SECTION ONE

Introduction

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CHAPTER 1

Nursing's History of Advocacy and Action

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OVERVIEW

The American Nurses Association (ANA) reminds nurses of the social contract between nurses and the public that "reflects the profession's long-standing core values and ethics, which provide grounding for health care in society" (American Nurses Association [ANA], 2010, p. 10). The ANA *Social Policy Statement* has articulated nursing's social obligation since it was first published in 1980. Nurses turn to this document to understand how nursing fulfills this obligation by providing ethical and culturally competent care to individuals, families, communities, and populations. It also helps nurses explain their role in the larger society, to new members of the profession, and to nurses already working in the field.

New position statements about inclusivity and diversity by the American Association of Colleges of Nursing (AACN) (2017) and the American Academy of Nursing (AAN) (2016) contribute to a sense of responsibility nurses share to fulfill the social obligation to society. The AACN (2017) states that "to have equitable systems, all people should be treated fairly, unhampered by artificial barriers, stereotypes or prejudices" (p. 173). It continues to address unconscious and conscious bias of which we as nurses must be aware to make a change. Advocacy includes, and if not, should include, the notion of inclusivity and diversity.

This chapter explores political advocacy in light of nursing's role and responsibility to advocate for and act on behalf of those for whom nurses have contracted to provide care. The first section of the chapter explains why nurses need to know history to be effective advocates and why knowing history matters to advocacy. It provides historical exemplars to highlight how history informs the profession as it continues to invoke the social contract that nursing maintains with society. The second part of the chapter examines a more contemporary look at nursing's political advocacy efforts and what it means for nurses, the profession, and the health of the public at large.

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OBJECTIVES

- Discuss why nursing history is relevant to health policy and nursing advocacy and action.
- Explore historical exemplars that provide evidence of nursing's ability to advocate for individuals, families, communities, and populations.
- Analyze nursing's role in how political advocacy impacts nurses, the profession, and the health of the public at large.

Nurses as Advocates

Although society reportedly trusts nurses to work toward accomplishing the goals set forth for them by the profession (ANA, 2010), nurses may not be grounded in how they reached these "long-standing core values" that the nursing profession developed over time. As nurses advocate for their patients—whether seen as individuals, families, communities, or populations—an understanding of nursing's enduring and long-standing values that are rooted in its history provide depth and breadth to their efforts. To this end, it is important to know nursing's historical role in ensuring access to care; it is important to know nursing's contributions toward patient quality and safety measures; it is important to know how nursing interventions changed over time in response to the context in which nurses practiced; and it is important to know how nurses and the profession adapted to shifts in the social, political, economic, and cultural environment (D'Antonio & Lewenson, 2011). Fairman (2017) writes that "our past shapes everything we do, whether we explicitly acknowledge it or not" (p. xi).

Why Study Nursing History?

Historian and nurse educator Ellen Baer and colleagues respond to the question of why nursing history should be studied:

> Just as a nurse can make little progress caring for or curing a patient's presenting problem without knowing the patient's physiological, psychological, and cultural history so is it for a nurse trying to make sense out of the persistent problems and possibilities in nursing and health care. To make right decisions in planning nursing's future in the context of our complex health-care system, nurses must know the history of the actions being considered, the identities and points of view of the major players, and all the states that are at risk. These are the lessons of history. (Baer, D'Antonio, Rinker, & Lynaugh, 2001, p. 7)

Some lessons from the past that support the understanding of political advocacy and action can be learned by examining how Florence Nightingale influenced the development of nursing education programs that started in 1873, and led to what became known as the Modern Nursing Movement. It began with the first three United States Nightingale training schools: the Bellevue Training School for Nurses in New York City; the Boston Training School for Nurses at Massachusetts General in Boston; and the Connecticut Training School in New Haven, Connecticut. Following the opening of these three schools, hospitals around the country recognized the value that student nurses bring to the hospital because care could be provided at relatively low cost and the hospital would have no obligation to hire the nurses when they graduated. Nurses, after their training was complete, would need to find work elsewhere, typically in private duty or in the emerging field of public health nursing.

Twenty years after the opening of these schools of nursing, early nursing leaders

recognized the need to organize nurses to control the quality of practice and training as a way to protect the public. Between 1893 and 1912, four professional nursing organizations formed to do just that: the National League for Nurses, formed in 1893 (originally called the American Society of Superintendents of Training Schools for Nurses); the American Nurses Association, started in 1896 (originally named the Nurses' Associated Alumnae of the United States and Canada); the National Association of Colored Graduate Nurses, which formed to address racial bias in nursing and health care and was in existence between 1908 and 1952; and finally, in 1912, the National Organization of Public Health Nursing, formed to control practice and educational standards during the rising movement of public health and public health nursing in the United States. This organization ended in 1952 when the National League for Nursing assumed its role (Lewenson, 1993).

Even before women in the United States gained the vote in 1920, nurses sought legislation that would define nursing practice, and they advocated for the protection of the public by prohibiting anyone who was not professionally trained from calling him- or herself a nurse. This required convincing lawmakers, at that time only men, to support nursing legislation; the nurses knew they could not vote into law the early nurse practice acts. While nurses struggled for statewide nursing registration, they had to "fight battles against long hours of work and opposition to nursing education" (Lewenson, 1993, p. 171). To accomplish their goals, some nurses, either individually or through the early nursing organizations, began to support the work of the suffragist movement and aligned themselves with the larger women's movement of the early 1900s. Individual nursing leaders, like public health pioneer Lillian Wald and nursing suffragist Lavinia Dock, advocated for healthcare reforms in the community and the legislative arena. The professional organizations that formed during this period did so to protect the public from uneducated nurses and to develop standards for nursing education and practice.

Although an in-depth history of this period is beyond the scope of this chapter, it is important for nurses to understand that political advocacy was part of the profession's early identity. Political advocacy and action in nursing are not new or innovative. Nurses have always been political advocates for those in their care (Lewenson, 2012). As a result, the early efforts made by nurses and their professional organizations provide a narrative for and insight into today's advocacy efforts, where protection of the public means ensuring a level of education for all nurses, the development of quality and safety standards, and the ability of nurses to practice to the fullest extent of their education, as recommended by an Institute of Medicine report (2010).

