practices, but much of organized medicine did not see them as independent providers or partners.

Organized medicine could situate nurses in this way because it still had enormous political power and resources, but physicians' cultural authority has now been challenged. Fraud and payment scandals and the exposing of physicians' relationships with pharmaceutical companies generated public skepticism during a time of patient empowerment movements and civil and women's rights movements. As historians Beatrix Hoffman and Nancy Tomes (2011) noted, patients reinvented "new terms for themselves—consumers, clients, citizens, and survivors—in their search to be heard in the health care arena" (p. 2) and exercised greater control over their care. In their search, patients found nurse practitioners qualified and value-based providers, educated and willing to see the patient as the "source of control" as the IOM report *Crossing the Quality Chasm* posited (IOM, 2001).

The stories of nurse practitioners and public health nurses are also connected by the ability to thrive and continue negotiations within a slow and subtle policy process. Incremental change occurred in health policy at the turn of the 21st century, although this was not a naturally rational or progressive movement. One of the ways this transformation can be illustrated is by the shift in the language defining who could provide care and receive payment. Many stakeholders worked over decades to bring about these changes. These categories are politically constructed worldviews, bestowing advantages and disadvantages. The change in language signified the slowly occurring power shift and the power of professional nursing and its allies to renegotiate the boundaries of patient care. Federal legislation began to include the term "provider" instead of "physician," or the more inclusive phrase "physicians and nurses." Medicare recognized nurse practitioners as primary care providers, although the states still maintain their regulatory authority to allow or not allow full scope of practice.

Another lesson learned is that coalitions must be flexible and ready to change. As the power dynamics in health care started to shift, nurse practitioners gained new partners and support. Since the 1980s, the Federal Trade Commission produced advocacy letters declaring restrictive practice acts anticompetitive and against the interests of consumers. Their activity in this area accelerated in the first decade of the 21st century. The AARP, the largest consumer group in the world, had nurses in key leadership positions to steer the organization, which developed policy positions that supported nurse practitioners. As medicine was becoming more corporatized and less patient centric, the public began rating nurses as the most trusted health professional in Gallup polls, with the exception of 2001, when firefighters topped the list (Gallup, n.d.). Policymaker recognition of the high cost of physician education and the viability of nurse practitioners as a reasonable and faster option to provider supply growth was supported by reports by the Rand Health Foundation and the National Governors Association.

Even so, nurse practitioners have not always been part of the policy solutions, even when evidence of their contributions to the primary care shortage existed. The 2012 Graduate Nurse Education Demonstration Project (https://innovation.cms.gov/initiatives/gne/) funded by the Centers for Medicare and Medicaid Services illustrated the ability of the nursing schools involved to produce more primary care nurse practitioners if Title XVIII funds (which fund medical training only) were allocated to nurse practitioner training. Although the Demonstration Project was seen as a success, building more capacity in medical education continues to be the traditional policy strategy, even as it became harder and harder to attract physicians into primary care. Shifting alliances and priorities at the federal level will require deftness and political savvy the nursing profession must develop.

By the time the IOM's *The Future of Nursing* report was published in 2011, patient support, coalition building, and new partnerships had more effectively positioned nurse practitioners to be a consistent part of the policy process. Although the IOM report might have served as the spark, it was nested in both the policies and politics of the past century, as well as the context surrounding health

reform debates occurring in Congress. A litany of factors including rising health care costs, a shifting focus from specialty to primary care, and a shortage of primary care providers created a demand for new and more efficient models of care. Nurses gained willing and energetic partners in the public media and with the patients they served. A large private foundation, RWJF, leveraged its long-term interest in nursing to support the IOM report and will also support a follow-up study in 2020. Other new partners came forward; in particular, the Association of American Medical Colleges showed courage and strength by supporting nurse practitioners in press releases and policy statements. The nursing profession as a driver of policy change had come of age. It developed coalitions across nursing professional organizations that were focused on policy, and it developed new partnerships with powerful organizations outside of nursing that saw nursing's value while creating new opportunities and connections with nursing to both influence policymakers and drive policy change.

