PART I

HEALTH POLICY

Health policy can be a confusing concept and field of study. As an orientation to the field, Block describes the array of definitions and the dynamic and complex policy-making process. Health policy is designed to address problems or changes that need to be made, but the key to success is initially identifying and understanding the problem and then following a model to direct or intervene in the public policy-making process.

As health professionals have begun to better appreciate the importance of policy and politics in their practices, they are increasingly becoming involved in politics and political actions. Because participating in the political process effectively is an art, health professionals need to know the basic rules of politics. The article by Dodd, an experienced nurse who previously held a high-level presidential administrative appointment and served as a top staff person to Congresswoman Nancy Pelosi, Democratic Majority Leader in the U.S. House of Representatives, gives practical guidelines for understanding and participating in politics.

The political scene in the United States is not a pretty picture, with large corporate health insurers, health care organizations, and the pharmaceutical industry wielding sometimes intimidating influence through massive political contributions. An example of the political control of corporations is the historical failure of national health insurance legislation over the years and the failure of President Bill Clinton’s health reform legislation in 1994. Even the most conservative economists have noted the power that the health industry has had to stop any significant government reform. Interest-group politics are involved, and the health industry seeks to protect its economic position.

Corporations have not wanted government-guaranteed benefits that give workers more power and freedom to move between companies, and in and out of the workforce, without penalty. Even the Clinton health plan, which was designed to appeal to large corporate interests, was not able to win their support. The media and academia are also heavily influenced by corporate ideology in America, such that the public views of health reform they have presented in the past were aligned with those of the corporate world in opposition to the changes. The complexities of health reform are limited by the U.S. constitutional framework, making any change difficult, and the enormous influence of corporate and wealthy interests over the political and electoral processes.
Steinmo and Watts address why the United States does not have a comprehensive national health insurance program, showing that American political institutions are biased against reform. The U.S. political system places power in the hands of special-interest groups, and the political structure is decentralized, making it relatively easy to block legislation. Because of this political structure, it is difficult for any legislation to be passed. Thus, if Americans want Congress to act on a reform agenda, they need to focus on reforming political institutions and minimizing the influence of special-interest groups to make it easier for a democratic majority to get ground-breaking legislation enacted.
CHAPTER 1

Health Politics and Political Action

Teacher talking with students
Health Policy: What It Is and How It Works

Lester E. Block, DDS, MPH

INTRODUCTION

The usage and popularity of the word policy in regard to health has significantly increased over the past four decades. During the decade between 1992 and 2002, 2,132 books were published with the words health and policy in their titles as compared to 75 during the decade between 1959 and 1969 (WorldCat, 2003).

For the past 20 years, articles have been published about the emergence of health policy as an increasing concern to health professionals and the need for them to develop an adequate foundation of knowledge of health policy to be able to better analyze and influence the formulation of policies to support their professional objectives (Bodenheimer, 2001; Longest, 1997; Reeves, Bergwall, and Woodside, 1984; Rodgers, 1989; Roemer, 1980). Rodgers indicated that this was being hindered by the lack of a clear concept and definition of what policy is and that meager and inadequate attempts to define it give the assumption that its definition is too often assumed to be self-evident (Rodgers, 1989).

Almost 10 years before Rodgers' article was published, Falcone had written that deriving a useful definition and concept of health policy is complicated by the lack of a viable definition of the word policy, “not because of a scarcity of meanings with some currency but the lack of commonly accepted conceptions” (Falcone, 1981, p. 5). Ten years after the Rodgers article was published, Milstead (1999) commented that there still is not a clear definition of policy, and she, too, called for health professionals to be knowledgeable in their role as makers of public policy.

Although numerous attempts have been made in the past 20 years to clarify the meaning of policy, much of the ambiguity Rodgers referred to in 1989 remains. Ambiguity in regard to health care terms is not restricted, however, to the word policy. Many other health care–related terms, such as quality, reform, rationing, freedom of choice, managed care, spirituality, alternative care, and comprehensive care, are equally ambiguous. Even the simple word is has been questioned in regard to what is is (Ferguson, 2000).

The goal of this article is to provide a framework enabling the reader to examine the public policy issues discussed in this book. It is hoped that this framework can be used to better comprehend the policy-making process, to determine whether the policies in question appropriately address the public interest, and to view policy making as a process to solve problems. It should be noted that the major purpose of health policy is to enhance
health or facilitate its pursuit by the public and the defining purpose of the governmental health policy is to support the public in its quest for health (Longest, 1998).

**WHAT IS HEALTH POLICY?**

One of the reasons for the ambiguous usage as to the meaning of the word *policy* is that it has two quite different Greek roots, one meaning “demonstration or proof” and the other meaning “citizenship” (Chrichton, 1981). Definitions of policy based on the root meaning “demonstration or proof” include (a) a certificate of insurance more commonly known as an insurance policy and (b) a method of gambling in which bets are made on numbers to be drawn from a lottery (Oxford English Dictionary, 1989).

Definitions of policy derived from the root meaning *citizenship* include the following:

a. “Principles that govern action toward given ends” (Leavitt and Mason, 1998). “A guiding principle considered expedient, prudent, or advantageous in reference to conduct or action. For example, honesty is the best policy, or it was a good policy to consent” (Webster’s Dictionary, 1986).


c. “Statements that express the wisdom, philosophy, experiences, and beliefs of an organization’s senior management for future guidance toward attainment of goals and objectives” (Timmreck, 1997, p. 559). An example of the usage of policy in the context of this definition is management guru Peter Drucker’s comment on change: “The first policy and the foundation for all others—is to abandon yesterday” (Drucker, 1999, p. 74).

d. “Any stated position on matters at issue, such as an organization’s policy statement on universal health care” (Subcommittee on Health and Environment, 1976, p. 124).

e. “A plan or course of action of a government or business intended to influence and determine decisions, actions, and other matters. Examples include American foreign policy or a company’s personnel policy” (Webster’s Dictionary, 1986).

f. “A course of action adopted and pursued by a government, party, statesman, or other individual or organization” (Subcommittee on Health and Environment, 1976, p. 124).

g. “Measures that government (that is, the public sector) adopt or can adopt to achieve given ends or goals” (Brown, 1988).

h. “Authoritative decisions and guidelines that direct human behavior toward specific goals either in the private or the public sector” (Hanley, 1998, p. 125).

i. “Authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others” (Longest, 1998, p. 243).

Definitions a–d, although commonly used, do not reflect the meaning of policy as used in the context of the public policy-making process; definitions e–i do. The most applicable and appropriate definition for policy as applied to the public sector is definition i. In addition to these divergent definitions of policy, another confounding factor is that policy is considered as a field, an entity, as well as a process. As a field it is considered in a
manner similar to that of the field of sports, nursing, or teaching. As an entity it is often used to refer to goals, programs, and proposals as well as the “standing decisions” or formal documented directives of an organization (Milstead, 1999). As a process it is used to represent the public policy-making process (Iatridis, 1995). Charles O. Jones confirms the importance of defining policy more precisely although he thinks the task is not an easy one since the word policy is often used interchangeably with goals, programs, decisions, laws, standards, proposals, and grand designs. He suggests that when a reference is made to policy, the following question should be asked: Is the person referring to national goals, current statutes, or recent decisions, or “characterizing certain behavioral consistencies by decision makers”? His reason for asking these questions is not to “enforce one particular definition of the term policy but rather to clarify meanings and thereby improve understanding” (Jones, 1984, p. 6).

Jones, as well as Eulau and Prewitt, suggests that while the word policy is often used as an adjective, as in policy goals, policy programs, policy decisions or choices, and policy effects, using the word interchangeably as in the above terms can be confusing (Jones, 1984; Eulau and Prewitt, 1973).

A common misuse of the word policy appears in the following statement: “It is our policy to reduce national spending on medical care” (Laster, 1996, p. 864). Reducing national spending is certainly a most admirable goal, but it is not a policy. To achieve that goal, however, would require the formulation and implementation of public policies. Health policies include:

- Health-related decisions made by legislators that are codified in the statutory language enacted in legislatures—laws.
- Rules/regulations designed to implement legislation or to operate government and its various health-related programs.
- Judicial decisions related to health (Longest, 1998).

