Interweaving policy and diversity

Interweaving Policy and Diversity

Jeri A. Milstead, PhD, RN, CNA-B, CNS

Abstract

Nurses too often consider that direct patient care is the only focus of nursing. However, the role of the nurse is broader than that of direct care and encompasses many components, all of which must be integrated into the self of the nurse. Political activity and policy formation are two areas of nursing that are misunderstood and are not adopted enthusiastically by many nurses. This article examines the whole policy process that includes agenda setting; government response via laws, regulations and programs; policy/program implementation; and policy/program evaluation. The process is then linked to the concept of diversity to illustrate the need, ease and opportunity for nurse involvement.


Key words: cultural diversity, diversity, ethnicity, health policy, law, nursing knowledge, nursing shortage, political participation, politics, regulation

Interweaving Policy and Diversity

The term “policy” has many definitions. One refers to formal, documented directives of an organization that reflect the beliefs and values of executives and legislators and provide direction to employees. These are the “shoulds” and “thou shalts” that are exemplified in position statements, laws (such as nurse practice acts), and regulations. In contrast, the meaning of policy as used in the phrase “policy process” refers to a decision-making process that has a time frame, uses formal and informal relationships and is a series of actions and changes that bring about a particular result. This article will focus on the public policy process—that is, the process of getting problems to the attention of government and obtaining a response from government (Milstead, 1997a). Too often nurses think that policy refers only to legislation. This article will provide an overview of the whole policy process from agenda setting through program evaluation, showing the many connections between policy and diversity, and illustrating the interweaving of policy and diversity.

Policy Models

There are three major models of policy development: steps/stages, structural, and garbage can. In the steps or stages model, policy is seen as a series of veto points that are necessary for political decisions. This is a rational model--linear and “scientific.” That is, decision-makers are expected to set goals, obtain maximum information, consider all alternatives, select a solution, and evaluate the results. While this may be one way to analyze policy, the process does not occur this way in reality. Who can say when “all” information is obtained or that “all” alternatives are considered? Policy makers often use a model from industry referred to as “satisficing” to form decisions (Simon, 1960). This term indicates that one uses the first option that seems as if it will work (satisfactory), even if it does not meet all the criteria (suffices).

The second model, a structural one, encompasses three methods of policy development (Milstead, 1997b). A top-down approach is a familiar one in which decisions are made by executives and implemented in a hierarchical organization. Policy is made by officials and implemented by worker-bees. The bottom-up model purports that program objectives are altered at the local level. Supporters of this model argue that street level bureaucrats, the people who actually implement a program, make operational decisions in order to make a program work. This model assumes that general goals are determined by top officials and are written with some purposeful ambiguity to allow modification at the point of service. Forward-backward mapping, a blending of top-down and bottom-up, suggests a continuous examination and re-examination of objectives and outcomes throughout the process of making policy.

The garbage can model (Cohen, March & Olsen, 1982) assumes that an organization is a collection of people with problems and solutions, often seemingly unrelated, that continuously intersect, connect and disconnect.
When policy makers join a problem and a solution at an auspicious time, a window of opportunity opens and the result is a law, regulation or program.

The free flow of problems and solutions form a "policy soup" from which government experts make political choices. When policy makers join a problem and a solution at an auspicious time, a window of opportunity opens and the result is a law, regulation or program. This model assumes that solutions are floating around that do not have problems attached yet, a concept that should intrigue nurses who are adept at change and may have more solutions than problems. This article frames a discussion of an interweaving of the policy process with the concept of diversity using the garbage can model.

Public Policy Process

Nurses can think of the policy process as containing four components: agenda setting, government response, implementation, and evaluation. The process is fluid, not linear. That is, policy makers may not establish interest or activity at a logical beginning of a problem. Officials may be drawn into a problem when solutions are being debated or programs are being implemented. However, for the purpose of analysis and clarity, we will discuss the four components as if they occur in a logical, sequential fashion.

