“The true test of the American ideal is whether we’re able to recognize our failings and then rise together to meet the challenges of our time. Whether we allow ourselves to be shaped by events and history, or whether we act to shape them.”

—Barack Obama

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA)—now known simply as the Affordable Care Act—into law and ten days later signed a reconciliation bill to fine-tune it. This law is arguably the most significant piece of social legislation passed in the U.S. since Medicare was implemented in 1965. For more than a century, there have been organized efforts to provide universal health coverage in the U.S. While PPACA does not guarantee coverage for all, by 2019 it will cover up to 32 million of the 45 million who were uninsured when the bill was signed (94% of the population). It ends the ability of insurance companies to deny coverage to people with pre-existing conditions, to drop people once they acquire a costly illness, or to apply annual and lifetime caps on coverage.

But this landmark legislation promises to do more than reform the health insurance industry. It includes provisions for beginning to reform how care is delivered. The nation has realized that it can no longer afford a health care system centered on providing technology-intensive, acute care to individuals once they become sick or injured. Despite spending more on health care than most developed countries, the U.S. ranked last or next-to-last in 2004, 2006, and 2007 on five indicators of high-performing health systems (access, quality, equity, efficiency, and health lives) compared with five other nations (Australia, Canada, Germany, New Zealand, and the UK) (Davis et al., 2007). To improve the health of the public and reduce health care costs, the foundation of the health system must be remade into one that focuses on health promotion and wellness, disease prevention, and chronic care management (Katz, 2009; Woolf, 2009; Wagner, 1998). Acute care must use fewer resources, be safer, and produce better outcomes (Conway & Clancy, 2009).

Nurses know how to do all of this and, in fact, do so every day. After decades marked by nurses’ fighting to make their perspectives on health care count, the nation is realizing that they are key to making this shift a reality. The PPACA contains a number of measures that reflect this (PPACA, 2010). These include the following:

- The PPACA is replete with opportunities to test models of care that already hold promise for improving health outcomes and lowering health care costs. A new Center for Medicare and Medicaid Innovations and other pilot programs and demonstration projects will test and develop ideas ranging from transitional care to nurse managed centers, both of which have been innovations led by and using nurses (www.aannet.org/raisethevoice).
- One area identified in the law for testing is the patient-centered “medical” or “health homes”.

1The PPACA refers to refers to both “medical” and “health” homes; approval of such homes by the National Commission on Quality Assurance refers to a “medical home” designation, so this book will use that language, while recognizing that “health home” is more consistent with a health promotion model.
that take responsibility for coordinating all of the care for the patients it serves, whether this entails educating and coaching patients to better manage their chronic illnesses or ensuring that specialty care is provided and consistent with the patients’ needs or providing transitional care from hospital to home. Nurses and social workers are the people who are and will be doing most of this care coordination.

- Community-based health centers will be expanded in areas where there are health care provider shortages. Expansion of the National Health Service Corps is expected to ensure that providers, including registered nurses (RNs) and advanced practice registered nurses (APRNs) will be available to staff these centers. An emphasis on primary care will increase the demand for nurse practitioners, and the law authorizes additional support for primary care workforce development (loans, scholarships, new educational program development, and expansion of existing programs).

- Payment reforms include piloting bundled payments and care coordination through “accountable care organizations” (ACO). ACOs are similar to integrated delivery systems that combine services across health care settings and are able to focus on ways to improve care delivery and health outcomes under a bundled payment scheme. Bundled payments will provide financial incentives to providers and health systems to keep patients healthy, rather than doing unnecessary tests and procedures that are currently covered on a fee-for-service basis. Again, nurses are key to preventing complications in hospitalized patients, ensuring smooth transitions to home, and coaching the patient and family caregivers in self-care management and health-promoting behavioral changes.

- The PPACA authorizes demonstrations of “Independence At Home” models of care to keep older adults healthy and functioning in their own homes. The models’ aim is improving the quality of life and health outcomes while reducing costly nursing home, hospital, and emergency department usage. Nurses are already leading such programs and are essential care providers, often as APRNs.

