

ENTRY INTO NURSING PRACTICE: A FOUR STATE COMPARATIVE STUDY

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DISSERTATION ABSTRACT

ENTRY INTO NURSING PRACTICE: A FOUR STATE COMPARATIVE STUDY

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There is little doubt that the new administration will be forced to deal with the looming health care crisis in this country. But the political obstacles remain daunting, the least of which is the opposition by health care related interest groups. Most reformers believe that these groups are too powerful and would derail any single payer system as "big government." This type of influence is obvious even at the most basic levels of health care reform.

In 1965, the American Nurse Association (ANA) published a Position Paper that called for making the baccalaureate degree the minimum educational standard for Registered Nurses (RNs) and the associate degree as the minimum level of education for Licensed Practical Nurses (LPNs) (ANA 1965). The organization then established a proposed timeline for implementing the policy on a nationwide basis and chose four

Licensed Practical Nurses (LPNs) (ANA 1965). The organization then established a proposed timeline for implementing the policy on a nationwide basis and chose four focus states as early implementers: Oregon, Montana, North Dakota, and Maine. In effect, these states were to act as legislative testing grounds for the proposal. The ANA chose these states carefully, believing that this new policy would be easily adopted in each. However, of the four states, only North Dakota was successful at getting the policy passed and implemented, but even that success was diminished when the policy was rescinded in 2003.

One question looms: why did such a simple policy proposal get derailed? In looking at why the policy was ultimately defeated in all four states, I find that opposition by the same health care related interest groups was instrumental in the policy's demise. This paper focuses on how and why these groups worked to oppose and ultimately defeat the policy in all four states.

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## **CHAPTER 1: INTRODUCTION**

No policy issue is more unavoidable than our looming health care crisis, and no issue is more complicated (Pareto, 2008). The debate over health care reform in this country revolves around questions of access, efficiency, quality, and sustainability. According to the World Health Organization (WHO, 2008), our mixed public-private health care system is the most expensive in the world; we spend more on health care, both as a proportion of gross domestic product (GDP) and on a per capita basis, than any other nation. Current estimates put U.S. health care spending at approximately 16% of GDP. In 2007, the U.S. spent \$2.26 trillion on health care, or \$7,439 per person. Health care costs are rising faster than wages or inflation, and the health share of GDP is expected to continue its historical upward trend, reaching 19.5 percent of GDP by 2017.

The U.S. is the only wealthy, industrialized nation that does not have a universal health care system. Americans without health insurance coverage at some time during 2006 totaled about 16% of the population, or 47 million people (WHO, 2008).

The U.S. health care system has become increasingly inaccessible to most of our poor and lower middle class citizens. Those with insurance coverage are paying increasingly higher premiums while receiving fewer benefits. The financial tug of war between insurers and hospitals continues to consume more and more money and resources with the end result of the U.S. paying approximately twice as much per capita for health care

as the majority of western nations. Yet in comparison to those countries, our life expectancy is lower and infant mortality rate is higher (WHO, 2008).

Unfortunately, the political obstacles to any meaningful reform are many, the least of which is the opposition to reform by health care related interest groups. Most reformers believe that these groups are too powerful and would derail any single payer system as "big government." This type of influence is obvious even at the most basic levels of health care reform.

### **NURSING EDUCATION REFORM**

Over the last 100 years, the environment in which health care is practiced has changed drastically, and so too has the need for strengthening nursing education. There are several aspects of this change, ranging from an aging population, an increasing awareness of economics, and more complex, advanced technologies to an ever increasing number of new epidemics. In this rapidly changing environment, skilled-based competency is simply no longer adequate as more traditional fundamental nursing skills have been replaced by more up-to-date foundational knowledge (American Association of Colleges of Nursing, 2005; Association of California Nurse Leaders, 2000; Barter & McFarland, 2001; Henneberger, 1994; Lusk et al, 2001; Nelson, 2002; Rambur et al, 2005; Styles et al, 1991). This knowledge includes creative decision making and critical thinking skills plus the managerial skills needed for dealing with a diverse and multicultural workforce and patient population. On the practical side, today's nurses should also be familiar with such broad ranging topics as cost-benefit analysis and ethical decision making (Barter & McFarland, 2001; Lusk et al, 2001;

Nelson, 2002; Oermann, 1994a, 1994b; Salmon, 1994; Rambur et al, 2005; Shortell et al, 1994; Tebetts, 1995).

Unfortunately, the field of professional nursing education has a history of conflict among its stakeholders concerning a national standard for nursing education. Subsequently, there is no such standard. In most states, basic nursing education is divided into three levels:

- 1) Licensed Practical Nurse Diploma (LPN): A technical nurse training program administered at the Junior College level that ranges by state from 9 to 18 month;
- 2) Associate Degree Nurse (ADN): A two year nurse education program administered at the Junior College level; and
- 3) Baccalaureate Degree Nurse (BSN): A four year nurse education program administered at the upper college level.

The requirements for these levels vary by state and are controlled by forces within each state's higher education system, various national and state hospital and long-term care associations, and the nursing profession itself. Further, each state has its own licensure procedures and regulating laws are created by 50 individual state legislatures. As such, each of these nursing boards and legislatures must be convinced that there is a need for a unified standard.

Efforts towards reforming educational standards for professional nursing practice have been ongoing since the 1960's (see Table 1.1). In a 1965 position paper, the American Nurses Association (ANA) recommended the following:

- 1) That there be a requirement making the baccalaureate degree the minimum standard for a Registered Nurse (RN) license,

- 2) That a new license and title be created for associate degree nurses which designated these practitioners as Registered Associate Nurse (RAN), and
- 3) The elimination of two types of technical nursing education programs: hospital based diploma schools and practical nursing programs (ANA, 1965).

The major reasoning for these recommendations was that education for those in nursing should and must increase as medical knowledge expands.

Using a theoretical model focusing on interest group influence at the state level, this paper examines an attempt by the ANA to increase and streamline nursing education, and the causes for its failure. Though not directly related to the issue of health care reform, this case does highlight the complicated nature of attempts to change health care policy in this country. I am especially interested in the influence of interest groups, whether they be directly or indirectly involved in the health care industry, on health care policy, both at the state and national levels. It is my belief that in order for there to be any type of substantial health care reform in this country, there is a serious need for reform supporters to better understanding the nature and strength of those opposing reform; i.e. the health care industry.

### **ANA POSITION PAPER**

In this study, I identify the ANA's 1965 position paper on entry into practice for Professional Nursing as the focusing event that initiated the baccalaureate policy proposal in the four focus states. The origins of this paper can be traced back to a declaration of concern made by the organization in 1965 in which it stated that its chief concern was "what nursing is today and what it will be tomorrow." This declaration was

followed by the ANAs' position paper on nursing education, later published in the *American Journal of Nursing* (1965). This paper has gone on to become one of the most frequently cited documents in the nursing profession. The underlying assumption for the development of this position was that education for those in the health care professions must increase in depth and breadth as scientific knowledge expands.

The passage of the Comprehensive Nurse Training Act of 1964 prompted the ANA Committee on Education to study nursing education, practice, and scope of responsibilities (Jacobs, MiMattio, Bishop, & Fields, 1998). This study highlighted the ever increasing complexity of health care while raising concerns about hospital-based diploma programs. The ANA specifically noted the changes in nursing practice that included "major theoretical formulations, scientific discoveries, technological innovations, and the development of radical new treatments" (ANA, 1965, p. 107). As a result, the Board of Directors of the ANA adopted the Committees' statement. This became the 1965 "position paper" containing a recommendation that the "minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing" (ANA, 1965, p. 107).

It was the general consensus among the leaders in the nursing field that the professions' future was dependent on nursing education moving into higher education. There was a recognition that nursing was lagging behind other professions in raising educational standards as nurses remained the least educated among professional health care providers. It was also recognized that the educational gap between nursing and other health professions was growing. The ANA made it clear that it fully believed that

a baccalaureate education was needed if nurses were to maintain equal status with other health care professionals.

The rationale underlying the position paper considered the changing role of government, especially its investment in nursing education and manpower training, the changing pattern of education in the United States and the increasing availability of collegiate education for women, the expansion of science and technology and its impact on health and health care, and the new insights into the health problems of man (ANA, 1965). In an accompanying editorial, Barbara Schutt (1965) said that nurses were wasting their energies debating the merits of collegiate education for tomorrow's nurse. "For the facts of the matter are that the mood of the American public is to make collegiate education available for all our able youth, of which nursing students are only a part; and the nurse of the future is the one who will have to determine the role she will play at the time" (Schutt, 1965, p. 57).

### **FOCUS STATES**

Soon after the release of this position paper, the ANA began working on a proposed timeline for implementing the policy on a nationwide basis and chose four focus states as early implementers: Oregon, Montana, North Dakota, and Maine. In effect, these states were to act as a testing ground for the proposal. The ANA chose these states carefully, believing that the policy would be easily adopted in each. The ANA also targeted funds to these states to assist with the implementation process.

In 1984, the ANA officially adopted an implementation plan that included a timetable for diffusion across the states. This timetable envisioned state adoption as follows:

- 1986: 5% would have adopted the requirements
- 1988: 15% would have adopted the requirements
- 1992: 50% would have adopted the requirements
- 1995: 100% would have adopted the requirements

However, things did not work out as expected.

In Oregon, the Oregon State Board of Nursing (OSBN) had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it had the power to initiate such a measure. With this ability in mind, discussions within the OSBN concerning the entry issue began in 1977. On March 3, 1982, these discussions resulted in the OSBN adopting two motions relating to the requirements for licensure of Registered Nurses and Licensed Practical Nurses (Hicks, 1985, March 26). These motions called for RNs to hold a minimum of the baccalaureate degree in nursing and LPNs to hold a minimum of the associate degree in nursing. However, in 1985 the Oregon Community College Association (OCCA) successfully sponsored legislation that stripped the power of the OSBN to set educational standards for nursing. This move effectively stalled efforts to adopt the ANA proposal within the state.

In Montana, the Montana Board of Nursing (MBN) presumed it had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it was assumed by the organization that it had the power to initiate such a measure. Discussions within the MNA concerning the entry issue began in 1977 (Munger et al., 1987). These discussions resulted in the introduction and adoption of the first entry resolution by the MNA's House of Delegates in 1978 (Munger et al., 1987).

The resolution asked that two categories of nursing practice be identified, that the baccalaureate for entry be in place by 1985, and that a plan for implementation be developed (Munger et al., 1987). However, due to a number of legal challenges to the proposal brought by opponents, the issue was eventually brought before the state legislature in 1987 and subsequently defeated.

Maine was the only state in which the State Board of Nursing did not have the authority to change the nursing educational requirements on its own. Although it is a regulatory board for nursing in the state, it does not have the power to initiate such a measure. All such changes must be brought before the legislature. The statewide effort to adopt the new educational standards began in 1984 after the members of the Maine State Nurses Association (MSNA) voted to adopt the ANA proposal. The proposed target date for implementing the new standards was to be January 1, 1985. In 1986, the state legislature adopted the proposal, but due to stiff opposition from a number of health care groups, full implantation was postponed until certain criteria could be fulfilled. However, those same opposition forces were able to successfully rescind the new educational standards when the issue came before the legislature again in 2003.

In North Dakota, the North Dakota Board of Nursing (NDBM) had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it had the power to initiate such a measure. In 1984, the Board established the rules that called for the baccalaureate degree as the minimum level of education for Registered Nurses and associate degree as the minimum level of education for practical nurses. The new rules also gave the Board the authority to close any nursing program that did not comply with the new rules (Rose, 2006). After

defeating several challenges from a number of opposing health care groups, North Dakota became the first and only state to fully implement to ANA proposal. However, in 2003, those same opposing groups successfully sponsored legislation to rescind the new educational requirements.

## **STUDY OUTLINE**

So the question is: why did this policy proposal fail? Much of the answer to this question lies within the nature of the proposal. The concept of making the baccalaureate degree the minimal level of education for RNs and the associate degree the minimal level of education for LPNs was definitely an innovative idea. Until that time, no policy with such sweeping ramifications on the nursing field had ever been proposed, especially at the state level.

In chapter two, the literature review examines a number of variables that I believe explain the defeat of the ANA proposal. These variables include state policy innovativeness, policy diffusion, political culture(s), interest group dynamics, agenda setting, issue framing and reframing, and public opinion.

In chapter three, I developed two theoretical models: one specifying the required conditions within a state that would make it a good candidate for a smooth policy adoption process, and one which specifies conditions that would make a smooth policy adoption process less difficult to achieve. I use a comparative case study approach to examine the above outlined variables within each focus state, North Dakota, Montana, Maine, and Oregon.

Chapter four examines the approaches and tactics used by both supporters and opponents of the proposal in each focus state. I specifically look at the part each of the identified variables play in the ultimate outcome of the proposal in each.

Chapter five brings the findings from each state together. I then compare and contrast these findings for my conclusion and make recommendations for further research.