CONCLUSION

The two stories—about public health nurses shaping health outcomes of immigrant populations during the early 20th century and about the evolving policy support (via the IOM report) for nurse practitioners—show how health care policies and politics, perhaps even more than nurses' work, shape the delivery of care and the outcomes sought. An important lesson is that nurses are not a homogenous group. For the public health nurses, the day-to-day politics between and among professionals and the various private and public enterprises that offer health care options, especially to vulnerable populations, have typically directed their focus on more traditional methods of providing care rather than seeking nursing as part of the solution to the delivery of primary health care. Yet, the value public health nurses brought to community and population health argue for nurses to participate in policymaking and to advocate their inclusion in health care solutions. For nurse practitioners, history is a reminder of how they gained policy momentum amid the shifting weights of reasoning and power and with the growing power of consumer movements. New coalitions will have to be formed as political ideology changes. Learning to participate effectively while continuing to maintain the values of patient advocacy and equity in a reframed health care arena with shifting values and priorities will be a critical journey. Both stories illustrate how messy policymaking can be, how alliances can be tenuous while understanding the value of coalitions and partnerships as stabilizing agents in uncertain policy environments. History provides rich data that can help nurses to advocate the role this profession holds as part of a larger solution to improve health care in the United States.

DISCUSSION QUESTIONS

1. What types of alliances exist, and what types need to be cultivated to affect change in your own areas of nursing practice?
2. What are the problems and/or the possibilities in developing cross-disciplinary, as well as public and private, alliances to effect change?
3. What type of historical evidence can be used to support nursing's political advocacy in providing primary health care?
4. Explore the advocacy efforts Lillian Wald, public health nurses in urban and rural settings, and nurse practitioners used to effect change in health care.

REFERENCES

Brooks Carthon, M.J., Wiltse, K., Altares Sarik, D. & Fairman, J.A. Effective strategies for achieving scope of practice reform in Pennsylvania. *Policy, Politics and Nursing Practice, 17*(2), 99-102.

D'Antonio, P. (2010). *American nursing: A history of knowledge, authority and the meaning of work.* Baltimore, MD: Johns Hopkins University Press.

D'Antonio, P. (2013). Cultivating constituencies: The story of the East Harlem Nursing and Health Service, 1928–1941. *American Journal of Public Health, 103*(6), 988–996.

D'Antonio, P. (2014). Lessons learned: Nursing and health demonstration projects in New York City, 1920-1935. *Policy, Politics and Nursing Practice, 14*(3–4), 133–141.

Fairman, J. (2011). Patients and the rise of the nurse practitioner profession. In B. Hoffman, N. Tomes, R. Grob, & M. Schlesinger (Eds.), *Patients as policy actors* (pp. 215–230). New Brunswick, New Jersey: Rutgers University Press.

Fairman, J., Rowe, J., Hassmiller, S., & Shalala, D. (2011). Broadening the scope of nursing practice. *New England Journal of Medicine, 364*(3), 193–196.

Gallup. (n.d.). *Honesty/ethics in professions.* Retrieved from www.gallup.com/poll/1654/Honesty-Ethics-Professions.aspx.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health.* Washington, DC: The National Academies Press.

Lewenson, S.B. (2015). Town and country nursing: Community participation and nurse recruitment. In J. Kirchgessner & A. Keeling (Eds.), *Nursing rural America* (pp. 1–19). New York: Springer.

Maternity Center Association. (1924). Columbia University Health Sciences Center, Box 52, Folder 2.
Stone, D. (2001). *Policy paradox: The art of political decision making* (revised ed.). New York: Norton.
Tomes, N., & Hoffman, B. (2011). Introduction: Patients as policy actors. In B. Hoffman, N. Tomes, R. Grob, & M. Schlesinger (Eds.), *Patients as policy actors.* New Brunswick, NJ: Rutgers.
Wald, L. D. (1915). *The house on Henry Street.* New York: Henry Holt and Company.