- Public health will get a boost from investments in prevention research, health screenings, health education campaigns, and other programs aimed at promoting health. Public health nurses are already providing such services and will be increasingly sought after as these programs expand. Nurse researchers study ways to promote health and prevent illness; their work will be highly relevant to the nation’s understanding of how to improve health.

- A Center for Innovation will support research that focuses on how to improve the safety and quality of care. Nurses are key to quality and safety in health care; they are leading quality departments in hospitals and health systems. The new Center provides such nurse leaders and nurse researchers with opportunities to demonstrate new methods for improving care in cost-effective ways.

- Various measures authorize funding for nurse-managed centers, improved payment for advanced practice nurses including nurse midwives, and workforce development, including the nursing workforce.

This PPACA demonstrates that nursing’s time has come, but it doesn’t mean complacency can now be acceptable. First, the law is only a first step in reforming health care delivery in the U.S. The Social Security Act, when first passed by Congress in 1935, excluded most minorities and women through exemption of specific job categories such as domestic workers. But over the subsequent years, the law was amended to extend coverage to all Americans. This perspective can alert nurses and others to the need to continue to develop statutes that improve upon PPACA. At the same time, some people who opposed PPACA will seek to dismantle it. Others will examine PPACA’s impact on local and state health systems and policies and look for ways to use its mandates and provisions to improve care on a local level. Nurses can and must identify opportunities to implement and improve the law and shape local responses to it.

Second, the implementation of the law is dependent upon the regulations developed by the Department of Health and Human Services (HHS) and state responses including expansion of Medicaid (www.healthreformgps.org). For example, the PPACA provides the HHS Secretary with wide authority to expand pilot programs once tested. The staff of the Center for Medicare and Medicaid (CMS) will write regulations that could remove barriers to APRN practice, such as the restriction that a physician must order hospice and home health services to be eligible
for Medicare coverage. This requirement initially was intended to limit federal costs but now is viewed as 1) impeding efficient care delivery, 2) costing more because of duplication of providers and continuation of more expensive acute care services, and 3) presenting unnecessary barriers to access to care.

Another example is the law’s call for an expansion of home visitation programs for high risk mothers and infants. The Nurse-Family Partnership is the model for this measure, but the law does not specify that the services be provided by nurses despite evidence that nurses produce significantly better outcomes than non-nurses as home visitors (Karoly, Killburn, & Cannon, 2005). States will be responsible for developing health insurance exchanges to provide options for coverage for those who are not covered by employers.

Third, while there are some measures in the law that bypass the Congressional appropriations process, most of the public health and workforce initiatives must have funding appropriated by Congress every year. As the nation’s deficit increases, Congress is unlikely to appropriate funding for programs that do not have strong, vocal advocates.

So while nursing is well positioned to contribute to a reformed health care system, we cannot assume that those making the decisions about how to reform it will automatically seek nurses’ input. A 2010 Gallup poll of over 1500 non-nurse, health-care opinion leaders revealed that these leaders viewed nurses as essential for quality and safety in health care, but only 14% believed that nurses would be influential in reforming health care (Gallup, 2010). Whether developing new models of care, sharing ideas for regulations with policymakers, working with health care organizations to develop demonstration projects that the new law seeks to test, or advocating new legislation to amend and improve upon the law (or preventing it from being dismantled), nurses must assume the mantle of politically savvy leaders who are shaping health policy at the local, state, and national levels within government, workplaces, health-related organizations, and communities.

POLICY AND THE POLICY PROCESS

Policy is the deliberate course of action chosen by an individual or group to deal with a problem (Anderson, 2006). Public policies are the choices made by public or government officials to deal with public problems (Kraft & Furlong, 2010). Public policies are authoritative decisions made in the legislative, executive, or judicial branches of government intended to influence the actions, behaviors, or decisions of others (Longest, 2005). When the intent of a public policy is to influence health or health care, it is a health policy. Social policies identify courses of action to deal with social problems. All are made within a dynamic environment and a complex policymaking process.