**Table 1.1 Baccalaureate Entry into Nursing Practice Timeline**

<p><b>1964:</b> The American Nurses Association (ANA) develops the Nurse Training Act.</p> <p><b>1965:</b> ANA develops "A Position Paper on Educational Preparation for Nurse Practitioners and Assistants to Nurses."</p> <p><b>1977:</b> Oregon starts laying ground work for adoption of the policy.</p> <p><b>1984:</b> The ANA established the goal that the baccalaureate be recognized as the educational base for professional nursing practice in 5 percent of the states by 1986; 15 percent of the states by 1988; 50 percent by 1992; and 100 percent by 1995, with the ultimate goal being congruence of professional nurse licenser with the educational base of the baccalaureate in nursing.</p> <p>Efforts to establish a bi-level system begin in Montana, Maine and North Dakota.</p> <p><b>1985:</b> The issue is brought before the Oregon House Education Committee; no action taken.</p> <p><b>1986:</b> The issue is passed in the Maine legislature but amended to allow time for a study to determine the new laws impact; projected implementation date of 1995.</p> <p><b>1987:</b> The issue is defeated in the Montana legislature. The issue is passed in the North Dakota legislature.</p> <p><b>1993:</b> The issue and follow-up study is brought before the Maine legislature and defeated.</p> <p><b>2001:</b> The California Nurse Leaders (ACNL) developed an initiative to require the baccalaureate degree as the credential for entry into practice as a registered nurse by the year 2010.</p> <p><b>2003:</b> In North Dakota, opponents of the policy are able to get legislation passed that eliminates the mandate for a four year Bachelor of Science (BSN) degree and the two year Associate Degree Practical Nursing.</p> <p><b>2006:</b> The New York Board of Registered Nursing submits a proposal to the legislature requiring all associate degree RNs to obtain a baccalaureate degree; no action taken.</p> <p><b>2006:</b> The New Jersey Nurses Association endorsed a resolution to require all entry-level nurses to obtain a baccalaureate degree within 10 years of entering nursing practice.</p>
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Source: Author

## **CHAPTER 2: LITERATURE REVIEW**

What causes a state government to adopt or reject a new program or policy?

Specifically, what explains the different outputs in each focus state to the American Nurses Association's baccalaureate proposal? In this chapter I examine a variety of factors that I believe contributed to the ultimate outcome of the ANA proposal. These variables include policy innovation and diffusion, agenda setting, policy framing and reframing, state political culture(s), state interest group activities, strength, and coalitions, and public opinion (see Figure 2.3). It is my belief that the key to understanding the final outcome of the proposal in these states is the unique interaction of each of these factors.

### **POLICY INNOVATION**

The proposal by the American Nurses Association (ANA) to make the baccalaureate degree the minimal level of education for Registered Nurses (RNs) and the associate degree the minimal level of education for Licensed Practical Nurses (LPNs) was definitely an innovative idea. Until that time, no policy with such sweeping ramifications on the nursing field had ever been proposed, especially at the state level.

At the state level, an innovation can be defined in several ways. Walker defines it as “a program or policy that is new to a state(s) adopting it, no matter how old the program may be or how many other states have adopted it” (Walker, 1969). According to Savage, “an innovation is a policy adopted by a state for the first time” (Savage, 1978). For

Downs and Mohr, an innovation is the “earliness or extent of use by a given organization of a new idea, whether ‘new’ means only new to the adopting agent, and not necessarily to the world in general” (Downs and Mohr, 1979). Polsby defines innovation as “a policy or set of policies that seem to have altered (or promise to alter) the lives of persons affected by them in substantial and fairly permanent ways (Polsby, 1984).

David Nice (1994) proposed that an innovative state is simply one that adopts an innovative policy. His study integrated a number of his own previous studies while focusing on tax relief and using a comparative method, Nice examined the casual process underlying the adoption of eight different policy innovations. The adoptions examined included teacher competency testing, sunset laws, rail passenger service, public financing of election campaigns, ratification of the Balanced Budget Amendment to the United States Constitution, property tax relief, deregulation of intimate behavior, and state ownership of freight railroads. Nice integrated these various policies into one analysis in order to draw his conclusions

Among other things, Nice concludes that the adoption of a policy innovation is the result of a state’s openness and orientation toward government activity and change, its political ideology, and general innovativeness. He noted that a state’s problem environment significantly stimulates policy innovation, but found little support for the role of slack economic resources for any of his eight policies. He also found that, contrary to his hypothesis, a more liberal political ideology does not create support for policy adoption. However, he did find that it created a supportive environment in

instances where the policies in question were of a more liberal nature such as property tax relief, public financing of elections, and the repeal of sodomy laws.

Others tend to define innovation in broader and less specific terms. Bingham simply defined innovation as a “public policy” (Bingham, 1976). Drucker views innovation as a “change that creates a new dimension of performance” (Hesselbein et al, 2002), while Rogers defines it as “getting ideas adopted” (Rogers, 1995). Implicit to these and other definitions is the broad understanding that innovation is not just about the introduction of a new idea but also about putting that idea into practice.

A review of the literature on the determinants of state policy innovation identifies three basic explanations for what causes a state government to adopt a new policy:

1. Internal determinants,
2. Regional diffusion, and
3. Federal influences.

The internal determinants model has an assumption that a state’s policy making processes are generally independent of any influence from other states, but not always.

This would include such factors as the specific socio-economic and political characteristics of a state as well as organized interest group strength within that state.

The regional diffusion model states that a state is more likely to adopt a specific policy if nearby states have already adopted the same or a similar policy. A national interaction model is indicative of a national communication network among state officials. Via this network, officials of adopter states interact and mix with officials of non-adopter states.

During the 1960’s, researchers initially began to study policy innovation in response to the federal governments expansion of its policy making role in relation to the states.

Two early researchers who examined the process of policy innovation within and across states were Jack L. Walker and Virginia Gray.

In his article, *The Diffusion of Innovations Among the American States* (1969), Walker looked at various determinants for policy innovation among the states. His study looked at the speed and spatial patterns of adoption of new policies across the states. He examined eighty-eight different programs enacted by at least twenty state legislatures prior to 1965. Walker then developed an innovation score based on the number of years from the date that the first state enacted a program until the date when the last state enacted the program. Each state then received a number for each program expressed in a percentage that reflected the time between the first adoption of the program and that individual state's adoption of the program. The innovation score was then calculated as 1.00 minus the average of the sum of the state's scores for all issues in the study (see Table 5.2).

Walker's results showed that a states measure of industrialization, urbanization, and wealth were significantly correlated with the innovation score. He also concluded that the likelihood of a state adopting a new program is higher if other states have already adopted the program with the likelihood increasing if the state that adopts is perceived by other states as a point of legitimate comparison. Walker also placed great emphasis on interstate communication.

Walker also found that the main trend in intergovernmental relations was an assertion of policy leadership by both the legislative and judicial branches of the Federal government, even as the states were experiencing the most dramatic make-over in their history via various forms of policy experimentation. (p. 132). Accordingly,

policy research fell into three emphases: (1) determinants models based on political, economic, and demographic factors underlying diffusion; (2) regionalism models based on intergovernmental relationships among states in a region; and (3) federalism models based on the effects of federal incentives and interventions.

Using Walker's work as a base, several researchers explored a number of policy areas in which innovation and the subsequent diffusion of an innovation have occurred. These areas have included state lotteries (Berry and Berry, 1990), state tax increases (Berry and Berry, 1994), state environmental policy (Daley and Garand, 2005), and Living Wills (Glick and Hayes, 1991).

In 1973, Gray looked at state policy innovation with a different model and included several criticisms of Walker's model. The three questions Gray asks are:

1. How are new ideas diffused among states?
2. Why are some states more innovative than others?
3. Are there patterns to the innovation?

Gray's study looked at hypothesized factors that would reflect a liberal or progressive leaning in the states. This included measures of spending on welfare programs, expenditures for education, and legislation involving civil rights. She found that a progressive atmosphere is not necessarily a one-dimensional factor that underlies all policy but instead that the majority of states are progressive in at least a few areas. She noted that states that had high rankings on welfare expenditures were not always ranked high on education spending. Surprisingly, she found that the only area with a consistently high progressive rating was in anti-discrimination legislation.

Although Walker and Gray disagree on the appropriateness of aggregation of data, they both offer a quantitative option of approaching the issue to be examined. Gray chose not to aggregate the issues that she studied on the premise that some states may be innovative on certain types of issues and not on others. She also concluded that innovative states tend to be wealthier and more competitive than other states at the time that an innovation was adopted. She measures for wealth and competitiveness where per capita income and the governor's electoral margin in the most recent election.

The three groups of factors examined for this research include internal determinants, diffusion and regionalism and, federal influences.

### **Diffusion and Regionalism**

Diffusion and regionalism is one of the three main groups of variables fueling innovation. All four states chosen by the ANA as early implementers of their policy proposal believed that they were setting a new educational standard that other states would soon emulate via diffusion. Though that expectation did not come to fruition, it is important to examine the various diffusion theories.

Everett M. Rogers is the researcher most associated with classic diffusion theory. In the most recent version of his 1962 book, *Diffusion of Innovation*, Rogers defines diffusion as "the process by which an innovation is communicated through certain channels over time among the members of a social system" (Rogers, 1995:5). He finds that innovation is relative to the adopter and defines it as "any idea, practice, or object that is perceived as new by an individual or other unit of adoption." Rogers found three factors that were associated early adoption: time, space and importance. Earliest

adopters tend to be identified as more important places (supported by Walker, 1969; Brown & Cox, 1971; Leichter, 1983), while places that are closest to an innovation adopt earlier than those not in close proximity (supported by Hägerstrand, 1967; Brown & Cox, 1971; and Klingman, 1980). Rogers' research found that the rate of adoption follows an S-shaped logistic curve with slow increases in adoptions until a tipping point is reached when adoptions accelerate rapidly, then plateau and increase only slowly to reach the last adopters (Brown & Cox, 1971:551). Thus, adopters may be characterized as innovators, early adopters, early majority, late majority, and laggards.

According to Rogers, there are four elements to diffusion:

1. An innovation (something perceived as new);
2. A communication system (a transmission system from one individual, group, or society to another);
3. A social system (provides the domain for the diffusion process);
4. Time (from awareness of innovation through to adoption saturation in the social system).

Rogers' theory is also based in the effects of five factors:

1. Characteristics of the innovation itself (complexity, compatibility with existing structure and methods, observability of benefits, relative advantage over existing forms, and trialability - the extent it can be tried out on an experimental or pilot basis);
2. Characteristics of communication channels (ex., interpersonal, organizational, mass media);
3. Process characteristics (ex., voluntary, mandated);

4. Characteristics of the social system (ex., compatibility of the innovation with social norms); and
5. Characteristics of the change agents promoting diffusion (ex., technocratic vs. background in organization development; low-level vs. high-level).

In addition, Rogers found that diffusions progress through five stages:

1. Knowledge (awareness of the existence of the innovation);
2. Persuasion (mobilizing positive attitudes toward the innovation);
3. Decision (securing commitment to adopt the innovation);
4. Implementation (operationalization in use); and
5. Confirmation (positive outcomes reinforce the process of diffusion).

Rogers (1995) found early adopters to be younger, more educated, more tolerance for risk, better networked with others, seek the advice of opinion leaders, work for larger organizations, be less rigid, have more lofty goals, and be more innovation-minded in general.

As noted earlier, Jack L. Walker's (1969) study, "The Diffusion of Innovations Among the American States" popularized diffusion (and innovation) theory within the field of political science. Walker theorized that the spread of an innovation from one state to another could not be attributed solely to traditional expenditure models, but was instead a definite diffusion process. Policy research following Walker found that policy research fell into three main areas:

1. Determinants models based on political, economic, and demographic factors underlying diffusion;

2. Regionalism models based on intergovernmental relationships among states in a region; and
3. Federalism models based on the effects of federal incentives and interventions.

Berry and Berry (1999) used different terminology to identify the same concepts:

1. National interaction models focusing on the role of such groups as the National Conference of State Legislatures or the National Governors Association;
2. Regional diffusion models focusing on the influence of neighboring states; and
3. Vertical influence models focusing on the influence of the national government.

Berry and Berry (1999) also found three motives that lead to state policy adoption:

1. Copying what has been a success elsewhere;
2. Seeking competitive advantage; and
3. Responding to citizen pressure.

Early diffusion research focused on regional proximity as a main determinant of innovation adoption (McVoy, 1940; Walker, 1969; Walker, 1973). More recent studies continue to find a regional diffusion effect (adoption of Social Security by nations, Collier & Messick, 1975; state adoption of lotteries, Berry & Berry, 1990; state tax policy, Berry & Berry, 1994; state environmental policy, Daley & Garand, 2005; and local anti-smoking ordinance adoption, Shipan & Volden, 2005).

In terms of successful peer adoption, Walker (1969) argued that when peer states adopt an innovation, deprivation became a major motivator for other states to follow suit. Based on logistic regression for 12 laws including civil rights, welfare, and education, Gray (1973) found that the cumulative proportion of adopters of a given policy to be a predictor of the rate of spread to other potential adopters. Berry & Berry

(1990) found that the successful adoption of state lotteries in neighboring states increased the likelihood of adoption. Mintrom (1997) examined policy innovation in education and found that states that border a state that has adopted a particular innovation are more likely to adopt or at least consider the innovation. Mintrom (1997) also examined the role of policy entrepreneurs in educational innovations.

Gray (1994) noted the importance of the role of the governor as a policy entrepreneur in adopting economic development innovations. Akers (2006) found that states may have a culture of innovation more than others, and this culture may mediate between determinants and adoption. However, it should be noted that some studies failed to find a relationship between entrepreneurs and innovation adoption. Hoyman & Weinberg's (2006) study determined that there was no relationship between human capital and county adoption of prisons to achieve economic development.