ONLINE RESOURCES

American Association for the History of Nursing
www.aahn.org
The Future of Nursing: Campaign for Action
https://campaignforaction.org
Learning Historical Research
www.williamcronon.net/researching/
Nursing History and Health Care
www.nursing.upenn.edu/nhhc/Pages/Welcome.aspx

3

Advocacy in Nursing and Health Care

Susan Apold[a]

"Advocacy is a dish best served coordinated."

Suzanne Miyamoto, Nurses in Washington Internship speech, 2014

The word *advocacy* is defined as "the act or process of supporting a cause or proposal." It is derived from the Latin "advocatus," meaning "legal counselor." Labonte (1994) describes advocacy as influencing public policy. Within that context, it is the active support for causes, individuals, and groups, particularly those who are unable to voice arguments or positions on their own behalf.

Advocacy has not always been an explicit expectation of the professional nurse; however, the early writings of Nightingale reflected her commitment to health, healing, and acting in the best interests of patients. The rise of consumerism in the 1970s made explicit the role of the nurse as a patient advocate. Currently, the very definition of nursing in the 21st century addresses the role of the nurse as advocate (Table 3.1). This chapter will explore nurses' responsibility to advocate for policies that address access to health care, health promotion, disease prevention, and issues that affect health.

EVOLUTION OF NURSING'S ADVOCACY ROLE

Nurses have a long history of advocating on behalf of and alongside patients, families, and communities to promote health, equality, and justice. The nursing profession also has staunchly advocated for itself in an effort to provide patients with the essential work of nurses.

For example, Nightingale's advocacy is foundational to modern nursing practice. Her staunch devotion to human rights drove her advocacy for quality patient care, outcome-based interventions, respect for the relationship between the environment and the patient, and the role of education in preparing qualified women to provide patient care.

Dorothea Dix advocated for the dignity and care of patients suffering from psychiatric illness and advocated for humane treatment of the mentally ill. She influenced state and federal legislatures and helped to craft laws that protected the "insane" and "mentally disturbed." She petitioned Pope Pius IX to consider the plight of institutionalized people.

Beginning in the 1980s, Loretta Ford recognized the need for children to have quality primary care and identified nurses as a resource to provide access to such care. Ford is responsible for developing the role of the nurse practitioner (NP) and advocating that nurses practice to the full extent of their education and licenses.

Currently, the nurse's role as advocate is codified in the profession's definition and principles. Nursing belongs to society and exists because of an identified social need—the need for "careers" of health, wellness, and illness. The profession is charged by society for providing this service in every situation in which nursing is needed. For this reason, nurses have a professional and moral imperative to use their voices to present the unique and essential perspective of nursing at every forum where nursing and health care is discussed. *Nursing's Social Policy Statement: The Essence of the Profession* (American Nurses Association [ANA], 2010) outlines nursing's accountability to society and identifies nursing's leadership role in essential health-related issues. This leadership implies advocating for health as a human

[a]This chapter adapts some content developed by Chad Priest from the chapter on advocacy published in the prior edition of this book.

