CHAPTER 2

Agenda Setting

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KEY TERMS

Contextual dimensions: Studying issues in the real world, in the circumstances or settings of what is happening at the time.
Iron triangle: Legislators or their committees, interest groups, and administrative agencies that work together on a policy issue that will benefit all parties.
Stakeholders: Policy actors, policy communities, and policy networks; people and groups that have a say in what goes on.
Streams: Kingdon's concept of the interaction of public problems, policies, and politics that couple and uncouple throughout the process of agenda setting.
Window of opportunity: Limited time frame for action.

INTRODUCTION

This chapter will emphasize the agenda-setting aspect of policy by using exemplar case studies at both the state and national levels. Agenda setting is the process of moving a problem to the attention of government so that solutions can be considered. Advanced practice nurses can apply the knowledge from these case studies to the many current concerns they face.

"At the end of my pilgrimage, I have come to the conclusion that among the sins of modern political science, the greatest of all has been the omission of passion" (Lowi, 1992, p. 6). This criticism does not apply to public policy researchers' current scholarly interest in agenda setting, policy design, and alternative formulation, nor does it apply to certain policy communities who push for selected public policies. The passion of the former group, the researchers, is seen in their search and inquiry for a better understanding of public policy. The passion of the latter, policy communities, is reflected in their tenacity on policy design, in pushing to make sure that a policy is put into practice as it was intended.

Advanced practice nurses, as well as policymakers and citizens, are interested in the best public policy to address society's concerns. In the past, political science researchers have mostly studied the latter steps of policymaking—implementation and evaluation—to gain an understanding of public policy and knowledge that could be used by policymakers to create better public policy. Although all stages of the policy process have been studied, the need for more research on the earlier parts of

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policymaking—agenda setting, policy formulation, and policy design—has been drawing more discussion (Bosso, 1992; Ingraham, 1987; May, 1991). Thus, research interest in these latter areas grew during the 1980s and 1990s and it continues into the 21st century.

In this chapter, examples will be given of agenda setting at both the state and the federal level. First, the state example will be discussed. By discussing this case study, APNs can learn ways that issues can get on the legislative state agenda, how interest groups both propose and block such agenda issues, how such interest groups persist over years to accomplish their goals, and how opponents plan strategies to prevent such agenda items. Following the state agenda setting example, a classic national legislative example will be given.

Case Study 1: Immigration and Perinatal Care

For APNs (and all nurses, health providers, and the lay public), a major concern in the United States is how nondocumented immigrants are treated relative to healthcare access and other human rights issues. At the time of the submission of this chapter (Spring 2011), Nebraska is facing an outlier state policy dictated and implemented by Governor Heineman in Spring 2010 that states that nondocumented pregnant women would no longer receive government-reimbursed health care through Medicaid or other state programs. The outlier aspect of this policy was noted by the author when attending a conference forum presented by an expert on immigration issues in the United States, who mentioned the outlier prenatal care policy of Nebraska. This ruling was implemented through the Nebraska Health and Human Services administrative office. When this new policy was promulgated during Spring 2010, Senator Kathy Campbell attempted a legislative change to prevent this, but was unable to obtain the necessary 30 votes (Senator K. Campbell, personal communication, January 2011). She (and others) had attempted many strategies, including the available option of an administrative agency nonlegislative strategy, i.e., a transfer of money from one financial area to another area that would allow the program to continue. Further, she and many others worked at negotiation with the governor. None of the above strategies was successful. For one year, nondocumented, pregnant women have been and continue to be placed at health risk in one midwestern state.

APNs in Nebraska responded in three ways: 1) being active lobbyists throughout the state with their respective state senators; 2) responding directly by providing perinatal care to these women in selected settings; and 3) collecting data of unmet needs for Senator Campbell's office for the January 2011 Unicameral Session. One example of the second response is what APNs and other health providers did at one federally funded community health center in Omaha, Nebraska. At the One World

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Community Health Centers, the APNs and others created a new program titled Every Baby Matters, putting into place a new volunteer clinic that was open one night a week for these women. APNs, physicians, physician assistants, and other health providers donated their time and expertise to this population of women, and that care has now been integrated into their regular clinic (B. Buschkemper, personal communication, February 26, 2011).

"Politicians and the media may occasionally pander to some greedy, fearful, narrow-mindedness within us" (Lowney, 2009, p. 193). This is the analysis by those who are opposed to Governor Heineman's Spring 2010 policy. Previously, the non-documented women could receive health care based on the Medicaid eligibility of their unborn children. During a December 2010 vigil at the Lincoln, Nebraska, state capitol, speakers noted that 5 infants had died since implementation of the policy and 1500 women were denied health care; 840 of these women were non-documented (Stoddard, 2010). The above "pandering" to fear is ascribed partly to how this issue got on the policy agenda. The above policy is one of several policies introduced in Nebraska that are anti-immigrant in purpose.