The question has been raised as to whether programs such as Medicare and Medicaid should be referred to as policies as well as programs. Brown (1992, p. 21) indicates that “laws when they are more or less freestanding legislative enactments aimed to achieve specific objectives” should more appropriately be referred to as programs, not policies. Based on Brown’s thinking, Medicare and Medicaid created by “freestanding legislative enactments aimed to achieve specific objectives” as well as rules and judicial decisions should rightly be thought of as programs comprising a collection of laws, rules, and judicial decisions—that is, policies.

GLOSSARY OF PUBLIC POLICY-RELATED TERMS

In an attempt to address the aforesaid inconsistencies and definitional confusion, the following glossary suggests the most appropriate meanings of policy-related terms, as applied to the public policy process.

A Policy—“Authority decision that is made in the legislative, executive, or judicial branches of government. It is intended to direct or influence the actions, behaviors, or
decisions of others." As Longest so perceptively points out, the word *authoritative* is the crucial element of this definition (Longest, 1998, p. 4).

**Policies/Policy**—“Authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others” (Longest, 1998, p. 243). While all policies are solutions, not all solutions are policies.

**Solutions**—Ideally, the “definitive answers that solve problems or make them disappear” (Nadler and Hibino, 1998, p. 306). It is often the case that improvement rather than total resolution is a more realistic expectation.

**Private Policy**—Policy made by nongovernmental agencies and organizations that includes directives and guidelines governing such issues as conditions of employment, product lines, pricing, marketing strategies, and other related service provisions (Leavitt and Mason, 1998; Longest, 1998).

**Public Policy**—Policy made at the legislative, executive, and judicial branches of federal, state, and local levels of government that affects individual and institutional behaviors under the respective government’s jurisdiction. Public policy includes all policies that come from government at all levels (Magill, 1984). It can be considered as the response of government to address society’s problems (Weissberg, 1986) or as government’s attempt to seek solutions in response to society’s problems (Jones, 1984). Examples include legislation passed by Congress and signed by the president, regulations written to address that legislation, and judicial decisions made by the courts (Leavitt and Mason, 1998).

The three major public policy categories are defense, domestic, and foreign. Included under the rubric of domestic policy are employment and labor, transportation, tax, economic, and social policy. Social policy includes health and welfare policy (Dunn, 1994). Examples of health policies are the 1965 federal public law (P.L. 89–97) that established Medicare and Medicaid and a state’s procedures for the regulation of health care professionals (Longest, 1998).

There are two main types of public policy: regulatory and allocative. Regulatory policies such as the regulation of health care professions by the states are designed to influence the actions, behaviors, and decisions of others. “Allocative policies provide net benefits to some distinct group or class at the expense of others in order to ensure that public objectives are met” (Longest, 1998, p. 9). Although it is true that a rich and complex blend of public and private sector policies and actions shape American health policy and America’s pursuit of health, given that this book primarily addresses policy at governmental levels, the word *policy* will be used interchangeably with *public policy*.

**Health Policy**—“The collection of authoritative decisions made within government that pertain to health and to the pursuit of health” (Longest, 1998, p. xxii). “It is at any given time, the entire set of health-related policies/authoritative decisions made at any level of government that can be said to constitute that level’s health policy” (Longest, 1998, p. 5). It should be noted that the term *health policy* is considered by some to include policies in the private sector as well (Hanley, 1998).

**Health Policies**—Policies that pertain to health or influence the pursuit of health. Additional examples of health policies include a city government’s banning smoking in public buildings,
the requirement of nonsmoking sections in restaurants within the jurisdiction of that city, or the U.S. Supreme Court’s rulings on the legality of abortion (Longest, 1998).

Social Policy—Public policies and directives that promote the welfare of the public (Leavitt and Mason, 1998). Along with education, crime and correction, and economic security, a nation’s health policy is part of its overall social policy (Barker, 1995).

Intentions—“The true purpose of an action” (Jones, 1984, p. 27).

Goals—“The stated ends to be achieved” (Jones, 1984, p. 27).

Plans or Proposals—“Specified means for achieving goals” (Jones, 1984, p. 27).

Programs—“Authorized means for achieving goals” (Jones, 1984, p. 27).

Decisions or Choices—“Specific actions taken to set goals, develop plans, implement and evaluate programs” (Jones, 1984, p. 27).

Effects—“The measurable impacts of programs or policies which can be intended or unintended” (Jones, 1984, p. 27).

Unintended Consequences (also known as blowback)—Unanticipated or unintended effects arising from actions of people and especially of government, both of a positive and negative nature. They are, however, usually considered as “perverse unanticipated effects of governmental policy” (Norton, 2003, p. 1).

Policy Analysis—A term used to describe both the overall policy-making process as well as a specific component of that process, with the latter being the preferred meaning (Dunn, 1994; Hanley, 1998). The dual definition creates confusion. The primary role of policy analysis in the public policy-making process is to provide the knowledge and information required for making public policy utilizing various evaluation and measurement processes by which broad questions of need, scope, allocation, utilization, capacity, resources, and goals are critically assessed (Dunn, 1994).

Policy analysis is carried out by people from various disciplinary and professional backgrounds. The policy analysis field falls under the umbrella of general social sciences as well as within the disciplines of economics, political science, and sociology (Einbinder, 1995). Policy analysts investigate the causes, consequences, and performance of public policies and programs (Dunn, 1994) and assist in the public policy-making process by providing input into the structuring of the problems, forecasting, making recommendations, monitoring, and evaluating (Barker, 1992).

Thus, policy analysis as contrasted with policy making is concerned primarily with explanations rather than with prescriptions. It involves the careful investigation into the causes and consequences of policies and not the making of proposals. It is a set of techniques that seeks to determine what the probable effects of a proposed policy will be and what were the effects subsequent to policy implementation (Dunn, 1994).

THE PUBLIC POLICY-MAKING PROCESS

The public policy-making process in the United States is complex, dynamic, confusing, and at times mysterious. It is complex because the making of public policy involves an interaction among various government institutions whose players have differing political and social perspectives, interests, and political party affiliations. In addition, the process includes the participation of self-interest groups, private and nonprofit organizations, and
the public at large. To varying degrees and depending on the policy issue at play, all of these players are operating in the policy-making process, doing their best to influence the adoption of their policies and to sabotage opposing ones. While the process is ostensibly an open one, the reality is that much of the process is not visible to the public, making it seem all the more confusing and mysterious. Given that the three main arenas of living in a society—government, the economy, and private life—are interrelated, complicated, multilayered, and dynamic (Einbinder, 1995). The public policy formation process has been dominated by three major players: interest groups concerned about and affected by a particular policy area; the agency of the executive branch of government that has administrative responsibility over the related policy area; and the committees and subcommittees in Congress with responsibility for legislative authority in those areas. These three players have been termed the Iron Triangle in deference to their lock on policy development (Kronenfeld, Whicker, and Lynn, 1984).

A variety of public policy-making models has been suggested by policy scholars (Chrichton, 1981; Dunn, 1994; Hanley, 1998; Jones, 1984; Kingdon, 1995; Leavitt and Mason, 1998; Longest, 1998; Magill, 1984; Milstead, 1999; Paul-Shaheen, 1990). While these models have commonalities, there are differences among them. The problem-centered model proposed in this article is based primarily on the work of Dunn (1994), Kingdon (1995), Longest (1998), and Paul-Shaheen (1990). It relies on the premise that policies emanate from problems, whether they are real, perceived as real, or claimed to be real. Given the significance of problem conceptualization in the policy-making process, a discussion of “problems” will precede the presentation of the model.

**Meaning and Definition of Problems**

Just as there is ambiguity in regard to the meaning of policy, there is ambiguity regarding the meaning of problem. The definition of a problem ranges from a medical condition or a mathematics or physics proposition to definitions that contain the concept of a problem as something that is a perplexing situation of concern. The following two definitions of problem specifically apply to the policy-making process:

a. “an unsettled matter demanding a solution or decision and requiring considerable thought or skill for its proper solution or decision” (Webster’s Dictionary, 1986).

b. “a difficult or puzzling question proposed for a solution” (Oxford English Dictionary, 1989).

Thus, the two requisites of a problem are (1) a perplexing or vexing situation and (2) an invitation for a solution.