TABLE 3.1 Profession of Nursing's Imperative to Engage in Advocacy

Document	Exemplars of Language Regarding the Role of Nurses in Advocacy
Definition of Nursing	"Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, communities, and populations" (American Nurses Association [ANA], 2010).
ANA Code of Ethics	Provision 2: "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient" (ANA, 2015).
The Essentials of Baccalaureate Education for Professional Nursing Practice	"Baccalaureate Generalist nurses are providers of direct and indirect care. In this role, nurses are patient advocates and educators . . . Baccalaureate generalist nurses are members of the profession and in this role are advocates for the patient and the profession . . . . As advocates for high quality care for all patients, nurses are knowledgeable and active in the policy processes defining healthcare delivery and systems of care" (American Association of Colleges of Nursing [AACN], 2008, pp. 8 and 9).
The Essentials of Master's Education in Nursing	Standard VI: Health Policy and Advocacy: "Recognizes that the master's prepared nurse is able to intervene at the system level through the policy development process and to employ advocacy strategies to influence health and health care" (AACN, 2011, p. 5).
The Essentials of Doctoral Education for Advanced Nursing Practice	Standard V: Health Care Policy for Advocacy in Health Care: " . . . the DNP graduate is able to design, implement and advocate for health care policy that addresses issues of social justice and equity in health care" (AACN, 2006, p. 13).
International Council of Nurses (ICN) Code of Ethics for Nurses	"The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations . . . The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services" (ICN, 2012, p. 2).

right, providing for strategies to promote health and prevent disease, advocating for expansion of health care access, and identifying and delivering resources and strategies that will enable all members of society to access health care and be able to live healthy lives (ANA, 2010).

Advocacy is a prominent theme in myriad documents that govern and describe nursing practice and education (see Table 3.1). Nurses' role as advocates transcends the traditional bedside action and advocacy for an individual patient. It has expanded to influencing public and private sector policies that pertain to health, including advocating for what communities need to be healthy.

The role of the nurse as advocate has evolved over the years, from performing nursing functions adequately and safely to advocating for issues of social justice. It is a central tenet of nursing practice throughout the world (Hanks, 2013; Vaartio et al., 2006).

Early in the history of the profession, nurses advocated that the best interests of patients were served by supporting the actions and decisions of physicians and promoting confidence in the health care system—such as it was. Instructional books from the early period of the profession characterized the nurse as a warrior in the battle against disease and illness, glamorizing a life of "toil and discipline" in which nurses pledged loyalty to their physician leaders. Nurses were explicitly taught that loyalty to the physician equated with faithfulness to the patient (Priest, 2016; Winslow, 1984). The Florence Nightingale Pledge of 1893 included: "With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care" (Florence Nightingale

Pledge, n.d.). Patient advocacy was nursing's responsibility only in so far as that advocacy was promoted as loyalty to the physician and his decision making.

In 1929 a new graduate nurse, Lorenza Somera, was given an order by a surgeon to administer cocaine instead of *procaine* injections to a tonsillectomy patient (Priest, 2016; Winslow, 1984). Somera loyally carried out the physician's order, resulting in the death of the patient. Although it was clear that the physician had erred in ordering the incorrect medication, he was acquitted of all charges while Somera was found guilty of manslaughter for failing to question the orders of the physician. The Somera case sparked worldwide protests from nurses and served to push nursing toward independent practice and accountability. It was also one of many events that led to a reconceptualization of the dominant nursing metaphor from loyalty to physicians to advocacy for patients.

A contemporary public demonstration of a nurse advocating for her patient that led to policy change occurred in July, 2017, when registered nurse (RN) Alex Wubbles was arrested for refusing to allow police officers from drawing blood on a patient without the patient's consent. Wubbles' primary allegiance and responsibility was to the patient. Her false arrest resulted in a settlement of $500,000 with both the University and State of Utah. Wubbles will continue to advocate for patients because she will be donating half of that settlement to a campaign that will provide Utah citizens with free body camera footage of any encounter with the police. The law firm that represented Wubbles agreed to provide free legal services to support this initiative. As a result of this incident, in 2018, the University of Utah Medical Center revised its policies to continue to support the rights of its patients and nurses' responsibility to advocate for those rights (Stevens, 2017).

Professional advocacy involves nurses championing issues that support the profession (e.g., safe staffing, nurses' health, healthy work environments). *Issues advocacy* involves the role of the profession in championing social, economic, legal, and environmental factors that influence the health of the population. Nurses can and should also engage in *political advocacy*—the active engagement in the political process through activities such as voting, campaigning for candidates running for office, donating to a political action committee (PAC), and lobbying and educating elected officials about important issues.