History Counts

Fairman and D'Antonio (2013) wrote, "history counts in health policy debates" (p. 346). Bringing a historical perspective to discussions about health care deepens our understanding of the issues by recognizing the evolution of ideas across time. In the debate about control of the "newly" minted medical homes of today, understanding the roles of early public health nurses in providing primary healthcare services to individuals, families, communities, and populations in both urban and rural settings can trigger some useful ideas or solutions about what to call the new entity, who should finance it, and who should lead it (Keeling & Lewenson, 2013).

The current debate centered on medical homes provides such an example. The term was first coined in the 1960s and defined a medical model of care for chronically ill pediatric patients that looked at control issues, inter- and intradisciplinary issues of providing care, and the financial aspects of care. Physicians led the earlier medical home movement that has evolved to mean "a model of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective" (American Academy of Pediatrics, 2002, as cited in Keeling & Lewenson, 2013, p. 360).

Nurses use the words that define the medical home of today to describe nursing's work of providing accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. Knowing the history of nursing serves to highlight the profession's strong contribution to health care in the United States.

Advocacy and Public Health Nursing

Exploring some of the public health initiatives that Wald established—the Henry Street Settlement and the American Red Cross Town & Country—offers excellent examples of how nursing, history, and political advocacy and action intersect. By studying the work of those nurses and nursing leaders within these settings, we not only learn about the role nurses played in primary health care (as described by Keeling & Lewenson, 2013), but we can also learn about the healthcare advocacy that public health nurses sought for those individuals, families, and communities. We also learn about the unconscious and conscious bias shared by society, including nurses, towards black nurses and the subsequent outcome that race played in healthcare outcomes. The next section uses these two early 20th-century public health initiatives as examples of political advocacy by public health nurses.

Advocacy at Henry Street

Lillian Wald graduated from nurses' training in 1891 from the 2-year diploma-based program at New York Hospital in New York City. Within 2 years of graduating, she and her school friend Mary Brewster recognized the overwhelming healthcare needs of immigrant families living in the overcrowded and unclean conditions of the tenement houses on the Lower East Side of New York City. Filled with a sense of social obligation to improve the health of society, Wald and Brewster began the Henry Street Settlement and found support for the venture from philanthropists and other nursing leaders. Wald's work expanded from just nine public health nurses working in one settlement house that was established in 1893 to more than 250 nurses working throughout the New York City area in at least seven different locations (Buhler-Wilkerson, 2001; Keeling, 2007; Lewenson, 1993). The Henry Street Settlement was one of the few public health organizations to hire black nurses to care for black patients (Pitt-Mosley, 1996). This policy of inclusion did not exist in most healthcare settings, and discrimination was typically the order of the day, whether in the north or south or whether conscious or unconscious.

While caring for the families, Wald saw a close relationship between the health of the public and civil responsibility. In a speech she delivered in 1900 at the sixth annual meeting of the American Society of Superintendents of Training Schools for Nurses, Wald said that "among the many opportunities for civic and altruistic work pressing on all sides nurses having superior advantages in their practical training should not rest content with being only nurses, but should use their talents wherever possible in reform and civic movements" (Wald, 1900, as cited in Birnbach & Lewenson, 1991, p. 318). In keeping with her beliefs, Wald and her colleagues at Henry Street introduced several legislative initiatives that would improve the health of children, such as the introduction of nurses in public schools (Wald, 1915). Wald (1915) described how she advocated for hiring nurses in the local public schools to decrease truancy rates, given that children were sent home due to illness and lack of treatment. As of 1897, physicians had only recently been hired by the New York City Department of Health to assess children in school. Doctors sent children home from school when any contagious illnesses were found. However, this did not address some of the pressing health issues because the physicians did not provide treatment for conditions such as trachoma, a contagious eye infection that plagued school-age children at the time. Wald (1915) wrote about her experience convincing legislators of

the value of assigning public health nurses in the schools in her book *The House on Henry Street*.

In 1902, when a reform administration came into power, the medical staff was reduced, the physicians' salary was increased to $100 per month, and they were expected to work only 3 hours per day. The health commissioner ordered an examination of all public school pupils and was horrified to learn of the prevalence of trachoma. Thousands of children were sent away from school because of this infection. Where medical inspections were the most thorough, the classrooms were empty. It was ironic that Wald watched the children who had been turned away from school playing with the children they had been sent home to protect. Few children received treatment, and it followed that truancy was encouraged:

> The time had come when it seemed right to urge the addition of the nurse's service to that of the doctor. My colleagues and I offered to show that with her assistance few children would lose their valuable school time and that it would be possible to bring under treatment those who needed it. . . . I exacted a promise from several of the city officials that if the experiment were successful, they would use their influence to have the nurse, like the doctor, paid from public funds. Four schools from which there had been the greatest number of exclusions for medical causes were selected, and an experienced nurse, who possessed tact and initiative, was chosen from the settlement staff to make the demonstration. . . . Many of the children needed only disinfectant treatment of the eyes, collodion applied to ringworm, or instruction as to cleanliness, and such were returned at once to the class with a minimum loss of precious school time. Where more serious conditions existed the nurse called at the home. (Wald, 1915, pp. 51–52)

Within 1 month, the experiment was deemed successful, and an "enlightened Board of Estimate and Apportionment voted $30,000 for the employment of trained nurses, the first municipalized school nurses in the world" (Wald, 1915, p. 53). School nursing continues to be a concern for those interested in political advocacy to improve the health of our young and vulnerable populations. Historian Mary Gibson (2017) writes that:

> Today's philosophy still reflects the protective and hopeful beliefs of leaders in education of 100 years ago concerning the influence of child health on our nation's future. . . therefore, keeping children in school, healthy and ready to learn, is a universal goal throughout the United States. (p. 37)

Advocacy in the Town & Country

Wald's advocacy extended to families living in rural settings. One of the most compelling examples is the establishment of the American Red Cross Rural Nursing Service (later known as the Town & Country). As Keeling and Lewenson wrote (2013), this organization "served as the point of contact for families in rural communities where remoteness, isolation, and fewer physicians and nurses created barriers to care" (p. 362). Wald believed that the American Red Cross—already organized to provide nursing services during wartime and natural or manmade disasters—was the right vehicle in which to organize public health nursing services throughout the country during peacetime (Dock, Pickett, Clement, Fox, & Van Meter, 1922; Keeling & Lewenson, 2013). Through Wald's influence, philanthropists supported the implementation of this new rural public health nursing service. During the first year, criteria were established for nurses who would collaborate with community leaders, physicians, and families to provide both curative and preventive health care in rural settings. The requirements to become a rural public health nurse were far reaching and included

pragmatic skills. Nurses were expected to ride a bicycle or a horse, or drive a car so that they could access their patients.