Agenda Setting

Kingdon's qualitative research (1995) provides a seminal work on how problems gain the attention of government.

The president and his advisors maintain a list of issues they will pay attention to. The list may focus on defense, the environment, health care, transportation, education or other major areas of governmental control. Ways to improve the chance of getting on the agenda include a crisis (such as the September 11, 2001, terrorism attacks), a change in a highly regarded indicator (such as the number of smallpox cases), "hot" topics (such as tobacco) or items magnified by the media (such as the homeless).

Defining a problem automatically limits the range of solutions, but provides a focus. AIDS was first defined as a health concern of intravenous drug users and homosexuals. Meager attempts were made to address the disease. These attempts focused on the use of condoms and "just say no" to drugs campaigns, but neither approach was identified with by the general public. Federal funding for research in developing drugs for treatment increased greatly after AIDS was re-defined as a public health concern.

A policy entrepreneur can be used to keep the issue from fading. This is a person with a known reputation who invests time, money, and expertise in an issue such as a legislator, an agency head, a lobbyist, an academic, or a celebrity, such as Michael J. Fox, who lobbies for funding for Parkinson's Disease. Interest groups, such as the American Nurses Association or the American Hospital Association, also use their power to influence government decisions.

Government Response

"Government" is a broad term that encompasses an "iron triangle" of Congressmen/women, bureaucratic staff, and interest groups. Legislators have staff with specific, usually multiple, foci such as health, economics, international, labor, and other interest areas. These legislative aides (LAs) often research issues for the 'members' (i.e., Congressmen/women) and serve as knowledgeable and influential conduits between the member and constituents. The President's advisors work closely with bureaucratic agencies (the Departments of Health and Human Services, Labor, Education, Defense, etc.) and staff of congressional committees and subcommittees such as Appropriations, Veterans Affairs, or Finance. Directors of these agencies are short-term political appointees who are charged to carry out the President's policies. Agency staff usually are long-time career bureaucrats who understand how things get done in government. Interest groups such as the American Nurses Association and the American Hospital Association use the power of their organizations to influence their own political agendas. There is a vast network of people in government, business, and industry that serve as consultants and who provide information about problems and suggest possible solutions. Solutions often arrive as laws, regulations, or programs.

Laws. Legislative response in the form of a law is a serious, often lengthy process and should be considered seriously before requesting initiation. Is the problem something that government should attend to? Not all problems are solved (or should be solved) by government intervention. Whom do we want to have authority over decisions concerning the problem? Should the health problem be resolved between the patient and the health care provider? Will government intervention be part of the solution or will it produce more obstacles? Are you alone in perceiving this problem or do you have broad support to address the problem and solutions?

U.S. Representatives or Senators must introduce bills into their respective houses; the President cannot introduce a bill.
Programs are the third method of government response. Some public problems demand a program, and nurses have the opportunity to use our expertise by participating in designing programs. Policy instruments or tools are used in the planning phase to encourage people to use a program that might otherwise not use. Authority tools provide legitimate government authority to grant permission, prohibit, or require action. For example, the courts mandated tobacco settlement funds be used for educational purposes. Incentive tools are tangible payoffs that induce compliance, such as vouchers for school programs or subsidies to plant or not plant certain crops. Symbolic tools assume an inner motivation based on values of justice and equality. Symbolic tools are used to persuade people to do the "right" thing such as not drinking and driving. Learning tools are used when problems are not understood or there is little or no agreement on solutions. Hearings, study sessions, and meetings that focus on presentation of a special topic are examples of learning tools.

Implementation

Once a program is authorized and funds are appropriated, the program is assigned to an agency for implementation.

Which agency a program is assigned to is a political decision...