Another major bill that was introduced in January 2011 was an Arizona-type anti-immigrant law that required showing documentation during a lawful stop. A third example is a bill, resubmitted in 2011 (not passed during the last 2-year legislative session) that attempts to deny certain college privileges to children of immigrants. Political analysts note the conservative ideology of many Nebraskans and acknowledge that many individuals in the state support such anti-immigrant policies. Another variable that affects the issue is the decline of the economy in the past three years, the fear that this downturn generated, and the seeking of victims to blame. There are legislative structural variables (term limits) and partisan political reasons why the governor has major influence on the predominantly Republican legislature and their voting patterns (such as members' concern about their political ambitions).

The political actors (**stakeholders**) supporting the "no prenatal care policy" have been Governor Heineman, many Republicans, and many citizens. The actors opposed to the policy have been some senators, the healthcare-provider communities (including APNs), the Nebraska Catholic Conference (the dioceses of Nebraska), Voices for Children (a major state child advocacy organization), Nebraska Appleseed for Law in the Public Interest, concerned citizens, and federally funded community health centers throughout the state.

There have been many strategies by the above policy opposition groups to reobtain pregnancy coverage for the women. In January 2011, Senator Campbell introduced LB 599 to make such coverage possible. This author notes that the public hearing at the committee level did not occur until March 16th, 2011 (the third to last day for all public hearings), and such late hearings do not bode well for

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passage of a bill during that particular legislative session. Further, only two additional senators have signed on as cosponsors of this bill; bills have a better chance of passage when there are many cosponsors.

As this chapter goes to press, APNs in Nebraska are proud of how they have responded to the needs of prenatal women, whether or not they are "documented." They are proud of their policy activity, their practice skills, their research skills, and their living by the American Nurses Association Code of Ethics.

CASE STUDY 2: The National Center for Nursing Research Amendment

Victor Hugo wrote, "Greater than the tread of mighty armies is an idea whose time has come" (Kingdon, 1995, p. 1). For nurses, one example of this was the initiation of legislation in 1983 that increased the funding base for nursing research. An amendment to the 1985 Health Research Extension Act, which created the National Center for Nursing Research (NCNR) on the campus of the National Institutes of Health (NIH), is the focus of this chapter's national example of agenda setting.

Creation of the NCNR came about because a group of nurse leaders wanted to create a national institute of nursing within the NIH. In order to pass the legislation in 1985, a political compromise was made with legislators to create a center instead of an institute. However, in 1993 the NCNR was changed to an institute, and today the agency continues as the National Institute of Nursing Research (NINR). Discussion in this chapter of the NCNR amendment focuses on the agenda setting and policy formulation that occurred from 1983 to 1985.

The Influence of National Nurse Groups

The creation of the National Center for Nursing Research on the campus of the National Institutes of Health was a policy victory for national nurse organizations. But, despite this victory, those organizations still need a better understanding of agenda setting, policy formulation, and policy design as they work for other policy changes in the future. Although nurses' groups traditionally have not been considered strong political actors, these groups recognize the importance of political activity to bring about public policies that enhance patient care (Warner, 2003). In the last decade of the 20th century, nurse groups were just emerging as actors in policy networks; however, "a full cadre of nurse leaders who are knowledgeable and experienced in the public arena, who fully understand the design of public policy, and who are conversant with consumer, business and provider groups does not yet exist" (DeBack, 1990, p. 69).

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In a study of national health organizations that play a key role in the health policymaking area (Laumann, Heinz, Nelson, & Salisbury, 1991), no nurse organizations were cited. The scope and nature of nursing care and certain restrictions to providing that care are closely related to public policy. APNs are well aware of this, as state legislative and regulatory activity affects their professional practice on a daily basis. Raudonis and Griffith (1991) and Warner (2003) are three of the many nurse leaders who challenged nurses to be more knowledgeable about health policy. These leaders also urged nurses to become more empowered on health policy issues; if nurses were to become more involved in policymaking, public policy could better reflect the contributions of nurses to patient care, to the health of citizens, and to cost-effective quality solutions for the financial crisis of the healthcare system. Nagelkerk and Henry echoed this concern: "To date, few studies in nursing can be classified as policy research. Leaders in our field, therefore, have identified this type of undertaking as a priority" (1991, p. 20).