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More important, and often difficult to find, were nurses who had an education that prepared them to negotiate and collaborate with others in the community. Typical nurses' training programs did not provide these skills. It was determined that a minimum of a 4-month education was needed to prepare nurses to work independently in communities across America (American Red Cross Rural Nursing Service, 1912–1914). Educational programs were established, like the one at Teachers College in New York, in conjunction with the Henry Street Settlement and the rural District Nursing Service of Northern Westchester, soon after the American Red Cross Rural Nursing Service formed. By 1914, the new public health nurse curriculum offered courses in sociology, municipal and rural sanitation, and experiences in rural and urban public health settings. These courses were valuable for nurses who practiced in rural settings because they did not have the same support systems as urban areas.

Black nurses faced barriers to attending some of these early public health courses and, as a result, contributed to few entering this service. Frances Elliot Davis, a graduate of the Freedman's School of Nursing in Washington, DC, did attend the 4-month program at Teachers College and was admitted as a Town & Country nurse in 1917. She was considered the first black nurse to be admitted into the American Red Cross (Hine, 1989; Lewenson, 1993). Influenced by the returning soldiers and the influenza pandemic in 1918, Davis, along with other black nurses, were finally accepted into the American Red Cross reserves at the end of World War I. The bias of the military and, subsequently, the American Red Cross, reared itself in several ways. One of the most blatant ways was the designation of race on each of these nurses' badges, separating them from their white colleagues. Frances Elliot Davis received her badge with the number 1-A inscribed on the back. This was one way the Red Cross that served as the gatekeeper into the Army Nurses Corps could maintain the practice of segregated living quarters and segregated health care. The National Association of Colored Graduate nurses advocated changes in these practices that eventually ended by mid-20th century (Lewenson, 2017).

Wald's advocacy extended to the use of media to show the public what a rural public health nurse could do and to garner support for the initiative. While she was at the third meeting of the American Red Cross Committee on Rural Nursing—the committee established by the American Red Cross in 1912 to develop the criteria for the Town & Country—Wald suggested that the committee "get in touch with the Publication Syndicate, and Rural Nursing written up possible [*sic*] in story form for the *Ladies' Home Journal* and other popular magazines" (American Red Cross Town & Country Nursing Service, 1913, p. 2). At the same meeting, it was noted that Wald and others supported establishing a relationship with the Metropolitan Life Insurance Company

and the Steel Corporation whereby the Rural Nursing Service would "undertake nursing for these large concerns" (American Red Cross Town & Country Nursing Service, 1913, p. 4). Many of the communities in question were rural mining communities that required public health nursing services. The committee believed this relationship would be beneficial in many ways, including possibly raising the standards of other nursing associations and economically supporting the cost of nursing supervision in these locations.

Advocacy took many forms, which ranged from sitting on national committees to seeing that care was provided at local levels. The work of the public health nurse was framed by the needs of the community, the kinds of public healthcare organizations that were organized, and the geographical location. Each Red Cross rural nurse chapter—whether in the mountains of New Hampshire, in Kentucky, or in the West—directed the kinds of work that public health nurses would do, including bedside care for frostbite, well-baby clinics, school nursing, industrial nursing, classes in home hygiene and care of the sick, advocacy on town boards, and educational and publicity efforts about their work (Fox, 1921). Sometimes there was only one public health nurse in an area. At other times, public health nurses shared a district. Sometimes a nurse faced barriers by communities that were uncomfortable with outsiders offering care. The success of these American Red Cross Town & Country nurses relied on the ability to recruit and retain those who could handle the challenges of rural settings. This concern remained a constant and enduring problem throughout the life span of the American Red Cross Town & Country.

History and Political Advocacy

Political advocacy requires the depth and breadth of an evolving historical narrative to inform contemporary debates in health care, to reflect the variety of perspectives that history can bring to the debate, and to offer a "way to think about the future" (Fairman & D'Antonio, 2013, p. 346). The work of the nurses at the Henry Street Settlement and the American Red Cross Town & Country gives two examples that can stimulate discussions about healthcare reform today. Readers are encouraged to explore the many historical studies being completed and the early writings of nurses that can be found in nursing journals, such as the *American Journal of Nursing*. This journal has digitalized its entire collection from 1900 to the present, allowing readers to access articles online and explore nursing advocacy over time. The American Association for the History of Nursing (AAHN) (www.aahn.org) also provides information and resources for where one can go to find nursing archives, learn more about historical methods, and attend the association's annual meeting where the latest in historical research is presented. The AAHN also publishes a well-respected journal, *Nursing History Review*, where readers can find outstanding historical research by leading historians. There are also many archival centers around the country, such as the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania and the Eleanor Crowder Bjoring Center for Nursing Historical Inquiry at the University of Virginia. Centers such as these provide a wealth of archival data and support for those interested in historical research. The websites for these centers and other resources are available on the AAHN website.

Nursing's Political Advocacy and Action

The next part of this chapter moves from the historical to the contemporary and further explores the meaning of advocacy and action, as well as what that means for nurses, the profession, and the health of the public. Today nurses must be politically active in professional nursing practice and health policy issues like the nurse reformers and activists before them. Nurses who can purposefully and effectively contribute to

shaping public policy at the national, state, and local levels serve both the public and the profession by advancing the nation's health and professional practice. Nursing's historical roots in important advocacy and action have shaped the profession's political astuteness and work to keep pace with professional regulatory, statutory, and legal changes in education, practice, and research. The profession must remain nimble and responsive to policy changes by promoting and protecting the well-being of the population and nurses themselves. How can nurses have a profound influence on health outcomes? The answer is simple: We cannot afford not to. As long as the United States lags behind other developed countries in care outcomes, despite the fact that the U.S. spends more on health care—$3.2 trillion in 2015, up 5.8% from the year before (Centers for Medicare & Medicaid Services [CMS], 2015)—nurses need to advocate and act to promote health, prevent disease, and eliminate health disparities. Access to affordable, quality health care is a basic human right for all people (Daley, 2012).