Which agency a program is assigned to is a political decision that may weigh an agency's prior experience with similar programs, whether or not specific staff expertise is available, if the staff are supportive, and if there is a need for a source of new funding that accompanies the program. In his classic book, Bardach (1977) identified many games that are played related to funding. For example, in the Budget Game an agency head spends its funding quickly to demonstrate that the agency was able and ready to implement a program. This will look good in the eyes of legislators. On the other hand, in the Funding Game, an agency obtains funds but tries to maximize the flexibility in spending them. For example, an agency may inflate the anticipated costs of a program and receive the estimated funds, a portion of which can be used for discretionary purposes. A commonly used game that does not hinge on funding is Tokenism, an intentional strategy to delay or obstruct implementation. Most often used in school desegregation and civil rights in the 1960s and 1970s, this game will be discussed vis-à-vis diversity later in this article.

Evaluation

Program evaluation may rarely occur in government in the same way that evaluation occurs in the private sector. In business and industry, evaluation has become the feedback loop of a quality improvement model; objectives and processes are assessed and data are used to improve products. In the private sector formative appraisal occurs more often than just in mid-process and has come to replace summative (final) evaluation in the post-Deming era.

Criteria for choosing a committee or subcommittee may be which members will support or oppose the bill, which committee staff has the expertise to direct appropriate activity and other items on a committee's agenda that may serve as barriers to moving on a bill. A policy entrepreneur is quite helpful in advising where to funnel a bill for optimum outcomes.

Caucuses are meetings of members and their staff to discuss the issue and line up votes. Votes may be traded for unrelated measures, local projects, or future votes on other issues. Bills are authorized or given life, such as creating a program, and appropriated (funds are allocated). Both authorization and appropriations activity has to wend its way through the legislative process in both the House and Senate. After a bill is passed in one chamber, the other chamber must also pass a bill. A Conference Committee makes up of members from both the House and Senate that negotiates the final product settles differences. The final bills must be approved ("marked up") in both houses. When settled, the approved bill is sent to the President for signature.

Nurses should pay attention to committee reports. These very important documents accompany bills and express the intentions of the committee. Reports often direct specific funding to a specified target. For example, if $50M is appropriated to nursing education, $5M may be designated in the Committee Report to nurse anesthesia programs. This is one method of accommodating compromise in the committee and retaining legislative commitment for a particular activity.

Regulations. The regulatory or rulemaking process is a powerful course of action that parallels legislation (Loquist, 1999). Laws provide general goals and direction to government agencies; agencies, in turn, write regulations to help the public interpret the law. For example, the Occupational Safety and Health Administration (OSHA) in the Department of Labor, is charged with the safety of workers in the workplace. OSHA develops standards, compliance directives and compliance guides (www.OSHA.gov). Hospitals and other health care organizations must adhere to the regulations or suffer fines and other sanctions.

Regulations often specify how a law will be carried out and provide specific rules to assure legislators' intentions. For example, each state board of nursing operates within a law that governs the practice of nursing in that state. Each state board of nursing develops regulations that ensure nurses and standards and policies that provide compliance with the law. The regulatory process follows a formal procedure defined by the Administrative Procedures Act (APA). This law requires notification to the public of a proposed rule, time for public comment, and publication of the final rule. In the federal system, these notices are found in the Federal Register (www.access.gpo.gov/ceds.html). Public comment can be made through phone calls, letters to the particular agency, emails, and direct office visits. All comments must be considered by the agency during deliberations, but agencies are not required to include all comments or suggestions in the final rule.

Programs. Programs are the third method of government response. Some public problems demand a reply over time that is addressed by administration of an agency. The "bureaucracy" is a vast collection of departments, institutes, and other organizational entities that provide services to citizens and residents. Agencies often are charged with managing plans and conducting activities that focus on a specific legislative goal. Nurses have the opportunity to use our expertise by participating in designing programs.