Dornblaser has provided a useful conceptualization of a problem in the context of the making of public policy. He considers a problem as a discrepancy between “the way the world is and the way it should be,” and he defines a problem as the “gap between what is and what ought to be” (Dornblaser, 1995, p. 3). More specifically, a problem is an unachieved goal—“it is a condition or a set of circumstances that a person or group thinks
should be changed" (Nadler and Hibino, 1998, p. 39). Dornblaser has suggested for purposes of policy making that the problem should be stated in the form of a question that begs for a solution/policy (Dornblaser, 1995).

There is a difference between a problem and a condition or a situation. People put up with many conditions and situations every day. Situations and conditions become problems when it is believed that something should be or needs to be done about them. Kingdon suggests, for example, that losing a finger is not a problem but a situation (Kingdon, 1995). It can become a problem if the person missing the finger is a concert pianist.

Both Dornblaser and Dunn have emphasized the importance of asking the right questions when examining a problem statement because problems that initially may appear to be insoluble may be reformulated so that previously undetected solutions emerge. “A problem well formulated,” Dunn wrote, “is a problem half solved” (Dunn, 1994, p. 2; Dornblaser, 1995). Ackoff (1974, p. 8) perceptively suggests that “successful problem solving requires finding the right solution to the right problem. We fail more often because we solve the wrong problem than because we get the wrong solution to the right problem.” Raiffa (1968, p. 263) also emphasized the importance of identifying the correct problem and warned against making “an error of a third kind: solving the wrong problem.” He also proposed an “error of the fourth kind: solving the right problem too late.” Another warning worth noting is the importance of not developing a policy in search of a problem.

Defining or structuring a problem is essentially a process of separating causes from symptoms and repeatedly asking “why is that a problem” until the point is reached at which the essential problem has been defined. The appropriate parallel in science is the popular aphorism that “If in the course of performing an experiment, you pose the question in the wrong way, you are doomed to arrive at the wrong answer” (Hall, 2000, p. 17).

**Proposed Model for the Making of Public Policy**

The public policy-making process in real life is a complex, dynamic, nonlinear, cyclical, evolutionary, and iterative process. In the two-dimensional proposed model shown in Figure 1.1.1, an attempt has been made to reflect this reality. Given the premise that policies emanate from problems and that the policy-making process is problem centered, “problems” has been placed in the center of the model. Another premise of the model is that problem recognition is a necessary condition for the formulation of a policy but it is not a sufficient condition for policy formulation; that is, all policies result from problems, but problems do not necessarily lead to policies. (See the following definition of Window of Opportunity/Policy Window.)

Although problems can be generated by any of the players directly or indirectly connected to the public policy-making process, the major players are legislators, members of the executive branch of government, and various interest groups (Dunn, 1994; Longest, 1998).

As mentioned previously, policy making and policy analysis are considered as two separate entities, with policy analysis providing the needed analytical information for the decision makers. Policy made in the legislative and executive branches of government usually follows this format. It is also the case, however, that policy making and policy analysis are often concurrently engaged in by individuals or groups of policy makers.
In the proposed model, six phases of the policy-making process are identified. In a rationally evolving process, the order in which these components are listed should be the order in which they occur once the problem is identified and defined. Before examining the model, it would be helpful to review the following definitions of the model's components.

**Phases of Policy Making**

1. **Agenda Setting**—Agenda setting is the initial and crucial phase in the policy-making process. During that phase a multiplicity of problems compete for sufficient
recognition to warrant their passage through the window of opportunity/policy window to the policy formulation phase of the process. What determines whether a particular problem passes through this window is dependent on (1) the overall appeal of the problem (problems), (2) the political support it has generated (politics), and (3) the view of perceived viability of the proposed alternative solution (solutions). These three factors—problems, politics, and solutions—have been termed the three policy streams (Kingdon, 1995; Longest, 1998; Paul-Shaheen, 1990). For the policy window to open and allow the problem to pass through, the three policy streams must coalesce into a single policy stream (Kingdon, 1995).

Window of Opportunity/Policy Window—The policy window is essentially a filter through which problems entrapped in the agenda-setting phase must pass to reach the policy-formulation stage to become serious contenders (Kingdon, 1995; Longest, 1998). The policy window is comparable to the gatekeepers at the entrance to an exclusive club or at an HMO.

2. **Policy Formulation**—The development or devising of alternative policies to address a problem (Longest, 1998).

3. **Policy Adoption**—The adoption of a policy alternative with the support of the legislative majority, consensus among agency directors, or a court decision (Longest, 1998).

4. **Policy Implementation**—The carrying out of an adopted policy by administrative units that mobilize human and financial resources to comply with the policy (Longest, 1998).

5. **Policy Assessment**—The determination of whether the implemented policy is in compliance with its statutory requirements and achieving its objectives in regard to the problem (Dunn, 1994).

6. **Policy Modification**—Depending on the results of the policy assessment and the political climate, the policy could be maintained, modified, or eliminated (Dunn, 1994). An example of the latter is the repeal of PL 100-360, the Medicare Catastrophic Coverage Act of 1988, in 1989 (Longest, 1998).

**Phases of Policy Analysis**

In the proposed model, the related components of policy analysis have been placed between problems and policy making for the reasons indicated previously.

1. **Problem Structuring**—The aspect of policy analysis that yields information about the conditions giving rise to a problem (Dunn, 1994).

2. **Forecasting**—Providing information about the future consequences of acting on policy alternatives, including taking no action (Dunn, 1994).

3. **Recommendations for Policy Adoption**—Providing information on the probable effects of adopting a policy and the “value or worth of the above mentioned consequences in solving or alleviating the problem” (Dunn, 1994, p. 14).


5. **Evaluation**—Providing information about the value or worth of the policy in solving or alleviating the problem.
6. **Recommendations for Policy Modification**—Providing information needed for determining the future status of the implemented policy.

**SUMMARY**

It is important to remember that the public policy-making process and its results are influenced by confounding factors that are often external to the process itself. Longest includes among those factors the preferences of individuals, organizations, interest groups, and a host of biological, cultural, demographic, ecological, economic, ethical, legal, psychological, social, technical, and political factors (Longest, 1998).

When reading articles about the wide variety of health policy-related issues, it would be instructive to first identify the primary problem and whether it has been appropriately defined and stated; second to determine what, if any, policies have resulted in response to the problem and whether those policies have helped alleviate the problem; and third to identify the outcomes of the policies in regard to unintended consequences. When confronted with a health-related issue or problem, common sense will often indicate whether a proposed policy is viable. In the early 1800s, Supreme Court Justice Oliver Wendell Holmes was well aware of the value of common sense when he said, “Science is a first rate piece of furniture for a man’s upper chamber, if he has common sense on the ground floor” (Bartlett, 1992).

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Play to Win: Know the Rules

Catherine J. Dodd, RN, MS

The result of Otto von Bismarck’s famous quote, “Laws are like sausages—it is better not to see them be made” (Brainy Quote.com, 2006), is that politics is often left to those with iron stomachs. Because legislation, according to health economist Paul Feldstein, “redistributes wealth” (1996, p. 17), it is essential that pragmatic idealists—both the self-appointed guardians of the public good and elected officials—participate in the political process. Only their cooperation can ensure that health policy is not designed by and implemented by the well-financed interest groups motivated only by profit.

Politics has been defined as “the art and science of government,” and political affairs as “competition between competing interest groups of individuals for power and leadership” (Morris, 1962, p. 1015). The division of scarce resources is almost without exception political, being characterized by competition between interest groups, some more powerful than others. It is rarely fair. Political decisions are not made during the hearings in the hallowed halls of the Capitol. Rather, political decisions are made long before the day of the vote and are based on external influences that may or may not include expert knowledge.

Political decisions influence many aspects of our daily lives. Politics determines the outcomes of proposals in governing bodies, in the workplace, in the neighborhood, and at the dinner table. Parents may decide which child gets the largest piece of pie based on who has been the most helpful around the house or who has completed their homework. Similarly, a state legislator may vote to fund a new health center because many voters from that neighborhood support her, even though that decision may jeopardize another clinic in another legislative district. Those who fail to participate in the political process are allowing the decisions to be made by people who may seek to control resources for their own personal or political gain (Dodd, 2004).

Political expertise is essential for success in organizations, institutions, and local, state, and national governments. Developing and maintaining political power requires establishing and maintaining relationships. It also takes time and practice.