Nurses have played a role in advocating for a variety of social reform issues influencing health, including smoke-free environments, calorie and restaurant labeling, and protections in the work environment (Ezeonwu, 2015; Johnson et al., 2012; Nagelhout et al., 2014). Every nursing organization engages in both professional and issues advocacy. For example:

- The ANA (2018) ". . . believes that advocacy is a pillar of nursing. Nurses instinctively advocate for their patients, in their workplaces, and in their communities; but legislative and political advocacy is no less important to advancing the profession and patient care." The ANA gives voice to the profession at state and federal levels and advocates for issues such as reducing gun violence, environmental safety, and promotion of policies that support access to care for all Americans.
- The American Association of Nurse Practitioners (AANP) supports patients, issues, and the profession through their advocacy work in removing legislative barriers to practice for NPs. It has been successful in expanding scope of practice for NPs in 22 states and the District of Columbia (AANP, 2018). In addition, the AANP participated in changes in the payment schedule for health care providers and influencing Medicare reform.
- In 2018 the American Academy of Nursing (2018) released a statement in opposition to a policy which separated children from their parents at the United States border. That same year, the National Association of Pediatric Nurse Practitioners (NAPNAP) released a position statement opposing border separation of children and parents (NAPNAP, 2018).
- The Nursing Community Coalition brings more than 60 nursing organizations together in pursuit of professional and issues advocacy. In 2018 more than 40 nursing organizations urged President Trump and Congress to make high-quality, affordable health care a top priority policy initiative.

MODELS OF NURSING ADVOCACY

A number of nursing theorists have developed models of nursing advocacy (Ezeonwu, 2015). Curtain (1979) proposed a theory of human advocacy and used the concept of "advocate" to describe the philosophical foundation and ideal of nursing. In this model, advocacy does not refer to "legal advocacy" or even "health advocacy" but human advocacy. The role of the nurse is to be a human advocate. This does not necessarily mean intervening on a patient's behalf but advocating for the patient's humanity. Curtain believes that illness wounds patients and robs them of their humanity. The nurse assumes the role of advocate by healing the wounds of "loss of independence," "loss of freedom," and "loss of ability to make informed decisions." In this early theory of advocacy, the nurse is not specifically called upon to act or support a cause, provide a patient with a voice, or influence public policy, but to prevent a loss of humanity.

Gadow (1983) proposed a theory of existential advocacy that requires humans to be "authentic" or self-directed.

The nurse becomes an existential advocate by "participating with the patient in determining the personal meaning which the experience of illness, suffering, or dying is to have for that individual" (p. 97). Kohnke's functional model of advocacy (1978) focuses on patient choice. In this model of advocacy, the nurse provides the patient with important information, determines that the patient understands that information, and then supports the patient's right to make the best decision for himself/herself even if the nurse disagrees with it. In 1989 Fowler proposed a broader theory of nursing advocacy: advocacy for social justice. This theory includes the role of nurse as patient advocate not only at the bedside but within health care facilities and throughout society.

Bu and Jezewski (2007) built upon all of these theories and proposed a unified theory of advocacy with three basic tenets: "(a) safeguarding patients' autonomy, (b) acting on behalf of patients, and (c) championing social justice in provision of health care" (p. 104). Contemporary models of advocacy address patient needs *and* the nurse's role in advocating for all issues that pertain to the health of patients, including advocacy for the nursing profession.

PREPARING NURSES FOR THEIR ROLE AS ADVOCATES

Although advocacy is viewed by nurses and the public alike as a major role for the nurse, very little is done to formally prepare nurses for this role. Nursing curriculums at the undergraduate and graduate levels do not make explicit the skill set necessary to advocate effectively. Advocacy is primarily learned after graduation in practice settings and often by observing other nurses acting as advocates (Foley et al., 2002; Hanks, 2008).