Research on the NCNR amendment is important because it studies political actors who are not generally studied (e.g., nurses' interest groups), and so this research contributes to public policy scholars' knowledge of all actors in policy networks. Laumann et al. acknowledged that "we may even run a risk of misrepresenting the sorts of actors who come to be influential in policy deliberation" (1991, p. 67). The significance of this research becomes obvious when the Schneider and Ingram model of social construction of target populations in policy design is applied to the nurse interest groups (1993a). For example, how nurses were viewed by policymakers—the social construction of nurses as a target population—influenced not only the policy that nurses were interested in, but also passage of the total NIH reauthorization bill.

Dohler (1991) compared health policy actors in the United States, Great Britain, and Germany, and found that it is much easier to have new political actors in the United States because there are multiple ways to become involved, and he has written of the great increase in new actors since 1970. Baumgartner and Jones (1993) also described multiple paths of access to becoming involved.

OVERVIEW OF MODELS AND DIMENSIONS

Several researchers have developed models of agenda setting and policy formulation (Baumgartner & Jones, 1993; Cobb & Elder, 1983; Kingdon, 1995), and several political scientists are developing theoretical modeling of policy design (Hedge & Mok, 1987). Ingraham is one of several authors who have noted the lack of one design, one theory, or one model in policy design (1987). Meanwhile, public policy scholars are pushing for more empirical study of agenda setting, alternative formulation, and policy design (Schneider & Ingram, 1993a).

Data analysis reveals the importance of the Schneider and Ingram model (1993a) of the social construction of target populations, and of the Kingdon model (1995)

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for an understanding of the agenda-setting process of this amendment to the NIH reauthorizing legislative bill. Analysis of this legislation over the period of a decade also underscores the importance of the Dryzek (1983) definition of policy design. An analysis of the legislation supported the importance of studying the **contextual dimension** that has been advocated by Bobrow and Dryzek (1987), Bosso (1992), deLeon (1988–1989), Ingraham and White (1988–1989), May (1991), and Schneider and Ingram (1993b). The value of other models—institutional, representational communities and institutional approach, and the congressional motivational model—is addressed as these models contribute to an understanding of this example. During the study of interest groups opposed to this legislation, the researcher noted two occurrences of **iron triangles** in the early 1980s. These findings will be discussed in more detail.

Kingdon Model

One model that was explanatory for this research was the Kingdon model (1995), which explains how issues get on the political agenda, and, once there, how alternative solutions are devised. The four important concepts are the three **streams** (policy, problem, and political) and the **window of opportunity**. A problem stream can be marked by systematic indicators of a problem, by a sudden crisis, or by feedback that a program is not working as intended. A practical application for APNs is that they can be attentive to these indicators and maximize such opportunities to get an issue on the agenda. A policy stream relates to those policy actors and communities who attach their solutions (policies) to emerging problems. This concept also relates to the actual policy being promoted, and so APNs can be attentive to identifying problems and framing their solutions to such concerns. The third stream of Kingdon's model is the political stream, which consists of the public mood, pressure group campaigns, election results, partisan or ideological distributions in Congress, and changes in administration. Other factors include committee jurisdictional boundaries and turf concerns among agencies and government branches. Thus, APNs need to be constantly attentive to all of these political factors, which can integrate with the fourth concept, the "window of opportunity." This is when the above three streams integrate at a time that is favorable to solve a problem with one's preferred policy and with least resistance. This window of opportunity is most usually affected by the problem and political streams.

Interview data and a review of the literature showed many ways in which the Kingdon model explained the agenda setting for this bill. For example, for the problem stream, these were variables: 1) the need for nursing research was recognized by many (e.g., Rep. Madigan (R-IL), legislative staffers, and national nurse leaders); 2) there were data about financial disparity in funding for nurses; and 3) the timing of an Institute of Medicine (IOM) report (Cantelon, 2010) on this problem. For the political stream, these were the variables: 1) this policy would be valuable for Rep. Madigan's re-election and 2) this was an important policy proposal for the Republican Party

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to secure increased voting by women voters. For the policy stream, it was sound public policy. There was a window of opportunity; the release of the IOM report in conjunction with the election cycle, the presence of many national nurse leaders who were policy and politically knowledgeable, and a U.S. representative who initiated the idea for this bill all came together quickly and at an opportune time. In summarizing these findings in relation to the Kingdon model, this example validated the importance of the political and problem streams. However, the NCNR amendment was passed without meeting the policy stream processes described by Kingdon, in that it did not go through a softening-up phase.

Advanced practice nurses may be able to apply the Kingdon model to ongoing priority practice issues with which they are concerned. For example, APNs can be attentive to the three streams (policy, problem, and political) and a window of opportunity in which to move forward their agenda. Every year a legislative update is printed in *The Nurse Practitioner*, and this is one way to recognize the advances made in state policies in the areas of scope of practice, prescriptive authority, reimbursement practices, title protection, and emerging issues.