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TEN UNIVERSAL COMMANDMENTS
OF POLITICS AND REASONS TO OBEY THEM

1. The personal is political. Each of us is just one personal or social injustice away from being involved in politics. Every vote counts.

2. In politics, friends come and go but enemies accumulate.

3. Politics is the art of the possible. The majority rules.

4. Be polite, be persistent, be persuasive, and be polite.

5. Ignore your mother’s instructions. Talk to strangers.

6. Money is the mother’s milk of politics.

7. Negotiate visibility. Take credit, and take control.

8. Politics has a “chit economy,” so keep track.

9. Reputations are permanent.

10. Don’t let ‘em get to you.

1. The personal is political. Each of us is just one personal or social injustice away from being involved in politics. Every vote counts.

Injustices and tragedies, whether individual or collective, often ignite social movements that result in advocacy and collective action. Elected officials are inspired to introduce legislation because of their own personal experience or the experience of someone they know, or because of collective demands of constituents.

Representative Caroline McCarthy, LPN, ran for Congress and was elected after her husband and child were shot on the New York subway. She promised the voters that she would fight for stricter gun laws. She challenged the National Rifle Association (NRA) enthusiasts, who believe their personal freedom will be impinged upon by limiting access to automatic weapons, and who frequently initiate very successful letter writing and e-mail campaigns in key congressional districts to protect their “constitutional rights.” NRA activists also raise money for key candidates from members all over the country.

MADD (Mothers Against Drunk Driving) was founded in 1980 by Cindy Lightner, whose 13-year-old daughter was killed by a drunk driver. Today, MADD is the largest crime-fighting organization in the country, with chapters in every state. Its members include relatives and friends of victims of drunk drivers as well as health professionals and supportive members of the public. MADD has been extremely effective in achieving its objectives at the local level, lobbying for speed bumps and the installation of stoplights; at the state level, increasing penalties for drunk driving, and at the national level, placing restrictions on alcohol advertising (Mothers Against Drunk Driving, 2006).

Many health advocacy organizations, such as Families USA (www.familiesusa.org), emerged from the movement to support access to health care. The recent proposals to privatize Social Security and Medicare helped increase the national membership of the National Committee to Preserve Social Security and Medicare (www.ncpssm.org). Environmental health (www.breastcancerfund.org) and social justice organizations have emerged to address the unfair burden of exposure to toxic chemicals borne by communities of color located in polluted neighborhoods (www.ejfoundation.org).
The more voices that participate in our democracy, the more likely that the weakest voices will be heard. Individuals who choose not to vote or not to be involved in politics, in essence, relinquish their power to those who do vote. Long ago, Plato advised that “One of the penalties for refusing to participate in politics is that you end up being governed by your inferiors” (en.thinkexist.com, 2006).

Every person can make a difference, especially when one considers how the outcome of an election may affect the lives of those who do not believe that their voices count. Many recent elections at all levels of government have been decided by one or fewer votes per precinct.

2. In politics, friends come and go but enemies accumulate.

This old adage can be applied to many relationships. Its application includes two important concepts: Never surprise your friends, and politics makes strange bedfellows. It is imperative to not jeopardize working relationships, with public officials or other advocates, by publicly opposing someone, by not inviting them to a meeting, or by voting against them without talking to them before taking action. Maintaining relationships does not require disclosing strategy; it means simply showing respect for the right of others to have a different perspective. Trust and respect are commodities in politics that once lost, are rarely regained. While you may disagree on one issue, there may exist agreement on another issue, and a relationship sustained by respect allows for discussion, compromise, and progress. Handling conflicts respectfully will allow for future collaboration. Maintaining working relationships allows for “strange bedfellows.” Managing conflicts respectfully allows for future collaboration with partners who may agree with your position on other issues.

For example, advocates for women’s and children’s health frequently testify to protect women’s reproductive freedom and argue against the testimony of advocates from conservative religious organizations. On issues affecting children’s health, however, the two organizations come together as strange bedfellows and make powerful allies. Representative Henry Hyde and Senator Ted Kennedy disagree on most issues, but they worked together to create the State Children’s Health Insurance Plan during President Clinton’s administration.

3. Politics is the art of the possible. Count votes in advance.

The majority rules.

The policies that are adopted and the legislation that is signed into law reflect compromise and rarely resemble what was initially introduced. Successful politicians strive for what is possible. In diverse political cultures where there are many different opinions and philosophies, the most successful legislators are those with an ability to find compromises acceptable to the majority that do not destroy the intent of the original legislation. Votes are not won during dramatic debate on the floor of the House or Senate. Instead, they are won one by one, by talking to individual legislators, seeking their support, and finding out what compromises would be required to gain their support. Sometimes asking others for assistance in lining up additional votes is necessary. Once commitments are made they are
rarely changed, because trust is the basis of future relationships. If legislation is controversial, legislators may not commit to a position until the actual vote because no one wants to be the “deciding vote.” Legislators do not willingly vote for legislation that is opposed by powerful lobbies if they believe the legislation is going to fail anyway (because friends come and go but enemies accumulate, and no one wants to alienate powerful lobbies if the bill will fail anyway).

For example, strange bedfellows came together to oppose the passage of the 2003 Medicare Modernization Act, which represented the first major change to Medicare in more than 25 years. The act added some coverage for prescription drugs for seniors. Conservative Republicans opposed the law because it would cost too much; almost all Democrats opposed it because it was not comprehensive and did not impose cost controls on the pharmaceutical industry. Some of the conservative Republicans finally agreed to support the legislation when a section was added to begin to privatize Medicare in 2010. This part of the act was not debated: The party in the majority makes the rules, and the Republicans ruled that no debate was needed, despite opposition to this move from Democrats. This amendment has far-reaching implications for the future of Medicare because it changes Medicare from a guaranteed benefit package to an insurance program that will compete in the market. On the day of the vote on the Medicare Modernization Act, pharmaceutical company lobbyists, who are known for their large campaign contributions, made calls to legislators who were uncommitted and who had competitive elections, as did President George W. Bush. The vote was ultimately “held open” into the middle of the night, longer than the rules allowed for, until enough votes had been changed to pass the bill.

If the margin for passage of a law is close, how a legislator votes usually depends on whether the voters in his or her district care about the issue and on whether major campaign contributors support or oppose the issue. Advocates need to be certain of those votes they can count on and then ensure that the supporting legislators, board members, and so forth will be in attendance the day the vote is scheduled, especially if it is expected to be close.

Many people wonder why so few pieces of legislation are passed and signed into law. Two factors explain this phenomenon.

Since the 1994 elections, Congress and state legislatures have become more partisan, and the voters have become disillusioned with “incumbents—career politicians.” In 1993, Congress spent an entire year debating President Clinton’s health care reform proposal. Special interests (against reform) targeted candidates in swing districts who supported reform, spending $400 million to ensure their defeat. For the first time in 40 years, the Republican Party gained a majority in both houses of Congress (the Senate and the House of Representatives; see Tables 1.2.1 and 1.2.2 for a summary of their organization). The 1994 elections produced a class of “freshmen” (new senators and representatives) dominated by business people/owners who lacked experience in negotiating with other people who hold entirely different philosophies or agendas. These new legislators simply refused to negotiate with their Democratic colleagues, leading to legislative gridlock. In the corporate world, of course, business owners who cannot agree on terms merely find other contractors.

The Republicans elected to the 104th Congress were also very conservative, and their majority created a more conservative Congress. This same trend was echoed throughout the country at the state and local levels as conservative (religious anti-women’s reproductive freedom) campaign strategists successfully ran candidates in primaries who were then
elected in general elections, defeating Democratic career-politician incumbents. All votes cast in the subsequent 104th Congress were significantly more conservative on health, education, human services, and environmental issues than those produced by previous Congresses. Democrats representing swing districts voted more conservatively than they might have previously in an attempt to appeal to moderate Republicans in their districts during an election year. Elected officials do not ordinarily have this option, because they are elected by and work for the voters rather than for themselves. However, the Republicans' control of the Congress gave them more power to determine what would be negotiated and what would not even be discussed.

After President Bush's election in 2000, the Republicans had total, one-party control of the federal legislative agenda. The majority of states also had Republican governors. Following the 2000 census, not surprisingly state legislatures redrew district lines to enhance the election of Republicans in many states. These new lines served to solidify the Republican majority in Congress for the rest of the decade.

