Seventh Edition

MILSTEAD'S HEALTH POLICY *and* POLITICS

A NURSE'S GUIDE

NANCY M. SHORT

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Contents

List of Exemplars

Preface

This is a contributed text for healthcare professionals who are interested in expanding the depth of their knowledge about public health policy and in becoming more sophisticated in their involvement in the political and policy processes. The scope of the content covers the whole process of making public policy within broad categories of problem identification and agenda setting, policy analysis, strategy and policy development/design, policy adoption/enactment, and implementation of policy and evaluation of the programs spawned by policy. The primary focus is at the federal and state levels, although the reader can adapt concepts to the global or local level. Content is focused on the importance of three aspects of engagement for nurses and other health professionals: health policy advocacy, health policy analysis, and health policy research.

Why a Seventh Edition?

With this seventh edition, we celebrate 22 years of serving instructors, students, health professionals and others both here in the United States and abroad. The *Seventh Edition* has an addition to the title: it is now ***Milstead's*** *Health Policy and Politics* in recognition of the founding editor of this widely used textbook, Dr. Jeri A. Milstead.

This edition introduces new authors with fresh perspectives—all of whom have a significant experiential basis for their health policy expertise. I heartily welcome Dr. Amy Anderson, Ms. Julie George, Dr. Rick Mayes, Dr. Catherine Moore, Dr. Cynthia Vanek, Dr. Annmarie Walton, and Dr. Kenneth White and delight in those who have continued as authors over the years: Dr. Leslie Sharpe, Dr. Anne Derouin, and, of course, Dr. Milstead.

New to this edition:

- A full chapter on discerning bias in resources and references as well as news and information literacy.
- New illustrations and a consistent layout to clarify key terms and ideas and to stimulate discussion via case studies.
- Sentinel references are now indicated by shading to help students comprehend the past and the trajectory of political science theories and research.

Example of shading of sentinel references:

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- Discussions of the concept of power and structural racism are new in this edition.
- A guide on how to use Twitter to influence health policy and politics.
- Significantly revised and updated chapters: Chapter 6, "Policy Implementation: Avoiding Policy Failure"; Chapter 7, "Government Response: Regulation," and Chapter 11, "The Impact of Nurse Influence on Global Health Policy."
- Includes updates and discussion of the 2020 elections.
- Answers for chapter discussion questions and case studies are available for instructors within the Navigate digital course materials from Jones & Bartlett Learning.

The sequence of the chapters is presented in a linear fashion, in accord with the Centers for Disease Control and Prevention's policy process model. However, readers will note immediately that the policy process in practice is not linear. The "stages" of policymaking do not just overlap, they often are inseparable. In the real world, policy problems and policy solutions frequently emerge together, rather than one after another. In defending their work, members of Congress love to repeat a quotation often (wrongfully) attributed to Otto von Bismarck: "If you like laws and sausages, you should never watch either one being made." In other words, the legislative process, though messy and sometimes unappetizing, can produce healthy, wholesome results. For health professionals who champion evidence-based decision making, political processes that lead to health policies can be a real challenge to understand.

Letter from the Founding Editor

Perhaps you are wondering about the change in the title of the *Seventh Edition* of this book. The change is part of my succession planning. This book grew out of several coincidences (do you believe in coincidence?). When I moved in 1985 from my home state of Ohio to South Carolina to teach at Clemson University, I knew I would have to obtain a doctoral degree. At that time, there were only four PhD in nursing programs in the U.S. South, and with none in South Carolina; I had to choose a related field. Part of my former position included the role of lobbyist, and I found the whole experience fascinating. Working with legislators, lobbyists, and government officials opened my eyes to a whole new approach to nursing, although there was little focus in this area in nursing education at the time. I was fortunate to be less than 2 hours away from the University of Georgia that, at that time, had one of the top 10 programs in political science in the United States. By the time I graduated, Hilary Clinton was working to create a healthcare system at the national level and both health care and policy were at the top of the governmental agenda.

About this time, I discovered four other nurses with master's degrees in nursing who had earned PhDs in political science, and our dissertation research had been conducted on five different components of the policy process. A book was born. This theory-based, research-based textbook on health policy and nursing was the first of its kind in the profession and set a high standard for those that followed. There were very few resources for nurses at the time, and the book took root.

Over the years, authors retired or dropped off and we were fortunate to maintain our standard with new and seasoned experts and excellent writers from across the country. The original research became examples for case studies, and the political theory continued to provide a solid base for nursing practice. We moved through many editions, and the book has been sold in more than 20 countries (and on six of the seven continents!) and has become a standard in many nurse educational programs. It has been my pleasure to work with intelligent, committed, well-educated nurses and other professionals throughout the years who have shared their knowledge, expertise, and skills with readers. Their impact on the profession, on the policy process, and on the health of the nation has been awe-inspiring. They have led the way to an awakening within nursing of the power we wield and the importance of our participation beyond the bedside.

After five editions, I realized I needed to think about future versions and the leadership needed to continue the work. I canvassed the contributing authors about their interest in working with me in succession planning. Dr. Nancy Short

responded, and we arranged a face-to-face meeting. We spent a whole day getting to know each other personally, sharing our thoughts about what we wanted for the book: to educate, inspire, and motivate readers, especially graduate students and to make the connection between nurse practice, policy decisions, and politics, or the art of influence. We talked about content gaps we wanted to fill or enhance. We discussed ideas about how to keep the book alive for readers, such as including more case studies and interactive activities.

I valued Nancy's public health background and her education and experience in economics and finance and decided she would bring an expanded view to the focus of the book; she was a "good fit." We agreed that we would be co-editors and senior authors on the *Sixth Edition* and that Nancy would be the sole editor/author on the *Seventh Edition*. After 22 years of a successful textbook, the publisher decided to title the *Seventh Edition*, edited by Short, as ***Milstead's*** *Health Policy and Politics: A Nurses Guide*. I was delighted and very humbled.

I want to thank the publisher, Jones & Bartlett Learning, for their unstinting expertise and guidance. Their advice and support and the excellence of their staff have contributed immensely to the high standard of excellence, readability, and content integrity of this book. And we kept them happy by meeting their deadlines!

As always, I will put in a "plug" for the greatest group of cheerleaders anyone could ask for—my family. My four children and spouses: Kerrin (the late George) Biddle, Kevin Milstead and Gregg Peace, Joan and Nick Russell, and Sara and Steve Lott; my three grandchildren and spouses (well, George just got engaged): Sunny and Heath Nethers, George Biddle and Lindsay Lachowsky, and Matt and Cynthia Lott; and two great-grandchildren Colton and Gunner Lott. My siblings: Mary Lorane Davis, Dr. Lynne Boylan, Joe (Shirley) Boylan, and the late Jack (Nete) and Mike (Sandy) Boylan are just the best. I love you all dearly. My husband, Glenn, died at age 42 but always thought I could do anything and my late-in-life fiancé, Ed Salser, brought light into my life for three whole years. I wake up every morning and say, "I'm the luckiest woman I know."

So, *Health Policy and Politics* will continue to educate readers about the whole U.S. policy process from agenda setting to government response (usually legislation and regulation) to policy/program design, implementation, and evaluation. The book offers opportunities for research on different aspects of the policy process. We hope to excite readers and point out places in this fluid, nonlinear, "messy" process of decision-making where they can become involved actively, whether at the local, state, national, or global level. Nurses' voices must be heard—we are the largest component of the healthcare workforce globally and consistently are the most trusted among a wide range of professionals. There are so many occasions where nurse expertise can identify problems, critically think through the issues, and recommend solutions. Access to health care, health disparities, equity, discrimination and lack of diversity, cost, quality, professional scope of practice—all are issues in which nurses have a vested interest. Nurses will learn how to move from being novices to becoming more sophisticated spokespersons and patient advocates for nursing and health issues. We will continue and enhance Nightingale's legacy.

—Jeri A. Milstead

Contributors

Amy Anderson, DNP, FAAN, is an Assistant Professor in the Harris College of Nursing and Health Sciences and an Assistant Professor and Health Policy & Advocacy Lead for the School of Medicine at Texas Christian University. Dr. Anderson is a Visiting Fellow at The Heritage Foundation in Washington, D.C. and a former International Council of Nurses Global Nurse Leadership Institute Policy Program Fellow.

With an exceptional nursing career spanning 25 years, Dr. Anderson is respected as a policy fellow, thought leader, and educator. Dr. Anderson's policy contributions include providing consultation, presentations, and workshops for the AARP Future of Nursing Campaign and the American Association of Nurse Practitioners. Her signatures include a conservative case for full practice authority, Title VIII funding, and healthcare workforce legislation. One of her most notable accomplishments was shifting the strategy and messaging in West Virginia to advance HB4334.

Dr. Anderson recently served as expert counsel for the National Coronavirus Recovery Commission on COVID-19. Dr. Anderson was an inaugural member of the Global Think Tank Townhall convened by the Think Tanks & Civil Societies Program of the Lauder Institute at University of Pennsylvania working on global policy solutions to the pandemic crisis. Her op-eds have been featured on Fox Business, The Daily Signal, Real Clear Health, *The Washington Times*, and *Tribune* line.

Dr. Anderson holds a BSN and MSN from Abilene Christian University and a Doctor of Nursing Practice from Texas Tech University Health Sciences Center. She is a fellow in the American Academy of Nursing.

Anne Derouin, DNP, APRN, CPNP, FAANP, is a Clinical Professor, Duke University School of Nursing. She also holds an appointment in the Division of Community and Family Medicine at Duke. She currently serves as Assistant Dean for the MSN Program. Prior to her role as Assistant Dean, she was Lead Faculty for the PNP-Primary Care/MSN program at Duke University School of Nursing. A full-time faculty member since 2011, she is a dual-certified pediatric nurse practitioner with more than 30 years' experience in pediatric nursing. She has strong ties to the Duke and Durham communities and has completed clinical service and research projects in Africa and Central America. She received her BSN in 1989 from the University of Michigan, master's degree in nursing in 2000 and a Doctor of Nursing Practice in 2010, both from Duke University.

Dr. Derouin is on the Executive Advisory Board for the Duke–Johnson & Johnson Leadership Training program and has served as a coaching circle mentor to Duke–J&J fellows since 2013. Dr. Derouin serves as the North Carolina Advocacy Chair for the National Association of Pediatric Nurse Practitioners (NAPNAP) and currently sits on the Executive Board of Directors. Considered an adolescent clinical expert, she is active in the Society of Adolescent Health and Medicine (SAHM), the American Academy of Nurse Practitioners (AANP), and is the co-chair for the Adolescent Special Interest Group of NAPNAP. She has participated in pediatric, school-based health and advanced nursing practice advocacy efforts at the state and federal levels and has been selected for advocacy fellowships for several professional organizations, including the School-based Health Alliance (formally National Assembly of School-based Health Centers), Nurse in Washington Internship (NIWI), Shot@Life (World Health Organization's global vaccine efforts), and as a Faculty Policy Intensive Fellow for the American Association of Colleges of Nursing (AACN).