Although one of the exemplar case studies used in this chapter is that of the National Institute of Nursing Research getting on the political agenda and being passed as national legislation, APNs also need to be aware that taking political activity in regulatory agencies could also be an ideal way to problem solve. Nurse practitioners are finding increased difficulty in having mail-order pharmacies recognize and fill their prescriptions (Edmunds, 2003). Two nurse practitioners from New York and South Carolina addressed this problem stream by working with the Food and Drug Administration and the Federal Trade Commission. They recognized that the value of working through regulatory agencies was the best initial solution for this problem (Edmunds, 2003).

Importance of Contextual Dimensions

Some authors, notably Bobrow and Dryzek (1987), Bosso (1992), deLeon (1988–1989), Ingraham and White (1988–1989), May (1991), and Schneider and Ingram (1993b), have emphasized the need to analyze the political context in which policies get on the agenda, alternatives are formulated, and policies are put into effect. Although neither a definitive nor an exhaustive list, five contextual dimensions are suggested by Bobrow and Dryzek (1987) for studying the success or failure of any designed policy: 1) complexity and uncertainty of the decision–system environment; 2) feedback potential; 3) control of design by an actor or group of actors; 4) stability of policy actors over time; and 5) the audience must be stirred into action. deLeon writes that sometimes researchers, because of their unstructured environment, have chosen to study approaches and methodologies that may meet scientific rigor better, but in doing so come "dangerously close to rendering the policy sciences all-but-useless in the real-life political arenas" (1988–1989, p. 300).

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deLeon notes that it is difficult to impossible for researchers to "structure analytically the contextual environment in which their recommended analyses must operate" (1988–1989, p. 300). Researchers have to work in a world with great social complexity, extreme political competition, and limited resources. Of these writers, Bosso and May are especially strong in their advocacy of this contextual approach to the study of public policy. Bosso (1992) echoes deLeon's concern: "In many ways, the healthiest trend is the admission, albeit a grudging one for many, that policymaking is not engineering and the study of policy formation cannot be a laboratory science. In policy making contexts do matter, people don't always act according to narrow self-interest, and decisions are made on the basis of incomplete or biased information" (p. 23).

Data from congressional documents, archival sources, and personal and telephone interviews show the importance of the political context to all aspects of policy design—how the policy arrived on the agenda; how policy alternatives were formulated; the legislative process; implementation; and redesign of the legislation eight years later, resulting in new legislation within two years to accomplish the original goal (Bobrow & Dryzek, 1987; Bosso, 1992; deLeon, 1988–1989; Ingraham & White, 1988–1989; May, 1991; Schneider & Ingram, 1993b).

Examples of Political Contextual Influence

First, partisan political party conflict within Congress influenced the initial agenda setting of the amendment and the legislative process throughout the two years. Opposition to Rep. Waxman's (D-CA) NIH bill in the spring and summer of 1983 resulted in Rep. Madigan's initiating a substitute policy. As noted by two congressional staffers, this was an example of partisan conflict. Another example of partisanship, noted by an interviewee, was that the appointment of Dr. Ada Sue Hinshaw as the first director of the NCNR was made easier because she was Republican. (The administration at the time was Republican.)

Second, a U.S. representative's concern with his reelection chances influenced the initial agenda setting because of the congressional perception that nurses were a target population that could help his reelection chances. Several respondents noted that this was an important factor in the initial decision for this type of public policy.

A third contextual dimension was the bipartisan negotiation to enact policy. Such negotiations by Rep. Waxman and Rep. Madigan in early Fall 1983 resulted in a firm resolve during the 97th and 98th Congresses to stay with the proposed NINR policy and during the 99th Congress to accept a compromise of an NCNR. Another example of bipartisan negotiation was the early committee work by Rep. Madigan, Rep. Broyhill (R-NC), and Rep. Shelby (D-AL) to forge a simple bipartisan amendment that was four lines long. The bipartisan effort of these three representatives smoothed the way for passage of this amendment by the subcommittee. If there is bipartisan support for issues, there is a greater chance for passage of legislation. Legislators used this strategy early in the legislative process.