For legislation to pass, a majority of members of the legislature need to vote in for it. The majority rules in more ways than one. All parties have their own philosophies and agendas. The majority party determines which issues will be debated and whether the

<table>
<thead>
<tr>
<th>TABLE 1.2.1 Congress at a Glance</th>
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<tbody>
<tr>
<td><strong>Senate</strong></td>
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<tr>
<td>Upper House</td>
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<tr>
<td>100 members, two from each state</td>
</tr>
<tr>
<td>6-year terms</td>
</tr>
<tr>
<td>One third are up for election each 2 years</td>
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<tr>
<td><strong>House of Representatives</strong></td>
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<tr>
<td>Lower House</td>
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<tr>
<td>435 members, apportioned every 10 years</td>
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<tr>
<td>based on population changes</td>
</tr>
<tr>
<td>2-year terms</td>
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<tr>
<td>Up for election every 2 years</td>
</tr>
</tbody>
</table>

To gain a better understanding of party priorities, search the websites of the majority and minority “leaders” in each party.
debate will allow for alternatives or compromise. Many pieces of legislation are introduced and never put on the agenda for consideration if the party in the majority does not want the issue considered.

Partisan ideology has taken the place of pragmatic bipartisan compromise and problem solving. The Republican ideology emphasizes competition in the “market” to reduce budgets. In contrast, the Democratic ideology favors greater public protection through government regulation. The increased partisanship in halls of government across the United States has produced very few compromises. Leadership in both parties is necessary for legislators to work together and, one by one, meet, talk, and identify acceptable compromises.

4. Be polite, be persistent, be persuasive, and be polite. Send thank-you notes, write, write, write, ghost write, and write.

In this era of instant messaging, it is difficult to determine the preferred method of communication for individual elected officials. Elected officials listen to those who elect them and/or support them financially in their campaigns. Perennial voters (those who vote in every election, rain or shine) tend to be more highly educated and are more likely to write a letter or craft an e-mail message. For that reason, an individually written letter (mailed, faxed, or e-mailed—but not a chain message) is the most effective lobbying tool. Preprinted letters or postcards and “linked” e-mails off advocacy Internet sites are effective only in specific mass strategy campaigns. In general, phone calls urging a vote are used in last-minute attempts and are considered an effective lobbying tool only if they are from constituents who leave their addresses and ask for a written response explaining how the elected official plans to vote (or has already voted).

Letters from voters who live in the elected official’s or legislator’s district do make a difference. Some elected officials, however, believe their constituency goes beyond their legislative district. For example, an RN legislator may consider and respond to the opinions of RNs regardless of where they live, or a gay legislator may consider and respond to letters from people in the lesbian/gay/bisexual/transgender community regardless of where they live.

If your legislator is not a member of the committee that will hear the bill in which you are interested, find out the staff person who is assigned to the committee, address your letter to the Chair of the Committee “care of” the staff person at the committee’s address, and then send a copy of your letter to your legislator with a brief note.

It is best to gather information about the legislator’s position in advance by communicating with the staff person responsible for the issue. Call the capitol office and ask to speak to the staff person responsible for the issue; if he or she is unavailable, ask for an e-mail address. Thousands of constituents are making similar requests, so keep your communication clear and concise. Thank the staff person for his or her assistance, and if your legislator agrees with your position, write your letter or message so that it acknowledges the lawmaker’s position and states that you are pleased with it. Communication with legislators should establish the sender’s credibility as a constituent (e.g., a nurse, a mother, student, expert) and should be polite, persuasive, and succinct. Communications should state the sender’s position early in the communication, offer support for the position with research or personal experience or belief, and ask for a response prior to the vote. This message is not a
term paper, so it need not be perfect grammatically, only persuasive. It is likely to be read only by staff [unless the sender has a personal relationship with the elected official].

Multiplying the effectiveness of your effort by demonstrating broad support or opposition can be accomplished by assisting, collecting, and mailing similar letters from friends, family, and colleagues. When 1 letter arrives in a legislator’s office, it is recorded; when 10 arrive, it becomes an issue of constituent concern; when 20 individually written communications arrive, staff alert the elected official. To be effective, letters must arrive before the vote is scheduled, so send them early. If the bill fails and is introduced in subsequent years, you must write again, and again, and again, if necessary. Many bills are amended during the process, so it is important that you continue to communicate with your legislator if you no longer support or oppose the bill along the way.

Always be polite: In talking to legislators, staff, or the press, never say or put in writing anything you do not want printed on the front page of the newspaper. Reputations are permanent (Commandment 9). Many a career has ended because of an angry quote (Commandment 2: Friends come and go but enemies accumulate).

The two most effective kinds of communication are thank-you notes and letters to the editor. If the legislator, organizational board member, or coworker takes the desired action, follow your mother’s advice: Write a thank-you note! Everyone enjoys being recognized and thanked. Those colorful envelopes in the mail are the first to be opened by each of us, and elected officials are no exception. This kind of communication also shows you are monitoring their vote. Politicians, like relatives and friends, remember people who send thank-you notes.

Letters to the editor and op-ed columns in local newspapers are extremely effective lobbying tools. The editorial section of the newspaper is the first section read by political staff each day because the opinions expressed are those of voters. Politicians give extra credence to letters to the editor for two reasons. First, the people who write these missives subscribe to the paper and are more likely to be perennial voters. Second, letters are not printed unless the paper has received more than one on the subject. Letters written by women are more likely to be printed because editors try to balance the page with equal numbers of letters from men and women. Agreeing with or lauding the paper for its coverage of an issue also increases the likelihood of publication. Letters from suburbs often have a better chance of being printed because they demonstrate a wide readership for the paper.

Health professionals have very high credibility, so a letter to the editor published in a local paper will have significant public influence that is recognized by politicians. Use your credentials.

Letters should be well written (they will be read by thousands of people) but should not exceed 250 words. (Many papers have publication policies that can be acquired from the paper’s website or a call to the paper.) Letters can be e-mailed, faxed, or mailed and must include the address (and often the phone number) of the sender. Editors often contact the sender to verify or clarify the content of the letter. The same letter, with a different sender, can be submitted to a paper in another geographic area of the state or country.

Op-ed pieces should not exceed 750 words and usually require a four- to six-week lead time. Communicating first with the editor of the opinion page will increase the likelihood that an op-ed piece will be printed. Op-ed pieces are published on topics of broad interest. Generating letters to the editor to demonstrate interest in the subject or position prior to submitting
an op-ed piece or following the publication of an op-ed piece is a more sophisticated and very effective strategy for influencing public opinion and hence the opinion of elected officials. The best way to plan an editorial page lobbying effort is to become acquainted with the editorial pages of the newspaper. If you want to be a future source as an expert, call the reporter and compliment him or her. If you are sending a positive letter to the editor, send a copy to the reporter because reporters do not see all the responses to their work.

Whether it is voting for a piece of legislation when it comes before the legislature or voting for a candidate in an election, health professionals are very persuasive. After all, if you can convince people to change their health behaviors, you can surely convince them to vote. Health professionals are very effective in campaigns. When health professionals walk door to door for candidates or work on phone banks, voters listen. The public especially loves nurses and health professionals. Just about everyone has a relative who is a nurse, or a relative who was just cared for by a nurse. Nurses poll higher in public trust measurements than members of any other profession.

In 2002, a political action committee (PAC) was formed called Physicians for a Democratic Majority (www.demdocs.org). Many types of health professionals and students support this organization with both their time and money. In every general election, they pay the expenses of students, nurses, and physicians who are willing to go work in elections where the race is very close. They wear lab coats and name tags, and they talk to voters about why their votes are important. Another benefit of working on campaigns in this way is that legislative staff frequently take time off to work on campaigns, so you may meet the very people you will be contacting regarding legislation in the future.

5. Ignore your mother’s instructions. Talk to strangers, or network. Carry business cards. Build your network. Flaunt your professional credential proudly.