Policies are crafted everywhere from small towns to Capitol Hill. Federal health policy takes many forms including bills passed by Congress such as the Medicare Modernization Act of 2003 and workplace safety regulations enforced by the Occupational Safety and Health Administration. President Bill Clinton banned smoking in federal buildings by executive order, another type of policy (Cook & Bero, 2009). States use policies to specify requirements for licensure in the health professions, to set criteria for eligibility for Medicaid, and to mandate immunization requirements for public university students, for example. Hospitals use policies to direct when visitors may visit patients, to manage staffing, and to respond to disaster. Public schools employ policies to specify who may administer medications to schoolchildren. Towns, cities, and other municipalities use policies to manage public water supplies, to define who may run for office, and whether or not residents may keep exotic pets.

In a capitalist economy such as the U.S., private markets are permitted to control the production and consumption of goods and services, including health services. The government “intrudes” with policies only when the private markets fail to achieve desired public objectives. When it is necessary for the government to intercede, two types of policy are used:

- Allocative policies are used to provide benefits to a distinct group of individuals or organizations, at the expense of others, to achieve a public objective (this is also referred to as the redistribution of wealth). The implementation of Medicare in 1966 was an allocative policy that provided health benefits to older adults and others using federal funds (largely from middle- and higher-income taxpayers).
- Regulatory policies are used to influence the actions, behavior, and decisions of individuals or groups to
ensure that a public objective is met (Longest, 2005). The Health Insurance Portability and Accountability Act of 1996 is a regulatory policy. It regulates how individually identifiable health information is managed by users as well as other aspects of health records.

**FORCES THAT SHAPE HEALTH POLICY**

Many forces shape health policy. Some of the most prominent forces appear in Figure 1-1.

**VALUES**

Values influence all political and policymaking activities. Public policies reflect a society’s values—and also conflicts between values. A policy reflects which value (or values) is given priority in a specific decision (Kraft & Furlong, 2010). Once framed, a policy reveals the underlying values that shaped it. This is usually apparent in health policies; these often affect those who are unable to protect themselves like the young, poor, sick, old, and disabled. Different people value different things, and when resources are finite, policy choices ultimately bring a disadvantage to some groups; some will gain something from the policy, and some will lose (Bankowski, 1996). To support or oppose a policy requires value judgments (Majone, 1989). Conflicts between values were apparent throughout the debate on health care reform; for example, despite a strong contingent of advocates for a government-run, non-profit insurance option that would compete with private insurers, it was not included in the law after opposition from the insurance industry and from people who believed that it represented an increase in the government’s control of health care.

**POLITICS**

*Politics* is frequently associated with a negative connotation, yet it is actually a neutral term. Politics is the process of influencing the allocation of scarce resources to ensure that a public objective is met (Longest, 2005). The Health Insurance Portability and Accountability Act of 1996 is a regulatory policy. It regulates how individually identifiable health information is managed by users as well as other aspects of health records.

![Diagram of forces that shape policy](image-url)
resources. Policymaking involves the distribution of resources; so politics or political action can be viewed as the efforts and strategies used to shape a policy choice. The definition of politics contains several important concepts. **Influencing** indicates that there are opportunities to shape the outcome of a process. **Allocation** means that decisions are being made about how to distribute resources. **Scarcie** implies that there are limits to the amount of resources available—and that all parties likely cannot have all they want. Finally, **resources** are usually considered to be financial, but could also include human resources (personnel), time, or physical space such as offices (Mason, Leavitt, & Chaffee, 2007). Politics can also be considered to be how conflicts in a society are expressed and resolved in favor of one set of values or interests over another (Kraft & Furlong, 2010).

Political skill has a bad reputation; for some it conjures up thoughts of manipulation, self-interested behavior, and favoritism (Ferris, Davidson, & Perrewe, 2005). “She plays politics” is not generally considered to be a compliment, but true political skill is critical in health care leadership, advocating for others, and shaping policy. Ferris et al. (2005) consider political skill to be the ability to understand others and to use that knowledge to influence others to act in a way that supports one’s objectives. They believe political skill has four components:

1. **Social astuteness**: Skill at being attuned to others and social situations; ability to interpret one’s own behaviors and the behavior of others.