Advocacy often involves conflict, and it always involves communication. It requires sophisticated leadership skills, including emotional intelligence, self-awareness, relationship management, team building, conflict management, interprofessional collaboration, problem solving and sensitivity, effective communication skills, and use of influence (Tomajan, 2012). Nursing education must provide students at all levels of education with this knowledge and these skills. This includes using role-playing scenarios on advocacy and examining advocacy behaviors in clinical experiences. Curriculums need to identify advocacy mentors for students to consult when advocacy issues arise. These mentors can be found in clinical settings and in nursing organizations.

The literature supports experiences and characteristics that are common to nurses who advocate for patients and who seek advocacy opportunities in their practices. Altun and Ersoy (2003) reported that nurses who had ethics courses or who were taught ethics were more likely to engage in advocacy behavior. Others have shown that nurses' advocacy behaviors are linked with higher levels of education (Hanks, 2010; Kubsch, Sternard, Hovarter, & Matzke, 2003). Nurse educators can use this information to design curriculums that address students' development of advocacy skills through opportunities such as lobby day activities, patient advocacy days, and structured class debates. This education should include practicing nurses and students.

Advocacy education also requires a discussion about what advocacy "feels" like. Serving in an advocacy role takes courage. An advocate is often called upon to speak truth to authority and stand in the tension of an opposing point of view. Cultivating that courage requires conversations about the affective dimension of advocacy: the physical, emotional, and psychological energy needed to advocate effectively.

OVERCOMING BARRIERS TO ADVOCACY

Hanks' (2007) concept analysis of barriers to advocacy suggests that powerlessness, fear of punishment, conflicts of interest, and lack of institutional support are major reasons why nurses do not engage in advocacy.

As a predominantly female profession, nursing has never been considered powerful. Women's voices are not considered to be as powerful as the voices of men. Nurses have difficulty advocating for themselves, and the consequences of oppressed group behavior (lateral violence, infighting, incivility) continue to be prevalent even 35 years after Roberts (1983) first used Freire's (1968) theory of oppressed group behavior to describe nursing's relative powerlessness. Members of oppressed groups fear their oppressors and are angry at them. When that fear and anger are internalized, the oppressed come to believe that they are inferior, powerless, and unable to unify enough to gain power in their own right within the system. This reality, coupled with a history that valued and encouraged subservience, obedience, and unquestioning loyalty to physicians and health care institutions, contributes mightily to the image of the nurse as powerless and not influential. Although nurses do appear to engage in advocacy activities when confronted with the well-being of their individual patients, they are less inclined to engage in the long-term organized advocacy necessary for social justice.

Nurses also fear retribution. Although much has been done to protect employees from retaliation for "whistleblowing," advocacy requires risk taking and no small measure of courage. Nurses—in reality, anyone who advocates on behalf of another—can experience punishment, demotion, and labeling. Advocacy can disrupt relationships in employment and policymaking settings.

Overcoming the Barriers

Little research has been done to identify the characteristics of nurses who are successful advocates, but it appears that nurses who have a good self-concept, strong values, confidence, and a positive professional identity are more likely to take risks in the name of advocating for patients, communities, and the profession (Panticuff, 1989). Forums in which to share stories of successes and failures in advocacy and their impact on future advocacy activities can be motivating to novice and experienced nurses alike.

Building on her work—oppressed group behavior in nursing—Roberts (2000, 2015) posits that a strong sense of professional identity is necessary to engage in leadership and advocacy work. This identity is developed over time. It begins with early career acceptance of the role and status of the professional nurse; connection with other nurses through participation on committees and in professional organizations; synthesis of professional experiences leading to a positive view of nursing; and ultimately, commitment to create change and advocate for issues of social justice. Nursing curriculums, professional organizations and nursing leaders can use this model to foster a strong professional identity in pursuit of overcoming barriers to advocacy.