In 2010, Institute of Medicine (IOM), now known as the National Academies of Medicine, published its report, The *Future of Nursing*, which offered a blueprint for how the nursing profession should advocate to improve the health of the nation, lead change in healthcare delivery, and increase the educational preparation of the nursing workforce. This blueprint is evidence on how nurses uphold the dignity and well-being of society by revolutionizing how nurses can be change agents and leaders in developing healthcare delivery systems that will address health disparities and the social determinants of health like education, poverty, transportation, and housing.

To effectively manage the ever-evolving healthcare delivery system, as well as the emerging needs of populations and the profession, every nurse must understand and appreciate his or her role in advocacy. Advocacy is the ability to use one's voice and position to address, support, and protect the rights and interest of another (Zolnierek, 2012). The American Nurses Association suggests that high-quality nursing practice include advocacy as an essential aspect of patient care (ANA, n.d.). Advocacy is considered both a philosophical principle of the profession and a part of ethical nursing practice that ensures that the rights and safety of the patient are protected and safeguarded. Advocacy is the one professional construct that demonstrates a complex interaction among nurses, patients, professional colleagues, and the public (Selanders & Crane, 2012). It is important to note that patients have rights and nurses have a legal and moral obligation to protect those rights. As patient advocates, the ANA *Code of Ethics for Nurses with Interpretive Statements* (2015) offers nurses a moral framework to help shape their values to direct and influence actions so as inspire their advocacy.

From the classroom to the bedside to the boardroom, nurses can leverage their professional expertise to provide the critical knowledge and analysis to transform public health policy and nursing practice. As stakeholders who are well prepared to engage in the policy-making process, nurses must stand ready to respond to an array of healthcare reforms confronting the nation's delivery system by being full partners, with physicians and other healthcare professionals, in redesigning health care in the United States (IOM, 2010). Just as our "foremothers" before us, and in some cases fathers as well, nurses of the 21st century have an integral role in shaping and advancing policy solutions at a time when there is tumultuous political climate and a health care environment that may not clearly understand the values and contributions of nurses and nursing practice.

Berkowitz (2017) recently described how important the need is for nurses to inform consumers about what nursing care is, including why and how it prevents illness, manages symptoms, treats disease, and transforms the health of communities. Nickitas and Ferguson (2017) note how critical it is to advocate for and ensure that nurses globally can practice to the full scope of their education and licensure, have equal opportunities for career development, and practice

in work environments that are free from violence, harassment, and discrimination; these concerns are essential in today's and tomorrow's healthcare delivery system. To become engaged in advocacy, and to set the agenda for human resources and nursing resources for health care, nurses must be at the forefront of policy engagement, dialogue, and implementation. This engagement requires sound evidence and a political strategy that allows for increased understanding of the potential impact of linking the nursing workforce with the globalization of health care, to ensure dignified and respectful health care for all persons, regardless of sexual orientation or gender identity (Nickitas & Ferguson, 2017). The demands for increased access and better healthcare outcomes will require nursing to widen its influence in policy areas that address the health and healthcare needs of underserved and minority populations (Villarruel, Bigelow, & Alvarez, 2014). Nurses are essential healthcare providers and make significant contributions to the body of knowledge of improving health and health care in the United States. One way nurses can impact the nation's health is to meet the 21st-century challenge of population health management and population health. To meet this challenge, the Robert Wood Johnson Foundation (RWJF) has committed to advancing a national initiative called the Culture of Health by addressing key social determinants of health and empowering support mechanisms to help people live healthier lives Robert Wood Johnson Foundation (2015). A Culture of Health involves creating increased collaboration among healthcare systems. For community organizations, this means making health a shared value, creating healthier and more equitable communities, and strengthening the integration of health services and systems (Martsolf et al., 2016).

As political advocates, nurses are uniquely positioned to lead system change to improve care for populations and contribute to a Culture of Health in their communities by focusing on the patient and family-centered care. Nurses naturally view their patients holistically and seek to include all aspects of family, community, and work environment in their care (Smith, 1995). By strengthening the protection of human rights and health equity, and promoting a Culture of Health, all can prosper and thrive. The next section of this chapter discusses how nurses will continue to amplify their voices and advocate to meet the changing landscape of health care.

Nursing Strong

Professional nursing care is essential to the healthcare system. Of the more than 3.6 million licensed registered nurses (RNs), approximately 84.7% are employed in nursing (62% in hospitals), and approximately 10% are employed in primary care or home care (U.S. Department of Health and Human Services, 2010, 2013), making registered nursing the largest healthcare profession (ANA, n.d.). As such, nurses must advocate by bringing problems to the government and seek decisions in the form of programs, laws, regulations, or other official responses that create innovations and care models to transform the delivery and advance the nation's health.

To begin, nursing must advocate for changes within the profession. To successfully advance health care, the nursing profession must make significant strides to change the composition of the future workforce. This will require greater efforts toward the successful recruitment of underrepresented minorities into nursing. Calculations of data from the U.S. Census Bureau (n.d.) reveal that the current RN workforce remains primarily female; the percentage of men in the workforce has increased to 12% from only 9% in 2001. Nurses from minority backgrounds represent 24% of the RN workforce. Considering racial/ethnic backgrounds, the RN population is composed of 75.8% white, 11.5% black or African American, 4.8% Hispanic or Latino, 5.8% Asian, 0.5% American Indian, 0.028% Native Alaskan, 0.2% Native Hawaiian/Pacific Islander, 0.1% Other Native, and 1% multiracial background (DATAUSA, 2018). The profession must do better to ensure that future nurses mirror the patient population

for which they will provide nursing care. The recruitment of indivdiuals from underrepresented groups in nursing—specifically men and individuals from African American, Hispanic, Asian, American Indian, and Native Alaskan backgrounds—is major priority for the nursing profession.