Walker (1969: 898) noted the role of professional associations, research centers, and interest groups in establishing norms of best practice, thus sanctioning innovation. He also found that information networks are a diffusion prerequisite (1969: 897-898). These networks foster the spread of information about innovations and the subsequent adoptions by peers. Mintrom and Vergari (1996; 1998: 146) found that policy networks facilitate agenda setting, which sanctions diffusion of innovation. They noted that "policy networks are important resources that successful policy entrepreneurs draw upon when developing and selling their policy ideas."

Some researchers have found political factors to be more important than economic or demographic factors (Martin, 2001; Lindlad, 2006). Mintrom (1997), for instance, found policy innovation to be less likely in election years. Gray (1973) found that

innovations involving controversial policies are linked to the political orientation of a location's chief political officer (ex., governor for states). She looked particularly at innovation in civil rights, welfare, and educational policy arenas. Grossback et al. (2004) found governors will often look to ideologically similar states for cues regarding policy innovation. Martin (2001) found a correlation between political orientation and adoption of living wage legislation. Still, other studies have found no correlation between leadership orientation and innovation adoption. Soule & Zylan (1997) found this to be true with regard to welfare eligibility reform. Hoyman & Weinberg (2006) found no correlation between political orientation and the adoption of prison settings as an economic development policy innovation. Berry & Berry (1994) found that the adoption of new state taxes was much more likely to occur when there was no election looming, since most legislators seek to minimize political costs.

In their study, Klingman and Lammers (1984) discussed several critical issues in regard to state policy trends and highlighted the contextual differences between the various states and regions. They outlined a link between policy adoption patterns and the various economic, political and legislative variables present in the states. States in the Snowbelt enjoyed higher levels of personal income and economic growth that helped support their habit of implementing innovative policy changes in the public sector. By the early 1980's, economic decline and a heavy loss of population in this region made it fairly unlikely that cultural and political forces would be able to maintain existing expenditure levels. In comparison, the economic growth of the Sunbelt created a larger demand from the public services, forcing the ruling elites to expand existing services and implementing new ones.

## **Federal Influences**

Federal influences are another of the three main groups of variables fueling innovation. But what exactly is meant by “federal influence” and what are some of those possible influences?

Hanson (1984) suggests that the nature of federal incentives to states plays an important role in their level of innovativeness. Using the Medicaid program as a base of study, Hanson looked at a state’s cultural orientation toward redistributive policies. Although it would seem obvious to many that federal aid would be most influential on states with the least resources, Hanson found this is not always the case. States with the least resources, mainly those in the Deep South, used federal funds to expand their Medicaid-funded services much less than other states. Also, they were far more likely to transfer fiscal responsibility from themselves to the federal level. As such, by using federal funds, the wealthier states are more likely to offer a broader range of optional social services and to increase the number of eligible participants.

In their study, Welch and Thompson (1984) looked at seven domestic state-policy areas that are influenced by federal incentives: education, health, welfare, environmental regulation, planning, agriculture and civil rights. The study looked at these areas from several time periods with differing amounts of fiscal incentives. Their results showed that policies sponsored at the federal level diffused much faster than those sponsored at the state level. A quick rate of adoption depended on whether the policy used positive incentives. This is in contrast to states that had slower rates of adoption in which their decision to adopt was more heavily influenced on whether there was any type of federal incentive offered. However, the fact remained that the amount

of federal involvement and the type of policy accounted for only a very small percentage of the variance in states of a states diffusion rate. As observed by Eyestone (1976) in his study: “A state adopts or rejects a policy due to a complex web of factors, of which the federal incentive is only one.”

Welch and Thompson warned that: “We should not minimize the impact of federal grants-in-aid. That the federal government chooses to deal with a problem through federal grants and incentives to states rather than through a direct federal program indicates that support for the policy is limited (Monypenny, 1960; Lowi, 1969). The adoption of a social initiative or a federal grant program may often be a political compromise, which reflects a failure by most states to adopt the policy prior to federal action, and which also indicates a lack of total commitment to the program by the federal government.

### **Internal Determinants**

Internal determinants are the last of the three main groups of variables fueling innovation. The internal determinants approach maintains that states adopt policies only when their own political, economic, and social environments are favorable (Gray, 1973, 1994). This approach focuses on policymaking processes internal to a single political system, typically arguing that larger, wealthier, and more economically developed states (Walker, 1969) and states with high levels of interparty competition (Haider-Markel, 1999; Mintrom, 1997) tend to be policy innovators.

Gold used a case study approach to examine the effects of a crisis on the innovativeness of a state (Gold, 1995). Focusing on six states, he compared situations in

each that contributed to a period of fiscal crisis during the early to mid 1990's.

Examining detailed case studies of California, Connecticut, Florida, Massachusetts, Michigan, and Minnesota, he concludes that fiscal crisis is very often the mother of policy innovation. Gold connects crisis with response and illustrates the variation in each states' response to similar crisis:

1. While Connecticut adopted its first income tax, Michigan and Massachusetts relied on increased efforts at privatization and on spending cuts.
2. Florida adopted several policy and procedural innovations while relying on incremental adjustments.
3. California initiated a major realignment effort in state and local relations.
4. Minnesota adopted major reforms in schools, welfare, and health care.

Basically, these states relied on two approaches: creative budgeting and innovation. Some of the creative budgeting approaches included the use of Medicaid loopholes to enable the state to qualify for greater federal funds, and one-time budget reductions during the fiscal crisis that were specifically intended to keep the budget balanced.

Innovations varied from comprehensive welfare reform focusing on child care, health care, training, and earnings retention, to adopting school choice in education and focusing on organizational restructuring as a means of increasing efficiency.

Gold concludes that while states may respond in a variety of ways to a crisis, they will often look at what other states are doing in a similar situation. This is true even among those states with reputations for policy innovativeness.

## **Political Culture**

A state's unique political culture is one of the key internal determinants for policy innovation. While some states may have similar socio-economic and political characteristics, none are identical.

Political culture is a distinctive and patterned structure of beliefs on how governmental, political, and economic life should be carried out in specific locales. Political cultures create a framework for political change.

Of all the factors that affect policy innovation, political culture is perhaps the most difficult to analyze, yet one of the most important. This is because the interaction of individuals and their varying economic, ethnic, religious, and social backgrounds influence it. Political culture is important to consider because it influences local attitudes toward taxes, services, and how the government should respond to social issues. This, in turn, affects the decisions of the local and state government.

Political culture theories help explain the differences in the political processes, political behavior, and policies and programs of local and state governments. These theories offer an understanding of: (1) what state and local governments do, (2) how they are organized, (3) what political rules they observe, and (4) who participates in the political process.

Over the last few decades, there have been a number of studies that have attempted to explain the differences among states' policy adoption processes. A number of researchers have looked at what conditions and characteristics the states have in common when adopting specific policy innovations. One of the most common factors identified is political culture, which generally includes not only cultural beliefs, but also

other political and state characteristics such as political party competition, interest group strength and activity, gubernatorial power, and public opinion (Key, 1949; Sharkansky, 1969; Elazar, 1984; Savage, 1981; Black and Black, 1987; Gray, 1973; Erikson, Platt, Whistler and Ziegert, 1999).

In examining three of the major political culture theories, I anticipate finding that the four focus states will fall within political culture categories that accurately reflect the response taken by each when confronted with the baccalaureate issue. The three theorists I will examine are: Daniel Elazar, Rodney Hero, and Joel Lieske.

### **Daniel Elazar**

Daniel Elazar defined political culture as "the particular pattern of orientation to political action (policies) in which each political system is imbedded" (Elazar, 1984).

Elazar found three political-culture types among American states: moralistic, individualistic and traditionalistic. Relevant to this study, the four states in question fall into the first two categories: moralistic and individualistic. Traditionalistic states are those generally associated with the old Confederacy of the South. The politics of these states are generally dominated by a small number of prominent leaders, many of whom have gained power through family ties. None of the states in this study fall into this category.

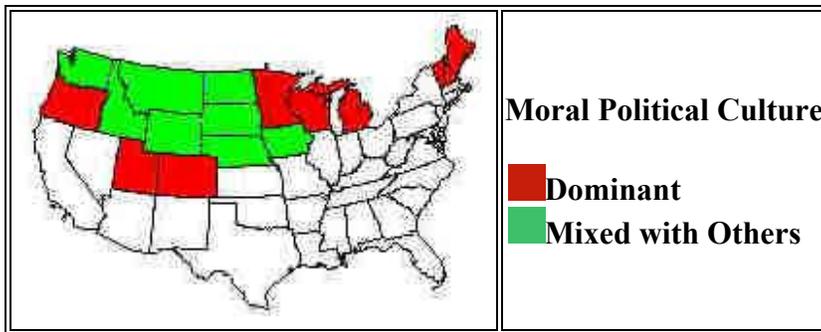
### **Moralistic Political Subcultures**

States with a moralistic political subculture generally have the following shared characteristics:

- Emphasizes the commonwealth.
- Government advances the public interest and is a positive force in the lives of citizens.
- Politics revolves around issues.
- Politicians run for office to advance issues.
- Corruption is not tolerated because government service is seen as public service.
- Bureaucracy is viewed favorably as a way to achieve the public good.
- It is a citizen's duty to participate in politics.
- View was brought to the United States by the Puritans who settled in New England.
- Transported across the upper Great Lakes into the Midwest to the Northwest (see Figure 2.1).
- Values reinforced by waves of Scandinavian and northern European groups.

A moralistic culture values a commitment by government to the public good and concern for public welfare. All civic and political power is aimed at promoting positive change by placing moral obligations on all public officials. This culture expounds democracy as a commonwealth concern that idealistically promotes full citizen participation in the political process. By their very nature, moralistic cultures tend to support greater government intervention into the political, economic, and social arenas of public life (Elazar, 1984: p. 117-8).

According to this view, states in this category are much more open to policy innovation in areas involving the “common good” of society. Education and health care policies would be central to this concept. Of the four states examined in this study, Oregon and Maine fall directly into this category. Montana and North Dakota are viewed as a mixture of both the Moralistic and Individualistic cultures.



**Figure 2.1** Elazar's Moralistic Political Subculture  
 Source: Elazar, Daniel J. 1972 (2nd edition). *American Federalism: A view from the states*. New York: Thomas Y. Crowell.

### Individualistic Political Subcultures

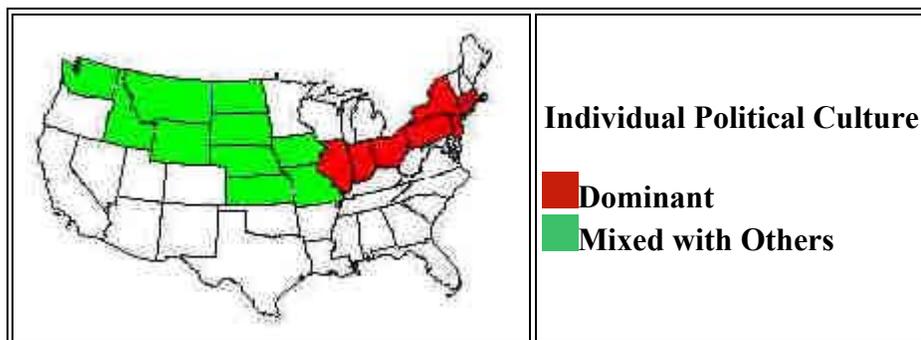
States with an individualistic political subculture generally have the following shared characteristics:

- The individualistic subculture relies on the marketplace.
- Government's role is limited, primarily to keep the marketplace functioning.
- Politicians' motives for running for office are based on material self-interests and to advance themselves professionally.
- Bureaucracy is viewed negatively because it hinders patronage.
- Corruption is tolerated because politics IS dirty.
- Political competition is partisan.
- Elections are oriented toward gaining office and do not deal with issues.
- View originated in Middle Atlantic states, settled by German and English groups.
- Migrated to lower Midwest, Missouri, and western states (see Figure 2.2).
- "Government should never get in the way."

In states with this type of political culture, government is viewed as being instituted for mainly utilitarian reasons. Community involvement by government is discouraged while individual initiative is encouraged thus creating a culture where private enterprise is placed before the public good (Elazar 1984: 115-7).

In an individualistic political culture, public officials are committed to giving the public what it wants. As such, public officials are willing to create new programs only

when they believe that there is an overwhelming public demand for these programs. Though the idea of the "good society" is not a central focus, it is not ignored. According to Elazar, Montana and North Dakota fall into this category but are not considered to be dominated by this culture. As stated earlier, both states are a mixture of both the Moralistic and Individualistic cultures. Though not quite as open to policy innovation as Maine and Oregon, their mixture of both cultures creates an environment in which innovation is still considered a norm.



**Figure 2.2** Elazar's Individualistic Political Subculture  
Elazar, Daniel J. 1972 (2nd edition). *American Federalism: A view from the states*.  
New York: Thomas Y. Crowell.

In response to Elazar's theories, various studies that have tried to measure political culture within states. Many researchers are somewhat wary of assigning a state to a specific political culture mainly because such measurements are often of questionable empirical grounding. Though it is well accepted that different state political cultures do exist, there is a definite need for further research.