Policy instruments or tools are used in the planning phase to encourage people to use a program that might otherwise not use (Smart, 1999). Five types of tools allow for great flexibility and creativity when planning government response to problems. Authority tools provide legitimate government authority to grant permission, prohibit, or require action. For example, the courts mandated tobacco settlement funds be used for educational purposes. Incentive tools are tangible payoffs that induce compliance, such as vouchers for school programs or subsidies to plant or not plant certain crops. Capacity tools provide information, training, or educational resources such as brochures about tobacco, drugs, and AIDS. Symbolic tools assume an inner motivation based on values of justice and equality. Symbolic tools are used to persuade people to do the "right" thing such as not drinking and driving. Learning tools are used when problems are not understood or there is little or no agreement on solutions. Hearings, study sessions, and meetings that focus on presentation of a special topic are examples of learning tools.
How does one evaluate a public policy in all of its complexity? Assembly line materials are finite goods; domestic governmental programs and policies are not concrete but are distributive, regulatory, or redistributive in nature. Distributive policies provide tools such as subsidies, loans, or grants to private activities in order to "distribute" public resources to the private sector. Regulatory policies are competitive or protective policies, such as the Hill-Burton Act that provided money for building hospitals or federal revenue sharing to states, offer public resources that benefit a segment of society. Protective policies, such as nurse practice acts or penalties for pollution, shield the public from harm. Redistributive policies, such as food stamps, shift wealth, rights, or property from the "have" to the "have nots" in attempts at assuring fairness.

Evaluation of public policy occurs as analysts probe into the correctness of decisions made by government officials. The media often analyze public decisions within a framework of political bias rather than a means of improvement. Government programs often are so big and affect so many people that it is difficult to determine the success or failure. Program outputs are measures of efficiency. For example, how many hospitalized women received Pap smears or how many elderly women received flu shots in hospitals as required by law? Efficiency measures often do not provide the depth and breadth of evaluation that is required to determine the effectiveness of a program. For example, what impact did Pap smears or flu shots have on women's health? Are older women discriminated against because health care providers only consider women of childbearing age at-risk for cancer or think flu vaccine should be provided for a younger, more robust population? Outcome measures may provide a much truer picture of the consequences of policy decisions.

Government Response Related to Diversity

Diversity in a broad sense indicates differences in "kind, form or character" (Steinmetz et al., 1997, p. 382). Diversity took on a more specific implication in the 1960s during the Civil Rights movement in the United States. Discrimination on the basis of many indicators (e.g., race, national origin, gender) became illegal in hiring practices, real estate transactions, and other market exercises. The concept of a diverse population originally referred to African-Americans and northern European-Americans (Caucasians). In the waning days of the 20th century, diversity entailed the inclusion of Latinos, Asians, and other ethnic and racial groups. Diversity in the 21st century assumes an even broader palette. Examples of this broader palette, such as challenges to the definition of viability, the point at which a mass of cells is defined as a human being, and to the ethics of cloning human beings (Greenhouse, 2002) will be swept up in the concept of differences and diversity.

Agenda Setting and Diversity

The importance of problem definition cannot be underestimated. A major policy change currently revolves around the definition of human subjects. In late 2002, the Bush Administration deliberately allowed a federal advisory committee to the Secretary of the Department of Health and Human Services (DHHS) to become inactive. The deputy assistant secretary for health operations, a presidential appointee, was then able to oversee revisions of the guidelines for the committee. Under the new charter, embryos and fetuses used in federally funded research are now classified as "human subjects" (Research embryos, 2002). Formerly, children, prisoners, and those "decisionally impaired" (unable to offer informed consent) were in the original charter; embryos and fetuses were not. While this change in definition does not provide any special protection to embryos and fetuses, the new definition indicates that the Administration (i.e., the President and his advisors) believes these two groups have special rights. Rewarding the charter is an example of how an issue gets on the national agenda, a strategy that keeps an item from fading. The Bush Administration presidential campaign platform contained a plank that clearly opposed abortion. This plank reflected the values of the Bush team and was supported by the conservative right.