By increasing the underrepresented groups in nursing there is a moral imperative to achieve equity and diversity, and inclusion of all nurses to embrace the policy process and create a culturally and linguistically diverse care environment. A diverse healthcare workforce increases both minority participation in the health professions and a commitment towards cultural competency of all patients. A U.S. Department of Health and Human Services report (2006) reveals that increased diversity among healthcare professionals leads to improved patient satisfaction, improved patient–nurse communication, and greater access to care for racial and ethnic minority patients who are best served by providers who are knowledgeable about their backgrounds and cultures. Increasing workforce diversity, ensuring fair and equal access to quality health care and healthcare resources, eliminating health disparities, and achieving health equity is where nursing's political advocacy and action upholds the dignity of all people through our actions and our words. The U.S. Department of Health and Human Services and Healthy People 2020 (2013) define health equity as the attainment of the highest level of health for all people.

Achieving health equity for all requires a collective effort across all disciplines and all sectors, including those outside nursing. Therefore, nurses must align themselves with other healthcare professionals to address health disparities and health equity, specifically within the context of the social determinants of health. As an interprofessional healthcare team, all professionals must "draw upon their moral responsibility to respond to human suffering and become acknowledged participants in the nation's efforts to correct health disparity" (Harrison & Falco, 2005, p. 261). Fostering interprofessional education and practice builds the health team's capacity to view high-risk vulnerable and underserved populations as a moral imperative and, as such, bring important perspectives to designing and delivering health services that are transformative to improving health, lowering costs, and increasing patient satisfaction.

To address care gaps and avoid service duplication, improve the quality of patient-centered care, and control costs within and across settings, nurses must understand and interpret legislation and health policy. By being able to interpret healthcare reform from a nursing perspective, nurses can determine how to best distribute resources to individuals, families, and populations. For example, chronic disease is the central healthcare problem in the United States and is the leading cause of disability and death in the United States (Centers for Disease Control and Prevention, 2015; Miller, Lasiter, Bartlett Ellis, & Buelow, 2015). In fact, nearly one in two Americans suffers from chronic conditions such as diabetes, arthritis, hypertension, and kidney disease; these account for 7 of 10 deaths among Americans each year and 75% of the nation's healthcare spending (Conway, Goodrich, Macklin, Sasse, & Cohen, 2011). The obesity epidemic and growing levels of preventable diseases and chronic conditions greatly contribute to the high costs of health care.

Additionally, an aging population has increased the demand to address end-of-life care in a cost-effective manner (Rice & Betcher, 2010). Because chronic disease remains the primary healthcare problem in the United States, nurses can lead change to improve the healthcare system at the population level (Lathrop, 2013; Miller, Lasiter, Bartlett Ellis, & Buelow, 2015). As skilled researchers and clinicians, nurses are in key positions to advocate, lead, and participate in interprofessional initiatives, community coalitions, and policy enactments. Being a nurse advocate means joining the ranks of the nation's care decision makers in order to become full partners in redesigning health care (IOM, 2011; Peltzer et al., 2015).

Conclusion

The concepts of advocacy and action serve as a reference and model for the future, demonstrating that all nurses can develop their influence and policy acumen to equip themselves with the knowledge and tools needed to serve the profession, healthcare organizations, and society. As the nursing profession reflects upon its historical roots in advocacy and action, nurses will strive to find innovative ways to advance the nation's health to reshape healthcare delivery, policy, and payment. These innovations must address the key social determinants of health that will empower and support all people to lead healthier lives.

Developing competencies in advocacy and action requires a clear understanding of how to create healthier and more equitable communities as well as strengthening health services and systems, creating diverse policy solutions, and building a consensus for evaluating policy solutions. For those who are just beginning to learn the advocacy process, it is important to recognize that there will always be divergent views around policy solutions, but the best solutions are those where diverse viewpoints are always heard, considered, and reflect consensus.

With over 3 million strong, nurses have provided evidence and reasoned solutions to healthcare problems. This chapter has addressed how nurses have had a long and vital history of advocacy and social action. It is through this effort towards improving health outcomes for individuals, families, communities, and populations that nurses are a valuable link to educate policymakers about health issues and promote policies to address contemporary public health issues. These issues include public health and emergency preparedness, food safety, hunger and nutrition, climate change and other environmental health issues, public health infrastructure, disease control, international health, and tobacco control (American Public Health Association, 2017).

Fairman and D'Antonio (2013) note that "nurses successes in moving policy forward will depend on their ability to give voice to a historical perspectives that recognize the political and contextual forces that shape health care and places nursing at the center of long-standing debate about health services delivery, knowledge formation, patient safety, technology and education for practice" (p. 351). To design and deliver health services that are transformative in the direction that our nation needs at this moment in time, we must remember how nursing's historical influences of the past shape our advocacy and actions of the future.

Discussion Questions

1. How does history inform nursing's efforts to provide primary health care?
2. What is the relevance of nursing's history to political advocacy today?
3. Describe the role of advocacy within the history of nursing's development in the United States.
4. Select a community or population with which you could become a full partner in redesigning and improving health outcomes to address a contemporary public health issue impacting this community or population, such as access to care, transportation, water safety, pollution, or gun safety.

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CASE STUDY

Strength Is in Coalitions

Pennie Sessler Branden

Purpose of the Case Study

The purpose of this case study is to describe an exemplar where nursing advocacy can be more effective through strong coalitions and partnerships.

The Case Study

Breast cancer is the second most common form of cancer in women and is the second leading cause of cancer deaths. According to the American Cancer Society (ACS) (2017) breast cancer will affect 1 in 8 women during their lifetime and about 1 in 37 women will die of breast cancer. The statistics show that women of color and those in poverty have a higher incidence of breast cancer than white middle- and upper-class women.