The three political cultures identified by Elazar often overlap within the states. It is highly unusual, if not impossible, to find a state with the same dominant political culture throughout. This simple fact necessitates the formation of subcultures that

consists of various combinations of the dominant political cultures that are present in a particular state (Elazar, 1984).

Ira Sharkansky (1969) created a nine-point scale of political culture to quantify Elazar's typology. This scale provides a numeric assignment for each political culture that takes the average of the regional political cultures within states. A numeric variable is then assigned to each state, thus determining its political culture label. By combining this technique with Elazar's differing political cultures, one is provided with a more accurate means to compare political culture among states. Sharkansky concluded that political culture can be related to several state traits regarding politics and public service.

Other researchers have been critical of Elazar's theory because of its obvious lack of empirical evidence. Clync (1972) argues that the addition of regionalism to Sharkansky's interval level scale changes the relationships with the other dependent variables. He notes that political culture is more intra-regionally than nationally.

Schlitz and Rainey (1978) conclude in their re-analysis of data from the Comparative States Elections Project that there is very little statistical evidence to support Elazar's classifications. Arguing in favor of Elazar's theory, Savage notes that the normative scale is the "one political measure that compares favorably with traditional socioeconomic indicators in explaining policy variations among the states" (Savage, 1981, p. 336).

Nardulli (1990) examines the usefulness of Elazar's typology in an effort to determine whether his assumptions about politics and citizens are correct. Specifically, he questions whether the citizens categorized in each political subculture actually

exhibit the required characteristics for these classifications. He found that many in the survey did not align themselves with the belief system identified in each subculture. He concludes that Elazar's failure to operationalize the way his theory categorizes geographic locales "makes it difficult to rebut the implication that his classifications measure little more than sectional differences" (Nardulli, 1990, p.304).

### **Joel Lieske:**

Joel Lieske (1993) developed an argument and provided evidence on regional subcultures based on ideas that are closely related to those of Elazar. Using Wildavsky's (1978) idea of "general" culture, Lieske views subcultures as a "way of life" and a system of shared values that legitimate a preferred set of relationships. Culture provides individuals with a basic social identity in which the norms for socially acceptable behavior are widely held and understood. Culture also sets the standards for judging social institutions. Lieske believes that these functions are carried out in a number of ways, but mainly through people's racial and ethnic kinship ties, religious or secular value systems, and social ways of life and lifestyles. It is these socializing agents that define the cultural context that shapes individual preferences and behaviors (Lieske, 1993).

Based on his findings, Lieske grouped the states into 10 clusters: (1) Germanic, (2) Ethnic, (3) Heartland, (4) Hispanic, (5) Nordic, (6) Mormon, (7) Border, (8) Blackbelt, (9) Rurban, and (10) Anglo-French. For purposes of this study, I concentrate on the three clusters in which the focus states fall: Rurban, Nordic, and Anglo-French.

## **Rurban**

The first subculture identified by Lieske is labeled “Rurban.” The states identified in this group match those identified by Elazar as rural-urban habitats. They are characterized by high levels of education, a large presence of professional and managerial occupations, working women, population mobility, and younger populations. This group is highly educated with a well skilled work force. This cultural stream is found in the less populated states west of the Mississippi. This grouping of states falls roughly between Elazar’s Moralistic and Individualistic subcultures. Under Hero’s groupings, these states are a mixture of the Heterogeneous and Homogeneous subcultures. Only one of the focus states, Oregon, falls into this category.

## **Nordic**

Lieske’s fifth subculture is identified as “Nordic”. This group of states is characterized by large numbers of residents of Scandinavian ancestry and who are members of the American Lutheran Church. This group is mainly white and racially homogeneous, and is found most predominantly in two states—Minnesota and North Dakota. However, influences of this culture can also be found in Wisconsin, South Dakota, and Montana. With an economic base ranging from agriculture to high-tech industries, these states tend to have a high degree of cultural autonomy. This group is a mixture of Elazar’s Moralistic and Individualistic subcultures. Within Hero’s groupings, this subculture would fall roughly between the Homogenous and Heterogeneous subcultures. As noted above, two of the focus states fall into this grouping, North Dakota and Montana.

## **Anglo-French**

Lieske identifies his tenth subculture as Anglo-French and it is found in New England and the Upper Midwest. This group of states is predominately white and ethnically diverse and represents a unique blend of the two largest ethnic groups—British and French—which are roughly the same size. This culture also encompasses the strongest Catholic regions in the country. Although New England is known for its excellent colleges, this subculture, overall, is not particularly distinctive in the proportions of college graduates, professionals, and managers in the work force. Of the four focus states, Maine falls into this category. This group of states roughly equates with Elazar's Moralistic and Hero's Homogeneous groupings.

## **Rodney Hero**

Contrasting to Elazar is Rodney Hero's social diversity perspective (1998). Hero's research indicates that a large portion of state politics, policy, and political culture can be directly tied to racial/ethnic diversity.

According to Hero, one of the main characteristic of the states is their racial and ethnic diversity, or relative lack thereof. Hero's research shows that the states fall into several groups defined by their unique racial/ethnic patterns and classifies them into three distinctive categories: homogeneous, heterogeneous, and bifurcated. For the purposes of this study, I will concentrate on the two categories in which the focus states fall: homogeneous and heterogeneous. Bifurcated states are those with high minority populations and low ethnic diversity. None of the focus states fall into this category.

## **Homogeneous**

Some states can be viewed as racially and ethnically homogeneous, and generally fall under Elazar's "moralistic" category. The populations of these states are of Northern and Western European descent and are white or Anglo. The percentage of minorities (Black and Latino) and white ethnics (non-Northern and non-Western European whites) is small. These states tend to be the most politically uniform.

Homogeneous states are characterized by a consensual pluralism. There is generally a high degree of political competition which includes high political party competition. However, this competition is held in check by an overriding consensus brought about by homogeneity. In this culture, a concern for the commonwealth is of central importance. Citizens strive to implement certain shared moral principles in order to maintain the best government possible.

In this type of culture, the common good or interest are more likely to be a shared concept since the population is less divided both ethnically and racially. The basic value structure in this context is characterized by general consensus on basic values that includes political, economic, and social equality. Community is of central importance due to a less divisive political and social order. Questions of race or ethnicity are few and far between. This requires less mediation from political and governmental institutions in such disputes. The social group setting tends to be less complex, which augments the underlying consensus. It is in these states that innovative social policies can be expected. Of the four states I examine in this study, Maine, North Dakota, and Montana fall into this category.

## **Heterogeneous**

States in this category have multiple groups and are something of an ethnic or racial melting pot. They have large white ethnic populations (Southern and Eastern European), with significant minority populations (Black/Latino/Asian), and moderately large white populations (Northern and Western European). These states generally fit into Elazar's "Individualistic" political culture category.

Heterogeneous states are characterized by a competitive pluralism in which many ethnic and racial groups compete for attention. Factors that foster this competition include a greater white ethnic and moderate-to-high minority diversity as well greater urbanization and population density. This type of social pluralism generally leads to an increase in political competition.

In this environment, core values are open to debate as the stakes are more obvious, both racially and ethnically. Issues that would be relatively neutral in a homogeneous environment often become politically tinged in a heterogeneous environment. According to Hero, these states rank moderate to high in producing innovative social policies. Of the four states I examine in this study, Oregon falls into this category.

## **INTEREST GROUPS**

While such factors as socio-economics and political culture may help determine the possible outcome of a policy proposal within a particular state, these factors do not by themselves determine public policy (Dye, 1966). The needs and demands of various sectors of a society must be articulated and pressed upon government. Organized

interest groups perform this function by transforming these demands into political influence via their particular area of influence.

An interest group is defined as any organization that seeks to influence public policy. There are at least two kinds of interest groups: institutional and membership. Typical of institutional interests are business, governments, foundations, and universities. Membership groups are supported by the activities and contributions of individual citizens.

### **Pluralist Model**

In this model of interest group theory, the marketplace is defined as having an almost even level of competition in which individuals, political parties, and interest groups compete to control various policy areas (Thomas, 1993). As such, it is based on four distinct premises:

1. An assumption of equal access to the policy making arena,
2. Fragmentation of the marketplace,
3. A more or less competitive process for the determining policies, and
4. The neutrality of government.

These theoretical factors create an environment in which all are free to organize politically, but in which policy making is not controlled by powerful political forces.

Whether an organization's political position will represent its members' interests will depend on at least four factors that include the homogeneity of the group, people's motives for joining, the size of the staff, and the level of militancy and activity of the membership.

Interest groups attempt to influence policy by supplying public officials with things they want. This includes credible information that may include policy information to

allow a legislator to take a position on an issue or technical information needed to implement a policy, public support, and money: Interest groups can establish political action committees to finance political campaigns or they can lobby Congress to reduce or increase the appropriations for government agencies.

Critics of the pluralist model have developed the elitist model, which points to wealthier individuals and groups in society as having more impact on policy making than other groups. Accordingly, this distortion of pluralism has led to an unequal ability of other groups to influence policy. Furthermore, the neutrality of the government is even questioned. Some have even gone so far as to claim that the state itself often favors some groups over others. This claim is a basic tenant of the neocorporatist model of interest group theory.

### **Neocorporatism**

This model of interest group theory describes a form of informal cooperation between government be it state or federal, and certain powerful interest groups (Thomas, 1993). Accordingly, this cooperation serves to maintain stability in the processes of developing and implementing policies. The neocorporatist model is primarily focused on economic policies in which three sectors of society, business, labor, and government are involved in negotiations about questions of policy.

The basic arguments of corporatism are that a government will grant a monopoly of representation to certain powerful interest groups in exchange for their cooperation in developing policy. Also, government intervenes substantially in the economy to achieve particular goals. Income policy in particular has been at the core of the neocorporatist

argument. According to this theory, a government will attempt to control inflation by influencing wage bargaining and the prices of goods and services (Lehmbruch, 1979). Critics of the neocorporatist theory claim that it is no more accurate in its description of interest group systems than pluralism.

It is my belief that the neocorporatist model best represents the current system of interest group influence on health care policy both at the state and federal levels.

### **Niche Theory**

In 1973, James Q. Wilson developed his “Niche Theory” of interest groups. According to this theory, some groups develop autonomy, or a distinctive area of competence in a clearly demarcated area of policy expertise that exclusively serves a particular clientele or membership. These groups tend to have a clear and undisputed jurisdiction over certain functions, services, goals, and/or causes. In most states, groups representing dominant economic interests are by far the most numerous and most influential. Thus, most state governments are heavily influenced by interest group pressures than is the federal government (Zeigler & van Dahlen, 1976; Thompson and Hrebenar, 1996).

### **Plural Elitist Theory**

In the 1960’s, Lowi and Schattschneider developed with their own “Plural Elitist” theory (Schattschneider, 1960, 1969; Lowi, 1969). According to this theory, special interest systems are only weakly organized for contention over policy, and that legislative committees organize the work of law making in such a way that most

interests are rewarded with specific benefits without competing with each other. The result is excessive government and a slowing of economic growth as government policy is used to shield interests from market competition.

In examining the interest group players in this study, I find that both the Niche and Plural Elitist theories have credibility. Health care policy in the states is heavily influenced by hospital and nursing home associations, while education policy is heavily influenced by higher education groups and in some instances (as in the baccalaureate issue), by the same hospital and nursing home groups. Each of these groups has staked out a claim on their own distinctive area of competence in a clearly demarcated area of policy expertise that exclusively serves a particular clientele or membership, i.e. the health care and higher education industries. Each of these groups has also used their positions on legislative committees to effectively shield their interests.

### **Interest groups in the states**

An understanding of state level interest groups is vital to the understanding of state politics. Gray and Lowery (1996) noted that “In modern scholarship on democracy, great emphasis has been accorded the role of interest organizations in providing a second and supporting channel of citizen communication and control” (p.1). In addition, state level interest groups have been shown to have a sizeable impact on public policy in the states (Nice, 1994). Therefore, it is important to understand the activities and actions of state interest groups. More specifically, Hojnacki (1997) explains, “To know how groups act to articulate their policy preferences and exert their influence, and why they choose particular strategies for advocacy is important” (pp. 61-62). Understanding

this process is important because it helps explain how and why interest groups have certain effects on state policy making.

Historically, politics in a number of states was dominated by one or a few major interests. This still occurs just frequently enough to give substance to the public's suspicions of special interests (Gray and Lowery, 1999). Truman (1951) assumed that those with common interests naturally joined together. So when no organization emerged to articulate a particular position on public policy, he assumed that the position must be insufficiently compelling to energize support.

Most of the time there are three types of organizations that are registered to lobby in the states: (1) membership groups, (2) associations, and (3) institutions (Gray and Lowery, 1996). Yet many groups are fluid and only exist for short period of time to specifically address particular issues. Accordingly, some groups, rather than being permanent, often enter and exit the lobbying community as issues of direct concern moves on and off the state policy agenda. This fact becomes quite obvious when examining the list of interest groups that were involved in the baccalaureate issue in each of the target states, North Dakota, Montana, Maine, and Oregon. A number of groups were formed solely for the purpose of either supporting or opposing the issue. Once the issue had been settled at the legislative level, they disbanded and ceased to function.