The Institute of Medicine Report (2011), *The Future of Nursing,* provides nurses at all levels and types of practice with a mandate to find and use individual voices and the collective voice of the profession in pursuit of advocacy work. Likely the most important report on nursing in our time, it looks to the profession to fill "new expanded roles in a redesigned health care system." However, this is not possible, without the voices of nurses raised up not in fear but in unity to make health care more equitable, accessible, and compassionate.

Nursing executives can build a culture of advocacy, one in which nurses and all members of the health care team engage in routine advocacy for patients, nurses, the profession of nursing, and public policies that affect health. Engaging in advocacy must become both an expectation and routine behavior. When nurses are encouraged, as part of their professional responsibility, to attend to social and economic factors that influence health and then advocate for policies that promote a culture of health, nurses will have an increased comfort level with raising their voices for patients at the bedside and society as a whole.

LIVED EXPERIENCE OF ADVOCACY

Hanks' (2008) qualitative work on the lived experience of advocacy identifies three themes: nurses experience with advocacy (speaking out and speaking for patients; being compelled to act on the unmet needs of patients); experiences with outcomes of advocacy (fulfillment and frustration; the change in the patient); and educational preparation for the advocacy role (primarily learned on the job; confidence gained through experience).

The lived experience of three nationally recognized nurse leaders are included here as exemplars of successful nursing advocacy experiences.

Patient Advocacy

Janis Sunderhaus, RN, is the President and Chief Executive Officer of Health Partners of Western Ohio, a Federally Qualified Health Center she established in 2003. With 12 locations in Western Ohio, these clinics provide medical, pediatric, dental, behavioral health service, substance abuse, pharmacy, and social services. Sunderhaus discusses the reality that the actual in-the-moment experience of advocating for patients is not taught in school and is often not encouraged by nurses. Advocating for patients requires nurses to "stick your neck out" and "stand between the patient and someone else." She recalls a time in the 1980s, when she worked on an infectious disease unit with patients who had all sorts of infections that no one understood. She asked a resident for orders for pain medication for a patient who was a sex worker and was in agony from herpes throughout her entire gastrointestinal system. The resident declined to give her pain medication because he wanted to "keep an eye on the disease progression." Sunderhaus saw a patient with whom she had a shared humanity. Her view of her patients was consistent with Curtain's perspective that nurses advocate for patients' humanity. When the medication was not forthcoming, Sunderhaus called the resident's attending physician at his home on "football Sunday." Janis recalls that it was a singularly unpleasant position to be in. "I was afraid, I was shaking, I really didn't want to have to do this. I was uncomfortable, but it had to be done. I had to be that patient's voice." Sunderhaus adds, "And you know what? It's like that every time." As nurses continue through their careers, it becomes easier, but it is also easier when nurses aggressively participate in building a culture of advocacy so that "doing the right thing" is expected behavior. "That way," she says, "you don't have to fight every single time."

Professional Advocacy

Donald Gardenier was a Peace Corps volunteer in Patagonia before becoming a nurse. A National Health Service Corps Scholar, he worked to place primary care providers in underserved areas. Gardenier had ample opportunity to advocate for his patients throughout his career. He makes the case that it is the nurse's job to get what the patient needs and then give it to him or her. He subscribes to

Kohnke's model of functional advocacy. Gardenier sought an opportunity to disseminate his clinical work more widely and use organized nursing to make that happen. He recounts, "I didn't know anything about this type of work, but I did it anyway, because it had to be done." Specifically, Gardenier participated in the merger of two nursing organizations into one to leverage the numbers and create a unified position that one large organization would bring to the political table. "I didn't always know the exact right course of action, but I was always confident that this work had to be done for the profession because our profession is about our patients." Gardenier recalls moments of conflict and discomfort, along with the awareness that these were necessary for a final positive outcome.