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Fourth, interest-group unity on the policy was a factor. Such unity by nurse groups was considered by many interviewees to be a crucial factor in the bill's passage, and this unity also was important in explaining why no other policy alternatives were pursued. Because the decision to support Rep. Madigan was officially made by the Tri-Council in the summer of 1983, and although other policy alternatives were considered after that, the priority of presenting unity with Rep. Madigan was maintained. Dohler (1991) reported on the importance of the unity of policy communities. He concluded that the deregulation of two organizations, the Professional Standards Review Organization and the Health Systems Agencies, occurred because of the "weakened stability of the network segment" (p. 267). Dohler also determined that if there is not a stable, united policy community, programs falter. If there is such stability (as with the nursing community in this research), there is an increased chance of success.

Fifth, lack of interest group unity with a congressperson was seen as a negative factor. Such behavior by the American Association of Medical Colleges had disillusioned Rep. Madigan and increased his interest in initiating the NINR policy.

Sixth, partisan conflict between the White House and an interest group (nurses) that generally supported Democratic presidential and vice presidential candidates had an influence on this legislation's history. This campaign support by the American Nurses Association (ANA) for the Democratic candidates was evaluated as the reason for the 1984 Republican presidential veto of the NINR amendment and the NIH bill that had passed Congress. Interviewee data reported one congressperson's concern with how the ANA Political Action Committee (PAC) distributed its money—mainly to Democratic candidates. Research by Makinson (1992) a decade later on the 1990 election reflected that the ANA PAC gave 85 percent of its money to Democratic candidates.

Seventh, ideological and partisan conflicts over other issues within the larger NIH bill affected the bill's legislative history. Concerns about fetal tissue research and animal rights research caused much difficulty in the early 1980s, while concerns about immigration laws and immigrants with HIV infection raised concerns in the 1990s and affected compromises and passage of the bills. Such other issues, although not about the NINR amendment, had a major effect on the bill's legislative history. APNs need to understand bills in their holistic content and the many pressures on a particular bill.

Eighth, concerns with the federal deficit influenced discussion of the bill and decision making. There was opposition to the creation of new federal entities because of the deficit concern, and President Reagan consistently used this argument as a reason not to create a NINR.

Ninth, legislation passed during a lame-duck presidential term was a factor. The NIH bill with the NCNR amendment was passed in 1985 when President Reagan was beginning his second term. Republican congresspeople did not feel as constrained to vote along party lines, and that was reflected in the 1985 legislative vote and the override vote. Thus, the timing of this vote in President Reagan's lame-duck term helped the bill's passage. When the president vetoes legislation, another option for

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passage is for Congress to secure the necessary number of votes and override the president's decision. As will be explained in the thirteenth contextual variable, this was a significant political event for this nursing issue.

Tenth, the history of Congress with selected administrative agencies influenced the political context. Rep. Waxman's attempted control of NIH was a factor in Rep. Madigan's initiation of NIH legislation during the summer of 1983. Data support the analysis that of all administrative agencies, the NIH consistently was regarded positively by Congress members, and this was reflected in ample funding levels on a consistent basis. Contrary to this usual positive regard was the negative situation between Rep. Dingell (D-MI) and the NIH. He had "captured" letters sent by NIH officials to research scientists asking them to lobby their Congress members for increased funding. Rep. Dingell reminded NIH officials that this activity violated law. Further, this situation led Rep. Dingell and other congresspeople to ask: Who was and who should be in charge of the NIH?

Eleventh, the interaction of Congress, administrative agencies, and the Office of Management and Budget (OMB) also influenced the political context. The congressional funding pattern identified in the 10th factor changed somewhat in the early 1980s. NIH officials became anxious when OMB dictated that NIH make a last-minute revised budget to honor a 1980 promise to fund 5000 new grants yearly. This mandated division of NIH's economic pie contributed to NIH officials' not wanting new research entities on their campus that would further erode current programs and projects. A second similar budgetary crisis occurred at NIH in Spring 1985 that again caused much consternation for NIH officials and research scientists.

Twelfth, the internal political dynamics of Congress also influenced this legislation. Rep. Waxman was a member of the congressional class of 1974, when the dynamic in Congress was a decentralization of power and an increasing congressional class. (A congressional class refers to that cohort of elected officials in a certain election.) The data revealed that Rep. Waxman was interested in gaining more power and control over NIH. Although his committee had authorizing power over NIH, it did not have the greater power of the appropriations committee that was responsible for funding. However, with his ability to authorize legislation, Rep. Waxman had leverage to gain more power. Waxman's attempt to micromanage NIH resulted in Rep. Madigan's initiating substitute policy.