Talking to strangers comes naturally to health professionals. Every new patient/client is first a stranger. If you go to an event and know very few people, act like a host. Introduce yourself. Practice your introduction, emphasizing what you want people to remember about you. Shake hands firmly, and make eye contact. Repeat the person’s name when you are ending your conversation (this both endears you to the person—people like hearing their names—and helps you remember the person’s name). Exchange business cards—and include your credential on your card. Don’t let the cards you collect just pile up. Immediately after the event, write the date and event on the card and something about the person. Then, enter your contacts into your database with a “note” section so you will remember them and/or can search for them.

Strangers cease to be strangers when their business cards become part of a phone list or database to be used for political action or fundraising. Follow up with an e-mail or “nice to meet you” card that endears you to your new network member. It really becomes a small world when strangers talk to strangers and they become friends and create networks.

In garnering support or opposition for issues or candidates, no one is a stranger to health professionals. If you are an RN, print “RN” on your checks after your name so candidates will know they’ve received hard-earned “nursing money.”
6. “Money is the mother’s milk of politics.” Give it early; if you don’t have it, raise it.

The invention of television, which allowed candidates to speak directly but not personally to voters, has diminished the importance of political parties as the mechanism for establishing party philosophy and disseminating political messages to voters. Television has not changed who has the right to run for office (any citizen can run, and only the president must be a native-born citizen of the United States), but it has changed who wins. Candidates who cannot afford television time invest targeted direct mail to bring their messages directly to your mailbox in well-planned, nonsubstantive glossy brochures. Targeted direct mail lists are purchased from campaign consultants who obtain voter information from the local Registrar of Voters and sort the data by any number and combination of fields depending on the target audience, such as who voted in the last three elections (called likely or perennial voters), political party, sex, age, votes by mail, owns or rents home, and neighborhood. The strategy in direct mail campaigning focuses on projecting how many votes are needed from the target audiences and then tailoring the message to that audience. The narrower the target, the higher the cost of the segmented campaign literature. Likewise, the more TV spots purchased during prime time, the higher the cost of the air time. Getting messages to voters is expensive.

Campaigns require money and more money, hence the saying, “Money is the mother’s milk of politics” (Jesse Unruh, former State Treasurer of California). The amount of money candidates raise early in their campaigns determines each candidate’s viability later in the race. The American Nurses Association (ANA) PAC is an example of a political organization that supports candidates who support nursing’s positions on issues. It has raised (from members in contributions averaging $40) and contributed more than $1 million in each congressional election since 1994. In evaluating candidates before primaries (when there are often several candidates in the field) for possible early endorsement, the PAC staff members compile information on how much money each candidate has raised and how much is projected to be spent. How much money has been raised gives an idea of the candidate’s viability. PACs do not support candidates who cannot raise enough money to win their election. If some candidates have not raised much money but others have, the field of possible endorsements is narrowed to those who are serious about winning.

EMILY’s List (www.emilyslist.org) is an example of a national fundraising effort for pro-choice Democratic women candidates. EMILY stands for “Early Money Is Like Yeast”: The organization believes that contributing to women candidates early helps them establish their viability as credible candidates and therefore to raise other funds. Republican women have a similar organization called the Wish List (www.thewishlist.org).

People and organizations that provide early financial support are always remembered once politicians get elected, because the winners know they would not have been elected without these early supporters. Relationships made early in campaigns may have exponential returns because many elected officials run for higher office—and those relationships are forever.

Many people are not affluent and cannot afford to make large contributions. Remember the networking principle (Commandment 5), and call friends, relatives, and colleagues to collect $10 to $50 from each contact. Collecting eight $25 contributions raises $200. Volunteering to help make fundraising calls is a key campaign activity. The worst that can happen is the person will say “no.”
Most people can afford a contribution of $45 per year (less than $5 per month) to a PAC that stands for their beliefs or to a political party. Raising and contributing money to friends of health care is important both for the candidate and for your profession. Some candidates are “shoe-ins” or in safe seats (where the voter registration favors their party) and are likely to be elected or re-elected. Nevertheless, they need to raise money so they can assist candidates in other parts of the state or country. Gaining leadership positions in elected bodies and recruiting allies for legislation require the support of colleagues, and one way to garner that support is to help raise money for colleagues who are in tight races who are seeking leadership positions. This is especially true when the number of terms an elected official may serve is limited by statutory term limits; this constraint requires them to climb to a leadership position much faster.

7. Negotiate visibility. Take credit, and take control.

Throughout history, different professions have had varying degrees of influence in legislative bodies. Today, the American Medical Association, the HMO industry, the pharmaceutical industry, and the nursing home industry (to name only a few) have significant power in the legislature. Not surprising, all of these entities contribute generous sums to candidates from both parties. The profession of nursing, while held in high regard by the public, has not been given (or taken) credit for the essential role that nurses play within health care systems. Traditionally, nurses, social workers, and public health advocates have had little control over the systematic decisions being made by health corporations and the business people and physicians who often control them.

Taking control requires taking credit, whether in the health care system or in politics. When a “Nurses for Nancy Pelosi for Congress” group raises $1,000 and produces 10 volunteers every Saturday, its members must negotiate visibility for nursing or for a few key nurses in the campaign. Credit may take the form of listing nurses on every piece of campaign literature, or getting 10 seats at a large fundraising dinner instead of only 5, or being included in the candidate’s policy “kitchen cabinet.” Visibility is never offered; it must be asked for and negotiated. First-time candidates and candidates in swing or highly competitive races never forget individuals and constituencies who were visible in difficult races. The Physicians for a Democratic Majority (“DemDocs”) PAC, for example, has been included on several citizen advisory committees organized by members of Congress because members’ visibility was so effective in getting out the vote (GOTV) in key races.

8. Politics has a “chit economy,” so keep track. Seniority counts.

Commandment 3 requires an ability to communicate, in some instances to ask for help, and then to count votes. Most people like to help—but this help comes at a price. The exchange of votes, lining up votes, raising money, and mobilizing volunteers to walk precincts are all activities that accrue chits. For elected officials, chits are exchanged for appointments to key committees and for leadership positions. At the federal level, the longer the tenure of the legislator, the higher his or her rank, regardless of the person's
status as a member of the majority or minority party. Seniority is given consideration in committee assignments, so it is to a district’s or state’s advantage to re-elect incumbent legislators who have good voting records. For individuals, chits mean access, support on key issues, and appointments to board and commissions.

9. **Reputations are permanent.**

In politics, as in life, there is no asset more important to success than a positive reputation. No one assigns reputations; they are earned and remembered. A key ingredient in developing a positive reputation is dependability. Deliver promptly what has been promised, whether it is an article, names and addresses of possible supporters, campaign funds, or volunteers. Answer questions honestly and directly, and offer to research unknown information. Return calls and respond to requests for assistance. These are routine practices of dependable people. If you identify yourself as an RN or as a member of an organization, the impression you leave is a reflection of the profession and the organization you say you represent, so make them proud to have you represent them.

In a congressional election for an open seat (no incumbent running), an RN activist promised to provide the American Nurses Association’s position statements on issues to assist with the candidate’s platform development after the candidate had been endorsed by the ANA PAC. Within two days, the RN activist had been asked to draft the candidate’s statements on health care, and she later became a staff member to that member of Congress. If the RN activist had failed to follow through on the promise of assistance, her credibility and nursing’s reputation would have been tarnished.

10. **Don’t let ’em get to you.**

Remember the words of childhood: “Sticks and stones may break my bones, but words can never hurt me.” Use this mantra: “I’m glad I’m here, I’m glad you’re here, I know what I know, and I care about you.” Or just picture those who mock you or challenge your positions sitting on a bedside commode in a hospital patient gown (nobody is attractive in a patient gown). Eleanor Roosevelt once said, “No one can make you feel inferior without your permission.” Unfortunately, a sense of inadequacy and inferiority has often been part of the socialization of women. To overcome this ingrained subliminal sense, when addressing hostile audiences (or any audiences, for that matter) the mantra mentioned previously does two things. First, it causes you to smile because it sounds so corny. Second, that smile warms the audience and makes them more friendly. This is as true of two-year-olds as it is of adults.