Political Advocacy

Denise Link is an NP and political activist who began practicing as an NP before the role's title and scope had been legally defined. During her first year of practice providing health services to underserved women, Link's clinic received a communication from the State Attorney General's office saying that, although the performance of a Pap test was within the scope of practice of an RN, use of a speculum to perform a pelvic examination was not. Understanding that if she could not use a speculum, she could not complete an exam, she says that she became a "political activist that day. I was not going to deprive my patients' access to care because of some poorly thought out regulation. I realized that if I wanted to make changes to my practice, it had to be in the political arena." And so it began for Link. She says, "I understood my power and I was not afraid to use it." She joined professional organizations at the local, state, and national levels. She used her voice in state capitols and on Capitol Hill in Washington, D.C. Link did not approach advocacy with trepidation or lack of knowing what to do because she came from a family of political activists. She had a voice early in her career, and she used it politically to provide her patients with the access and quality that they deserve.

Advocacy on behalf of the public's health can be extremely rewarding. Nurses are in a unique position to be advocates for health.

DISCUSSION QUESTIONS

1. What examples have you seen of nurses advocating for the health of populations, including through workplace or political action? What made these nurses effective advocates?
2. What experience do you have as an advocate for health in your workplace, a professional organization, or government? How did it feel? Were you successful? What are the barriers you experienced and how did you overcome these? What would you do differently?

REFERENCES

Altun, I., & Ersoy, N. (2003). Undertaking the role of patient advocate: A longitudinal study of nursing students. *Nursing Ethics*, *10*(5), 462–471.

American Academy of Nursing. (2018). *Separation of children from their parents increases likelihood of toxic stress.* Retrieved from https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/docs/Press%20Releases/2018/2018-Acadeny_Statement_on_Separation_of_Children-Parents_at_Border__1_.pdf.

American Association of Colleges of Nursing (2006). *The essentials of doctoral education for advanced nursing practice*. Washington, DC: AACN.

American Association of Colleges of Nursing (2008). *The essentials baccalaureate nursing education for professional nursing practice.* Washington, DC: AACN.

American Association of Colleges of Nursing (2011). *The essentials of master's education in nursing.* Washington, DC: AACN.

American Association of Nurse Practitioners. (2018). *State practice environment.* Retrieved from www.aanp.org/advocacy/state/state-practice-environment.

American Nurses Association. (2010). *Nursing's social policy statement: The essence of the profession.* Silver Spring, MD: ANA.

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: ANA.

American Nurses Association. (2018). *Advocacy.* Retrieved from www.nursingworld.org/practice-policy/advocacy/.

Bu, X., & Jezewski, M.A. (2007). Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing, 57*(1), 101–110.

Curtain, L. (1979). The nurse as advocate: A philosophical foundation for nursing. *Advances in Nursing Science,* 1(3), 1–10.

Ezeonwu, M. (2015). Community health nursing advocacy: A concept analysis. *Journal of Community Health Nursing, 32,* 115–128.

Florence Nightingale Pledge. (n.d.). *Vanderbilt nurse*. Retrieved from www.vanderbilt.edu/vanderbiltnurse/2010/11/florence-nightingale-pledge/.

Foley, B.J., Minick, P., & Kee, C. (2002). How nurses learn advocacy. *Journal of Nursing Scholarship*, *34*(2), 181–186.

Fowler, M. D. (1989). Social advocacy. *Heart & Lung: The Journal of Critical Care*, *18*(1), 97–99.

Freire, P. (1968). *Pedagogy of the oppressed.* New York: Bloomsbury Publishing.

Gadow, S. (1983). *Existential advocacy. Philosophical foundations of nurse-patient relationship*. Boston, MA: Allyn and Bacon.

Hanks, R. G. (2007). Barriers to nursing advocacy: A concept analysis. *Nursing Forum*, *42*(4), 171–177.

Hanks, R.G. (2008). The lived experience of nursing advocacy. *Nursing Ethics*, *15*(4), 468–477.

Hanks, R.G. (2010). The medical-surgical nurse perspective of advocate role. *Nursing Forum*, *45*(2), 97–107.