Julia L. George, MSN, RN, FRE, has spent much of her nursing career in nursing regulation. She has 25 years of experience with the North Carolina Board of Nursing (NCBON) and has served as the Chief Executive Officer of NCBON since 2008. She holds a master's degree in nursing from the University of North Carolina at Chapel Hill and is a fellow in the National Council of State Boards of Nursing (NCSBN) Institute of Regulatory Excellence. Ms. George has been actively involved at both the national and international levels of nursing regulation. She served for 13 years on the Board of Directors for NCSBN and served as president of NCSBN from 2018–2020. Ms. George is also the recipient of the prestigious R. Louise McManus Award, given by NCSBN for individual leadership in regulatory excellence. During her terms as President-Elect and President of NCSBN, she served as a member of the International Nurse Regulatory Collaborative (INRC). The INRC is a group of nine international nurse regulators seeking to identify commonalities, promote research and influence policy to protect the public's health, safety, and welfare around the world.

Ms. George is known for her innovation in nursing regulation. She was instrumental in moving to a philosophy of "Just Culture," both in North Carolina and throughout the country. She has made numerous presentations throughout the country related to Just Culture in healthcare regulation. Ms. George has frequently served as a source of education and information for the North Carolina General Assembly in matters of health policy related to nursing.

Toni Hebda, PhD, MSIS, RN-BC, CNE, is Professor of Nursing at Chamberlain College MSN online program and co-author of *The Handbook of Informatics for Nurses and Healthcare Professionals*, now in its sixth edition. She has presented internationally and nationally on nursing informatics, and has practiced as a staff nurse and nursing instructor, in addition to her work in information services. She is nationally certified in nursing informatics through the American Nurses Credentialing Center. Dr. Hebda is a member of the American Medical Informatics Association, the American Nurses Association, Sigma Theta Tau

International, the American Nursing Informatics Association, and the Healthcare Information and Management Systems Society.

Dr. Hebda earned a PhD, MSIS, and MNEd from the University of Pittsburgh, a BSN from Duquesne University, and a diploma from Washington (PA) Hospital School of Nursing. The focus of her doctoral program was on higher education. Her dissertation examined the use of computer-assisted instruction among baccalaureate programs.

Rick Mayes, PhD, is a Professor of Public Policy in the University of Richmond's Department of Political Science and chair of the Health Studies program. He is also a Professor of Nursing at the University of Virginia. He earned his PhD at the University of Virginia in 2000 and a National Institute of Mental Health postdoctoral traineeship at the U.C. Berkeley School of Public Health in 2002. From 1992–1993, he worked on Medicaid policy in the White House for George H. W. Bush, and thereafter on health insurance and Medicare policy at the AARP during the Clinton administration's healthcare reform effort of 1993–1994. He is a graduate of the University of Richmond (BA, 1991), and he has taught international public policy and global health on Semester at Sea.

His writings have appeared in numerous prominent newspapers and journals, and he is the author of several books, including *Universal Coverage: The Elusive Quest for National Health Insurance* (2005, University of Michigan Press), co-author of *Medicare Prospective Payment and the Shaping of U.S. Health Care* (2008, Johns Hopkins University Press) with Robert Berenson, MD, and co-author of *Medicating Children: ADHD and Pediatric Mental Health* (2009, Harvard University Press) with fellow University of Richmond professors Catherine Bagwell and Jennifer Erkulwater.

His most enjoyable and rewarding professional experiences have involved taking groups of University of Richmond students to Peru, the Dominican Republic, Appalachia, and Acadia National Park in Maine on healthcare research and community service trips. His classes are popular and his teaching has been recognized with several awards. In 2013, students elected him to give the university's "Last Lecture."

Jeri A. Milstead, PhD, RN, NEA-BC, FAAN, is senior nurse consultant for public policy, leadership, and education. Dr. Milstead is Professor and Dean Emerita, University of Toledo College of Nursing, where she served for 10 years, was director of graduate programs at Duquesne University for 3 years, and a faculty member at Clemson University for 10 years. She is the founding editor and senior author of *Health Policy and Politics: A Nurse's Guide* that is sold in 22 countries (and on 6 of 7 continents) and the *Handbook of Nursing Leadership: Creative Skills for a Culture of Safety*. She has invited chapters in four other current nursing textbooks, has published in national and international journals, and was editor-in-chief of *The International Nurse* from 1995 to 2006 when the publication was retired. Dr. Milstead was a policy advisor in the Washington, DC office of Sen. Daniel K. Inouye (D-HI), was president of the State Board of Nursing for South Carolina, and held leadership positions in the State Nurses Associations in Ohio, Pennsylvania, and South Carolina. She is a fellow of the

American Academy of Nursing and a member of ANA/ONA and Sigma Theta Tau International. She is board-certified as a Nurse Executive-Advanced by the American Nurses Credentialing Commission.

Dr. Milstead has been honored with the Mildred E. Newton Distinguished Educator award (OSU College of Nursing Alumni Society) and the Cornelius Leadership Congress award (the ONA's "most prestigious" award). She has been recognized as a "Local Nursing Legend" by the Medial Heritage Center at OSU and has been inducted into the Ohio Senior Citizen's Hall of Fame and the Washington Court House (Ohio) School System Academic Hall of Fame. She was named a "Transformer of Nursing and Health Care" (Ohio State University College of Nursing Alumni Association) and as a "Pioneer" in distance education and a career achievement (University of Toledo). She has also received a Creative Teaching award (Duquesne University) and two political activism awards. From 2005 through 2008, she was appointed to the Toledo–Lucas County Port Authority, where she chaired the port committee and was a member of a trade delegation to China. She has conducted research or consultation in The Netherlands, Jordan, Nicaragua, and Cuba.

Dr. Milstead holds a PhD in Political Science with majors in public policy and comparative politics from the University of Georgia, an MS and BS, cum laude, in nursing from The Ohio State University, and a diploma from Mt. Carmel Hospital School of Nursing where she is a Distinguished Alumna and current member of the Board of Trustees.

Catherine Moore, PhD, MSN, BSN, RN, is a regulatory consultant and legislative liaison with the North Carolina Board of Nursing (NCBON). A chief function of Dr. Moore's role with the NCBON is to provide consultative and educational services to members of the North Carolina General Assembly, nurses, occupational regulators, healthcare education and practice communities, and the public. A recent example of this work is the 2019 legislation which included provisions to update the North Carolina Nursing Practice Act. Dr. Moore serves as co-chair for the NCBON research committee, which focuses on conducting research to enhance public protection. She is also a current participant in the National Council of State Boards of Nursing International Center for Regulatory Scholarship.

Dr. Moore has 18 years of nursing experience with a clinical background in neonatal intensive care. Prior to her role with the NCBON, she served on the North Carolina Nurses Association's staff leadership team as the Director of Nursing Practice and Education—a role that enhanced her skills in interprofessional collaboration and the development and facilitation of liaison relationships. Dr. Moore is a strong proponent of healthcare policies that promote access to care and the safe delivery of nursing services. She has published and presented on policies that impact utilization of nurses in the delivery of health care. Her dissertation research, which explored how stakeholders for nurse practitioner full practice authority determine the appropriate time to pursue legislative changes to nurse practitioner scope of practice regulations, was awarded the Sigma Theta Tau Gamma Zeta Chapter PhD Award for Excellence. Dr. Moore's professional interests include nursing regulation, nursing workforce, healthcare safety, healthcare policy, and interprofessional collaboration.

Leslie Sharpe, DNP, FNP-BC, is a Clinical Assistant Professor at University of North Carolina-Chapel Hill (UNC-CH) School of Nursing and Lead Faculty of the FNP Program. She served as the lead provider and manager of Sylvan Community Health Center in North Carolina. Dr. Sharpe facilitated the opening and ongoing growth of this school-based community health center with the goal of increasing access to health care. She educates nurse practitioners and nurses about actively engaging in advocacy efforts related to health policy and improving the health of North Carolinians. As chairperson of the NC Nurses Association's NP Council Executive Committee from 2011–2014, she represented nurse practitioners at state legislative political events and educated legislators and other stakeholders in health care about advanced practice registered nurse issues. She currently serves as the NP PAC co-treasurer. One of her passions is serving as a mentor for NPs in the legislative and advocacy arena; as such, she facilitates a "leadership circle" of local APRNs in the NC Research Triangle. Dr. Sharpe completed her DNP at Duke University.

Nancy Munn Short, DrPH, MBA, RN, FAAN, is Associate Professor, Emerita at Duke University School of Nursing in Durham, North Carolina, where she was on the faculty from 2003 to 2020, when she retired. From 2002 to 2006 she served as an Assistant Dean at the school. Dr. Short received the School of Nursing's Distinguished Teaching Award in 2010 and the Outstanding DNP Faculty award in 2017, 2016, 2015, 2013, 2011, and 2010 (the DNP program began in 2009) for her courses on health policy, comparative international health systems, transformational leadership, and health economics. In 2009, she was recognized as an Arnold J. Kaluzny Distinguished Alumnus by the UNC-CH Gillings School of Global Public Health. Dr. Short completed a postdoctoral fellowship as a Robert Wood Johnson Foundation Health Policy Fellow from 2004 to 2007. As a part of this fellowship, in 2005, she served as a Health Legislative Aide for U.S. Senate Majority Leader, Bill Frist. With Darlene Curley, she served as co-chair of a AACN Think Tank charged with making recommendations to the board regarding improving health policy education for nurses.

Dr. Short is nationally known as an advocate for public health. She has provided consultation to the UNC Public Health Management Academy, the UNC Institute for Public Health on international issues related to distance learning, and the Johnson & Johnson Nurse Leadership Program at Duke.

She served as a member of the Durham County (North Carolina) Board of Health. In 2014, she completed a 2-year tenure on the Board of Directors of the National Association of Local Boards of Health, where she specialized in the development of performance standards for the approximately 3,000 boards of health in the United States. Under the auspices of the U.S. Department of State, she delivered leadership and quality management training to a bicommunal (Turkish and Greek) program for nurses in Cyprus.

Dr. Short earned a Doctor of Public Health degree with a major in health policy and administration at the University of North Carolina's Gillings School of Global Public Health and a Master of Business Administration and a Bachelor of Science in Nursing from Duke University.

Cindy Vanek, DNP, RN, CNAA, decided she was going to do something in the field of medicine/nursing at the age of 9 after her father experienced a prolonged illness. That decision has culminated in 42 years dedicated to the profession of nursing. Dr. Vanek earned her Bachelor and Master of Science degrees in Nursing from the University of Rochester. She began her nursing career at the University's Strong Memorial Hospital in the field of pediatric nursing and led an effort to open Strong's Pediatric Intensive Care Unit, the first PICU in upstate New York, then and now part of the Golisano Children's Hospital at the University.

In search of warmer weather, Dr. Vanek and her family moved to Florida in 1980 where she became the Chief Nursing Officer for Good Samaritan Medical Center in 1984 and, in 1997, she led a process for her hospital to sign an affiliation agreement with a leading medical center in eastern United States. The medical center chosen for that affiliation was Duke University Medical Center and led to the creation of the Helen and Harry Gray Cancer Institute at Good Samaritan Medical Center in West Palm Beach, Florida. This also commenced a 24-year relationship exemplifying dedication to excellence in nursing practice and quality patient care between Dr. Vanek and the Duke Health System.