Thirteenth, interaction between the White House and Congress affected the legislation. For example, President Reagan publicly vetoed the legislation in 1984, although he could have done it quietly by not signing the bill. This was done to alert Congress to expect conflict the following year if the bill's provisions were kept the same. An example of the negative relationship between the White House and Congress related to the override vote in 1985. Data showed that members of Congress (and many of the president's party) felt betrayed over their work on this legislation and over what they thought their communication had been with the president about passing this policy

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and putting it into effect. This sense of betrayal spurred their work in securing the veto override vote. Another example of the relationship between the White House and Congress was the number of presidential vetoes by President Reagan of congressional legislation and the few veto-override votes. Since his inauguration, President Reagan had vetoed 41 legislative bills; this override of the NIH bill veto was the fifth successful override vote since 1981 (Congressional Quarterly, 1985).

Fourteenth, even international political relations were a consideration. During Fall 1985, the Senate waited until the Geneva Summit was finished before beginning the veto-override vote. This was done to keep President Reagan from losing any credibility during the summit meeting because the Soviet leader would be aware of the veto-override vote.

Fifteenth, the skills and abilities of an interest group in furthering its intended policy had an influence on the context of legislation. Data revealed that in the early 1980s, many factors influenced the ability of the nurse interest group to promote this policy once it was on the agenda. These influences were: 1) the formation of the Tri-Council; 2) a special interest in public policy of the executive director of the National League for Nursing (NLN); 3) the coming need to reauthorize the Nurse Education Act; 4) many deans of nursing education programs who were policy oriented; 5) a combination of people who saw the need; 6) much networking by nurses; (7) the presence of highly motivated people who were interested in furthering the nurse profession; 8) nurses appointed to positions within the White House; 9) more nurses working on the Hill; and 10) the study conducted by Dr. Joanne Stevenson (personal communication, 1990) on nurse researchers' inability to obtain NIH grants. These 10 factors were obtained from interview data. Many of these influences demonstrate the increased numbers of nurses who were active in policy and politics in many dimensions and in many places: state and national governmental levels, professional associations, executive and legislative branches of the government, schools of nursing, and networking circles. Further, the research by Dr. Stevenson had shown that nurses had an increased opportunity of receiving NIH grants when they omitted their RN credential on their grant and only listed their PhD.

Sixteenth, the adage that "all politics is personal" influenced the legislation at various points. Data revealed the importance of personal relationships in getting the idea on the agenda, in gaining strategic information, in sharing needed information, and in making requests. For example, strategic networking at certain cocktail parties helped, as did carpooling with selected political actors. Savvy nurse leaders facilitated other nurses meeting with legislators and legislative aides in these settings so nurses could lobby effectively. The importance of congressional staffers to the initiation and passage of legislation must be noted. Several interviewees spoke of the importance of certain staffers in their tenacity to ensure that the NCNR amendment was passed. Other staffers noted the importance of the professional education background and socialization of staffers in influencing the types of policy options that are initiated

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and worked on with vigor. Interview data attested to the tenacity of one Capitol Hill staffer during the conference committee.

Two of Bobrow and Dryzek's (1987) five contextual dimensions were in evidence and contributed to the success of this policy, both because the NCNR was passed as legislation in 1985 and because the NCNR became a national institute of nursing research in 1993. The two criteria are related in this instance: the control of design by an actor or group of actors and the stability of policy actors over time. Once this policy was on the agenda and once nurses were united, the nurse interest group was committed to it. The nurse interest group showed unity in working with Rep. Madigan and staying the course. Although there were other policy alternatives discussed, they were never vigorously pursued by the nurse interest group. Once the compromise for NCNR was made in 1985, the nurse interest group found it acceptable because they knew they had a "foot in the door" and because they planned to accomplish their original design (an NINR) at a later date.

Stability of Policy Actors

The second dimension, stability of policy actors, also relates to the nurse interest group. This group of nurse leaders was stable for over a decade and kept tenaciously to its goal. Although the policy arrived on the formal agenda because of Rep. Madigan, a very stable group of nurse actors worked for over a decade to see that the original policy design eventually was enacted (change from an NCNR to an NINR).

May (1991) writes that regardless of how one defines policy design, there is the "emphasis on matching content of a given policy to the political context in which the policy is formulated and implemented" (p. 188). This statement describes the contextual dimension of how this public policy arrived on the formal agenda. Rep. Madigan was going to introduce substitute legislation for Rep. Waxman's NIH bill. Rep. Madigan's NINR amendment was based on an appraisal of what policy content would best work in that political context.

Ingraham and White wrote: "Politics can influence both design process and design outcome in a number of ways. It can constrain problem definition and the range of alternative solutions available for consideration. . . . It can, in fact, eliminate the process of design altogether" (1988–1989, p. 316). Data indicate that this happened. Partisan and reelection politics influenced the design process, specifically the policy option that was chosen (the NINR proposal). That policy option moved quickly to the formal agenda, where it then moved forward in the legislative process. The politics of that option kept other alternative solutions from being seriously considered. Thus, the politics of this situation influenced the design process and the selection of the policy option and constrained the availability of other policy alternatives.