Breast cancer screening has been utilized to diagnose breast cancer early enough to improve the treatments, interventions, and outcomes for breast cancer. With 90% of registered nurses (RNs) being female, the American Nursing Association (ANA) (American Nurses Association, n.d.) has educated nurses to better understand breast cancer risk factors and the importance of regular screening. Nurses and other healthcare providers look to the ACS recommendations for mammogram schedules. These recommendations have gone through a number of permutations, but since 2015 the American Cancer Society recommendations state:

> Women with an average risk of breast cancer—most women—should begin yearly mammograms at age 45. Women should be able to start the screening as early as age 40, if they want to. At age 55, women should have mammograms every other year—though women who want to keep having yearly mammograms should be able to do so. Regular mammograms should continue for as long as a woman is in good health. Breast exams, either from a medical provider or self-exams, are no longer recommended. (American Cancer Society, 2015)

Therefore, women should have mammograms as desired or as suggested by their healthcare provider based on their personal medical history and risk factor(s). This relies on the fact that a person has health insurance that covers these costs or is able to go to a free or reduced cost clinic such as Planned Parenthood (PP) for health care and screenings. Planned Parenthood and other clinics rely on funding from the federal government to assist in the costs for these services. Planned Parenthood follows the recommendations of the American Cancer Society regarding breast self-exam and can refer a person to a medical site where mammograms are done as needed. Planned Parenthood may be the only option for a woman to receive the necessary care for a breast cancer screening referral. However, if the U.S. Congress decides to reduce or completely remove funding to Planned Parenthood, what will those women do for breast cancer screening?

Congress assesses what monies will go to what groups and establishments based on a number of factors, including what is the agenda of the president and Congress at the time, what is beneficial for and needed by certain congressional districts, and other special interests. According to the American Public Health Association (APHA) (2017) and other websites, the federal government does not directly fund Planned Parenthood, but rather reimburses states that have paid Medicaid bills for services by such clinics as Planned Parenthood. According to their annual report in 2015–2016, Planned Parenthood received 41% of their operating costs from government health services reimbursement and grants. With a portion of this money, Planned Parenthood did 321,700 breast exams and diagnosed 72,012 incidences of cancer through breast exams and Pap smears. If PP did not have this funding, these numbers would probably be much lower because some women would not have this care due to the inability to pay for it.

For the past few years there has been a rolling debate about healthcare access and whether the federal and/or state governments will fund the health care needed by the working poor and uninsured who may not have the funds to pay for a mammogram. Initially, it seemed as though

the Affordable Care Act (ACA) would reduce these disparities, and it has. However, some state governments have found ways to reduce the potential advantages that the ACA offers. For example, in New Jersey (NJ), Medicaid funding for clinics that gave patients family-planning and well-women care along with referrals for mammograms was completely eliminated by Governor Christie in 2010 (Culp-Ressler, 2015). Christie vetoed those spending bills five times in 5 years. Consequently, between 2010 and 2015, there was a 25.1% increase in breast and cervical cancer cases in Latina women in New Jersey. This was five times higher than women overall in that state (Culp-Ressler, 2015).

Clearly the elimination of this funding has affected and will affect overall screening and care of vulnerable groups unable to pay for these expensive services. Contrary to this, a mid-July 2017 article by Brodesser-Akner reports that NJ legislators have enough votes with Democrats and Republicans together to override a governor's veto for $7.5 million for funding to family-planning clinics, including Planned Parenthood. They believe that the previous vetoes have significantly reduced opportunities for NJ women to obtain necessary health care and that this funding is integral to improving the health of all NJ women.

New Jersey is just one example of the ongoing divisiveness that has taken place over the funding of family planning and women's health clinics by state and federal governments. This is not a new debate but one that has been in discussion for decades. The American Public Health Association (APHA) published a policy statement in 1991 emphasizing that minority women are at higher risk of death from breast cancer than white women and that education and regular screening are integral to the efforts of healthcare providers to reduce the occurrence of breast cancer and to improve overall outcomes. Even with this data-driven information, the federal government currently wants to eliminate funding to Planned Parenthood, thus potentially reducing access to breast exams and early detection of breast cancer for the millions of women who utilize these clinics annually. Nurses have been involved in lobbying efforts to better educate and assist our representatives to understand the importance of breast screening for all women regardless of socioeconomic status. Further, nurses have recognized the importance of building partnerships and coalitions in order to maximize their efforts and have deliberately partnered with groups and organizations that support the many issues that nurses support.

If Congress is only looking at the cost of care given by Planned Parenthood clinics we must look at the entire picture of cost of preventive care versus the cost of breast cancer treatment. With these statistics, one would think that breast cancer screening, which can reduce cost and suffering, would be covered by insurance. The Affordable Care Act (ACA) covers an annual mammogram, as do most insurance companies as mandated by the ACA. The average cost for a mammogram is $456 (MDsave, 2018). According to a retrospective analysis by Blumen, Polkus, and Fitch (2016), the costs of complete breast cancer treatment for 1 year were from $60,637 for Stage I/II treatments up to $134,682 for Stage IV treatments. Not only will there be costs for breast cancer care but there will be potential loss of wages affecting partners and families in addition to an immeasurable psychologic toll. This huge disparity in costs for preventive mammograms and the overall cost for treatment seems to emphasize the importance of preventive care over the need to wait and treat women who get breast cancer. However, with the potential changes in the ACA and the current unemployment and underemployment numbers, what happens to those women who cannot afford the cost of a mammogram or the cost of insurance? Blumen and colleagues (2016) report that support for programs for breast cancer screening need to be implemented and strengthened to diagnose breast cancer and begin treatment earlier.

With all of the political wrangling that occurs over the health and well-being of women, nurses have become advocates for these issues, and with their coalition partners have taken to Capitol Hill to educate their representatives and senators about the importance of healthcare coverage to include things like breast cancer screening. To accomplish this, (1) nurses will continue to educate their colleagues, patients, and families; (2) nurses will continue to meet with their representatives on the state and federal levels; (3) the ANA will continue to write position statements and nurses will testify in front of legislators; and (4) nurses need to bring real stories to their legislators about women with breast cancer who have benefitted from healthcare

access and insurance, as well as stories where a person suffered due to lack of access and/or insurance.