In 1999, Dr. Vanek became a Consulting Associate faculty member for Duke University's School of Nursing (DUSON). Within that appointment, Cindy helped DUSON's distance-learning students find quality clinical placements and mentors in West Palm Beach, and later in Vero Beach, Florida. Key to her role as faculty, were monthly trips to Duke that were primarily focused on aspects of cancer services that were needed in West Palm Beach. Those services included a Patient Support Program partnering cancer survivors with recently diagnosed patients, the first cancer research clinical trials program in West Palm Beach, a cancer genetics screening program, and an education program for oncology nurses to expand their knowledge and skills preparing them to sit for the oncology nursing certification exam. During this time, Dr. Vanek watched her two sons graduate from Duke University, served on the Board of Overseers for the Duke Cancer Institute and the Board of Advisors for Duke's School of Nursing, and developed an ardent love of Duke basketball.

In 2005, Indian River Medical Center recruited Dr. Vanek to Vero Beach, Florida, as Vice President, Chief Nurse Executive, and later as Senior Vice President/Chief Operating Officer. While there, Dr. Vanek led two Duke affiliations, one with the Duke Heart Center and another with Duke's Cancer Institute. It was also during this time that Dr. Vanek's desire to teach leadership skills to others grew and she enrolled in the Doctor of Nursing Practice program concentrating on Executive Leadership at American Sentinel University. She graduated summa cum laude and received her DNP degree in December of 2013. Her interest in and experience with health policy developed during these years as she advocated for health services within her healthcare system, community, and state. Dr. Vanek teaches leadership courses for Duke University's School of Nursing and Southern New Hampshire University.

AnnMarie Lee Walton, PhD, MPH, RN, OCN, CHES, FAAN, is a tenure-track Assistant Professor at the Duke University School of Nursing, in Durham, North

Carolina, where she teaches health policy and population health courses. In this role, she educates future nurse leaders to value and apply their expertise in quality, safety, and the patient experience, to consider social contributors to health, and encourages them to lead improvements in health and health care in our country. Prior to becoming a faculty member, Dr. Walton worked for 13 years in inpatient hematology/oncology in roles from Clinical Nurse I through Clinical Nurse IV and co-created the first nurse manager job share in the state of North Carolina. Dr. Walton's program of research centers on understanding and minimizing occupational exposure to carcinogens. She has been a leader in developing, advocating for, and implementing a North Carolina state law focused on safer hazardous drug handling. As a result of that work, and activities with the North Carolina Future of Nursing State Action Coalition, Dr. Walton was named a Breakthrough Leader in Nursing by the Future of Nursing Campaign for Action in 2014 and honored as the Oncology Nursing Society Health Policy and Advocacy Award winner in 2016. She became a fellow in the American Academy of Nursing in 2020. Dr. Walton feels passionately about nurses understanding and then bringing their expertise in quality, safety, and the patient experience to serve on boards and commissions and has done some avocational research on nurses' engagement on boards, commissions, and in elected positions. She was a co-chair for the sustainability workgroup of the National Nurses on Boards Coalition and cofounded the North Carolina Nurses Association's Nurses on Boards 2020 Council. She frequently speaks to local and regional audiences about board service. Dr. Walton earned her PhD in nursing from the University of Utah, a postdoctoral fellowship, MPH, and BSN from the University of North Carolina at Chapel Hill, and a BS from the University of Maryland College Park.

Kenneth R. White, PhD, AGACNP, ACHPN, FACHE, FAAN, is the UVA Health Professor of Nursing Emeritus at the University of Virginia School of Nursing. He is also Sentara Healthcare Professor of Health Administration, Emeritus, and Charles P. Cardwell, Jr. Professor, Emeritus, at Virginia Commonwealth University (VCU). Dr. White is also visiting professor at the Luiss Guido Carli University in Rome, Italy.

Dr. White received a PhD in health services organization and research from VCU, an MPH in health administration from the University of Oklahoma, and an MS in nursing from VCU and a post-master's acute care nurse practitioner certificate from the University of Virginia. He has more than 40 years of experience in healthcare organizations in clinical, administrative, governance, academic, and consulting capacities. Dr. White is a registered nurse, an adult-gerontology acute care nurse practitioner, a certified palliative care nurse practitioner, and a fellow and former member of the Board of Governors of the American College of Healthcare Executives and a fellow of the American Academy of Nursing. He is also a member of the board of the American Academy of Nursing and served a 4-year term as President-Elect (2019–2021) and President (2021–2023).

He is author of five editions of *The Well-Managed Healthcare Organization, Thinking Forward: Six Strategies for Highly Successful Organizations*, and *Reaching Excellence in Healthcare Management; Take Charge of Your Healthcare Management*

Career: 50 Lessons That Drive Success; Boost Your Nursing Leadership Career: 50 Lessons That Drive Success; and a contributing author to the books *Human Resources in Healthcare: Managing for Success, Managerial Ethics in Healthcare: A New Perspective*, and *Evidence-Based Management in Healthcare* (all published by Health Administration Press). Dr. White is also a contributing author to the books *Advances in Health Care Organization Theory* (Jossey-Bass), *Peri-Anesthesia Nursing: A Critical Care Approach* (Saunders), *On the Edge: Nursing in the Age of Complexity* (Plexus), and *Introduction to Health Services* (Delmar).

Dr. White has received American College of Healthcare Executive's James A. Hamilton Award (2012), Exemplary Service Award (2011), Distinguished Service Award (2009), Edgar C. Hayhow Award (2006), and two Regent's Awards (1999 and 2010). He has also received the Virginia Nurses Association award for Virginia's Outstanding Nurse (1999), the VCU President's Award for Multicultural Enrichment, and numerous teaching awards. He is the founding chair of ACHE's LGBTQ Forum. In 2019, Dr. White received ACHE's Gold Medal Award, its highest award for contributions to leadership in health care.

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CHAPTER 1

Informing Public Policy: An Important Role for Registered Nurses

Nancy M. Short

KEY TERMS

Advanced practice registered nurse (APRN): A registered nurse with an advanced degree in nursing, certified by a nationally recognized professional organization. The four types of APRNs are nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse–midwife (CNM), and certified registered nurse anesthetist (CRNA).

Canons: Rules of thumb, or guidelines, typically used by courts to interpret and rule on disagreements between policy and public law.

Healthcare provider professionals (HCPs): Registered nurses, advanced practice registered nurses, physicians, pharmacists, dentists, psychologists, occupational and physical therapists, dieticians, social workers, and physician assistants, and others who are licensed or authorized by a state or territory to provide health care.

Policy: A consciously chosen course of action: a law, regulation, rule, procedure, administrative action, incentive, or voluntary practice of governments and other institutions.

Policy process: A process that involves problem identification, agenda setting, policy design, government/organizational response, budgeting, implementation, and evaluation of the policy.

Political determinants of health (PDoH): Political forces, ideologies, processes, and decisions that determine the health of individuals and populations.

Political power: Political and social sciences refer to executive, legislative and judicial powers. For our purposes, common types of governmental powers exerted on health professionals and health programs are coercive power, blocking power, and purchasing power, which influence what nurses can and cannot do as well as the environments in which nurses work.

Politics: The process of influencing the allocation of scarce resources.

Public policy: A program, law, regulation, or other legal mandate provided by governmental agents; also includes actual legal documents, such as opinions, directives, and briefs, that record government decisions.

Rules and regulations: Instructions authorized by specific legislation detailing the actions to be taken to implement that legislation. They are developed by government agencies, often with the assistance of experts such as registered nurses.

Statutes: Written laws passed by a legislative body. They may be enacted by both federal and state governments and must adhere to the rules set in the U.S. Constitution. They differ from common law in that common law (also known as case law) is based on prior court decisions.

System: Spelled with a capital "S," the U.S. healthcare delivery and finance system (usage specific to this text).

system: Spelled with a lowercase "s," a group of hospitals and/or clinics that form a large healthcare delivery organization (usage specific to this text).

Introduction

In March 2020 the nursing profession was thrust into the national and global spotlight as the nature of "essential workers" gained momentum and meaning amid the COVID-19 pandemic (see **Figure 1-1**). Ironically, long before the emergence of the novel human coronavirus, 2020 had been designated as "The Year of the Nurse and Midwife" by the World Health Organization to honor Florence Nightingale's 200th birthday. The severity of the pandemic propelled nurses into high visibility as they invented new ways to use ventilating equipment, led public health efforts, found ways to preserve personal protective equipment (PPE), identified improvements in patient treatments (e.g., turning patients prone), and provided astounding examples of compassionate care day after day in the face of danger. Largely because of the 24-hour news cycle and social media, today nursing has momentum and a platform unlike any other time in its history. But is this really the case? Nurses have thought "Now is our time!" at other important moments in history.

The Politics of Clinical Practice

Looking back to the 2010 Institute of Medicine[1] (IOM) report, *The Future of Nursing: Advancing Health, Leading Change*, nursing seemed positioned to gain more authority (or at least shed some "supervision"). The report examined how nurses' roles, responsibilities, and education should change to meet the needs of an aging, increasingly diverse population and to respond to a complex, evolving healthcare system. In response to the IOM report, the Robert Wood Johnson Foundation (RWJF) and the American Association for Retired People (AARP) launched a joint *Campaign for Action* that was soon translated into state-level activities (AARP Public Policy Institute, 2021). The *Campaign for Action* was crafted as a prescription for nurses to facilitate the nation's shift

[1] Important to note: The name of the Institute of Medicine was changed to the National Academy of Medicine in 2016.

Figure 1-1 Health policy and politics determines who gets personal protective equipment.

from hospital-based services to a system focused on prevention and wellness in the community: nursing's time had arrived. It was a strong push that influenced nursing education and practice for a decade. The IOM report coupled with other evidence spurred changes in policy and practice, and in many ways positioned the profession to take advantage of its magnified voice in 2020.

A 10-year follow-up report card featuring two national nurse leaders, Drs. Sue Hassmiller and Mary Dickow, discussed significant gains in the nursing profession, including a dramatic increase in the number of registered nurses (RNs) with bachelor's degrees; the removal of many barriers to nurse practitioner (NP) practice in many states and the Veteran's Administration system; improvements in the percentage of minority students entering nursing, along with an emphasis on improving diversity and inclusivity; and success in placing more RNs on healthcare governance boards (Stringer, 2019).

This progress has spurred the RWJF to fund a second study focused on the future of nursing. This time the focus is on the nurse's role in addressing the social determinants of health and health equity. Dr. Hassmiller, who served as the National Academy of Medicine Senior Scholar in Residence and Adviser to the President on Nursing from 2019 to 2021, was tapped to lead the study. The RWJR report will be completed and distributed in 2021.

Nursing practice—that is, what we are allowed to do, required to perform, or prohibited from engaging in—is determined by **public policy**. Thus, nursing practice is a highly political activity. Policy is the end result of the process used to discover the best solution to an identified social problem. Politics is the process of this discovery—the dickering about values, ideology, and costs.

This text is framed around the **policy process** and is best read by progressing from beginning to end. Nurses and other **healthcare provider professionals (HCPs)** are ideally positioned to participate in the policy arena because of their history, education, practice, and organizational involvement. In this chapter, *policy* is an overarching term used to define both an entity and a process. The purpose of public policy is to direct problems to the government's attention and to secure the government's response. Not all health and healthcare issues require a government response: some are best resolved by volunteers, philanthropy, or professional organizations. In this text we will explore what rises to the level of public policy.