2. **Interpersonal influence**: Convincing personal style that influences others featuring the ability to adapt behavior to situations and be pleasant and productive to work with.

3. **Networking ability**: The ability to develop and use diverse networks of people and the ability to position oneself to create and take advantage of opportunities.

4. **Apparent sincerity**: The display of high levels of integrity, authenticity, sincerity, and genuineness (p. 11).

**POLICY ANALYSIS AND POLICY ANALYSTS**

Analysis is the process of examining an object and breaking it down to understand it better. Policy analysis uses different methods to assess a problem and determine alternative ways to resolve it. This encourages deliberate critical thinking about the causes of problems, identifies the various ways a government or other group could act, evaluates the alternatives, and determines the policy choice that is most desirable. Policy analysts are individuals who, with professional training and experience, analyze problems and weigh potential solutions. Citizens can also use policy analysis to better understand a problem, alternatives, and potential implications of policy choices (Kraft & Furlong, 2010).

**ADVOCACY AND ACTIVISM**

Advocacy for one patient at a time has long been considered a core nursing role. Advocating for change through policy and politics permits nurses to advocate on a larger scale and is endorsed in Nursing’s Social Policy Statement (ANA, 2003), a document that defines nursing and its social context. Political activism may be associated with protests and “sit-ins” but has grown to include diverse and effective strategies such as blogging, using evidence to support policy choices, and garnering media attention in sophisticated ways.

**INTEREST GROUPS AND LOBBYISTS**

Interest groups advocate for policies that are advantageous to their membership. Groups often employ lobbyists to advocate on their behalf, and their power cannot be underestimated. In the U.S. in 2009, about 1,750 businesses and organizations spent at least $1.2 billion on lobbyists to advocate for their interests in the health care reform debate and on many other issues (Center for Public Integrity, 2010).

**THE MEDIA**

In 2009 and 2010, Pulitzer-prize winning journalist Charles Ornstein and his colleague Tracy Weber published a series of investigative reports on the California Board of Registered Nursing’s excessive delays in acting on reports of professional misconduct by RNs for whom evidence of wrongdoing was well documented (Weber & Ornstein, 2010). The board took an average of three years to take disciplinary action, including against nurses who were charged with physically and sexually abusing patients or were in prison but still getting their licenses renewed. The journalists’ initial reports resulted in more staff being hired by the board, but when it was not clear that they had successfully improved processing.
times and more reports were published by Ornstein and Weber, the governor dismissed the board’s members and replaced them with new ones. The executive director of the board—a nurse—subsequently resigned. The governor advocated new legislation to require employers to notify the board whenever they fire or suspend a nurse for serious wrongdoing and permit a state official to suspend the license of any nurse who is deemed to represent a threat to the public. In 2010, the legislation was opposed by leading nurses’ unions in the state (Weber & Ornstein, 2010).

Ornstein and Weber work for ProPublica, one of a growing number of non-profit investigative news organizations. They used traditional newspapers (the Los Angeles Times) to help disseminate their stories, but also created an interactive web site (www.propublica.org/series/nurses) that profiled individual nurses and provided comparative data on disciplinary actions by other state boards for nursing. They also used new media, or social media, to further push their work out to other audiences. But new media have also introduced easily accessible tools for activists and advocates to use to become citizen journalists and influence policy.

SCIENCE AND RESEARCH

Scientific findings can play a powerful role in the first step of the policy process—getting attention for particular problems and moving them to the policy agenda. Research can also be valuable in defining the size and scope of a problem (Diers & Price, 2007). This can help to obtain support for a particular policy option and in lobbying for support for it. Evidence should be used to inform policy debates and shape policy choices to help ensure that the solution will be effective.

PRESIDENTIAL POWER

The president embodies the power of the executive branch of government and is the only person elected to represent the entire nation. As the most visible government official, the president is able to propel issues to the top of the nation’s policy agenda. Though the president cannot introduce legislation, he can provide draft legislation and legislative guidance (Weissert & Weissert, 2006).