Nurses will continue to advocate for their patients and what is best for them by enlarging their reach through coalitions and partnerships. The Connecticut Nurses Association (CNA) is guided each year by their Connecticut (CT) legislative agenda and their prioritization of issues, which is informed by nurses and their relationships and partnerships with organizations across the healthcare and health spectrum. The CNA regularly engages in advocacy on health and nursing throughout the year and during the legislative session. To address the widespread impact of healthcare reform, the CNA is actively involved in the campaign entitled Protect Our Care CT (PCCT) (Connecticut Nurses Association, 2017). PCCT represents a coalition of organizations and individuals to support and represent the health needs of people of CT, including those who rely on the ACA, Medicare and Medicaid, and women's health programs (personal interview Clear Sandor, 2017). For example, the CT Senate Bill 586 supported state Medicaid expansion of health benefits for children and women (State of Connecticut General Assembly, 2017). There is a long history of CNA's active participation in the state regarding access to essential services and their partnership with other groups and coalitions; the CNA has supported this bill for increased essential benefits and access to care and members have been very vocal about this to their legislators through lobbying efforts, letters, etc. Although the bill does not increase funding for or access to breast screening mammograms, it does mandate breast cancer counseling, genetic testing, and risk assessment. In the future this bill could be expanded to include mandated mammograms no matter what a person's insurance status is. This is an example of the impact of indirect action by multiple groups, including nurses, in strong coalitions. The CNA works collaboratively with its coalitions to strategically exert its influence and increase its voice on multiple healthcare issues that affect women. Coalition building is a key piece of being heard and getting legislation passed. Coalitions have provided nurses with a strong voice and enhanced their ability to provide high-quality, safe care.

Summary

This case study is one relevant example of the potential for possible negative outcomes related to decreased funding by governmental agencies; it also delineates the potential positive outcomes that are achieved with partnering, collaboration, and coalition building. Even though the issue of continued funding for Planned Parent clinics is not addressed directly, successes can be made incrementally that will increase support of important healthcare programs moving forward.

Advocacy, in order to influence policy, is best operationalized through partnerships, collaboration, and coalitions. Although someone in power, such as Governor Christie, can veto a bill to reduce funding to a particular group, the representatives in the New Jersey legislature can introduce bills that can, with a bipartisan majority, override a veto by the governor. Similarly, the Connecticut Nurses Association maximizes its efforts through collaborating and partnering with various groups to form strong influential coalitions that can educate legislators about all of the pieces of breast cancer prevention and care. The combined efforts, along with the increased numbers of individuals actively participating in the process, enhances the work of lobbyists, who in turn influence the policymakers. The overall consequence is the increase in the voice of the public that influences the outcomes. This influence enhances the possibility of providing more adequate healthcare services to all citizens.

Case Study Questions

1. This case is a good example of nursing power through building partnerships and coalitions that have similar missions. Can you identify two coalitions that your state nursing association actively works with? Can you describe the policy issues that these coalitions address?
2. Successful advocacy is best defined as moving toward the ultimate goal(s) in a positive, substantive manner. Explain what advocacy you have done, besides direct patient advocacy, to support health care in your nursing specialty.

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CASE STUDY

A Career in Politics to Role Model: Bethany Hall-Long's Nursing Pathway to the Lieutenant Governor's Office in Delaware

Veronica D. Feeg

A career in politics might be the aspiration for a college student in political science or pre-law, but is seldom one for a nursing student. In fact, courses in health policy or politics may be absent or scarce in nursing undergraduate or graduate curricula, and the notion to become active in politics is unlikely. In fact, Bethany Hall-Long, first woman Lieutenant Governor of Delaware, would be the first to admit that it was not in her plans in the beginning of her personal journey. In fact, she attributes her current position, stated with candor in her numerous inspirational presentations to nurses over the years, to her tardiness for class when the only seminar topic left for students to choose was about nurses in politics—and she was "stuck with it" (personal interview Hall-Long, 2017).

Although she only learned after she won her first race in 2002 that her great-grandfather had been a member of the Delaware House of Representatives, she had little kitchen table discussion about politics growing up. In fact, her farm upbringing and spiritual roots in rural Delaware taught her about taking care of people—"where much is given, much is expected, and it is how you treat the least among us" (personal interview Hall-Long, 2017)—but not about public policy. What is noteworthy in this model career in politics, which she defines as "public service," is her early commitment to caring for the homeless in community health nursing, which became the foundation of her academic career: to understand policy and serve "the many." She attributes her incremental successes, beginning from the day when she was late to her graduate school class, to being coached by mentors such as Catherine Malloy in Charleston, South Carolina, with whom she continued to work throughout her doctoral program in nursing administration and policy at George Mason University. Using what she learned from her study of health policy, she became active in her local city government and organizations such as the League of Women Voters and a federal health clinic that served the homeless. In these experiences, public policy was "made real" and prompted her continued volunteer service in other nonprofit organizations.

She claims that she learned from working with these groups that as nurses, we do not have to stay in our lane of just working with other nurses. She learned how to organize, to use her health knowledge to work for things that people care about, and to build coalitions of groups for action. She says that a leader at the League of Women Voters told her that she "had what it takes—drive, personality, and skills—to think about running for office," which she tucked away at that time. With her husband in the military at the time, she moved to Washington D.C.

Entering the doctoral program, still moonlighting as a nurse, she continued to grow into real public policy experiences that were fueled by taking care of homeless veterans and at-risk populations. To make a real impact, she believed that we had to elect nurses who could make a difference, but she realized she needed experience to be taken seriously. Along the way, it was nurse mentors who connected her with Capitol Hill opportunities on an assignment that would influence a dissertation and numerous other connections, including Bob Dole and Ted Kennedy from a U.S. Senate Committee. While a student, she served as a U.S. Senate Fellow and a U.S. Department of Health and Human Services policy analyst for the Secretary's Commission on Nursing. In her own words, she was not afraid to pick up the phone, encouraged by her mentor, and ask if the national commission studying the nursing shortage needed a policy graduate student—for

free. This opportunity gave her access to the four presidents of the Tri-Council for Nursing (American Nurses Association [ANA], National League for Nursing [NLN], American Association of Colleges of Nursing [AACN], and American Organization of Nurse Executives [AONE]) at age 25. She grew friendships and experience that laid the framework for her dissertation.

Lt. Governor Hall-Long's doctoral dissertation is noteworthy: *A Policy Process Model: Analysis of the Nurse Education Act (NEA) of 1991–1992*. Along with her work in politics, she studied the policy process, knowing clearly that public service mandates an understanding of public policy. This exploratory case study examined a theoretical model and applied it to explain the Tri-Council for Nursing's political efforts during the reauthorization of the Nurse Education Act that year. She interviewed members of the Tri-Council for Nursing, U.S. Division of Nursing, and U.S. Congressional staff, and examined 75 public documents and records as secondary sources of data. Her findings supported the conceptual categories and organization of the model and its ability to discern differences among political actors and corresponding policy stages. This grounding and depth of understanding would serve her well in her subsequent political journey, recognizing fully that in order to improve services or make substantial change for the health of constituents, one needs to know the underlying policy and politics that are successful.