The definition of *public policy* is important because it clarifies common misconceptions about what constitutes policy. In this text, the terms *public policy* and *policy* are used interchangeably. The process of creating policy can be focused on many areas, most of which are interwoven. For example, environmental policy deals with determinants of health such as hazardous materials, particulate matter in the air or water, and safety standards in the workplace. Education policies are more than tangentially related to health—just ask school nurses. Regulations define who can administer medication; state laws dictate which type of sex education can be taught. Defense policy is related to health policy when developing, investigating, or testing biological and chemical weapons. There is a growing awareness of the need for a health-in-all-policies approach to strategic thinking about policy.

Health policy directly addresses health problems and is the specific focus of this text. In general, **policy** is a consciously chosen course of action: a law, regulation, rule, procedure, administrative action, incentive, or voluntary practice of governments and other institutions. By comparison, **politics** is the process of influencing the allocation of scarce resources. See **Table 1-1** for an explanation of the ideology and priorities of the five major political parties in the United States.

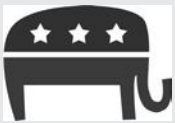
Policy Instruments

Official government policies reflect the beliefs and values of elected Members, the administration in power, and the will of the American people. Laws (or **statutes**) are one type of policy instrument that serve as legal directives for public and private behavior. Laws are made at the international, federal, state, and local levels and are considered the principal source in guiding conduct. Lawmaking usually is the purview of the legislative branch of government in the United States, although presidential vetoes, executive orders, and judicial interpretations of laws also have the force of law.

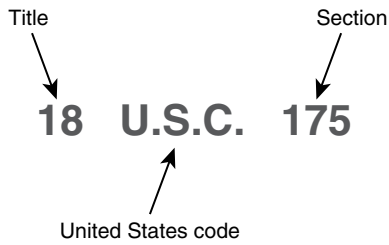
Policy instruments at the level of national governance include, but are not limited to, the following:

- *Bills*: A bill is proposed legislation under consideration by a legislative body (i.e., the U.S. Senate or the House of Representatives).
- *Act*: An act is legislation that has passed both houses of Congress and has been either approved by the president or has passed Congress over his veto, thus becoming law. Also known as a *statute*.

Table 1-1 Political Parties in the United States and Their Ideological Perspectives

Democratic	Republican	Libertarian	Green	Constitution
 © Matt Trommer/Shutterstock.	 © Hafakot/Shutterstock.			
■ Raise incomes and restore economic security for the middle class. ■ Create good-paying jobs. ■ Fight for economic freedom and against inequality. ■ End systemic racism. ■ Guarantee civil rights (especially for vulnerable groups). ■ Protect voting rights. ■ Secure environmental justice. ■ Ensure the health and safety of all Americans.	■ Preserve the U.S. Constitution. ■ Require a balanced budget for the federal government. ■ Repeal and replace the Affordable Care Act. ■ Maintain a strong military. ■ Make America energy independent. ■ Secure U.S. borders. ■ Promote hard work to end poverty. ■ Promote family. ■ Promote religious liberty.	■ Protect civil liberties. ■ Encourage noninterventionism. ■ Promote laissez-faire capitalism. ■ Abolish the welfare state. ■ Keep government to a minimum. ■ Ensure that the role of government is to protect the rights of every individual, including the rights to life, liberty, and property.	■ Ensure protection of the environment. ■ Promote nonviolence and antiwar positions. ■ Decentralize wealth and power to promote social justice. ■ Encourage grassroots democracy. ■ Promote feminism and gender equity. ■ Encourage respect for diversity and promote LGBT rights. ■ Focus on community-based economics. ■ Promote personal and global responsibility. ■ Encourage a future focus and sustainability. ■ Acknowledge ecological wisdom.	■ Restore honesty, integrity, and accountability to government. ■ Limit the federal government only to those roles outlined in the U.S. Constitution; the best government is local government. ■ Restore "true capitalist" principles to U.S. economic policies.

- *Executive orders*: An executive order is an instruction issued by the president that is used to direct the actions of the executive branch and has the effect of law. Executive orders are given numbers and are abbreviated as EO.###. Executive orders may amend earlier orders.
- *Presidential directive*: A presidential directive is a specific type of executive order that states the executive branch's national security policy and carries the force and effect of law that states requirements for the actions of the executive branch.
- *Rules and regulations*: **Rules and regulations** are the guidelines or instructions for doing something correctly and are the principles that govern the conduct or behavior of a person or organization. The primary difference between a rule and a regulation is that a rule is not legally binding, whereas a regulation is. These two terms are often erroneously used as synonyms.
- *Resolution*: A resolution is a form of legislative measure introduced and potentially acted upon by only one congressional chamber and is used for the regulation of business only within the chamber of origin. Depending on the chamber of origin, they begin with a designation of either H.Res. or S.Res.
- *U.S. Code*: All federal laws passed by the U.S. Congress are codified (included) into the U.S. Code for reference. The U.S. Code is divided by subject area into 50 sections called *titles*. Each title is then divided into chapters, subchapters, parts, sections, paragraphs, and clauses. U.S. Code references are written as follows:



Additional commonly used terms, such as *position statement*, *resolution*, *goal*, *objective*, *program*, *procedure*, *law*, and *regulation,* are not really interchangeable with the word *policy*. Rather, they are the formal expressions of policy decisions.

Several tools can be used to help determine the meaning of an ambiguous statute or to recognize the multiple plausible interpretations of a statute. These tools fall into the following four categories: (1) the text of the statute, (2) legal interpretations of the statute, (3) the context and structure of the statute, and (4) the purpose of the statute. Because laws are formatted and written in "legislative language," they are often difficult to read or understand. **Table 1-2** describes two commonly used **canons** of public law.

The agency assigned to interpret a particular law may have difficulty interpreting the law due to the speed with which some laws are passed and the nature of legislative language. Sometimes the interpretation of a law is legally challenged in the court system. Judicial interpretation of public law occurs in four ways: (1) through the court's interpretation of the meaning of broadly

written laws that are vague regarding details; (2) by the court determining how some laws are applied, that is, by resolving questions or settling controversies; or (3) by the court interpreting the Constitution and declaring a law unconstitutional, thereby nullifying the entire statute; and (4) by the court resolving conflicts between states and the federal government (Brannon, 2018). Judicial decisions about statutes are generally the final word on statutory meaning and will determine how a law is carried out—at least, unless Congress acts to amend the law. The legitimacy of any particular statutory interpretation is often judged by how well it carries out the will of the legislative body that generated it. For example, aspects of the Affordable Care Act (ACA) have been challenged many times in the judicial branch. Three of these challenges have been heard by the U.S. Supreme Court.

Table 1-2 Functions of Commonly Used Canons of Legislation Language

Terminology	Function Served
And versus **or**	"And" typically signifies a list, meaning that each condition in the list must be satisfied, whereas "or" typically signifies a disjunctive list, meaning that satisfying any one condition in the list is sufficient.
May versus **shall**	"Shall" indicates that a certain behavior is mandated by the statute, whereas "may" grants discretion to the agency charged with implementing the law.

Spotlight: The Patient Protection and Affordable Care Act of 2010 in the U.S. Supreme Court

***National Federation of Independent Business v. Sebelius (Sec. of HHS)* (2012).** In its 2012 ruling, the Court upheld the constitutionality of the ACA's individual mandate, which required most people to maintain a minimum level of health insurance coverage to begin in 2014. However, the Court found that the ACA's Medicaid expansion mandate was unconstitutionally coercive of states, and held that this issue was fully remedied by limiting the enforcement authority of the Health and Human Services Secretary. The ruling left the ACA's Medicaid expansion intact in the law, but the practical effect of the Court's decision made Medicaid expansion optional for individual states.

***King et al. v. Burwell (Sec. of HHS)* (2014).** David King did not want to buy health insurance. The 64-year-old Vietnam veteran worked as a limo driver and made $39,000 a year, and if it weren't for the subsidies (in the form of tax credits) afforded him by the ACA, King would not be able to, or have to, buy health insurance. King and three others filed a lawsuit against the government arguing that subsidies were supposed to be only for those purchasing health care through state-run health exchanges, not the federal one. The case focused on four words: "established by the State." Thirty-four states had

(continues)

opted against establishing exchanges under the Affordable Care Act, instead allowing residents to purchase health care through HealthCare.gov, the federal marketplace. The plaintiffs' suit argued that subsidies/tax credits were only for people purchasing health care on exchanges "established by the State." Although the legislative language of the ACA pertaining to the tax credits only referred to the exchanges established by the states, the Internal Revenue Service created a regulation that made the tax credits available to those enrolled in plans through federal as well as state exchanges.

The Court held that Congress did not delegate the authority to determine whether the tax credits are available through both state-created and federally created exchanges to the Internal Revenue Service, but the language of the statute clearly indicates that Congress intended the tax credits to be available through both types of exchanges. When the plain language of the section in question is considered in the context of the statute as a whole, it is evident that the federally created exchanges are not meaningfully different from those created by the states, and therefore federally created exchanges are not excluded from the language referring to exchanges created by the states (Oyez, 2014).

California v. Texas (2020). In 2018 the Republican-controlled Congress enacted an amendment to the ACA that set the penalty for not buying health insurance at zero. Texas and several other states and individuals filed a lawsuit challenging the individual mandate to purchase insurance, arguing that because the penalty was zero, it could no longer be characterized as a tax, and was therefore unconstitutional. California and several other states joined the lawsuit to defend the individual mandate. Arguments were heard in November 2020, and the decision is expected to be released in summer 2021. Questions to be answered include: (1) Is the individual mandate of the ACA, which now has a penalty of zero for not buying health insurance, now unconstitutional? (2) If the individual mandate is unconstitutional, is it severable from the remainder of the ACA? The result of this case may overturn the ACA, in effect repealing it (Oyez, 2020).

Policy as a Process

For the purposes of understanding just what policy is, it is best to think in terms of policy as a process. Policymaking comprises six processes that are conducted within the context of stakeholder engagement and education (see **Figure 1-2**):

1. Problem identification and agenda setting
2. Policy analysis
3. Policy design
4. Policy enactment
5. Policy implementation
6. Evaluation of policy outcomes

This text discusses the six steps of the policy process. Note that the steps in the policy process are not necessarily sequential or logical. For example, the definition of a problem, which usually occurs in the agenda-setting phase, may change during fact-finding and debate. Program design may be altered significantly during implementation. Evaluation of a policy or program (often considered the last phase of the process) may propel onto the national agenda

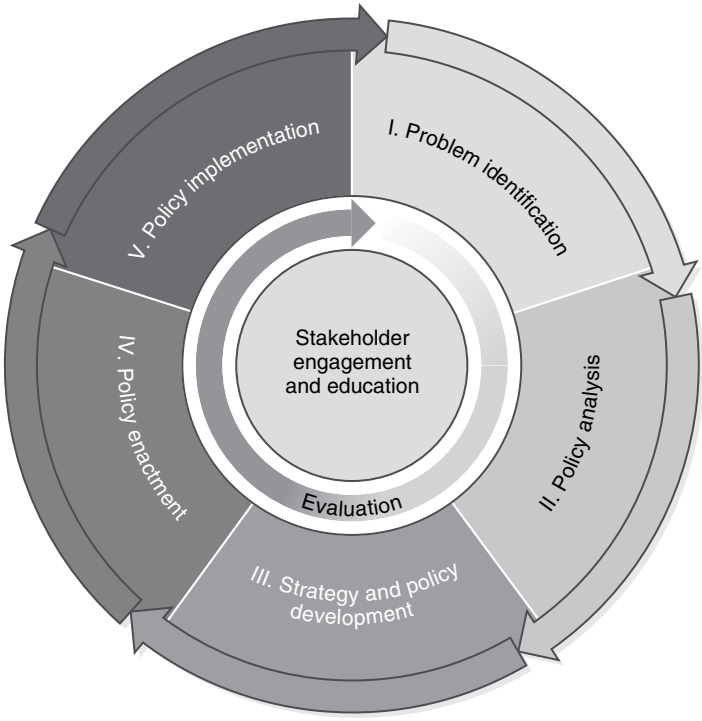


Figure 1-2 The policy process.