Regrettably, we live in a world that thrives on crises and negativity. Negative campaigns cast doubts on the character and abilities of candidates. Doubt translates into not voting for a particular candidate, or not voting at all. Recognize that negative comments are going to be made and reported. Rebuttals are not always possible and are often wasted on hysterical, angry responses. The best defense is a good offense: Accept that comments will be misinterpreted and reported, and measure your response just as you did on the playground in grade school. Correct the misinterpretation, refute the allegation, and repeat over and over to yourself: “Sticks and stones may break my bones, but words can never hurt me.”
SUMMARY

Health care professionals have a unique and broad perspective on the health care delivery needs of individuals and populations. They also have excellent communication skills and organizational skills. Few other professions are so well suited to be activists, lobbyists, leaders, and legislators. Failure to apply these skills and unique expertise in politics is to fail the patients who rely on us. As Margaret Sanger, a graduate public health nurse who founded Planned Parenthood, once said, “If one is to truly live, one must put one’s convictions into action.” So get involved!

REFERENCES

Primer on Policy: The Legislative Process at the Federal Level

Sara Hart and Nadine Jackson

INTRODUCTION OF A BILL

The legislative process formally begins when a member of Congress introduces a bill. It is then assigned a number with the designation of H.R. for a House of Representatives bill and S for a Senate bill. House or Senate leadership then assigns the bill to the subcommittee or committee that has jurisdiction over the particular issue that is addressed by the bill. This starts the legislative process rolling. The committee or subcommittee may choose to hold hearings, which allow supporters and opponents the opportunity to present their concerns. These same committees may also decide not to hold hearings or not to move the legislation forward in the process. Many bills die from neglect in committees or subcommittees. If the political climate is ripe and the issue is high on the congressional policy agenda, committee members may decide to move the bill out of committee. They accomplish this by calling for a mark-up, adding any amendments or deleting problem areas. The clean bill, once voted on, is reported out to either the full committee (if a subcommittee held the mark-up) or to the full chamber in which the bill originated if the full committee marked up the bill.

Aside from House and Senate Appropriations Committees, there are a number of committees in each chamber that have jurisdiction over health legislation. In the House they are the Commerce Committee, Subcommittee on Health and Environment; and the House Ways and Means Committee, Subcommittee on Health. On the Senate side, the Health, Education, Labor and Pensions Committee, Subcommittee on Public Health; and the Senate Finance Committee, Subcommittee on Health Care consider the majority of health-related legislation.

FLOOR ACTION AND CONFERENCE COMMITTEE

In the House, the legislation then goes to the powerful Rules Committee, which determines the terms and length of any floor debate and if amendments can be introduced from the floor. The Senate has no Rules Committee, but senators can filibuster (delay a floor vote) or add amendments to the existing legislation once the bill comes to the full Senate for a vote. The Speaker of the House or the Majority Leader in the Senate sets the legislative
calendar, which determines when and if a bill will actually reach the floor for debate. Once these processes are completed, representatives and senators are ready to cast their yea or nay vote. It may be a recorded roll call vote or a voice vote if leadership decides that this is more appropriate for the legislative issue under consideration. If the legislation is successful, it is referred to the other chamber to repeat the process. A bill must pass both chambers of Congress before it is sent to the president for his signature.

Often companion bills are introduced into the House and Senate. This means that the legislative process occurs simultaneously in both Houses. Companion bills speed up the lengthy legislative process. Because each bill may differ slightly from the other, once it passes its respective chamber it is sent to a conference committee to reconcile any differences.

The leadership in both chambers creates a conference committee, and committee chairpersons and prominent sponsors of the original bills are appointed to serve. When the conference committee reaches an agreement, a report is prepared that describes the recommended changes. The conference version of the bill must then be returned to the full House and Senate for a final vote.
EXECUTIVE ACTION

The legislation is now ready to be sent to the chief executive. He may sign the legislation or take no action for 10 days when the Congress is in session. Either way, the legislation becomes law. If the president vetoes the bill, a two-thirds majority vote of Congress is necessary to override the veto. If Congress sends the bill to the president and goes out of session, the president may use a pocket veto to kill the legislation. The president’s options may be influenced by political pressures and party politics. Once the legislation is signed into law, it is referred to the appropriate regulatory agency for rulemaking. It is the regulatory process that puts the meat on the bones and enables a statute to become transformed into a fully functioning government program (see Figure 1.3.1).

CONCLUSION

Knowledge of the inner workings of the federal legislative process is an invaluable tool for nurses wishing to improve access and quality in health care. Effectively influencing the policy making process requires close monitoring of issues that are under consideration by policy makers. Establishing ongoing relationships with public officials creates an important line of communication that allows one to share his or her nursing expertise.
It’s the Institutions, Stupid!
Why Comprehensive National Health Insurance Always Fails in America

Sven Steinmo
University of Colorado

Jan Watts
Yale University

By the time this essay is published, both pundits and scholars will have analyzed and reanalyzed the failure of the Clinton health care plan. The most obvious explanations have already been offered. They blame President Clinton, his plan, his advisors, his wife, the Democrats, the Republicans, the medical industry, and the American voters. They will argue that if Clinton had only been smarter, tougher, or more savvy, or if his plan somehow had been more “in tune” with America, the Democrats would have retained their control of Congress. Clearly, they will argue, Americans want comprehensive health care reform as much as the American economy needs it. If Clinton had not missed this golden opportunity, surely Congress would have finally passed what every other democratic legislature in the world passed long ago. Bill Clinton’s burden must be heavy.

We argue that this line of analysis is wrong; instead we believe that America did not pass comprehensive national care reform in 1994 for the same reason it could not pass it in 1948, 1965, 1974, and 1978. The United States is the only democratic country that does not have a comprehensive national health insurance system (NHI) because American political institutions are structurally biased against this kind of comprehensive reform.

This institutional bias begins with a political structure forged by America’s founding fathers that was explicitly designed to pit faction against faction to protect minority factions from majority factions. Progressive reforms have exacerbated this bias by undermining strong political parties. Subsequently, several generations of congressional reforms unwittingly turned national politicians into independent political entrepreneurs. This institutional context explains (and could be used to predict) the failure of national health care reform in America—not flaws in the plan, the planners, or political strategy.

We offer a brief overview of the history of NHI politics through an institutionalist lens. It does not make sense to blame the Clinton administration for its inability to pass NHI yet forget the failures of the Roosevelt, Truman, Kennedy, Johnson, Nixon, Ford, and Carter administrations. With this history we show how the structure of American political institutions shaped the political strategies of both proponents and opponents of reform and thereby explain the unique and often curious health care reform policies that have passed in America. Finally, we suggest that the policies actually passed have confirmed the anti-statist “public understanding” (Jacobs 1993a) that is part of the American political culture.

SOME ARGUMENTS FOR REFORM’S FAILURE

Culture

The most common explanation for the absence of NHI is that the United States is exceptional because of its unique political culture (Anderson 1972; Jacobs 1993; Rimlinger 1971). America has developed unique individualistic and anti-statist political values that have biased the polity against the welfare state.

As intuitively appealing as this argument at first appears, flaws in both the logic and evidence that have been marshaled in its favor undermine its utility. First, and most obviously, public opinion polls have consistently shown that most Americans have favored some kind of comprehensive NHI system for most of the post-war era (see Table 1.4.1).

Second, even to the extent that Americans are highly individualistic, whether this general cultural predisposition translates into specific attitudes toward specific governmental programs is not clear. Political cultures, after all, contain various (and sometimes competing)

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<tr>
<th>Year</th>
<th>Percentage Expressing Support for Increasing Government Role in Health Care Delivery</th>
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<tr>
<td>1937</td>
<td>80</td>
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<tr>
<td>1942</td>
<td>74</td>
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<tr>
<td>1961</td>
<td>67</td>
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<td>1965</td>
<td>63</td>
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<td>1976</td>
<td>66.7</td>
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<td>1978</td>
<td>61.3</td>
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<td>1992</td>
<td>75</td>
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aData were taken from different polls that asked similar, but not identical, questions. See sources for exact questions.

political values (Page and Shapiro 1992). Thus, although Americans do hold highly individualistic values, they are also profoundly egalitarian—especially with respect to the value of equal opportunity.

Third, a critical lacuna in the culturalist argument is the paucity of comparative historical evidence. The argument implies that Americans did not pass NHI but Europeans did because this program was demanded in Europe, whereas it was not in the United States. In truth, however, little evidence shows that NHI was the product of widespread public demand in other industrial democracies. Instead, the various comprehensive public health programs initiated throughout the world were, in fact, the product of governing elites’ attempts to address pressing policy problems (Immergut 1992; Heclo 1974).