Schneider and Ingram Model

In addition to the political context emphasis, Schneider and Ingram (1991, 1993a, 1993b) specifically push for empirical research that studies the social construction of

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target populations (those groups affected by the policy). They propose that one can best understand agenda setting, alternative formulation, and implementation by knowing how elected officials perceive different target populations; in other words, by knowing the "social construction"—images, symbols, and traits—of such populations.

In their beginning work in this area, Schneider and Ingram proposed a theory in which there is a continuum of target populations categorized as the advantaged, contenders, dependents, and deviants. Their model suggests that there are pressures to initiate beneficial policy that help those groups that are seen positively, while groups that are seen negatively will receive punitive policy. They argue that groups that are viewed positively are the "advantaged" and the "dependents," while the negatively perceived groups are the "contenders" and the "deviants." This is a beginning categorization, and they call for empirical research in this area. They admit that their theory needs three items:

1. A definition of target populations and of social constructions.
2. An explanation of how social constructions influence public officials in choosing agendas and designs of policy.
3. An explanation of how policy agendas and designs influence the political orientations and participation patterns of target populations.

The Schneider and Ingram theory, together with Kingdon's research, provide the best explanation for understanding the process of the NCNR legislation. Schneider and Ingram (1991, 1993a, 1993b) say that one can best understand agenda setting, alternative formulation, and implementation by knowing how elected officials see different target populations and by knowing the social construction, or images, symbols, and traits, of such populations. The data consistently revealed that this NCNR policy was initiated by Rep. Madigan because of the social construction of this target population. Proposing public policy for this target population would help him pass his substitute NIH legislation. Nurses, as a target population, would be on the continuum of positively viewed groups. Although Schneider and Ingram acknowledge that theirs is an emerging model that needs empirical testing to refine and define several of its phenomena, this author found it to be of explanatory value and extreme importance.

Mueller (1988) wrote: "Politicians must be convinced that they will gain from new policies—either through political success or through program effectiveness" (p. 443). The selection of nurses as a target population when Congress members, especially Republicans, needed the female vote contributed to a convincing argument for potential political success for them.

CONCLUSION

"No data are ever in themselves decisive. Factors beyond only the data help decide which policy is formulated or adopted by the people empowered to make the decision to form policy" (James, 1991, p. 14). James is referring to data in a problem stream as described

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by Kingdon. The accuracy of this quote was seen in this research because the Schneider and Ingram theory of the "social construction of target populations," together with the Kingdon model and the contextual dimension, explained the policy process.

The contextual dimension influenced all aspects of the policy, from agenda setting in 1983 through policy redesign in 1991, with passage of the amended legislation in 1993 that accomplished the original 1983 goal. The importance of studying the political context was demonstrated by the 17 contextual dimensions that influenced this legislative policy process.

Of particular explanatory value in the early agenda-setting and policy-alternative formulation of this legislation were the Schneider and Ingram model and the Kingdon model. The particular amendment was pursued because of application of the "social construction of target populations;" that is, the target population of nurses was chosen because they would help Rep. Madigan's and other Congress members' chances for reelection. With this model, the Kingdon theory adds to the further understanding of this legislation. Within Kingdon's model, neither the problem stream nor the policy stream was decisive for the process of this legislation; rather, it was the political stream. The factors of the political stream (reelection chances for Rep. Madigan and other congresspeople, partisan ideology in Congress, the public mood about gender issues, and turf concerns between government agencies) all strongly influenced the setting of this issue on the agenda. The hypotheses supported by this empirical research include: that policy is more likely to be initiated for those target populations who are positively viewed by members of Congress; issues are more likely to reach the formal agenda when the political stream factors are related to positively viewed target populations; and policy process is best understood in a contextual perspective.

For APN scholars, these case studies contribute to an understanding of agenda setting and policy design by having evaluated the importance of the Schneider and Ingram model, the Kingdon model, policy design, and the contextual dimension to policy initiation, development, implementation, and policy redesign in the creation of the National Institute for Nursing Research and in a state issue relating to prenatal care policy for pregnant women who are not documented.

DISCUSSION POINTS AND ACTIVITIES

1. How did the Kingdon model explain the NCNR getting on the political agenda?
2. How can APNs become aware of factors in the problem stream to which Kingdon alluded?
3. What are examples of policy streams that APNs could be advancing relative to their practice?
4. How can APNs be involved in the political stream?
5. How can APNs anticipate windows of opportunity?