Centers for Disease Control and Prevention. (2012). Overview of CDC's Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/policy/analysis/process/

(often considered the first phase of the process) a problem that differs from the originally identified issue. For the purpose of organizing one's thoughts and conceptualizing the policy process, we will examine the policy process from a linear perspective in this text, but it is important to recognize that this path is not always strictly followed.

Opportunities for health professionals' input throughout the policy process are unlimited. Nurses are articulate experts who can address both the rational shaping of policy and the emotional aspects of the process. Nurses cannot afford to limit their actions to monitoring bills; they must seize the initiative and use their considerable collective and individual influence to ensure the health, welfare, and protection of the public and healthcare professionals.

Public Policy, Political Determinants of Health, and Clinical Practice

In our basic education as nurses and HCPs, we learned about the social determinants of health (SDoH) as the root causes of good or bad health. But what are the drivers of the SDoH? In general, the drivers of the SDoH are political decisions; therefore, the causes of health and of disease/illness are driven as

much by policy and politics as by any other cause. These political determinants of health do not get nearly the attention they deserve from the health professions. Yet, there is nothing radical in acknowledging the part played by political choices in affecting the nation's health; indeed, the premise of this text is that nurses affect the health of populations through their influence on the policy process. Think of areas as disparate as vaccines, air quality, seat belt safety, and smoking cessation—all cases where the public's health was better off for the legislative choices made by lawmakers, political appointees, and politicians at the state and federal levels (Mishori, 2019). See **Figure 1-3** for a depiction of the **political determinants of health (PDoH)** as envisioned by Ranit Mishori (2019).

Health is largely based on political choices, and politics is a continuous struggle for resources/power among myriad competing interests. Looking at health through the lens of political determinants means analyzing how different power constellations, institutions, processes, interests, and ideological positions affect health within different levels of governance. Health is political: health is unevenly distributed in our populations, many social determinants of health are dependent on political action, and health is a critical dimension of human rights, even though there is no "right" to health care guaranteed within the U.S. Constitution (Kickbusch, 2015).

"Lack of political will" is often cited as the main reason for failing to deal with political factors affecting health. How do nurses encourage a culture in which health-in-all-policies is a reality? How do nurses affect the political will of our nation? Nurses can engage in health policy analysis, health policy advocacy, and health policy research (often referred to as health services research). Sometimes it is difficult to discern any difference between advocacy

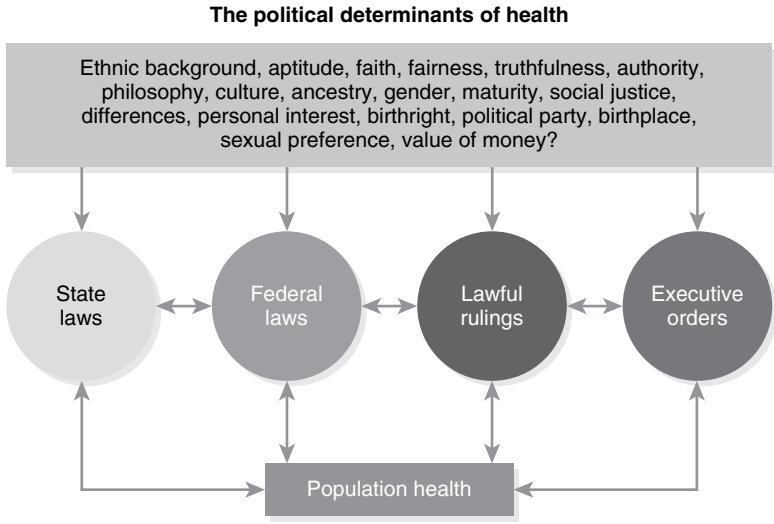


Figure 1-3 The political determinants of health.

Data from Mishori, R. (2019). The social determinants of health? Time to focus on the political determinants of health!. *Medical care*, 57(7), 491-493.

and analysis. This text will help you distinguish among advocacy, analysis, and research in health policy.

Legislation, along with rules and regulations, are the upstream causes that affect most aspects of our health, with the list being too exhaustive to include here. For example, downstream effects of reproductive health laws, such as the content of sex education in public schools, influence teen pregnancy as well as infant and maternal mortality rates; natural disaster planning and preparation results in downstream health effects of who lives and dies during a catastrophic event; the apportionment of parks and recreational spaces provides or disallows safe play spaces for children; the chemicals included in our water systems prevent dental caries or poison us; corporate oversight results in clean air or polluted air; a declaration of war determines what is spent on the military versus on schools and clinics; and so on. At this point, you may be wondering if there is anything related to health and health systems that is not affected by politics and policy. In a 2015 editorial in the *British Medical Journal*, Kickbusch wrote, "Health is a political choice and politics is a continuous struggle for power among competing interests." So why aren't these determinants of health taught broadly in health professionals' education? The main challenge for creating the field of "political epidemiology" lies in creating opportunities, either by design or in the analysis, to identify causal effects of political variables on population health. As stated by Mackenbach (2014):

> Overcoming this challenge will require ingenuity, as well as some stealing from other disciplines (such as comparative political science). Combining quantitative approaches, such as econometric techniques for evaluating natural experiments, with qualitative studies to reconstruct the causal pathways leading all the way from upstream politics to downstream health, is also likely to be useful. (p. 2)

Most of us have been educated and acculturated to believe that an individual's health is largely the result of personal choices and behaviors; however, during the COVID-19 pandemic we saw that government planning, preparation, funding, and policies had a huge effect on the health of individuals and populations, with some nations faring much better than others. **Case Study 1-1** provides the opportunity to further delve into the direct relationship between health policy and clinical practice.

CASE STUDY 1-1: Legislation to Address Health Professional License Portability During a Public Health Emergency: It's All in the Details!

Regulating the practice of nursing (and other health professions) is accomplished at the state level. In the early days of the COVID-19 pandemic, patients turned to telehealth to continue receiving care from the safety of their homes. At the same

time, states that were being hardest hit by the virus were beginning to experience provider shortages, especially nurses, forcing hospitals and health systems to seek assistance from professionals from other states. In August 2020, bills were introduced in Congress that were aimed at improving access to care through provider mobility and interstate telehealth by allowing providers to practice anywhere in the country with one state license—with some critical exceptions.

"The Nurse Licensure Compact (NLC) and other interstate compacts allow providers in many states to quickly relocate or reach patients using telehealth. However, the response during the COVID-19 pandemic was slow in states that had not already joined compacts, a complication that was at least partially due to lack of health provider license portability. In response to the growing COVID-19 crisis, governors across the country issued executive orders waiving state licensing requirements for healthcare providers, allowing providers to deliver in-person and telehealth services outside of their states of licensure in order to improve patient access to care. However, many stakeholders argued that these changes were happening too slowly and were inconsistent from state to state, complicating telehealth responses to patients from out of state. A number of healthcare advocates began to urge the federal government to intervene and pre-empt state licensing laws, allowing providers to practice across state lines as long as they had one state license. However, as many discovered for the first time, the federal government does not currently possess the legal authority to do so" (NCSBN, August 21, 2020).

In response to this problem, Members of Congress introduced a number of bills that would temporarily allow providers to practice across state lines when a Public Health Emergency has been declared:

- *Equal Access to Care Act (S.3993)*: This bill was introduced in the U.S. Senate on June 17, 2020, to allow healthcare providers to deliver telehealth services in any U.S. jurisdiction with only one license. If this bill had become law, it would have legally pre-empted the Nurse Licensure Compact and other compacts with regard to the location of care during telehealth interactions. The National Council of State Boards of Nursing (NCSBN) opposed the bill.
- *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S.421).* The TREAT Act was introduced in the Senate on August 4, 2020. A companion bill (H.R.8283) was introduced in the House of Representatives on September 17, 2020. These bills provided for the temporary licensing authority for healthcare professionals to practice in-person or via telehealth anywhere in the United States with a license in good standing in only one jurisdiction during a period where both a Public Health Emergency has been declared by the secretary of Health and Human Services (HHS) and a national emergency has been declared by the president. The temporary licensing would remain in effect for up to 180 days after the emergency period concluded. When practicing telehealth, healthcare professionals would be required to follow the practice laws and regulations in their jurisdiction of licensure, not the jurisdiction where the patient is located.

  Unlike the Equal Access to Care Act, the TREAT Act addressed concerns related to state-based licensure, discipline, and the NLC through the addition of three critical provisions in Section 4 of the bill:

  - *Subsection (f): Investigative and Disciplinary Authority.* This provision would allow jurisdictions to investigate and take disciplinary action against a provider by preventing them from practicing in their jurisdiction, and then require such as preclusion to be reported to the licensing authority in the provider's state of licensure.

- *Subsection (g): Multiple Jurisdiction Licensure.* This provision would require a provider to follow the practice laws and regulations in the jurisdiction where the patient is located if the provider holds a license in that jurisdiction, alleviating legal confusion about which license would apply in these situations.
- *Subsection (h): Interstate Licensure Compacts*. This provision would exempt providers who hold a multistate license or privilege to practice in multiple jurisdictions through an interstate compact from being subject to this bill.

The inclusion of these provisions better preserves state-based public protection regulatory models and addressed federal legislation's inherent legal conflicts with the NLC and other compacts. In response to the provisions included, the NCSBN remained neutral on the TREAT legislation.

This case study reminds us of the need for constant vigilance to ensure that nursing avoids the unintended consequences of well-intended public policies.

Why You Are the Right Person to Influence Health Policy

When we think of **political power**, we may think of how people, governments, and powerful groups may compel us to do things or even to think a certain way. This sort of power is known as *coercive power*. Coercive power is typically exercised by parents over children. It is also exercised by laws such as those establishing a minimum drinking age for purchasing alcohol or tobacco products or permitting underage marriage only with the consent of a parent or guardian. The second type of power important for nurses to understand is *blocking power*. This type of power has also been referred to as *negative decision power*. Blocking power is used to prevent issues from rising to legislative attention either by limiting an issue from getting on the agenda or by relegating it to a low priority on the agenda. Impeding or limiting policy and social choices has been studied much less than coercion. Examples of blocking power include the political gridlock we typically see around the annual federal budget process based on the use of congressional rules to create a stalemate and control of information flow. Google has been said to be the world's largest censor by blocking access to millions of websites (Epstein, 2016). A third type of power affecting health programs and systems is *purchasing power*. The best example of this in the healthcare arena is the purchasing power of the federal Medicare program, which determines reimbursement rates for healthcare providers.

Influence and power may also be gained from the strategic use of social media or from the 24-hour news cycle (**Figure 1-4**). The COVID-19 pandemic catapulted nurses and other essential workers into the limelight, providing the nursing profession with a voice that is not usually available.