### **Strength of interest systems**

A number of studies have highlighted the variations in the strength of interest systems across the states. Researchers including Zeller in the 1950's, Morehouse in the

1980's, and Thompson and Hrebenar in the 1990's have ranked the states by the strength of their interest systems (Zeller, 1954; Morehouse, 1981; Thompson and Hrebenar, 1996). In addition to identifying which interests are reputed to be the most influential in each state, these studies measure how powerful interest organizations overall are reputed to be relative to other political actors.

In their study, Thompson and Hrebenar identified five types of interest systems, four that were observable and another type (e.g., subordinate) no longer found (see Table 5.9). The four most obvious types range from dominant (very strong interest group influence), through dominant/complementary (strong interest group influence) and complementary (less than strong interest group influence), to complementary/subordinate (weak interest group influence). They ranked seven states, most of them in the South, as having extremely powerful or dominant interest systems, with interests being relatively weak in Delaware, Minnesota, Rhode Island, South Dakota, and Vermont.

While there is some variation across states and over time, the power rankings of Zeller (1954), Morehouse (1981), and Thompson and Hrebenar (1996) strike a common theme: the professions (school teachers, lawyers, and physicians) and general business groups have been and remain the most influential lobbying organizations in the states. Pertinent to this study, the general business groups identified are long-term care and hospital associations, and higher education associations. The professions represented included higher education and health care teachers along with a variety of health care professionals.

In explaining the professions' and business organizations' continuing status as the most effective members of interest communities, Thomas and Hrebenar point to a common array of strengths: "They all have extensive financial resources which they use to hire full-time political staffs and lobbyists, and in many cases they contribute to election campaigns. Their membership also tends to be spread geographically and is fairly politically cohesive. All this, plus the services they provide, makes public officials dependent on them to a high degree (Brace, 1993)." This leads directly back to Wilson's "Niche Theory." These very strong organizations have established extremely viable niches in terms of both the resources needed to survive and those needed to project their influence outward to alter decisions of elected and unelected officials.

### **Business Organizations:**

Central to this study is the activities and strength of nursing home, hospital, and community college associations in the states examined. These groups have strongly opposed the baccalaureate issue at both the state and national levels.

### **Nursing Home Associations**

The nursing home industry is the third most powerful health association in most states, including the four focus states in this study, North Dakota, Montana, Maine, and Oregon. (Vladeck, 1980; Thomas & Hrebenar 1996; Hrebenar & Thompson, 1987, 1992, 1993A, 1993B, 2004). In terms of power, nursing home associations are highly organized, collecting large contributions for political campaigns and political lobbying activities. The major efforts of these associations are toward influencing the

development of administrative regulations, rates, licensing activities, and also focus on legislators and their legislative activities. This lobbying activity has promoted weak regulation of the industry. Litigation has also been used as an effective tool by the nursing home industry to promote favorable public policies. The industry is able to invest substantial sums in such activities and hire talented individuals for legislative, administrative, and legal actions. Nationally, the American Health Care Association is the largest and most influential nursing home organization (American Health Care Association, 2008; Hrebemar & Thompson, 1987, 1992, 1993A, 1993B, 2004).

One fact frequently overlooked is the political impact of the growth in large chain-owned nursing home corporations. Not only are such corporations able to build effective economies of scale and to maximize profits, they are effective in using their resources to influence political decision making at both federal and state levels. The corporations are also immune to a great extent from local political processes, unlike the small locally owned nursing homes. Local community organizations have less influence in bringing about changes in quality, costs, or management when nursing homes are owned and operated by large corporations with management based out of the local area or even out of state. Even more important, professionals working with nursing homes, whether nurses, physicians, or health facility administrators, also have less influence on the policies and practices of large corporations than they do on locally owned and operated facilities. As a result, both state and federal policymakers are often reluctant to implement any broad changes in nursing home related policies.

Long-term care policy has always been heavily influenced and shaped in a political environment dominated by these organizations. Their fundamental goal has been to

minimize regulation and maximize profits. In regard to the baccalaureate issue, the nursing home industry has opposed the proposed policy from the beginning. They have steadfastly stood by their position that an increase in educational requirements for nurses will drive potential nurses away from the field, and thus exacerbate the nursing shortage. However, the real reason has far more to do with profits than the nursing shortage. Most nursing homes are staffed mainly by Licensed Practical Nurses (LPNs). These nurses are less educated and less compensated than Registered Nurses (RNs). The adoption of the baccalaureate degree as the minimum educational requirement for nurses would force nursing home owners to pay higher salaries for nursing staff. This would undoubtedly have a significant negative impact on their profits.

### **Hospital Associations**

The hospital industry is the most powerful health association in most states, including the four focus states in this study, North Dakota, Montana, Maine, and Oregon (Vladeck, 1980; Thomas & Hrebener 1996; Hrebener & Thompson, 1987, 1992, 1993A, 1993B, 2004). Hospital associations are also highly organized, collecting large contributions for political campaigns and political lobbying activities. The major efforts of these associations are toward influencing the development of administrative regulations, rates, and also focus on legislators and their legislative activities. Nationally, the American Hospital Association is the largest and most influential hospital organization (AHA, 2008; Hrebener & Thompson, 1987, 1992, 1993A, 1993B, 2004).

All hospitals in each of the four focus states (North Dakota, Montana, Maine, and Oregon) belong to the various state chapters of the AHA. The AHA represents almost 5,000 hospitals, health care systems, networks, and other providers of care along with 37,000 individual members (AHA, 2008). Via representation and advocacy, the organization seeks to ensure that its members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Its advocacy efforts include the legislative and executive branches, as they influence law and rule-making processes. Headquartered in Washington, D.C., the AHA also has a team of regional executives throughout the nation, most often housed in state hospital association offices (AHA, 2008).

Although the AHA publically opposed the ANA proposal in each of the focus states, internally there was a grudging acceptance that it was only a matter of time before the changes would happen. By early 1986, forty-nine state nurses associations had adopted positions favoring the baccalaureate degree as the entry level for professional nursing. The AHA believed that the change was already occurring, and that it was in their best interest to try and make it as easy for their members as possible.

In 1986, in order to assist its member facilities with the expected change, the AHA commissioned a study via a private consulting firm to examine various “questions and issues regarding two levels of nursing practice” (Questions and answers,” 1986). The study was conducted by Health Care Consulting Associates of Denver, Colorado, under the direction of AHA, Region 8, and its state hospital association executive officers.

The focus of the study was the proposed change to limit entry into nursing practice to two levels. The purpose was to identify and describe questions that would need to be

answered and the factors or concerns that needed to be considered in making significant changes to nurse practice acts. The organization did not take sides on the issue but made their neutrality very clear: “It is not its (the study’s) intent to provide opinions, recommendations, or solutions to any aspect of this issue, but should be considered a working document to be used to facilitate the orderly review of the entry into practice issue. This project has been developed in a general manner without state specific issues in mind. Consequently, it should be useful to any state association, nurse organization, employers’ of nurses, nurse educators and state legislators examining this change.”

In releasing the finding of the study, the AHA noted that although much planning and coordination had been done by various groups nationally, the real focus of the issue was at the state level where each state would ultimately be responsible for determining what, if any, changes would be made to its nurse practice act and/or to its Board of Nursing rules and regulations.

It further noted that the implications of change to two levels of nursing practice would be far-reaching and would affect not only the nursing profession, but also the state educational system, hospitals, nursing homes, other health care providers and the public. In examining the possibility of adopting the proposed change, the AHA believed that some legislative activity on the topic was imminent. They also believed that it was necessary to obtain more information and direction on the issue before taking a position with their state legislatures and their member hospitals. The organization understood that entry into practice issue is very complex and should be examined in as systematic a manner as possible. If the change was to be accomplished, it would require tremendous coordination and communication between all those involved, and collaboration between

the groups would be essential. It was hoped that the study would enable groups to focus on areas of concern, formulate a position and implement a program regarding entry into practice.

### **Community College Associations**

Community colleges are the primary source of new Registered Nurses in the United States (AACC, 2008). In 2007, 1,195 community colleges awarded associate degrees in nursing. In the health care field, 50% of all new nurses and the majority of other new health care workers are educated at community colleges.

Community colleges are represented at the state and local legislative levels of government by the American Association of Community Colleges (AACC). As of 2007, AACC's membership represented almost 95 percent of all accredited U.S. two-year community, junior and technical colleges and their 10.5 million students, as well as a growing number of international members in Puerto Rico, Japan, Great Britain, Korea, and the United Arab Emirates (AACC, 2007).

Headquartered in Washington, D.C., AACC touts itself as the primary advocacy organization for community colleges at the federal level. The organization also works closely with directors of its state offices to influence state policy. In addition, AACC is a member of six presidential based associations and collaborates with a number of entities within the higher education community to monitor and influence federal policy (AACC, 2007). The organization seeks to actively interact with the departments of Labor, Education, Energy, Homeland Security, and Commerce and the National Science Foundation. According to its official website, the AACC "supports and promotes its

member colleges through policy initiatives and by providing information to business and industry and the national news media that present the organization in a positive light (AACC, 2008).”

The AACC has taken a position against the baccalaureate issue from the beginning. Over the years, they have adamantly stood by their position that adopting the baccalaureate degree as the minimum level for entry into professional nursing would further exacerbate the nursing shortage in this country. The truth, however, has much more to do with control and money than the AACC is willing to admit. If adopted, the baccalaureate proposal would effectively end the Associates Degree Program for Registered Nurses. This would be a huge blow to community colleges both in enrollment numbers of nursing students and to the associated financial windfall from the Associate Degree Nursing programs. In effect, it would end a monopoly that they do not want to surrender.

In a 1997 research brief, the AACC made their position clear:

It is important to note that emerging policy shifts may diminish or even eliminate the impact of such efforts, however successful they might otherwise be. Most notable is a move to redefine the scope of practice for RNs on the basis of the educational setting in which they were prepared. Efforts to make the baccalaureate degree the entry-level requirement for Registered Nurses are underway in a number of states. Support for such policy change continues, despite a lack of evidence of differences in job performance between RNs who enter the profession holding an associate degree and those who hold a bachelor’s degree. Imposing such limitations could create an unnecessary barrier for

those seeking to become RNs and could exacerbate the current nurse shortage. (Viterito and Teich, 1997)

In 2000, the AACC issued a Position Statement supporting the Associate Degree as the continued minimum level of education for Registered Nurses (AACC, 2000):

Whereas, Registered Nurses who have graduated from Associate Degree Programs have demonstrated competency in nursing specialty roles and have consistently performed well on certification exams should not be restricted from certification in specialty areas; and

Whereas, many different groups periodically attempt to change the present minimum educational qualifications for all candidates for licensure as Registered Nurses;

Be It Therefore Resolved, by the Board of Directors of the American Association of Community Colleges that the Board of Directors endorses continued recognition of the successful attainment of an Associate Degree in Nursing as a minimum educational requirement to sit for the licensure exam (RN-NLCEX) and to be eligible for the interstate compact for multi-state licensure in the United States;

Be It Therefore Resolved, that the Board of Directors strongly supports continuing to provide affordable access to historically underserved populations; and,

Be It Therefore Resolved that the Board of Directors continues to support competency-based Associate Degree Nurses.

## **Professional Associations**

### **The American Nurses Association**

The major professional group examined in this study is the American Nurse Association (ANA). The baccalaureate proposal was first suggested by this group in a 1965 Position Paper. The (ANA) is the largest and most influential professional nursing organization in the U.S. The ANA represents approximately 2.9 million Registered Nurses (RNs) through 54 constituent member associations, mostly at the state level (ANA, 2008). The ANA advances the nursing profession by lobbying Congress and regulatory agencies on health care issues.

The ANA was founded in 1896 as the Nurses Associated Alumnae of the United States and Canada, but changed its name to the American Nurses Association in 1911. At that time there were no laws licensing nurses or overseeing the practice of nursing in the US.

Today, the ANA continues to expand its membership and services. It publishes a large collection of material on nursing practice and the profession. It has established a code of ethics for professional nursing, and developed and instituted the means for Registered Nurses to be credentialed in areas of specialization. It also touts itself as the voice of nursing in health care policy. It justifies this claim via policy development, lobbying, publications/newsletters, and partnerships with other organizations. The ANA reaches a broad spectrum on nurses through membership and its website, NursingWorld.org and two publications, *The American Nurse* and the official journal *American Nurse Today*. These publications, along with conferences, provide a forum for dialogue among nurses on important policy issues. Also, partnerships and collaboration with other

organizations further strengthens the voice of nursing by expanding the influence of professional nursing in the legislative arena.

The ANA's House of Delegates and the ANA Board of Directors work to set policy in a variety of health care settings. When a major issue affecting nursing and/or health care arises, the House of Delegates and/or the Board of Directors may address these concerns through a position statement. These statements serve as an explanation, a justification or a recommendation for a course of action (policy) that reflects the ANA's stance on the issue. Their 1965 position statement on the baccalaureate as the minimum level of education for Registered Nurses is the basis of this study. The organization has steadfastly supported the issue in each of the focus states.

The first step in the creation and development of position statements involves internal deliberation by the Congress on Nursing Practice and Economics. The second step is the drafting of the proposed position statement that is then posted on ANA's website for public comment. Following public comment, the third step involves revising the statement as needed and then the approval by the ANA Board of Directors. This process allows all nurses within the organization to voice their views and opinions on the various dimensions of the issue at hand. Once a consensus is reached, the organization's official stance is then pressed through various legislative channels via its considerable political clout.