Although defense, not health, has been the major thrust of the 2002 national agenda, a few health items did surface. However, Medicare reform did not receive much support, nor did tort reform that attempted to cap the amount of personal or professional damages requested in a lawsuit. Prescription coverage for Medicare patients was touted by the Administration but the President could not obtain enough support in the 107th legislature to effect a law. Anti-abortion advocates (interest groups) lost rounds to prevent animal cloning. The interest groups continued to work with congressional and presidential staff to keep their values visible on the agenda. The anti-abortion policy community includes academics, health care professionals, and members of religious organizations as well as government workers. Colleagues searched the policy soup of problems and solutions, discussing solutions and weighing a variety of potential responses from public opinion. Eventually, policy makers decided that a change in definition of eligibility of those the advisory committee is charged to safeguard would expand the scope of protection and keep pro-life issues on the agenda. Opponents assert that pronouncing an embryo or fetus as a human subject does not render the same a "human person." Adversaries further claim the revision strategy is a back-door attempt to keep abortion on the agenda (with the idea of eventually overturning Roe v. Wade in the Supreme Court) and to insert other groups into law outside the legislative process. Government officials noted that the DHHS would have to write regulations or legislators would have to provide any special protection to embryos and fetuses, the new definition indicates that the Administration (i.e., the President and his advisors) believes these two groups have special rights.
little to address the vast cultural, technological, and legal documentation differences that foreign nurses
hospital policies and other issues. Opponents counter that these regulations facilitate “poaching” of
orientation, or other term) with clinical supervision by an RN and a classroom phase for clarifying
BONs are considering rules that would mandate a period of transition (known as an internship,
BONs before authorizing a foreign applicant to take the NCLEX-RN. Boards are being confronted by
nurse has passed both the English language and nursing components and is a requirement of most
assessment of English proficiency (About CGFNS, 2002)). A CGFNS certificate signifies that a foreign
and will affect education laws and programs. An influx of people from other countries into the United
“Reverse discrimination” is a mantra of some who challenge college admissions/hiring practices/policies
and will affect education laws and programs. An influx of people from other countries into the United
States is prompting challenges to immigration laws from those who fear that public policies that support
diversity are undermining their livelihood and sustaining foreign governments to our detriment. The crisis
States is prompting challenges to immigration laws from those who fear that public policies that support
diversity are undermining their livelihood and sustaining foreign governments to our detriment. The crisis
of terrorist attacks in September 2001 pushed the latter onto the national agenda.
Nurses have a responsibility to provide policy makers with the latest research and reason related to all of
these issues. Nurses who are in contact with government officials can help them understand the effects
of any laws or programs they may consider. For example, a diverse nurse workforce can provide
culturally competent care to a varied population. Funding for nursing education for ethnic groups or
funding for educating nurses about ethnic groups would assist in improving the delivery of care. Nurse
researchers should plan outcome studies that identify and explore the beliefs and values of the
researcher, the caregivers, and the recipients of care.
Nurses have begun to understand the value of working with other disciplines.