Nursing's education requirements, communication skills, rich history, leadership, and trade association involvement, as well as our practice venues, uniquely qualify nurses to influence thought leaders and policymakers. Nursing and nurses have an ongoing impact on health and social policies.

Figure 1-4 Frontline nurses catapulted into the 24-hour news cycle in 2020.
Tom Stiglich at Creators.com.

Figure 1-5 illustrates some aspects of nurses' impact on the health and well-being of populations.

Advanced studies build on education and experience and broaden the arena in which nurses work to a systems perspective, including both regional health **systems** and the overall U.S. **System** of healthcare delivery and finance. Nurses not only are well prepared to provide direct care to persons and families, but also act as change agents in the work environments in which they practice and the states/nations where they reside.

Nurses have developed theories to explain and predict phenomena they encounter in the course of providing care. In their practice, nurses also incorporate theory from other disciplines such as psychology, anthropology, education, biomedical science, and information technology. Integration of all this information reflects the complexity of nursing care and its provision within an extremely convoluted healthcare System. Nurses understand that partnerships are valued over competition, and that the old rules of business that rewarded power and ownership have given way to accountability and shared risk.

Communication skills are integral to the education of nurses, who often must interpret complex medical situations and terms into common, understandable, pragmatic language. Nurse education programs have formalized a greater focus on communications than is present in any other professional education program. From baccalaureate curricula through all upper levels of nurse education, major segments of nursing courses focus on individual communications and group processes. Skills include active listening, reflection, clarification,

1852	**Florence Nightingale** used statistics to advocate for improved education for nurses, sanitation, and equality.
1861	**Clarissa "Clara" Barton** was a hospital nurse in the American Civil War. She founded the American Red Cross.
1879	**Mary Mahoney** was the first African American nurse in the United States and a major advocate for equal opportunities for minorities.
1903	North Carolina creates first Board of Nursing in the nation and licenses the first registered nurse.
1906	**Lillian D. Wald**, nurse, humanitarian, and author, made many contributions to human rights and was the founder of American Community Nursing. She helped found the NAACP.
1909	The University of Minnesota bestows the first bachelor's degree in nursing.
1916	**Margaret Higgins Sanger** was an American birth control activist, sex educator, writer, and nurse. Sanger popularized the term "birth control" and opened the first birth control clinic in the United States (later evolved into Planned Parenthood).
1925	The Frontier Nursing Service was established in Kentucky with advanced practice nurses (midwives).
1955	**RADM Jessie M. Scott, DSc**, served as assistant surgeon general in the U.S. Public Health Service; led the Division of Nursing for 15 years; and provided testimony before Congress on the need for better nursing training that led to the 1964 Nurse Training Act, the first major legislation to provide federal support for nurse education during peacetime.
1966	The nurse practitioner (NP) role is created by **Henry Silver, MD**, and **Loretta Ford, RN**.
1967	**Luther Christman, PhD**, became the first male dean of a School of Nursing (at Vanderbilt University). Earlier in his career, he had been refused admission to the U.S. Army Nurse Corps because of his gender. He was the founder of the American Association for Men in Nursing, as well as a founder of the National Student Nurses Association.
1971	Idaho statutorily recognizes advanced practice nursing.
1978	**Faye Wattleton, CNM**, was elected president of the Planned Parenthood Federation of America—the first African American and youngest person ever to hold that office. She was the first African American woman honored by the Congressional Black Caucus.
1987	**Ada S. Hinshaw, PhD**, became the first permanent leader at the National Institute of Nursing Research at the National Institutes of Health.
1989	**Geraldine "Polly" Bednash, PhD**, headed the American Association of Colleges of Nursing's legislative and regulatory advocacy programs as director of government affairs. She became CEO of AACN in 1989 and coauthored AACN's landmark study of the financial costs to students and clinical agencies of baccalaureate and graduate nursing education.
1992	**Eddie Bernice Johnson, BSN**, was the first nurse elected to the U.S. Congress (D-TX), where she was a strong voice for African Americans and pro-nursing policies.

Figure 1-5 Prominent nurses who have influenced policy. *(continues)*

1996 **Beverly Malone, PhD**, was elected president of the American Nurses Association; President Clinton appointed her to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and to the post of deputy assistant secretary for health within the Department of Health and Human Services.

1998 **Lois G. Capps, BSN**, was a U.S. Representative from California from 1998–2017, where she founded the Congressional Nursing Caucus.

2001 **Major General Irene Trowell-Harris, EdD, RN, USAF (Ret.)**, served as director of the Department of Veterans Affairs, Center for Women Veterans. She was instrumental in establishing fellowship for military nurses in the office of Senator Daniel K. Inouye (D-HI).

2009 **Mary Wakefield, PhD**, became the first nurse appointed as director of the Health Resources and Services Administration. In 2015, she became the acting deputy secretary for the Department of Health and Human Services. She also served as chief of staff for U.S. Senators Quentin Burdick (D-ND) and Kent Conrad (D-ND).

2010 **Mary D. Naylor, PhD**, was included as a member of the Medicare Payment Advisory Commission, which influences health policy, and she also holds memberships on the RAND Health Board and the National Quality Forum Board of Directors, as well as serving as past-chair of the board of the Long-Term Quality Alliance.

2011 **LTG Patricia Horoho, MSN, RN**, became the first female and nurse to command the U.S. Army's Medical Command and serve as the surgeon general of a military department over the 239-year history of the Department of Defense. She was honored by Time Life Publications for her actions at the Pentagon on September 11, 2001.

2013 **Marilyn Tavenner, MHA, RN**, became the first nurse confirmed as administrator of the Centers for Medicare and Medicaid Services, serving during the rollout of the Affordable Care Act of 2010.

2013 **Joanne Disch, PhD**, became an influential voice for health policy as chair of the national board of directors for the American Association of Retired Persons and the American Academy of Nursing.

2019 **Ernest Grant, PhD**, became the first male elected as the American Nurses Association's president, championing the plight of immigrants and refugees to the United States.

2020 **Sheila P. Burke, MSN**, chaired Baker Donelson's influential Government Relations and Public Policy Group, following a distinguished career in government. In 1995, she was elected secretary of the Senate, the chief administrative officer of the U.S. Senate. She served from 2000 to 2007 as a member of the Medicare Payment Advisory Commission. She worked for 19 years on Capitol Hill on the staff of the Senate Majority Leader Bob Dole. She then served as the deputy secretary and chief operating officer of the Smithsonian Institution.

Figure 1-5 Continued.

assertiveness, role playing, and other techniques that build nurse competence levels. These same skills are useful when talking with policymakers.

Nursing care is not only a form of altruism, it also incorporates intentional action (or inaction) that focuses on a person or group with actual or potential health problems. The education of nurses puts them in the position of

discovering and acknowledging health problems and health System problems that may demand intervention by public policymakers. For these reasons, accrediting agencies require policy content within nurse education programs.

Practice and Policy

Evidence and theory provide the foundation for nursing as a practice profession. Nurses stand tall in their multiple roles—provider of care, educator, administrator, consultant, researcher, political activist, and policymaker. In their daily practice, nurses spot healthcare problems that may need government intervention, although not all problems nurses and their patients face in the healthcare System are amenable to solutions by government. Corporations, philanthropy, or collective action by individuals may best solve some problems. Most nurses are employees (as are most physicians today) and must navigate the organizations in which they work. By being attuned to systems issues, nurses have developed the ability to direct questions and identify solutions. This ability is reflected in the relationships that nurses can develop with policymakers.

Nurses bring the power of numbers when they enter the policy arena. According to a 2018 report from the National Council of State Boards of Nursing (NCSBN), there were 4,096,607 registered nurses (RNs) and 920,655 licensed practical nurses/licensed vocational nurses (LPN/LVNs) in the United States as of October 2019 (NCSBN, 2020). Collectively, nurses represent the largest group of healthcare workers in the nation.

Nurses have many personal stories that illustrate health problems and patients' responses to them. These stories have a powerful effect when a nurse brings an issue to the attention of policymakers. Anecdotes often make a problem more understandable at a personal level, and nurses are credible storytellers. By applying evidence to a specific patient situation, nurses may also bring research to legislators in ways that can be understood and can have a positive effect.

Nurses live in neighborhoods where health problems often surface and can often rally friends to publicize a local issue. Nurses are constituents of electoral districts and can make contacts with policymakers in their districts. Nurses vote. It is not unusual for a nurse to become the point person for a policymaker who is seeking information about healthcare issues. A nurse does not have to be knowledgeable about every health problem, but a nurse often has knowledge of a specific patient population as well as a vast network of colleagues and resources to tap into when a policymaker seeks facts. The practice of nursing prepares the practitioner to work in the policy arena. Note that the public policy process depicted in Figure 1-2 involves the application of a decision-making model in the public sector.

All facets of nursing practice and patient care are highly regulated by political bodies. State boards of nursing and other professional regulatory boards exert much influence in interpreting the statutes that govern nursing. Scope of practice is legislated by elected members but then defined in the rules and regulations by boards. Because each state and jurisdiction defines the practice

of nursing differently, nursing scope of practice varies widely across the specific states. A fear expressed by many boards is that their decisions may interfere with Federal Trade Commission (FTC) rules that restrict monopoly practices. In 2014, the FTC published a policy paper addressing the regulation of the **advanced practice registered nurse (APRN)** that includes five key findings with important implications for policymakers:

1. APRNs provide care that is safe and effective.
2. Physicians' mandatory supervision of and collaboration with advanced nurse practice is not justified by any concern for patient health or safety.
3. Supervision and collaborative agreements required by statute or regulation lead to increased costs, decreased quality of care, fewer innovative practices, and reduced access to services.
4. APRNs collaborate effectively with all healthcare professionals without inflexible rules and laws.
5. APRN practice is "good for competition and consumers" ("FTC Policy Paper," 2014, p. 11).

Professional nurses who are knowledgeable about the regulatory process can more readily spot opportunities to contribute or intervene prior to final rule making.

Organizational Involvement

Professional organizations bring their influence to the policy process in ways that a single person may not. There are myriad nurse-focused organizations, including those in specialty areas, education-related organizations, and leadership-related organizations. For example, the American Nurses Association, the National League for Nursing, and Sigma Theta Tau International state a commitment to advancing health and health care in the United States and/or on a global scale, as noted in their mission statements and goals, and offer nurses opportunities to develop personal leadership skills. The Oncology Nurses Society, the American Association of Critical Care Nurses, the American Association of Nurse Anesthetists, the Emergency Nurses Association, and many other specialty organizations focus on policies specific to certain patient populations and provide continuing education. Participating on committees within trade associations provides opportunities to learn about the organization, its mission, and its outreach efforts in more depth.

Professional associations afford their members experiences to become knowledgeable about issues pertinent to the organization or the profession. These groups can expand a nurse's perspective toward a broader view of health and professional issues, such as at the state, national, or global level. This kind of change in viewpoint often encourages a member's foray into the process of public policy. Some nurses are experienced in their political activity. They serve as chairs of legislative committees for professional organizations, work as campaign managers for elected officials, or present testimony at congressional, state, or local hearings; a few have run for office or hold office.

Political activism is a major expectation of most professional organizations. Many organizations employ professional lobbyists who carry those organizations' issues and concerns forward to policymakers. These sophisticated activists are skilled in the process of getting the attention of government and obtaining a response. Nurses also have an opportunity to voice their own opinions and provide information from their own practices through active participation in organizations. This give-and-take builds knowledge and confidence when nurses help legislators and others interpret issues.