THE FRAMEWORK FOR ACTION

The first edition of this book, Political Action Handbook for Nurses: Changing the Workplace, Government, Organizations and Community, introduced readers to a model of political action for nurses (Mason & Talbott, 1985) named the Framework for Action. The model used “spheres of influence” to conceptualize the places where nurses use politics to shape policy and to work for change in the health system. The original Framework for Action’s four spheres of influence were labeled: (1) the workplace, (2) the government, (3) organizations, and (4) the community. The original “workplace” sphere has been broadened now to include the workplace and the workforce. This addresses the policy work that is done in a variety of places to influence the size, educational preparation, and competence of the nursing workforce. The original “organizations” sphere was defined as professional nursing associations (Mason & Talbott, 1985, p. 444). Recognizing that nurses work to influence policy through other types of associations, such as interdisciplinary groups and unions, this sphere has now been reconceptualized as “associations and interest groups” (Figure 1-2).

The Framework for Action has been updated to reflect current knowledge about health care and the impact of social determinants on health (Figure 1-3). It more thoroughly explains nursing’s role in
opportunities for nurses to influence health and social policy in communities. Nursing has a rich history of community activism with remarkable examples provided by leaders such as Lillian Wald, Harriet Tubman, and Dorothea Dix. This legacy continues today with the community advocacy efforts of nurses like Cora Tomalinas, Mary Behrens, Ruth Lubic, Patricia Tobal, Ellie Lopez-Bowlan, the Nightingales who took on big tobacco, and the nurses who are a part of the Canary Coalition for Clean Air (all of their stories appear in this book).

A community is a group of people who share something in common and interact with one another, who may exhibit a commitment with one another, and may share a geographic boundary (Lundy & Janes, 2001). A community may be a neighborhood, a city, an online group with a common interest, or a faith-based network. Nurses can be influential in communities by identifying problems, strategizing with others, mobilizing support, and advocating for change. In residential communities (such as towns, villages, and urban districts), there are opportunities to serve in elected and volunteer positions that influence policy. Many groups, such as planning boards, civic organizations, and parent-teacher associations, offer opportunities for involvement.

SPHERE OF INFLUENCE 2: THE WORKFORCE AND WORKPLACE

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

Outside of the workplace, policy is made that influences the size and composition of the nursing
workforce. The new PPACA authorizes increased funding for scholarships and loans for nursing education—potentially augmenting existing workforce programs funded under Title VII and VIII of the Public Health Act. The non-governmental Commission on Graduates of Foreign Nursing Schools is authorized by the federal government to protect the public by ensuring that nurses and other health care professionals educated in countries other than the U.S. are eligible and qualified to meet licensure, immigration, and other practice requirements in the U.S. (Commission on Graduates of Foreign Nursing Schools, 2009). The National Council of State Boards of Nursing is a not-for-profit organization that brings together state boards of nursing to act on matters of common interest affecting the public’s health, safety, and welfare, including the development of licensing examinations in nursing (National Council of State Boards of Nursing, 2009).

**SPHERE OF INFLUENCE 3: THE GOVERNMENT**

Government action and policy affects lives from birth until death. It funds prenatal care, inspects food, bans unsafe toys and cars, operates schools, builds highways, and regulates what is transmitted on airwaves. It provides for the common defense; supplies fire and police protection; and gives financial assistance to the poor, aged, and others who cannot maintain a minimal standard of living. The government responds to disaster, subsidizes agriculture, and licenses funeral homes (Heinemann, Peterson, & Rasmussen, 1995).

Though most health care in the U.S. is provided in the private sector, much is paid for and regulated by the government. So, how the government crafts health policy is extremely important (Weissert & Weissert, 2006). Government plays a significant role in influencing nursing and nursing practice. States determine the scope of professional activities considered to be nursing, with notable exceptions of the military, veterans’ administration, and Indian health service. Federal and state governments determine who is eligible for care under specific benefit programs and who can be reimbursed for providing care. Sometimes government provides leadership in defining problems for both the public and private sectors to address (Mason et al., 2007). At least eight House and Senate committees and subcommittees shape policy on health, and many more committees address social problems that affect health. In the House of Representatives, the House Nursing Caucus, an...
informal, bipartisan group of legislators who have declared their interest in helping nurses, lobbies for federal funding for nursing education (Walker, 2009).