### **Interest Group Alliance Formation**

Interest groups may choose to form an alliance with other groups that have similar goals, as in the case of the entry issue. In doing so, they will work closely together on a

particular issue or set of issues. One of the key reasons for alliance formation involves resource allocation. Often a group will decide that it would be in its best interests to form an alliance. In doing so, it makes the decision to share some portion of its own resources in an alliance, whether it be time, money, personnel or materials.

Rapid and often unpredictable changes in a given political environment have been a driving force for the formation of such alliances. Addressing politics at the federal level, Baumgartner and Jones (1993) highlighted the fact that the ever growing number of interest groups ultimately leads to a greater interaction among groups. With more groups competing for the same scarce resources, the need for more sharing and interaction has evolved. Accordingly, the majority of state level research has shown that the number of state level interest groups has been dramatically increasing over the last 20 years (Gray & Lowery, 1996). As Hojnacki (1997) indicates, “Given that more groups and more diverse types of interest are active, organizations’ opportunities for alliance involvement are surely greater than in decades past (p. 64).”

The activity of interest group alliances is directly affected by a number of factors. These factors include how much members of an alliance know about each other, the specific details of an issue, and the unique characteristics of each alliance member (Hojnacki, 1997). A group may seek to join an alliance to increase its power, cut costs, access needed information, and to have direct influence on proposals and debates involving particular policies they are interested in (Hula, 1995). Organizations will also join an alliance if it believes that doing so will increase its chance of meetings its own particular policy agenda (Hojnacki, 1997).

It should also be noted that the manner in which the individual characteristics of each potential alliance member interacts with the issue context appears to be a major factor in whether certain groups will form a coalition. A group is far more likely to join an alliance in which there is little issue conflict and high salience (Mahoney & Baumgartner, 2004).

How much and what type of contribution an organization will make to an alliance depends on the specific goals of other members, how much resistance the alliances faces, and more importantly, the amount of resources the member has at its disposal. Alliances always face the problem of free-riders, with one or more members receiving all the benefits of the alliance either without contributing at all, or at least very minimally (Halu, 1995; Hojnacki, 1998). However, members are much less likely to do this when the alliance is small, there is frequent interaction between members, and when there is a specified leader coordinating all lobbying activities Hojnacki (1998).

Interest groups are often key players in presenting an issue or problem to the policy arena. Most researchers concede that the manner in which a problem is defined has a direct bearing on both agenda setting and policy adoption (Baumgartner & Jones, 1993; Kingdon, 1995).

### **AGENDA SETTING, PROBLEM DEFINITION AND REDEFINITION**

Key to this research is the concepts of agenda setting, problem definition and redefinition (frequently referred to as reframing). The manner in which a problem is defined will determine a number of things including whether the evidence presented is

relevant, which possible solutions are feasible, who is to be a part of the decision process, and who the winners and losers will be in the process.

Problem definition helps identify the cause(s) of a problem and mobilizes political action and participation by directing certain interest groups into the process. This may ultimately lead to the displacement of an existing “issue monopoly,” thus resulting in a policy change (Baumgartner & Jones, 1993; Haider-Markel, 1999; Kingdon, 1995). It should also be noted that the mere process of drawing attention to one problem may be at the expense of another.

Agenda setting deals with how problems are identified and what solutions are offered (Kingdon, 1995, p. 16). Kingdon defines the political agenda as “the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time ” (1995, p. 3). According to Dunn (1994, p. 17), defining a problem helps “supply policy-relevant knowledge” to participants who are actively involved in the policy process. Stone goes a step further and states that “problem definition is the active manipulation of images of conditions by competing political actors” (1989, p. 293). Ultimately then, the exact terms in which a problem or issue is defined will determine what solutions are proposed. Thus, to reach those goals “political actors use narrative story lines and symbolic devices to manipulate so-called issue characteristics” (Cobb & Elder, 1983; Stone, 1989, p. 282). Policy change occurs when a new problem is given higher priority over others, thus making certain solutions more acceptable than others (Baumgartner & Jones, 1993; Rochefort & Cobb, 1994).

The theory of agenda setting evolved from communications studies and focused on mass media influence on setting political agenda. This concept was articulated in the seminal article by McCombs and Shaw (1972). Through content analysis of a local election, they documented a high correlation between media agenda and the public agenda, a correlation corroborated in numerous studies since. Their 1972 article coined the phrase “agenda setting.” For the purposes of this study, agenda setting is defined as determination of which public-policy questions will be debated or considered by a legislative body.

According to Cobb, Ross, and Ross (1976), there are three models that characterize the manner in which issues make the policy agenda:

1. The outside initiative model,
2. The mobilization model, and
3. The inside initiative model.

In the outside initiative model, an issue is initiated outside the usual or mainstream governmental structure. This model involves groups that do not generally participate in public policy debates organizing politically to get their issue on the policy agenda. They may or may not have experience with policy networking.

The mobilization model involves situations in which decision makers act to move an issue from the formal to public agenda. The formal agenda is the list of issues that decision makers have accepted for serious consideration, while the public agenda involves issues that have or will garner a high level of public interest. These issues gain immediate formal attention due to their connection to those who control the policy agenda. These issues are generally sponsored by policy makers who do not have enough influence or resources to garner strong insider cooperation.

With the inside initiative model, issues are sponsored by either those within the governmental structure or by those who have easy and/or frequent access to policy decision makers. This model takes place inside the official policy network in which an issue is placed on the formal policy agenda but is not expanded to the public agenda. Issues in this model are expanded to enlist only the support of certain influential groups who can be vital to its passage and implementation.

Problem redefinition is a repackaging of ideas about a problem that includes an opposing view of its causes and consequence. This is usually undertaken by those opposed to a particular policy response to the problem. It involves key factors including the role of policy entrepreneurs and their advocates, how the media covers the issue, policy venues, and the interaction between each (Baumgartner & Jones, 1993).

### **Policy Entrepreneurs**

Policy entrepreneurs identify a problem then work to get it on the legislative agenda for a possible policy change (Baumgartner & Jones, 1993; Cobb & Elder, 1983; Kingdon, 1995). These individuals work to shape the scope and terms of policy debate by not only identify and defining problems, but also by networking within the appropriate policy communities and building coalitions (Kingdon, 1995, pp. 179-183). They set the tone in favor of their own policy ideas by determining which arguments will most effectively persuade others to favor their proposals (Kelman, 1987; Kingdon, 1995; Schneider & Teske, 1992).

Similarly, interest groups play a key part on the policy process by framing an issue and then supplying elected officials with information on the issue (Baumgartner &

Jones, 1993; Haider-Markel, 1999). Considering how our system provides multiple access points to the policy process, some venues may be more receptive than others.

### **The Media and Agenda Setting**

The media is also a key player in the agenda setting process. It attracts new participants to the policy debate by expanding issue attention. Via the media, interest groups are able to present their needs and demands to a much wider constituency (Cobb & Elder, 1983, pp. 141-150; Haider-Markel, 1999; McCombs, 1972, 1982, 2004, 2005; McCombs & Shaw, 1972, 1977; McCombs & Weaver, 1973, 1985, McCombs, Shaw, & Weaver, 1997). By focusing attention on a particular issue, it plays an active role in definition and, in some instances, redefinition (Baumgartner & Jones, 1993; Bosso, 1989). According to Baumgartner and Jones (1993), the image of a policy issue is often determined by the “tone” of media coverage. Sudden and rapid change in media coverage will almost certainly be followed by policy mobilization patterns. In essence, tone defines a policy issue and subsequently the development of its policy image (Baumgartner & Jones, 1993, p. 31).

Early studies revealed a relatively mixed picture about the ability of media to influence opinions on a given issue. Cohen (1963), however, argued that the media has a much greater capacity to influence which issues were perceived as important. His findings indicate that the media agenda influences not only the public agenda, but also the policy agenda.

A major concept involving the media and agenda setting is the idea of salience transfer. This is the capacity of the media (or other actors, i.e. interest groups) to

influence the relative importance individuals attach to policy issues. A notable study proving the existence of salience transfer was undertaken by Iyengar, Peters, & Kinder (1982). Experimental groups were given baseline priorities, exposed to different news broadcasts with different policy emphases over four days, then ask to rate priorities again. The authors' findings revealed that the subjects' issue rankings realigned to match the media agenda. Also, how the media presents a news story affects how the general population interprets potential items on the public agenda (Chyi & McCombs, 2004).

### **PUBLIC OPINION**

It is rare that the public receives enough in-depth information necessary to purposely direct it in a certain direction. Competing political interests create public presentations of the same issue that often appear diametrically opposite. Add to this confusion the varying approaches of the issue presented by the press, and the end result is that the public very often receives conflicting information on the same issue.

However, Americans are neither blank slates nor the automatons that many politicians and interest groups want to think they are. A number of diverse studies have found that individuals are active agents who create their own interpretations by drawing on their personal interactions with peers and their personal life experiences. Using these interpretations, they then supplement, reject, or redefine the information supplied by the media, politicians, and or interest groups (Gamson, 1992; Neuman, Just, and Crigler, 1992). The end result are public attitudes and opinions that vary in stability across policy areas.

Dictating public opinion on a particular policy issue is conditioned by two factors: the framing approach used by the various groups involved and by the issue itself. It is these factors that produce the greatest variations in how effective competing groups are at changing public opinion. At one end of the spectrum is outright and willful manipulation of a large section of public by one or more groups that completely changes their previous views on a particular issue.

At the other extreme are those citizens who steadfastly reject this manipulation. Between these two extremes lies a core constituency that provides a stabilizing effect on public preferences concerning fundamental policy areas. Even though politicians and interest groups are rarely able to manufacture public opinion in the way they desire, the public's dependence on the media for information makes it vulnerable to a more subtle form of influence. The press, along with politicians and interest groups can seriously influence an unsuspecting public by emphasizing specific aspects of an issue that affects the judgment criteria used by many Americans when evaluating possible policy proposals concerning the issue (Jacobs, 1993b; Jacobs and Shapiro, 1994, 2000).

Public opinion in regard to policy preferences in the states has been, until recently, greatly understudied. Many researchers have simply ignored state level policy as being too arcane for an inattentive public (Treadway, 1985). Another problem is measurement. Since most research on national public opinion relies on national representative samples, any type of disaggregation of a sample of all fifty states will not produce reliable state level data. When used, the effects of demographic proxies have proven difficult to separate from the effects of socio-economic factors (Weber and Shaffer, 1972).

However, during the 1990's, new measures of state public opinion based on pooled, disaggregated national surveys uncovered a direct link between public opinion and state policy liberalism (Erikson, McIver and Wright, 1993; Hill and Hinton-Anderson, 1995; Lascher, Hagen and Rochlin, 1996). Other researchers have found that by employing similar strategies of pooling of national surveys, there is a significant degree of public policy-opinion congruence (Norrander, 2001; Brace, Sims-Butler, Arceneaux and Johnson, 2002).

Erikson, Wright, and McIver's "Statehouse Democracy: Public Opinion and Policy in the American States" (1993) emphasizes that the key to understanding state politics and policy is to understand public opinion in the states. In their study, the mean liberal-conservative self-identification of citizens from each state (measured by the state level aggregation of some 142,000 responses to *CBS/New York Times* random-digit-dialing telephone surveys conducted between 1976 and 1988) is related to the liberalism or conservatism of state policy (measured, ca. 1980, as a composite of eight issues -- education spending, scope of Medicaid, scope of Aid to Families with Dependent Children, consumer protection, criminal justice, legalized gambling, Equal Rights Amendment ratification, and tax progressivity). Their results revealed that across states, the bivariate correlation between public opinion and policy is .82, which rises, when measurement error is corrected, to .91.

On further examination, it becomes even clearer that the major force influencing American policy making is, in fact, public opinion (Erikson, Wright, and McIver, 1993, 9. 224). This is supported by the fact that controls for state socioeconomic variables attenuate the public opinion relationship only slightly. The impact on state policies by

economic development seems to work almost completely via citizens' attitudes. Indeed, a two-stage least squares analysis clearly indicates that causation is not reciprocal, and indeed opinion does affect policy rather than the other way around.

Perhaps the most interesting finding of their study was that public opinion within each state is not heavily affected by any one specific individual trait or demographic. However, they found that the state one lives in has a major effect on his or her opinions, especially towards politics and government in particular. However, what is it about each state that brings about this effect? To determine this, they examined certain omitted individual level variables, such as union membership and religious fundamentalism. They found that the former is actually of little consequence with religion having some impact on ideological identification. Yet even these factors had limited impact.

Going further, Erikson, Wright, and McIver examined the possible significance of regions, Elazar's political cultures, "social context" effects, and specific demographic variables. None of these was found to account for state effects, and that after setting aside the distinctiveness of the South, the state effect does not follow any type of distinctive regional pattern. Looking at contextual effects, Erikson, Wright, and McIver (1993, 69) found that "people's attitudes are influenced by the aggregated attitudes of those around them, and that these attitudes are typically operationalized as the attitudes of locally predominant social groups".

The authors concluded, "public opinion is of major importance for the determination of state policy" (Erikson, Wright, and McIver, 1993, 10). When measuring the preferences of the electorate, state ideology comes out as a major influence on policy outcomes.