Government Response and Diversity

Laws. Laws provide examples of government’s response to issues of diversity. One of the most far-
reaching examples of law that is an example of the redistributive policy of providing equity in human
rights is The Civil Rights Act of 1964. Title VI forbids discrimination on the basis of race, color, national
origin, or age (added later) in any type of federally-funded activity. Title VII forbids discrimination
(religion and gender included) in employment and compensation decisions (Clegg, 2002).
Educational institutions operationalized these sections of the law, commonly referred to as affirmative
action, to provide a student body and faculty that more nearly reflected the general public. Universities
initiated positive, i.e., “affirmative,” admissions policies in an attempt to remedy discrimination. These
policies did change the face of higher education and the professions. During the last half of the twentieth
century, many women, African Americans, and others of minority status were given the opportunity to
enter college to become educators, physicians, nurses, and other authorized and licensed specialists.
The purpose of this article is not to explore the benefits and shortfalls of the Civil Rights Act but to
encourage nurses to contemplate our responsibility and opportunity to assist policy makers as they
consider amendments in the light of our transforming world. The demographics of the United States are
changing in significant indicators, especially those of ethnicity. The concept of “racial profiling” opens
discussion about current practice and policy in the area of public law enforcement and criminal justice.
“Reverse discrimination” is a mantra of some who challenge college admissions/hiring practices/policies
and will affect education laws and programs. An influx of people from other countries into the United
States is prompting challenges to immigration laws from those who fear that public policies that support
diversity are undermining their livelihood and sustaining foreign governments to our detriment. The crisis
of terrorist attacks in September 2001 pushed the latter onto the national agenda.
Nurses have a responsibility to provide policy makers with the latest research and reason related to all of
these issues. Nurses who are in contact with government officials can help them understand the effects
of any laws or programs they may consider. For example, a diverse nurse workforce can provide
culturally competent care to a varied population. Funding for nursing education for ethnic groups or
funding for educating nurses about ethnic groups would assist in improving the delivery of care. Nurse
researchers should plan outcome studies that identify and explore the beliefs and values of the
researcher, the caregivers, and the recipients of care.
Nurses have begun to understand the value of working with other disciplines.

Funding for interdisciplinary research will help break the isolationism of nurses and enhance the framework of the caring professions.

Regulations. Regulations that affect nurses most directly are those written by the boards of nursing
(BONs). Legislators confer the authority to regulate to BONs. Current issues in nurse regulation center
on immigration and interstate practice. With the enormous worldwide nurse shortage, many health care
agencies are considering hiring foreign nurses. The Commission on Graduate of Foreign Nursing Schools (CGFNS) offers three services: review of educational credentials, a test to predict the ability of applicants to pass the National Council Licensing Exam for Registered Nurses (NCLEX-RN), and an assessment of English proficiency (About CGFNS, 2003). A CGFNS certificate signifies that a foreign nurse has passed both the English language and nursing components and is a requirement of most BONs before authorizing a foreign applicant to take the NCLEX-RN. Boards are being confronted by health care agencies to ease the regulations in order to facilitate entry of foreign nurses into this country. BONs are considering rules that would mandate a period of transition (known as an internship, orientation, or other term) with clinical supervision by an RN and a classroom phase for clarifying hospital policies and other issues. Opponents counter that these regulations facilitate “poaching” of nurses from countries that are then left without an adequate number of nurses (Zachary, 2001) and do little to address the vast cultural, technological, and legal documentation differences that foreign nurses
As nurses, we must search our hearts and minds to discover our own values about foreign-educated nurses.

Do we question foreign education systems? What do we know about nursing education in other countries? Many Asian countries, such as Thailand, require a baccalaureate education for nurses. The Bologna Agreement, signed by most Ministers of Education of the 15 European Union countries in 1999, calls for standardizing university education through the baccalaureate-masters-doctorate model. Nurse educators are moving programs into the baccalaureate degree (Bernstein & de Jong, 2001; Poole, 2001). Do foreign nurses have competence in written English to document properly on legal charts? Do foreign nurses have technical skills to function in a highly technological health care system in the United States? Can we articulate the difference between cultural sensitivity and cultural competence in providing care? Is the cultural chasm between U.S. and foreign nurses so different that the latter cannot function in an American setting or does a foreign nurse bring added value because of his/her culture? How are cultural differences explored? Are differences honored or demeaned? Are there data to suggest that foreign nurses will stay in nursing in this country or return to their homelands? What factors must be included in determining the cost of bringing foreign nurses to the United States? Is it ethical to poach nurses from countries in which their absence creates calamitous problems in the health care of those countries? All of these questions reflect our information and biases about diversity in nurses. How would questions be answered if we directed them to the issue of diverse clients? Students?

BONs need the input of nurse administrators, nurse educators and staff nurses not only in hospitals but in community and other non-hospital settings. Board members cannot make adequate rules without data about long-term vacancy rates of agencies, successful retention strategies, and examination of disciplinary actions of foreign nurses. The scope of the shortage is so long-term and serious that creative collaboration of nurses from many backgrounds is imperative. Nurses can communicate with BONs through membership in advisory committees, board hearings on the shortage, and through thoughtful written consultation.