Taking Action

Nurses cannot afford to limit their actions in relation to policy. Instead, nurses need to share their unique perspectives with bureaucrats, agency staff, legislators, and others in public service regarding what nurses do, what nurses and their patients need, and how their cost-effectiveness has long-term impacts on health care in the United States.

Many nurses are embracing the whole range of options available in the various parts of the policy process. They are seizing opportunities to engage in ongoing, meaningful dialogues with those who represent the districts and states and those who administer public programs. Nurses are becoming indispensable sources of information for elected and appointed officials, and they are demonstrating leadership by becoming those officials and by participating with others in planning and decision making. By working with colleagues in other health professions, nurses often succeed in moving an issue forward owing to their well-recognized credibility and the relatively fewer barriers they must overcome.

A Professional Nursing Workforce

Nurses can bring research and creativity to efforts geared toward solving public policy issues such as high drug prices, patient readmission rates, deployment of screening tools, and the most efficacious use of RN and APRNs. Aiken and colleagues have reported repeatedly that hospitals with higher proportions of baccalaureate-prepared nurses demonstrate decreased patient morbidity and mortality (Aiken et al., 2003, 2012, 2014; Van den Heede et al., 2009; Wiltse-Nicely, Sloane, & Aiken, 2013; You et al., 2013). Aiken's research includes studies in the United States and in nine European countries. Although the NCSBN has stated that it is not ready to support legislation or regulation that requires a bachelor of science in nursing (BSN) as the entry level into practice as a registered nurse, the marketplace is moving in a different direction (**Figure 1-6**). Many healthcare agencies limit new hires to those with a BSN and have policies that require RNs with associate's degrees or diplomas to complete a BSN within 5 years of employment. Academic institutions have expanded or created RN-to-BSN programs in response to the demand from the accrediting agency for Magnet status, the American Nurses Credentialing Center.

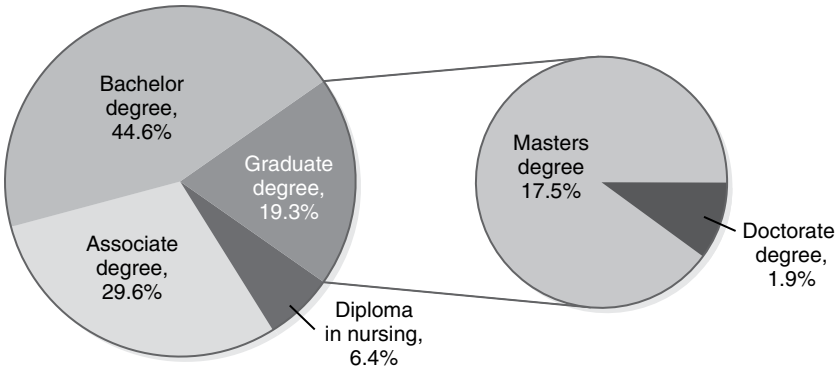


Figure 1-6 Highest nursing and nursing-related educational attainment.

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2019. Brief Summary Results from the 2018 National Sample Survey of Registered Nurses, Rockville, Maryland.

Spotlight: Title VIII of the Affordable Care Act: Community Living Assistance Services and Supports (CLASS) Act

The CLASS Act was intended to allow Americans who are or who become disabled to receive a $50 daily payment to put toward assisted living. The amount was to be spent on home health care, adult daycare, and other services to allow those with disabilities to stay in their homes when possible. The amount could also go toward care provided by assisted living facilities, nursing homes, and group homes. The program was intended to be self-funded and would have reduced the deficit by $70.2 billion over 10 years by allowing people to remain employed and stay out of nursing homes and hospitals. The CLASS Act entered into force on January 1, 2011, but by October 1 it was determined to be unworkable. It could not compete with private-sector plans that offered better benefits.

Innovation in Health Care: Reform or Incrementalism?

Starting with the Truman administration in the 1940s, every U.S. president's administration has struggled to reform the healthcare System to meet the needs of all U.S. residents. President Barack Obama declared early in his administration that a major priority would be health care for all, and in 2010 the Patient Protection and Affordable Care Act (commonly known as the ACA and "Obamacare") was established. More than a decade later, some aspects of the ACA continue to be controversial. The ACA includes 10 legislative titles; some of the titles were found to be unworkable or unsustainable during the implementation phase. The ACA is an example of sweeping reform, and its passage into law was a political feat. Most changes in health policy are incremental rather than sweeping.

During the 115th and 116th Congresses, the Trump administration, together with a Republican majority in the Senate, took steps to weaken the ACA, including the following:

- Eliminating of the mandate that all Americans purchase health insurance (Supreme Court case).
- Sharply reducing support for marketing the state-level health insurance exchanges as well as for the exchange navigators who could help guide those who need this insurance.
- Reducing the number of days of the annual enrollment period by one-half.
- Reneging on financial commitments to health insurers (the ACA provided for various subsidies to insurance companies to reduce their risks of losing money if they participated on the exchanges).
- Expanding access to cheaper insurance coverage that does not meet the quality standards for health insurance required by the ACA. (The ACA was originally intended to bolster the quality of health insurance through such measures as requiring insurers in the individual and small-group markets to cover 10 essential benefits, guaranteeing coverage of those with preexisting conditions at premium rates similar to heathier enrollees, and reducing risks of medical bankruptcy by prohibiting insurers from imposing certain spending caps on health care for an enrollee).

These and other actions to reduce the effectiveness and scope of the ACA did not require full legislative repeal. Instead, there has been a chipping away and erosion of the ACA's intended reforms to improve the U.S. healthcare System, reduce costs, and improve access to care for millions of Americans.

The 2020 elections did not provide a clear mandate to either a conservative or liberal point of view regarding the future of healthcare legislation. President Biden will need to work with a slim Democratic majority in the 117th Congress to amend, strengthen, and improve the ACA—or replace it. Former Senate Majority Leader Mitch McConnell, reelected in 2020 to his seventh 6-year term, will lead the Republican minority to possibly obstruct and delay much of the Biden administration's agenda (as he promised to do during the Obama administration). No party has a clear pathway to the super-majority (two-thirds of the Senate) needed to control specific types of votes. Based on recent history, the election cycle may return the congressional majority to the Republicans in 2022.

Divided government allows more points of view to be considered when designing policies; however, it can also cripple a government's ability to get anything done. As this text goes to press, Biden's cabinet appointments as well as other advisory positions are unknown; hopefully, nurses will be included. One of Biden's first actions as president-elect was to create a White House Coronavirus Task Force; the original appointees did not include any nurses.

Nurses must speak out as articulate, knowledgeable, caring professionals who contribute to the whole health agenda and who advocate for their patients and the community. All healthcare professions have expanded the boundaries of practice from their beginnings. Practice inevitably reflects societal needs and conditions; homeostasis is not an option if the provision of health care is to be relevant.

Spotlight: Voting in the Senate

Most issues in the Senate are decided by a simple majority vote: one-half plus one of the senators voting, assuming the presence of a quorum. For instance, if all 100 senators vote, the winning margin is at least 51. Under Senate precedents, a tie vote on a bill defeats it. Some super-majority votes (also known as extraordinary majority) are explicitly specified in the Constitution; implicitly, they also exist in authority granted in Article I, Section 5, which says, "Each chamber may determine the Rules of Its Proceedings." Under this constitutional power, the Senate has imposed on itself a number of additional super-majority requirements. These include invoking cloture, suspending the rules, postponing treaty consideration indefinitely, making a bill a special order (antiquated), and waiving the Congressional Budget Act of 1974, Senate Rule XXVIII, Senate Rule XLIV, and the Statutory Pay-As-You-Go Act of 2010 (also known as "pay-go").

What is cloture? A three-fifths vote of all senators (60 of 100) is required to invoke cloture—the closure of debate—on most bills. However, a two-thirds vote of the senators present and voting is required to invoke cloture on measures or motions to amend Senate rules. Once cloture has been invoked, the 30 hours of debate available during postcloture consideration may be extended by a three-fifths vote of all senators duly chosen and sworn.

Developing a More Sophisticated Political Role for Nurses

Nurses who are serious about political activity realize that the key to establishing contacts with legislators and agency directors is to forge ongoing relationships with elected and appointed officials and their staffs. By developing credibility with those active in the political process and demonstrating integrity and moral purpose as client advocates, nurses are becoming players in the complex process of policymaking.

Nurses have learned that by using nursing knowledge and skill, they can gain the confidence of government actors. Personal stories drawn from professional nurses' experience anchor conversations with legislators and their staffs, creating an important emotional link that can influence policy design. Nurses' vast network of clinical experts produces nurses in direct care who provide persuasive, articulate arguments with people "on the Hill" (i.e., U.S. congressional Members and senators who work on Capitol Hill).

Working With the Political System

Many professional nurses and APRNs develop contacts with legislators, appointed officials, and their staffs. Groups that offer nurse interaction include the U.S. House Nursing Caucus and the Senate Nursing Caucus (membership shifts with the election cycle). Members hold briefings on nurse workforce planning, patient and nurse safety issues, vaccinations, school health, reauthorization of

legislation (e.g., the Emergency Medical System Act, the Ryan White Act), preparedness for bioterrorism, and other relevant and pertinent issues and concerns.

Nurses must stay alert to issues and be assertive in bringing problems to the attention of policymakers. It is important to bring success stories to legislators and officials—they need to hear what good nurses do and how well they practice. Sharing positive information will keep the image of nurses positioned within an affirmative and constructive picture.

Conclusion

Healthcare professionals must have expert knowledge and skills in change management, conflict resolution, active listening, assertiveness, communication, negotiation, and group processes to function appropriately in the policy arena. Professional autonomy and collaborative interdependence are possible within a political system in which consumers can choose access to quality health care that is provided by competent practitioners at a reasonable cost. Professional nurses have a strong, persistent voice in designing such a healthcare system for today and for the future.

The policy process is much broader and more comprehensive than the legislative process. Although individual components can be identified for analytical study, the policy process is fluid, nonlinear, and dynamic. There are many opportunities for nurses in advanced practice to participate throughout the policy process. The question is not *whether* nurses should become involved in the political system, but *to what extent*. Across the policy arena, nurses must be involved with every aspect of this process. By knowing all the components and issues that must be addressed in each phase, the nurse in advanced practice will find many opportunities for providing expert advice. APRNs can use the policy process, individual components, and models as a framework to analyze issues and participate in alternative solutions.