State ideology does this by connecting electoral politics and party elites with governmental institutions. Their findings revealed that states act as political communities, each with unique and coherent ideological preferences. Rather than measuring various socioeconomic factors, the measure of liberalism versus conservatism serves to better predict state preferences. Liberal policy outcomes correspond in states where the mean voter is more liberal. Party leaders determine ideology, while state electorates set the “ideological tone of state policy by rewarding the state parties closest to their own ideological views” (11). Acting together, these factors lead to clear choices for the electorate.

Do public opinion and organized interests affect policy outcomes? If they do, how do they do it? Many policy frameworks include public opinion and organized interests as key components in the policy process.

### **Public Opinion and Interest Groups**

A number of policy frameworks have included public opinion and organized interests as key components in the policy process. In Kingdon’s policy streams framework, where policy emerges from confluence of the problems, politics, and policy streams, public opinion appears in the political stream as the national mood. Kingdon (1995) described the national mood as the shifting of public opinion. Shifting public opinion includes a large number of people that are thinking along the same lines. The change in national mood serves to raise some items on the policy agenda while restraining other ideas. The national mood creates “fertile ground” for an idea to grow (Kingdon, p. 147).

Specific state level studies have uncovered a strong link between interest group influences on public policy. Most of these studies have focused on entire state interest group systems instead of looking specifically at individual interest groups. In doing so, they have uncovered the link between organized interest groups and public policy adoption (Nice, 1994; Williams and Matheny, 1984; Brace, 1988). In addition, a number of state policy diffusion studies have reinforced this link between interest group influence and policy outcomes. Their conclusions point to organized interests having a direct effect on the likelihood of a state adopting an innovative policy (Shipan and Volden, 2005). There is even evidence to suggest state bureaucratic decision making is influenced by interest groups (Schneider and Jacoby, 1996).

Daniel Lewis (2005) concluded in his study that there is considerable empirical evidence pointing to non-governmental political conditions as key determinants of public policy. He found that the external pressures of public opinion and interest groups are more likely to have a direct influence on policy making decisions than the more widely recognized formal mechanisms of government. However, his study also revealed that the impacts of non-governmental political conditions on public policy can change according to the issues at hand. He found that different groups across different issue areas will often have contrasting and differing effects on policy as they seek to push it toward their own specific goals. Even within a specific issue area, interest groups can have varying goals and outcomes across specific policies. However, while interest group influence may vary greatly across the issue spectrum, public opinion appears to have a consistent effect across policy areas. It would appear that state governments are

operating in a representative manner, with policy being quite reflective of the will of its citizenry.

### **FOCUSING EVENTS**

Much has been written about how an issue gets on a governmental policy agenda. Policy issues must be pushed or presented in order to receive the attention they need to get on that agenda (Kingdon, 2003). Policy entrepreneurs will often use any window of opportunity available to get the attention of government officials. This opportunity may come in the form of some dramatic event such as a crisis or disaster or sometimes something less dramatic like new ideas or technologies. Kingdon (2003) noted that such a push from policy entrepreneurs “is sometimes provided by a focusing event like a crisis or disaster that comes along to call attention to the problem, a powerful symbol that catches on, or the personal experience of a policymaker (94-95).” These events will generally lead policy makers to focus their attention on the issue and seek to address it.

Focusing events not only open policy windows by underscoring policy failures and the need for a change, but they also allow for policy learning (Birkland, 1997).

Baumgartner and Jones note:

Even a casual observer of the public agenda can easily note that public attention to social problems is anything but incremental. Rather, issues have a way of grabbing headlines and dominating the schedules of public officials when they were virtually ignored only weeks or months before. Policy action may or may not follow attention, but when it does, it will not flow incrementally. (1993:10)

As various issues gain and lose the public's attention, existing policies are either put in doubt or reinforced. As noted by True, Jones, and Baumgartner (1999: 97-98): "Reinforcement creates obstacles to anything but modest change, but the questioning of policies at the most fundamental levels creates opportunities for dramatic reversals in policy outcomes." Once on the policy agenda, policy makers will pay special attention to focusing events, often leading to the creation of new institutional arrangements that will be better able to address similar future occurrences. This helps create and maintain a high degree of political and policy balance.

Policy development studies, especially empirical studies that examine focusing events within a particular domain are not uncommon. The very nature of these events makes them particularly attractive to researchers. The general approach is usually a case study that examines an apparent focusing event and then looks forward and backward in time in order to determine the degree of changes that resulted from the event (Fishman, 1999; Fleming, 2005; Schulzke, 2004).

Cobb and Elder (1983) were the first to address "triggering devices". They described them as events that have the capability of catapulting an obscure issue on the policy agenda to a level of higher prominence. Kingdon's multiple streams theory goes even further and identifies focusing events, crises, and symbols as the catalysts of major policy change within a policy arena (1995, pp. 94-96). Repeatedly in Kingdon's research, his interview subjects characterized government action as primarily responding to problems rather than initiating new programs. As one respondent stated: "Until there's a crisis, it is just one of many issues as governmental policy has been, and

always will be, a function of crisis” (Kingdon, p. 95). Kingdon states that focusing events are vital to the coupling process that enables the opening of policy windows.

Focusing events basically act to shift a policy system to positive from negative feedback on a particular issue. Although this is a very short period, systems that experience positive feedback tend to be unpredictable yet produce the most dramatic changes in both policy direction and composition of actors. Although a large amount of research has been done on the characteristics of subsystems under conditions of positive feedback, it is the point of change itself that is of interest for an essay on focusing events. According to Baumgartner and Jones (1993), “the points at which a political system or subsystem changes from negative to positive feedback are critical, but they have generally not been studied systematically by political scientists (p. 18).” However, although such focusing events may be identified as one type of cause for a shift, they cannot be the cause for every policy fluctuation (Baumgartner & Jones, p. 18). A system shift due to positive feedback may happen for a number of reasons, with some being the product of a focusing event.

### **POLICY ENTREPRENEURS**

Entrepreneurs are agents of change; they act as the driving force behind both the creation and adoption of new policies. They may work in or outside of government. With the rapid pace of change within any given political environment, they are required to be highly motivated, skillful, and always working on the next big innovative idea. They must be willing to invest their time and energy in order to accomplish large-scale change (Kingdon, 1995).

Policy entrepreneurs begin by recognizing and identifying the real needs of a locale, whether it is local, state, or national. They then try to decide how best to answer those needs. Once a new policy is created, the entrepreneur must convince policy makers of the benefits of the policy and then push for its full adoption. An entrepreneur will often seek to enhance the possibility of adoption by interacting and seeking the support of various networks and coalitions that would benefit from the new policy. This often requires the entrepreneur to invest much of his or her time and effort without any real guarantee of the policy being adopted (Mintrom, 1997; King & Roberts, 1987).

Although concern for a problem does motivate policy entrepreneurs, they are also motivated by benefits they receive for protecting an interest's territory or claiming credit for accomplishment. Policy entrepreneurs know how to highlight indicators to dramatize problems or to use focusing events to move problems higher on the policy agenda. Policy entrepreneurs use dimension manipulation, agenda control, and favor swapping to make sure their particular policies are moved to the forefront of the agenda. Dimension manipulation and agenda control are used most often. Dimension manipulation is a strategy for upsetting a political equilibrium by introducing new or redefining old aspects of a given issue. It is important because it affects how policy makers come to think about problems and appropriate solutions. Policy entrepreneurs can prompt letter writing campaigns, e-mails, visits to policy makers about government programs or performance. Kingdon argues persistence is the most important quality of a successful policy entrepreneur (Kingdon, 1995). Being a member of multiple arenas or institutional venues also helps entrepreneurs skillfully move issues from one venue to

another (Baumgartner and Jones, 1993). Skillful entrepreneurs hook solutions, proposals, and political events to policy problems.

For this study, I examine the roll that policy streams, agenda setting, and policy entrepreneurs play in the outcome of the ANA proposal in each of the target states.

### **PREVIOUS STUDIES: GEORGE AND YOUNG**

In their 1990 study, George and Young (1990) looked at the number of states that had considered the baccalaureate as the educational entry level for Registered Nurses. Using the innovation and diffusion process, they found that 27 state legislatures had considered policies that would have implemented the baccalaureate as the entry level for Registered Nurses. Subsequently, they identified three variables that contributed to the readiness of a state to implement such a policy:

1. Salience of the issue as measured by the proportion of associate degree and baccalaureate degree programs in the state;
2. Resource level of nursing organizations as measured by the ratio of RNs licensed by the state who belong to the professional association; and
3. Political environment, or window of opportunity as measured by the political party, occurrence of party turnover in the governor's office and state legislature, and geographic region of the state.

The findings of their study revealed four key facts. First, at least a one-to-two ratio of baccalaureate-to-associate degree nursing programs was needed for successful introduction of the entry-into-practice within a state. Second, there was no significant

relationship between the number of RNs licensed in a state and the number who belonged to the professional association. Third, there was a slight preference of consideration of entry-into-practice legislation in states that had a Republican majority in the state legislature, and fourth, regulatory attempts to change educational requirements occurred most frequently in the South and legislative proposals arose most frequently in the East.

George and Young's approach presents a means of model for the entry-into-practice issue achieving the policy agenda. However, their study makes no attempt to examine or predict possible factors that could have contributed to the failure of all but one state to implement the policy once it was placed on the policy agenda. Though their research does not break down data by individual states, it does leave open the possibility for such a breakdown.

In the case of North Dakota, the study found that baccalaureate programs outnumber associate degree programs by a ratio of two to one. If the LPN diploma programs are added, the ratio is 4:5 or one baccalaureate program to every 1.25 associate or diploma programs. Not coincidentally, it was the diploma programs that opposed the entry-into-practice proposal. The study also found that 10% of Registered Nurses belonged to a professional association at the time the entry-into-practice issue made the policy agenda.

The governor of North Dakota was a Democrat who was in his third year of his first term. The previous governor had been a Republican. In the legislature, Republicans were the majority in the House while Democrats were the majority in the Senate. Thus, according to George and Young's (1990) definition of the political environment

variable, North Dakota's environment was poised for a policy change for educational requirements for nursing.

## **CONCLUSION**

A review of possible factors responsible for state level policy adoption indicates the complexity of the issue. While each factor most likely has at least some influence on policy adoption, they cannot individually be held accountable for the policy's adoption or rejection. Each state has its own unique internal political environment in which each of the above factors, both individually and combined, play key roles in the policy process. But which factors are most important? The models I developed in the following chapter will provide a comprehensive approach to exploring this question.

<b>Key Influences</b>	<b>Source</b>
Industrialization and Urbanization	Walker (1969)
State policy liberalism in a particular area	Gray (1974)
Crisis	Gold (1995)
Federal Incentives	Hanson (1984) Welch & Thompson (1984) Dye (1990)
Regionalism	Klingman & Lammers (1964)
Economic growth and economic cycles	Dye (1990)
Proximity to early adopters	Rogers (1962) Berry & Berry (1999) Walker (1969, 1973)
In-state culture of innovation	Akers (2006)
Proximity to election year	Mintrom (1997) Berry & Berry (1994)
Governors political ideology	Grossback (2004) Martin (2001) Soule & Zylan (1997)
State Political Culture	Elazar (1984) Sharkansky (1969)
State Social Diversity	Hero (1998) Lieske (1993)
General state social policy liberalism	Klingman & Lammers (1984) Light (1978) Savage (1978)
Interest Groups	Truman (1951) Zeller (1954) Gray & Lowery (1996) Hojanki (1997) Wilson (1973) Morehouse (1981) Thompson & Hrebmar (1993) Baumgartner & Jones (1993) Mahoney & Baumgartner (2004)

**Figure 2.3** Key Influences on Social Policy Adoption by States

### CHAPTER 3: DATA AND METHODOLOGY

The entry into practice issue has not been examined from the perspective of a theoretical model focusing on interest group influence at the state level. The majority of research regarding effective advocacy by interest groups has been done primarily at the national level (Hoefler, 2000, 2001, 2002). Until recently, research focusing on state level interest group activity has been sparse.

Over the last ten years, however, there has been an increase in studies examining state level interest group activity. While Jacoby and Schneider (2001) noted that interest groups play an important role in the policy choices of state governments, Butler and Seguíno (1998) found that legislators in Maine are more influenced by research about conditions for people in their state than by national studies of the same problem. Hoefler (2000b) examined what human services groups in four states do and what their leaders think about their actions, but provided only descriptive data.

The last chapter discussed possible variables identified as having influence in the policy process specific to this study. In this chapter, I outline two theoretical models identifying the likelihood that a state will adopt an innovative new policy similar to the baccalaureate policy in this study. This is followed by a discussion of the research method used for this project, including an outline of the type of data collection and analysis employed.

## MODELS

In reviewing the literature concerning policy making at the state level, one thing is very clear: the concept of “one size fits all” definitely does not apply. Although all of the states have been categorized according to their internal characteristics, the fact is that there is no one precise way of predicting the outcome of a specific policy proposal. The best one can do is categorize each state according to its baseline tendencies on policy adoption, and even this is not absolute as the variables involved in the process are dependent on the unique circumstances surrounding each proposal. I base this conclusion on the internal determinants model of state policy innovation, which states that the main factors that lead a state to innovate are specific characteristics internal to that state (Berry & Berry, 1990, 1992, 1994, 1999). This best explains the varied outcomes of the policy proposal in the four focus states.