Programs. Government programs can support diversity through a variety of funding opportunities. The Nurse Reinvestment Act that was authorized by the House and Senate in August 2002 provides for student loan repayment and scholarships, public service announcements (PSAs) to encourage people to choose nursing as a profession, and faculty loan repayment programs for students who agree to teach in nursing schools (American Nurses Association, 2002). Section 831b also describes demonstration grants for practicing in underserved and high-risk populations (Donley et al., 2002). All of the policy tools can be used to recruit diverse people into nursing, help them stay in the profession, and provide incentives to practice in a wide variety of settings.

Diversity in nursing can mean men, ethnic groups, and non-traditional students.

Diversity in nursing also means providing nursing care to diverse clients and populations. What are the implications of not actively recruiting minorities? Is there a difference in care provided by minority or Caucasian nurses? Will the arrival of minority nurses change the role or function of the nurse? If so, in what ways? How does the current lack of diverse faculty affect the way that students are taught about different individuals and populations? How will the looming faculty shortage affect the education, practice, and research of nurses in the future?

Many nurse organizations urged their members to contact legislators to vote for appropriate resources for the Nurse Reinvestment Act. As of November 2002, the lame duck Congress had not taken action regarding appropriations that were voted on by each house. If funding is not secured, efforts to relieve the nurse shortage will be compromised.

Certainly nurses have had opportunity to influence their legislators about the importance of providing money for nursing education and practice.

Nurse organizations should enlist support from more corporate giants in our quest for recognition for funding.

However, we have not made our case. We have not enlisted enough assistance from powerful interest groups such as the American Association of Retired Persons. Perhaps we should re-define our allies—the American Medical Association (AMA) and the American Hospital Association (AHA) could join us in putting pressure on lawmakers. Physicians and hospitals cannot function without nurses. The National Education Association could promote their own agenda and nursing's with a united appeal for more school nurses. The industrial giant, Johnson & Johnson, has been a great boon to nurse recruitment through their PSAs that highlight the positive image of nurses and nursing. Nurse organizations should enlist support from more corporate giants in our quest for recognition for funding. The profession can exert its own power in gathering together diverse groups to promote our agenda.

Program Implementation and Diversity

Diversity today includes recognition of populations that oppose the basic principles on which the United States was founded: democracy, capitalism, and freedom. Freedom allows people to disagree about religion, government, and types of markets. Freedom also protects opponents and provides shelter for diverse populations. Sometimes diversity can strain the founding principles of our country. Experienced career bureaucrats and political appointees can either cloud the direction of implementation or facilitate appropriate governmental response.
Involvement in policy making is not an option for a professional nurse--it is a necessity. Nurses should grasp quickly that we have many, many opportunities to intervene in the process.

**Conclusion**

An academic analysis of the policy process demonstrates the fluidity of the components and the political nature of engagement.

**Program Evaluation and Diversity**

Program evaluation may not occur in the public arena. Some programs never are implemented, some change so drastically from the basic change that evaluation becomes too confusing, and often money for evaluation was not in the proposal or was used during implementation. Formative assessment of a program that has been running for years may uncover inefficiencies and may direct changes. Due to the enormity of many social programs and the negative public relations that could be incurred if the programs were stopped, evaluation may be postponed or ignored.

The interlacing of the nurse shortage, diversity, and government programs emerges when one considers the definition of shortage areas. The Bureau of Health Professions within the Health Resources and Services Administration (HRSA) specified Medically Underserved Areas (MUAs) and Health Profession Shortage Areas (HPSAs) in the 1970s to provide qualitative data for implementing community health centers. Evaluating the definitions for data that could be useful for problems encountered today produced evidence that the data do not measure nurse shortage areas. A federal Nurse Education and Loan Repayment Program (NELRP) uses AHA data from hospitals, but these data are not appropriate for illustrating the shortage in rural areas, nursing homes, rehabilitation centers, and other non-hospital or non-urban sites.