Over these years, she became active with the Democratic Party, working on political campaigns and serving to connect with nonprofit organizations and groups. She worked on community issues that were important and continue today: homelessness, housing, jobs, economic opportunity, and women's and children's issues, particularly infant mortality prevention through improving access for disadvantaged young mothers. She developed relationships in the community and in politics. She says that it was working with Mark Warner, who became Governor of Virginia and is currently a U.S. Senator, that she got her grassroots experience on the campaign trail together. She believed that she could enlighten and inform policymakers who do not understand nursing or health care. To most politicians, nurses are all the same and she was determined to be at the table to educate about issues that matter to nurses—jobs, environment, transportation, and environmental justice, as well as health care in general and women's health in particular. Returning as a faculty member to Delaware, her home state, she decided that her public health and health policy student assignments gave her reasons to run because: (a) she desired to make a significant contribution; (b) she had been well prepared to understand process and as a nurse, she already understood the needs; and (c) the opportunity presented itself to run for the Delaware General Assembly.

In her own words, her public life since 2000 did not begin smoothly—she won the primary but lost her first race by 1% in a race against a long-term male incumbent. But she says that she learned from that experience, pulled herself up by her bootstraps, ran again in 2002, and won in a tough election against the local school board president. She served continuously as the first nurse elected to the Delaware General Assembly from 2003 to 2017, as a member of the Delaware House of Representatives from 2003 to 2009, and then in the Delaware Senate from 2009 to 2017. She lists among her accomplishments cosponsoring a range of legislation including the Governor's Cancer Council and the Health Fund Advisory (Master Tobacco Settlement) Committee. She was the prime House sponsor of legislation creating a cancer consortium for Delaware. She cosponsored a blue ribbon task force to analyze the problem of chronic illness in Delaware and make policy recommendations. She cosponsored needle exchange legislation that has made an impact on HIV infection rates, and she updated the state's indoor tanning laws to prohibit children under age 14 years from using tanning beds and for those age 14 to 18 years to require parental consent (Hall-Long, 2007, 2012). Among her legislative accomplishments during her Senate years, she chaired several important committees including health care, community and county affairs, transportation committee, veterans committee, and insurance committee, among others, where nurses can play a significant role.

Her political campaigns and subsequent elections over these years are remarkable (see **TABLE 1-1**), but she acknowledges that it is not easy to run for office. She describes "running" for office as just that: experiences good and bad teach us how to continue on a path if we are passionate

CASE STUDIES

TABLE 1-1 Chronology of Bethany Hall-Long Elections

Year	Campaign/Election	Outcome
2000	Ran against Republican Representative incumbent Richard Cathcart for District 9 seat.	Lost
2002	Redistricted to District 8; ran unopposed in Democratic primary and against Republican nominee William Hutchinson in general election.	Won (60.7%)
2004	Ran unopposed for Democratic primary and in general election.	Won
2006	Ran unopposed for Democratic primary; ran against Republican nominee Edward Colaprete in general election.	Won (77.0%)
2008	Ran unopposed for District 10 Senate seat; ran against Republican nominee James Weldin in general election.	Won (64.9%)
2012	Incumbent; ran unopposed for Senate seat; ran unopposed in general election.	Won
2016	Ran against Republican La Mar Gunn in Lieutenant Governor race.	Won (59.4%)

Compiled from State of Delaware general election official results. (November 7, 2000; November 5, 2002; November 2, 2004; November 7, 2006; November 4, 2008). Dover, DE: Delaware Commissioner of Elections.

(Hall-Long, 2007, 2012). She loves meeting people on the campaign trail and she believes that being a nurse gets her past the doorbell when going door to door in a race because people can instantly relate to you. She believes that her communication skills come directly from her nursing experience and her connection with the community. She encourages nurses to think beyond healthcare committees—to recognize that we are good at solving problems that may be outside our usual reach, and there is no limit to the list of public policy problems that we can tackle, including, but not limited to, childhood sports activities, palliative care, or opioid addiction, depending on our clinical expertise and interests.

In January 2017, Bethany Hall-Long became the 26th Lieutenant Governor of Delaware. Her understanding of the policy process model that she developed in her dissertation continues to serve her well, and she notes that, although she grew up in a rural household, she is a descendent of Delaware's 15th governor, so it might have been her destiny to have a life in politics. She serves as the President of the Senate, a legislative body she has known for 8 years. As Lieutenant Governor she is proud to be able to influence the policy agenda in some roles and serve the state in her leadership role in moving systems issues such as health reform, workforce training, and mental illness.

The political career of Bethany Hall-Long should be an inspiration for nurses who are dissatisfied with the status quo and passionate about making change to serve the needs of individuals who are disadvantaged. Her message to nursing students and professional nurses is that they should not leave policy making and governing to men in closed rooms anymore; they should seek out ways to influence and consider running for office. She attributes her passion and strength to her grandmother with an 8th grade

education who vociferously advocated that women should be well educated.

Lt. Governor Hall-Long's advice to those with aspirations to impact "the many" is to get prepared, study the policy process, and become experienced in ways to communicate with all types of stakeholders on the issues, from classrooms to boardrooms to community involvement. Volunteer and do not be intimidated. This public servant, from rural roots to a nursing graduate education that includes a PhD, brought her passion for people and her skills in community nursing to the State House in Delaware, second to Governor Carney, and still has gas in the tank to go farther. Her career story should inspire other nurses—who she claims already have the skill set and knowledge to work with people—to pursue public service in the political arena so that the most vulnerable among us can be heard.

Case Study Questions

1. Which of Lt. Governor Hall-Long's list of nursing accomplishments played a role in her journey in politics?
2. What knowledge and characteristics are natural components of nurses' professional backgrounds that help them seek a public service life?
3. How can a political career unfold synergistically with a nurse's ambition to run for political office?
4. Why is "running for office" described by politicians as a challenging personal experience?

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