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

- Obtaining appointment or assignment to influential government positions
- Serving in federal, state, and local agencies
- Serving as elected officials
- Working as paid lobbyists
- Communicating to policymakers their support or opposition to a policy
- Providing testimony at government hearings or open meetings
- Participating in grassroots efforts, such as rallies, to draw attention to problems.

**SPHERE OF INFLUENCE 4: ASSOCIATIONS AND INTEREST GROUPS**

Professional nursing associations have played a significant role in influencing the practice of nursing. Many professional nursing associations have legislative or policy committees that advocate for policies that support their members’ practice. For example, the American Nephrology Nurses Association identifies advocacy as a core value in their strategic plan. One of their goals is to be the leading advocate for nephrology nursing and to advocate for individuals, families, and communities affected by real or potential kidney disease (American Nephrology Nurses Association, 2009). Many nursing specialty groups provide training and workshops for nurses interested in learning the ropes of political involvement as well as online resources to assist members in their advocacy efforts. Working with a group increases the chances for advocacy to be effective, provides an environment where resources can be shared, and enhances networking and learning. Nurses can be effective in association policy activities by serving on public policy or legislative work groups, providing testimony, and preparing position statements.

When nursing organizations join forces through coalitions, their influence can be multiplied. For example, the American Nurses Association (ANA) is a member of the Safer Chemicals, Healthy Families coalition, a coalition whose members are united by a common concern about toxic chemicals in homes, workplaces, and products used every day. The Coalition for Patients’ Rights is a group of 35 national organizations representing health care professionals who are working to fight the American Medical Association’s attempts to limit patients’ access to non-physician providers (www.patientsrightscoalition.org). Twenty-six of the members are nursing organizations.

Nurses can be influential, not just in nursing associations, but through working with other interest groups such as the American Public Health Association and the Sierra Club. Some interest groups have a broad portfolio of policy interests, while others focus on one disease (e.g., breast cancer) or one issue (e.g., driving while intoxicated). Interest groups have become powerful players in policy debates; those with large funding streams are able to shape public opinion with television and radio advertisements.

**HEALTH**

The Framework for Action now includes health as an element of the model to represent that optimal health is viewed as the goal of nursing’s policy efforts. Optimal health (either the individual patient’s or a population’s) is the central focus of the political and policy activity described in this book. This focus makes it clear that the ultimate goal for advancing nursing’s interests must be to promote the public’s health.

**HEALTH AND SOCIAL POLICY**

Health and social policy now appear as elements in the Framework for Action. Many factors that affect health status are social factors such as income, education, and housing. Thus it was important to identify the important role that social policies play in influencing health.

**SOCIAL DETERMINANTS OF HEALTH**

An important update to the framework is the inclusion of the concept of social determinants of health. Even in the most affluent nations, people who are poor have substantially shorter life expectancies and experience more illness than the rich (Wilkinson & Marmot, 2003). While health can be improved with changes to the health system, an agenda for health
The health of individuals and populations is determined significantly by social factors.

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

TABLE 1-1 Political Aspects of the Social Determinants of Health

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


CONCLUSION

Nurses are well-positioned for reforming health care in ways that promote a healthier public and reduce health care costs. But we must be strategic in our leadership, whether in clinical settings to improve the safety and quality of care or advocating for nurse-managed health centers that provide comprehensive primary care and community services to vulnerable and underserved populations. The health care opinion leaders in the 2010 Gallup poll discussed in the opening of this chapter identified two reasons why nurses would fall short of influencing health care reform: too many nurses didn’t want to lead, and the myriad nursing organizations rarely presented a united front. We must not fall short. This book can help nurses to overcome barriers. It is time.

For a list of related websites, please refer to your Evolve Resources at http://evolve.elsevier.com/Mason/policypolitics/

REFERENCES

CHAPTER 1 A Framework for Action in Policy and Politics