Federal officials need reliable and valid data to determine the extent of the shortage and where the shortage is most critical. Nurses can be persuaded to work in places with a shortage of nurses that provide care to indigent people, migrant workers, uninsured or underinsured groups--exactly what NELRP was created for. NELRP and the Nursing Student Loan (NSL) Program are examples of programs that specifically address nurses. Evaluating the current budgets illustrates that lack of funding reflects legislators' apparent lack of comprehension of the seriousness of the nurse shortage and the probable lack of understanding about the broad scope of practice of registered nurses. We must use evaluation data and act on our own behalf to educate policy makers and their staff about our role in health care, the crucial difference we make in helping people heal, and the devastating results that occur when there are not enough nurses.

**Collectively, nurses are a powerful group--not only because we are the largest group of educated health care providers but because we are agents for our clients and the profession.**
must integrate into our role our right and responsibility to be a part of crafting policy that affects and influences health care. Collectively, nurses are a powerful group—not only because we are the largest group of educated health care providers but because we are agents for our clients and the profession.

Diversity in health care providers and in providing health care are areas of interest in which nurses must exert power. We can choose opportunities from countless spheres to demonstrate our concern with the health and safety of the public. In summary, within the component of agenda setting, it is critical that we keep the nurse shortage on the national agenda. We must help policy makers define the shortage within the context of nurses as a scarce national resource and a public health crisis. Securing a policy entrepreneur to keep the issue from fading would be a positive strategy; but we must do our part, individually and collectively.

...it is critical that we keep the nurse shortage on the national agenda.

We must be adamant about securing government response in resurrecting and actually appropriating funding for the Nurse Reinvestment Act, the National Institute of Nursing Research, and other legislative initiatives that will benefit nursing education, practice, and research. We can be creative in placing programs not only in the Department of Health and Human Services but in the Departments of Defense, Labor, Education, and other bureaucratic agencies.

Implementation and evaluation are also needed. Implementation can focus on how to use policy tools to provide incentives or sanctions for programs such as those on bioterrorism and cloning. Nurses can provide details on how to implement programs and make them efficient, effective and responsive to public demands. Nurses must conduct outcomes research to demonstrate to legislators and the public that what we do is meaningful and worthy of reimbursement. The interweaving of nursing, health, and public policy provides a rich tapestry in which we can display our knowledge, intellectual acumen, and capacity to respond to the societal mandate that is nursing.

Author

Jeri A. Milstead, PhD, RN, CNAA-BC, CNS
e-mail: Jmilstead@mco.edu

Jeri A. Milstead, PhD, RN, CNAA-BC, CNS holds a PhD in Political Science with majors in health 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, Columbus, Ohio. She is Professor and Dean, School of Nursing, Medical College of Ohio, Toledo, Ohio. She is internationally known as an expert in public policy and the politics of health care, and serves as one of two health policy experts with the International Council of Nurses in Geneva, Switzerland. She is the editor and senior author of Health Policy and Politics A Nurseâ€™s Guide, a book in its second printing that is sold in five countries. Dr. Milstead was a policy advisor in the Washington, D.C. office of Sen. Daniel K. Inouye (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 has published in national and international journals, is a reviewer for several refereed nursing journals and is Editor-in-Chief of The International Nurse. She was awarded a Duquesne University Creative Teaching Award in 1998 for her pioneering work in designing and implementing the first online course taught in the PhD in Nursing Program that is offered completely online.

References


include workshops and training sessions on understanding the business need for Diversity & Inclusion, supporting organisations with policy articulation and implementation, and basic support in appreciating gender inclusion and sensitivity. A large part of our work covers training to develop women leaders internally, as well as building awareness of the unique challenges of working women. This includes building and sustaining safe and harassment-free workplaces, educating...