Finally, culturalist analyses tend to ignore or at least underemphasize the dynamic interactions between public preferences and public policy. Clearly what governments do (or do not do) affect attitudes toward government. But the emphasis on the permanence of cultural preferences belies this point.

In the end, culturalists offer quite static explanations. What we need is a better understanding of the relationship between what people think about government and what government does (or does not do). Politics is an iterative process, not a one-off game. Thus if government does well, it builds support. If it fails to act in response to public pressure, or if it acts poorly, we should not be surprised that citizens lose faith in public institutions.

Interests

Many of the best political histories of the politics of health care reform in the United States either explicitly or implicitly advance what we all an “interest” explanation (Poen 1979; Alford 1975; Navarro 1976). Although often explicitly sensitive to the peculiar cultural context of American politics, these analyses essentially argue that the United States has not developed an NHI scheme because of the determined opposition of powerful interest groups.

The evidence used to support this thesis in many ways is overwhelming. Any history of the politics of health care reform in the United States shows clearly that reformers in this country have faced an exceptionally well-organized and well-financed opposition, whereas the proponents of reform have been demonstrably less well organized and less well financed.

Still, as empirically satisfying as the interest explanation can be, we believe it has important analytic flaws. If the key explanation for the absence of NHI in the United States is that powerful interest group fought the reform, then proponents of this argument should be able to show that countries that did pass NHI legislation did not have powerful interest groups opposing their reforms. However, studies of the politics of health care reform in other democratic polities clearly show that physicians, hospitals, insurance companies, business interests, and conservative political forces generally bitterly opposed NHI in every country in which national health care policies eventually emerged. The important question is why the forces of opposition could stop some form of NHI in the United States but not in other democracies.

A second problem with the traditional interest explanation is that it cannot adequately explain why some policy reforms have been successful in the United States while others
have not. The for-profit medical industry was opposed to the creation of Medicare and Medicaid in the early 1960s, just as they had opposed NHI in the 1940s and 1950s. They used many of the same tactics against this reform that they used successfully to prevent passage of earlier reforms. Why, if powerful interest groups can veto policies they oppose, did the Medicare/Medicaid legislation pass despite this opposition?

NATIONAL HEALTH REFORM FINALLY COMES OF AGE?

With the election of Bill Clinton, almost all observers believed that comprehensive NHI would finally become a reality in America. There were many reasons to predict the success, and they are all familiar to our readers. Health care costs had clearly spun out of control. Now even traditionally powerful anti-state interests such as the corporate sector indicated their readiness to accept fundamental reform—even if that meant greater government involvement in the health care sector (Martin 1993). More than thirty million Americans without health insurance and tens of millions more were seriously worried about losing their insurance, and thus even the middle class saw a clear need for reform. Poll after poll indicated that 70 to 82 percent of the American public favored NHI (Roper Center for Public Opinion Research 1994b, 1994c). Bill Clinton also made NHI the keystone of his electoral campaign. Finally, as the previous quote indicates, even the provider community appeared to concede that health care reform was not only politically inevitable but also morally and economically necessary.

So what happened? Why were almost all predictions wrong? Why, given the fact that all of the cards appeared to be stacked in the direction of health care reform, did nothing pass? The answer, of course, is that reformers such as Bill Clinton are not playing on a level table. The game of politics in America is institutionally rigged against those who would use government—for good or evil. James Madison’s system of checks and balances, the very size and diversity of the nation, the Progressive reforms that undermined strong and programmatic political parties, and the many generations of congressional reforms have all worked to fragment political power in America.

This fragmentation of political power—which has become more severe in the past twenty years—offered the opponents of reform many opportunities to attack Clinton’s plan. This institutional bias, and not flaws in the plan or the political strategy pursued by the administration, once again killed plans for comprehensive NHI in America. A very brief overview of some of the new cards that are stacked against health reform is instructive. First, as both Peterson and Morone have suggested, American political institutions are not the same as they were twenty, thirty, or forty years ago. With the reforms of the 1970s “[t]he oligarchy had been changed into a remarkably decentralized institution. . . . Congress as a whole generally became a more permeable and less manageable institution than ever before” (Peterson 1993b: 418). Whereas policy making could at one time be characterized as “iron triangles,” now it appeared to be dominated by “issue networks” (Heclo 1974). But whereas Peterson and Morone appear to believe that these changes make reform more likely than before, we believe that the increased decentralization of institutional power makes meaningful reform less likely to pass today.

Second, the 1990s is marked by “an entirely new type of policy community.” According to Peterson, it “has lost its cohesiveness and its capacity to dominate health care politics
and the course of policy change" (Peterson 1993b: 408, 411). Now that health care is one-seventh of the U.S. economy, even more interests have something to lose if meaningful comprehensive health care reform were to pass. The fact that there are so many more interests (factions) that now have a stake in the extant system (a system that is enormously profitable) does not suggest to us that reform is more likely in the 1990s. Quite the contrary: Reformers now have to battle a medical/industrial/insurance complex that has more than $800 billion a year at stake.

Third, we must remember that the Clintons’ bill needed support from more than 50 percent of the members of the House and 50 percent of the members of the Senate. Congressional rules (that is, institutions) in force in 1994 allowed a minority to block legislation as long as they could control just forty of one hundred votes in the Senate. No other democratic system in the world requires support of 60 percent of legislators to pass government policy. This institutional fact appears even more absurd when we remember that the Senate was so radically malapportioned.

Fourth, despite the fact that the 1990s was marked by the highest level of public support for government intervention in health care financing (Peterson 1993b: 406–7), the incredible $4,500,000,000,000/000 debt facing American taxpayers (most of which has been accumulated in the past fifteen years) make government financing of health care reform exceptionally unlikely indeed.

Fifth, changes in the technology of electioneering have worked hand in hand with the increasing fragmentation of power in Congress to the point that members of Congress have become independent policy entrepreneurs. This means money. Between 1 January 1993 and 31 July 1994, candidates for the House and Senate received $38 million in campaign contributions from the health and insurance industries. The AMA had the most generous political action committee in the country, contributing more than $1,933,000 in 1993 and 1994 alone. These figures do not include small donations made by local constituents, nor do they include donations from small business, another bitter foe of Clinton’s health reform plans. “By the end of the year we expect that the health and insurance industries will have spent over $100 million to crush health care reform,” reported the public interest research organization, Citizen Action. “They will have spent over $40 million in campaign contributions and another $60 million in advertising, public relations, organizing and lobbying. In addition, previous reports have identified over $13 million in campaign contributions from other opponents of comprehensive [health] reform” (Citizen Action 1994: 2).

Sixth, the world around our political institutions has not remained static either. Undoubtedly, the most important change in modern politics is the role of the media. The techniques available for marketing research and media delivery are radically more sophisticated today than they were only fifteen or twenty years ago. This point was not lost on the opponents of health care reform. The insurance industry, for example, spent more than $14 million on the famous “Harry and Louise” advertisement alone. Moreover, as Hamburger and colleagues note, the American media increasingly falls into a ratings game, thereby eschewing serious discussion and presentation of policy issues in favor of misleading headlines and horse race reportage (Hamburger et al. 1994).

Finally, the repeated failure of American political institutions to address the polity’s problems—even when there has been clear public will for action—has worked to undermine dramatically the public’s faith in their governmental institutions.
**EPILOGUE: WHITHER REFORM?**

We opened this essay predicting that, after the failure of Clinton’s health care reform plan, pundits and scholars alike would blame the president, his administration’s policy team and their political strategy, the plan itself, interest groups’ dirty campaign in the media, and/or the American political culture for the failure of NHI in America. Once again, we think these analyses miss the point. The failure of the president’s health care reform plan is neither a failure of this president nor a failure of his specific plan. Rather it is a failure of American political institutions with which he has been forced to work and through which the plan had to be passed.

This suggests to us that reformers who want real reform rather than a continuation of the pattern of buying off interests and avoiding making tough choices should focus their efforts on reforming American political institutions rather than designing ever more sophisticated reform strategies that might be able to squeak or “slouch” through the American political system. Our history tells us that even if these more politically palatable piecemeal solutions do pass in some future Congress, they are likely to throw fat on the inflationary fire—while at the same time deepen the alienation between the American people and their government.

**REFERENCES**


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