Chapter Discussion Points

1. What is the number (or designation) of your voting district? Obtain your voting record from the board of elections and describe your citizenship in regard to voting in elections.
2. Identify a health- or healthcare-related problem you have encountered in your community or in practice (e.g., "My patients all have dental problems and have no means of paying for dental care"). Discuss how the diagram of the policy process (Figure 1-2) can help inform how you approach finding a solution to this problem. Reflect on which level of government might address this problem and why. Identify the stakeholders in this issue.
3. Read fact-based (not opinion) books or journalistic articles or listen to podcasts about the changing paradigm in healthcare delivery and payment systems. Suggestions for reading include *Priced Out* (2019) by Uwe Reinhardt,

Being Mortal (2014) by Atul Gawande, articles/blog postings in *The Atlantic* and *Health Affairs*, and *Which Country Has the Best Health Care* (2020) by Ezekiel Emanuel.
   a. List three questions you have after reading this material.
   b. List three new ideas you have gained.
   c. Commit to three actions that you will take as a result of being informed by this material.
4. Consider a thesis, graduate project, or dissertation on a specific topic (e.g., clinical problems, healthcare issues). Use the policy process as a framework.
5. Use a search engine to explore a policy related to a health or healthcare topic such as Supplemental Nutrition Assistance Program (SNAP) benefits, the nursing workforce, or the National Practitioner Database (NPDB). Which government agencies are responsible for developing the policy? For enforcing the policy? How has the policy changed over time? What are the consequences of not complying with the policy? What is needed to change the policy?
6. Identify nurses and healthcare professionals who are elected officials at the local, state, or national level. Follow them on Twitter and Facebook to determine how they became policy experts, what their objectives are, and to what extent they use their clinical knowledge in their official capacities. Ask the officials if they tapped into nurses' groups during their campaigns. If so, what did the nurses and HCPs contribute?
7. Watch a health- or healthcare-related hearing in the U.S. House of Representatives or the Senate. These are accessible online at www.congress.gov. The House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions Committee are good choices. Discuss three things you learned from the hearing. Was there testimony by nurses or other clinicians? Would nursing/HCP testimony be valuable at this hearing? How are witnesses chosen? What topics could you testify about (think of the patient population you work with)?
8. Discover how to get notifications (and agendas) of upcoming health-related committees in your state government. Who are the chairs of these committees?

CASE STUDY 1-2: The Addiction Epidemic

You are an acute care nurse practitioner who works in an urban emergency room (ER). You see many people who come to the ER who have overdosed on heroin. Emergency medical services (EMS) personnel may administer a drug that might reverse the overdose such as naloxone (Narcan). You may see three overdoses during each 12-hour shift; some of these patients are admitted to the hospital, and others are sent home with a consultation for psychiatric follow-up. You are becoming hardened to the issue and have begun to question what you can do to address this epidemic.

Case Study Discussion Questions

1. You hear that the state health director is convening a task force. List four actions you can take to be invited to participate in this task force.
2. Which other healthcare professionals should be included on the task force?
3. Which state agencies and regulatory boards could add value to the discussion?
4. Which information/experience could the APRN use to lead a discussion about widespread addiction?
5. Identify three issues that might be brought up at a meeting that could derail a focus on public safety. Which tactics can the nurse use to bring the discussion back to the issue of safety?

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CHAPTER 2

News Literacy

Cindy Vanek

KEY TERMS

Belief system: A group or set of principles that, together, become the basis of a philosophy.

Bias: An attitude of mind that predisposes one to favor something.

- **Gatekeeping bias:** Omission of news stories that do not adhere to the individual's predispositions.
- **Ideological bias:** Shaping information to mirror an opinion or belief.
- **Media bias:** The slanting of information about a news event or the selection of events or stories to be reported in a manner that aligns with a given belief system.
- **Personal and cognitive bias:** An error in thinking that impacts decisions or judgments of an individual.
- **Political bias:** The altering of information to make a political position more attractive to individuals.

Facts: Things that are is known or proven to be true.

Ideology: The opinions, values, and beliefs of either an individual or a group.

Information environment: The aggregate of individuals, organizations, or systems that collect, process, or disseminate information used for decision making.

Infotainment: Information presented as news in a style that is intended to be entertaining.

Journalism: The collection and editing of news for presentation through the media with the functions of informing, educating, guiding, or entertaining.

Journalist: A person who writes for newspapers, magazines, or news websites or prepares news for video broadcast.

Media: Communication channels through which news, entertainment, education, data, or promotional messages are disseminated. Includes every form of broadcasting and narrowcasting, including newspapers, magazines, TV, radio, billboards, direct mail, telephone, fax, and Internet.

Media literacy: The process of understanding and using the mass media in an assertive and nonpassive way. Includes having an informed and critical understanding of the nature of the media, the techniques used, and the impact of those techniques.

Personal values: A person's principles or standards of behavior; one's judgment of what is important in life.

Societal values: A set of moral principles defined by the dynamics, institutions, traditions, and cultural beliefs of a society that act as implicit guidelines to orient individuals and corporations to conduct themselves properly within the social system.

Value: The regard that something is held to deserve; the importance, worth, or usefulness of something.

Introduction

Most of us believe that we are not biased; we believe that we can read, hear, and consider both sides of an argument, find the facts, and come to a reasonable conclusion. But is this really the case? This chapter suggests that everyone is biased. Developing bias is the result of having opinions, values, and beliefs—it is a result of living. We are, in fact, taught to have opinions, values, and beliefs, and as we age, these concepts will morph and change, but they will remain. Opinions are valuable because they make us think. A **value** is a concept that we consider to be important; values may be **personal values** or **societal values**. They give us standards to live by. Beliefs are thoughts or statements that individuals hold to be true regardless of whether they can be seen or felt or proven. **Bias** develops from these opinions, values, and beliefs. It is unavoidable. We must recognize that we are not, nor can we make ourselves, a blank page. How we deal with and use our biases is what matters. How we react to others whom we know have biases is what matters. As nurses, we need to accept our biases and use them to improve our lives, the lives of our patients and their families, our communities, and our profession.

This chapter will discuss the various types of bias and how bias can be detected within the media, within professional articles, within research, and within everyday conversations. Types of **personal and cognitive bias** will be described. The dangers of bias will be presented, with aids provided to identify bias within organizations and to verify **facts**. The importance of self-reflection and strategies to minimize bias will be discussed with regard to the engagement of the nursing profession in health policy development and reform.

Bias Within the Media

Media, according to the Cambridge Dictionary (2020), includes newspapers, magazines, TV, radio, billboards, direct mail, telephone, fax, and Internet writings. It is available to all who choose to access a given medium. Within media, one will find news or journalistic reporting of an event or events; commentary, which is an explanatory series of notes or comments; and **infotainment**, which is a presentation of information in a manner that is meant to be entertaining. As journalists add commentary or blend information and entertainment, bias often is introduced. Dramatic elements often are added to factual material, resulting in what is often called *soft news*. The types of elements added, and the bias they convey, can change how an individual will interpret the information.

For example, a news report from a sporting event may state, "The Yankees defeated the Mets Saturday with a final score of 10 to 3." Adding commentary to the information might result in a statement that says, "The well-coached Yankees defeated a clumsy-looking Mets team Saturday with a final score of 10-3." If the journalist wants to entertain their audience or reader while presenting the information, they might report the final score while describing or adding multiple pictures of errors made by the Mets team that would make the audience laugh.

Common types of bias within the media include political bias and ideological bias. **Political bias** occurs when a story or news event is altered to make a political position more attractive to the listeners or readers. **Ideological bias** occurs when information is shaped to mirror an opinion, belief, or cause the media outlet supports. Some media outlets will either support or attack a candidate or political party based on their political bias. A media outlet might also criticize the need for a community service or healthcare policy based on its ideological bias. Bias within the media happens when a journalist slants information about a news event to align with a given **belief system**. Colloquial terms for media bias include *false news* or *fake news*. Media bias can be the result of multiple factors, including who owns the media outlet, its sources of income, and the ideology of both those working within the organization and those who make up its audience (University of Michigan, 2014).

Media bias can also stretch the truth to the point that it becomes a lie. Stories can be crafted to influence; they can also be crafted to deceive or misinform the reader or audience. Consider two opposing political candidates who want to convince the American public that they have a better answer for improving the country's healthcare system, specifically the cost of prescription drugs. It is reported in the news that the incumbent candidate stated, "I have reduced the average cost of prescription drugs for Americans from $1,200 per person to less than $750 per person per year." Another news outlet reports that the challenger stated, "Prescription drug costs for an American citizen currently averages $1,200 per year. We must reduce this cost for all Americans." However, the incumbent has provided false information in an effort to win votes. In the media, the incumbent's statement is called false news after a **journalist** or organization fact-checks the information and determines that the latest research shows that the average cost of prescription drugs per person is and remains $1,200 per year. They report the incumbent's statement as a lie, and they will suggest that it was stated to win political favor. Do we believe the incumbent, the challenger, or do we recognize our doubt and research the facts on our own? Given the many ways a story can be slanted to emphasize a point or to gain the approval of the audience, the reader/listener needs to be able to discern truth from fiction.

Understanding that media bias is often difficult to recognize, how do we look for and identify it? How do we develop **media literacy**? According to the University of Michigan (2014), "The most common ways bias manifests itself in the news are through word choice, omissions, the limiting of debate, framing of the story, and a biased selection and use of sources."

When reading or listening to reports about news events, we must be sensitive to the words being used. We must try to determine if key words are being

manipulated so that they are expressing a belief or opinion. Information can be manipulated by simple editing or rearranging words, lost content, staged pictures or video, computer generated material, or algorithm driven 'deep-fake' images, voices, or even movements that are very realistic and misleading. Journalists in a newsroom may be misled by a deceptive caption or story accompanying a picture; the picture is real but the caption twists the reality. A witness who does not fully understand a scene playing out in front of them may provide a false narrative to a real video. For example, a short film clip of a man being dragged by an angry an Arab group circulated on the Internet shortly after the attack on the American Embassy in Benghazi, Libya, with a story claiming that it depicted the U.S. ambassador. The photo went viral on Facebook and led many Americans to believe that Ambassador Stevens was tortured, castrated, and killed by this mob. The real situation was quite different: the picture had been posted to the Internet years before the 2012 incident. The gruesome photo is of an Argentine soldier in 2004 that appeared in a story by Spanish newspaper *HYPERLINK "https://www.diariodeleon.es/" Diario de León* about Argentinian military torture. Real photo. False narrative. (AP, 2019). Similarly, our interpretations of information can be influenced if the information we receive is purposely limited. This often happens when the issue involves a crime or national security. We must consider what sources are used when news is reported and how those sources are used.

News details can be framed to reflect conflict, consensus, or reactions. The details of an event can also be organized to demonstrate a wrong that has occurred. Reporting is supposed to answer the questions of who, what, where, when, and how. What we must understand is that our interpretation of the information can be influenced by how that information is framed.

When information is framed from a political perspective, an understanding of the political spectrum is necessary. The terms *left wing* and *right wing* became popular in the 18th century during the French Revolution. During this time, those who sat to the left of the presiding officer of the French National Assembly supported the revolution and opposed the old regime. They wanted radical change. Those who sat to the right of the presiding officer supported maintaining traditional society, and voila, the concept of left versus right was born (*Left Wing vs. Right Wing*, n.d.). Political theorists now support the idea of a spectrum of political ideology ranging from liberal (left) to conservative (right). One theory, the Horseshoe Theory, depicted in **Figure 2-1**, suggests that the continuum from the political left to the political right bends such that the extreme ends of the continuum are closer to each other; that is, they are not that different from one another.

Proponents of the Horseshoe Theory point to similarities between the far left and the far right—both are concerned with getting and holding power, both seek to organize groups, and both can become fanatical in the belief that they are correct. However, critics suggest that the Horseshoe Theory is a simplistic way to consider political ideologies and, more often, an individual will lean to the left on one matter and to the right on another. We move right or left, or we change position on the horseshoe, based on our personal **ideology** and values. Wherever one may fall on the political spectrum, the need to identify bias