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6. According to Schneider and Ingram, to which of the four target populations do nurses belong? Discuss the relevance to agenda setting.
7. What are ways that APNs can network with congressional members and their staffers?
8. How can APNs promote unity among themselves and with other nurses?
9. What current contextual dimensions can promote APN practice?
10. How can APNs use the Kingdon model and the Schneider and Ingram model?

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REFERENCES

Baumgartner, F. R., & Jones, B. D. (1993). *Agendas and instability in American politics*. Chicago: University of Chicago Press.

Bobrow, D. B., & Dryzek, J. S. (1987). *Policy analysis by design*. Pittsburgh, PA: University of Pittsburgh Press.

Bosso, C. J. (1992). Designing environmental policy. *Policy Currents, 2*(4), 1, 4–6.

Cantelon, P. (2010). *National Institute of Nursing Research history book*. Washington, DC: NIH Publishers.

Cobb, R. W., & Elder, C. D. (1983). *Participation in America: The dynamics of agenda-building* (2nd ed.). Baltimore: Johns Hopkins University Press.

Congressional Quarterly (1985, July 27), p. 1493. Washington, DC: U.S. Printing Office.

DeBack, V. (1990). Public policy—nursing needs health policy leaders. *Journal of Professional Nursing*, *6*(2), 69.

deLeon, P. (1988–1989). The contextual burdens of policy design. *Policy Studies Journal*, *17*(2), 297–309.

Dohler, M. (1991). Policy networks, opportunity structures, and neo-conservative reform strategies in health policy. In B. Main and R. Mayntz (Eds.), *Policy networks: Empirical evidence and theoretical considerations* (pp. 235–296). Frankfurt am Main: Campus Verlag.

Dryzek, J. S. (1983). Don't toss coins in garbage cans: A prologue to policy design. *Journal of Public Policy, 3*(4), 345–368.

Edmunds, M. (2003). Advocating for NPs: Go and do likewise. *The Nurse Practitioner, 28(*2), 56.

Hedge, D. M., & Mok, J. W. (1987). The nature of policy studies: A content analysis of policy journal articles. *Policy Studies Journal, 16*(1), 49–62.

Ingraham, P. W. (1987). Toward more systematic consideration of policy design. *Policy Studies Journal, 15*(4), 611–628.

Ingraham, P. W., & White, J. (1988–1989). The design of civil service reform: Lessons in politics and rationality. *Policy Studies Journal*, *17*(2), 315–330.

James, P. (1991). Bravo to the nursing emphasis on policy research. *Reflections, 17*(1), 14–15.

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Kingdon, J. W. (1995). *Agendas, alternatives, and public policies*. New York: Harper Collins College Publishers.

Laumann, E. O., Heinz, J. P., Nelson, R., & Salisbury, R. (1991). Organizations in political action: Representing interests in national policy making. In B. Marin and R. Mayntz (Eds.), *Policy networks: Empirical evidence and theoretical considerations,* (pp. 63–96). Frankfurt am Main: Campus Verlag.

Lowi, T. J. (1992). The state in political science: How we become what we study. *American Political Science Review, 86*(1), 1.

Lowney, C. (2009). *Heroic living*. Chicago: Loyola Press.

Makinson, L. (1992). Political contributions from the health and insurance industries. *Health Affairs*, *11*(4), 120–134.

May, P. J. (1991). Reconsidering policy design: Policies and publics. *Journal of Public Policy, 11*(2), 187–206.

Mueller, K. J. (1988). Federal programs to expire: The case of health planning. *Public Administration Review, 48*(3), 719–725.

Nagelkerk, J. M., & Henry, B. (1991). Leadership through policy research. *Journal of Nursing Administration, 21*(5), 20–24.

Raudonis, B. M., & Griffith, H. (1991). A model for integrating health services, research, and health care policy formation. *Nursing & Health Care, 12*(1), 32–36.

Schneider, A., & Ingram, H. (1991). The Social Construction of target populations: Implications for citizenship and democracy. Paper presented at the annual meeting of the American Political Science Association in Washington, DC.

Schneider, A. L., & Ingram, H. (1993a). How the social construction of target populations contributes to problems in policy design. *Policy Currents, 3*(1), 1–4.

Schneider, A. & Ingram, H. (1993b). Social construction of target populations: Implications for politics and policy. *American Political Science Review, 87*(2), 334–347.

Stoddard, M. (December 29, 2010). Vigil blames fund loss in infant deaths. *Omaha World Herald*, 2B.

Warner, J. R. (2003). A phenomenological approach to political competence: Stories of nurse activists. *Policy, Politics, and Nursing Practice, 4*(2), 135–143.

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