For this study, I develop two theoretical models identifying the likelihood that a state will adopt an innovative new policy similar to the baccalaureate policy in this study. The proposed theoretical models emphasize the specific elements necessary for successful adoption as outlined in this study. These elements include stakeholders in the form of policy entrepreneurs and interest groups, a state’s policy adoption history, state political cultures and public opinion. **Model A** outlines the optimal conditions necessary for successful policy adoption, while **Model B** identifies conditions that are less conducive for adoption:

### **Model A**

1. A higher ranking on Walker's state policy innovation scale
2. Homogeneous political culture
3. Weaker organized interest group influence on policy making
4. Strong internal cohesion among supporting groups
5. Stronger issue framing by supporting groups

### **Model B**

1. A lower ranking on Walker's state policy innovation scale
2. Heterogeneous or bifurcated political culture
3. Stronger organized interest group influence on policy making
4. Weak internal cohesion among supporting groups
5. Stronger issue reframing by opposing groups

## **RESEARCH QUESTIONS AND HYPOTHESES**

Based on the above outlined models, five research questions and hypotheses are discussed below. The dependent variable is the successful adoption of the ANA proposal, with the independent variables being policy innovativeness, political culture, interest group strength, issue framing and reframing, and public opinion.

**Question 1:** Based on Walker's state innovation scores, did the outcome of the proposal in each state accurately reflect the ranking of each?

**Hypothesis 1:** Ranking the states according to their innovation scores, those in which the proposal made the legislative agenda will have a higher ranking than those that did not.

I base this variable on Walker's (1969) classification of policy innovativeness among the states (see Table 9). The period in which this data was produced roughly coincides with the time frame of the ANA's position paper and proposal. Walker developed innovation scores for each state, and over time, and these rankings on state innovation

have remained extremely consistent (Gray, 1994). Thus, some units (ex., states) may have a culture of innovation more than others, and this culture may mediate between determinants and adoption (Akers, 2006).

**Question 2:** Using Hero's political cultures scale, did the outcome of the proposal in each state accurately reflect the political culture category assigned to each?

**Hypothesis 2:** States with a homogeneous political culture are more likely to adopt the proposal.

For this study, I find Eliza's model to be outdated. Since the inception of this model, there have been a number of socioeconomic changes due to migration, aging, and other trends. Also, there have been generational changes in the political and social environments that shape the public's core values. I find Lieski's model not specific enough in that he deals more with broad regional subcultures and characterizations rather than with specific states. Hero's model fits this study more aptly in that its social diversity perspective is more state specific and focuses on particular variables unique to each state. These variables include state politics and policy, political culture, and the racial/ethnic diversity of each state.

**Question 3:** In the states where the proposal made the policy agenda, was overall interest group strength a factor in it's doing so?

**Hypothesis 3:** In the states where the proposal made the policy agenda, overall interest group strength was weak.

State level interest group activity and strength has been shown to have a significant impact on public policy outcomes (Nice, 1984). For this study, I emphasize both the overall influence of interest groups on state policy outcomes and the direct influence that specific types of groups have had on the baccalaureate proposal in the four focus states.

I base this variable on two specific interest group theories: Wilson's "Niche Theory" (1973), and Thompson and Hrebenar classification of states by overall impact of organized interests (1993).

According to Wilson, some groups develop autonomy, or a distinctive area of competence in a clearly demarcated area of policy expertise that exclusively serves a particular clientele or membership. These groups have an undisputed jurisdiction over a function, service, goal, or cause. In most states, groups representing dominant economic interests are by far the most numerous and most influential. Most state governments are far more susceptible to interest group pressures than in the federal government (Thompson and Hrebenar, 1996).

I predict that the research will show that in the state(s) where the baccalaureate proposal was adopted, organized interest groups are weak, have little ability to influence the policy making process. Likewise, I expect to find that in the states where the proposal was defeated, organized interest groups are strong with the ability to exert much influence on the policy making process.

**Question 4:** In states where the proposal was not adopted, was reframing an effective tactic used by opposing groups?

**Hypothesis 4:** In states where the proposal was not adopted, opposing interest groups were able to reframe the issue successfully in their favor.

I predict that the research will show that in the state(s) where the baccalaureate proposal was adopted, issue framing by support groups was more successful at influencing public opinion than reframing efforts by opposing groups.

According to Dunn (1994, p. 17), defining a problem helps “supply policy-relevant knowledge” to participants who are actively involved in the policy process. Stone goes a step further and states that “problem definition is the active manipulation of images of conditions by competing political actors” (1989, p. 293). Ultimately then, the exact terms by which a problem or issue is defined will determine what solutions are proposed. Thus, to reach those goals “political actors use narrative story lines and symbolic devices to manipulate so-called issue characteristics” (Cobb & Elder, 1983; Stone, 1989, p. 282). Policy change occurs when a new problem is given higher priority over others, thus making certain solutions more acceptable than others (Baumgartner & Jones, 1993; Rochefort & Cobb, 1994).

Issue redefinition involves several key factors (Baumgartner & Jones, 1993):

1. The role of policy entrepreneurs and their advocates,
2. How the media covers and issue,
3. Policy venues, and
4. The interactions between each.

Policy entrepreneurs identify a problem then work to get it on the legislative agenda for a possible policy change (Baumgartner & Jones, 1993; Cobb & Elder, 1983; Kingdon, 1995). These individuals work to shape the scope and terms of policy debate by not only

identify and defining problems, but also by networking within the appropriate policy communities and building coalitions (Kingdon, 1995, pp. 179-183). They set the tone in favor of their own policy ideas by determining which arguments will most effectively persuade others to favor their proposals (Kelman, 1987; Kingdon, 1995; Schneider & Teske, 1992). Similarly, interest groups play a key part on the policy process by framing an issue and then supplying elected officials with information on the issue (Baumgartner & Jones, 1993; Haider-Markel, 1999). Focusing events have been widely referenced in policy studies literature as important drivers of major policy change. In multiple streams theory, punctuated equilibrium theory, and the advocacy coalition framework, they play a prominent role in explaining how major changes occur. Considering how our system provides multiple access points to the policy process, some venues may be more receptive than others.

**Question 5:** How did issue reframing affect public opinion?

**Hypothesis 5:** Successful issue reframing by opposing interest groups significantly influenced public opinion in their favor.

Dictating public opinion on a particular policy issue is conditioned by two factors: the framing approach used by the various groups involved and the issue itself. These factors produce the greatest variations in how effective competing groups are at changing public opinion. At one end of the spectrum is outright and willful manipulation of a large section of public by one or more groups that completely changes their previous views on a particular issue. At the other extreme are those citizens who steadfastly reject this manipulation.

Between these two extremes lies a core constituency that provides a stabilizing effect on public preferences concerning fundamental policy areas. Even though politicians and interest groups are rarely able to manufacture public opinion in the way they desire, the public's dependence on the media for information makes it vulnerable and a more subtle form of influence. The press, along with politicians and interest groups, can seriously influence an unsuspecting public by emphasizing specific aspects of an issue that affects the judgment criteria used by many Americans when evaluating possible policy proposals concerning the issue (Jacobs, 1993b; Jacobs and Shapiro, 1994, 2000).

I predict that in states where the ANA proposal was defeated, opposing groups were able to positively affect public opinion in their favor via issue reframing.

## **STUDY DESIGN**

The purpose of the study is to compare and contrast the outcomes of the ANA policy proposal in the four target states. The nature of the research questions in this study requires an in-depth exploration into state level social and political environments surrounding policy adoption. With the complexity of the variables, the qualitative approach is a logical choice for the type of data to be used within the case study design (Merriam, 1988; Yin, 1989). The overall study consists of four case studies, with the primary unit of analysis being the state level approach to policy adoption. The research focuses on the factors leading to ultimate outcome of the policy proposal in each target state. To further bound the research, the time interval of interest is the period between the original proposal by the ANA, i.e. 1965, and 1993, the year the proposal last made the policy agenda in any of the four states.

A comparative case study approach using qualitative data is used to examine the response by the four target states to the American Nurses Association (ANA) proposal that the baccalaureate degree be the minimum educational standard for entry into professional nurse practice. The four states examined, Oregon, Montana, Maine, and North Dakota, were originally targeted and funded by the ANA for early adoption of the policy proposal.

Case study is the best approach when one wants to know the “how” and “why” of a particular unique event. These questions are often posed when one is trying to understand the particular outcomes of the event being studied, particularly when the researcher has little control over the events that occurred within its natural context (Yin, 2003). The questions in this study include:

1. From a policy innovation standpoint, did the ultimate outcome of the proposal in each state accurately reflect the state’s innovation score assigned to each by Walker?
2. From a political cultures perspective, did the ultimate outcome of the proposal in each state accurately reflect the political culture?
3. What part did internal cohesion among supporting groups have on the ultimate outcome of the proposal in each state?
4. In states where the proposal was not adopted, was reframing an effective tactic used by opposing groups?
5. How did issue framing and reframing affect public opinion?

Case studies are the first step in any in-depth policy analysis. A good case study includes the background of the problem, the perceptions of the significance of the issue in

a policy context, description of the issue, analysis of the issue and development and analysis of possible solutions (Dunn, 2004). Case studies are particularly well suited for the analysis of policy formation. Lincoln and Guba (1985) found that case study research helps one grasp a better understanding of human action and interaction within given contexts. Since a change process is basic to any policy analysis, these researchers found that case studies are “better able to assess social change than more positive designs” (p.33).

Stake (2000) notes that case studies are not meant to be a methodological choice but rather a choice of what to study. Stake (1978) noted that case studies build a better understanding of a specific system by giving it an everyday life perspective. It does this by gaining knowledge from the experience. Stake further notes that “the case is a specific, complex, functioning thing” (p.2), and that “we are interested in it, not because by studying it we learn more about other cases or about some general problem, but because we need to learn about the particular case” (p.3).

Case studies are really about the particulars of a given situation and not about generalizations of the event. The first emphasis is on understanding the case itself, specifically noting how it is different from other cases.

Yin (2003) argues that a single-case design is justified when one is dealing with an unusual, extreme or revolutionary case, or when testing a formulated theory. The ultimate outcome of the policy proposal in the four target states may be considered rare and worth examining, thus lending itself to a comparative case study research method.

## **DATA COLLECTION**

The major strength of case study research is that it lends itself well for the use of a variety of sources of evidence. Yin (2003) outlines six sources of evidence for data collection in the case study protocol:

1. Documentation,
2. Archival records,
3. Interviews,
4. Direct observation,
5. Participant observation, and
6. Physical artifacts.

The use of all of the above is not necessary in all case studies. Documents are mainly used to corroborate evidence gathered from other sources. Interviews can take on several forms: open-ended, focused, or structured. In open-ended interviews, the researcher can ask for the subject's opinion on events or facts. This acts to corroborate previously collected information.

Documents, according to Yin (2003), are a key part in doing case study research. For data collection, this study will employ the use of archival document review. My sources include newspaper articles, minutes of meetings, position papers, legislative records, and written reports from various boards and agencies. I also collect data from Walker's state innovation scores, Elazar's and Sharkansky's state political culture index's (Elazar, 1972; Sharkansky, 1969), Hero's social diversity models, and Thompson and Hrebendar's classification of states by overall impact of organized interest.

## **DATA ANALYSIS**

According to Yin (2003), case study analysis is one of the least developed aspects of case study methodology. Researchers must rely on experience and the literature to present the evidence in varied ways, with various interpretations. Yin (2003) outlines two strategies for analyzing case study data:

1. Developing a case study description (descriptive or exploratory), and
2. Using the theoretical propositions on which the study is based to explain the case.

There are a number of approaches for analyzing qualitative data for exploratory/descriptive cases. Among these are content analysis, analytical induction, constant comparison, and phenomenological analysis. Though each mode of analysis is different, their purpose is the same: to examine, categorize, tabulate, or otherwise recombine the evidence to decide whether evidence from various sources intersects on a particular set of facts. Yin (2003) identifies theoretical orientation strategy as one that employs a predetermined theoretical perspective to guide the case analysis. In pattern matching, a priori predicted pattern derived from theory with an observed pattern is developed to see whether the patterns conform. Data for this study is analyzed using a time-ordered matrix of events.

## **LIMITATIONS**

First and foremost this is a descriptive method, not an explanatory one. That is, without the controlled conditions of the laboratory, conclusions about cause-and-effect relationships cannot be drawn. Behavior can only be described, not explained. This particular case study involves only four states and therefore may not be representative of

the other 46 states. By definition, case studies can make no claims to be typical, thus we have no way of knowing, empirically, to what extent the four focus states are similar or different from the other states. Furthermore, because the sample is small and idiosyncratic, and because data is predominantly non-numerical, there is no way to establish the probability that the data is representative of all nurses in all 50 states.

As with most social sciences case studies, this study relies heavily on descriptive information provided by different people, which leaves room for important details to be left out. When case studies are successful in revealing some of the complexities of social or educational situations, there is often a problem of representation. It is often difficult to present accessible and realistic pictures of that complexity in writing.

And last, case study data is time-consuming to collect, and even more time-consuming to analyze. Yet cutting corners on either of these facets is likely to seriously weaken the value and credibility of any findings produced. This means that large or multiple case studies can be very expensive.

## **CONCLUSION**

In this paper, I propose that before the ANA baccalaureate proposal could be adopted, at least five factors must be present. First, based on Walker's state innovation scores, those states in which the proposal made the legislative agenda will have a higher ranking than those that did not. Second, using Hero's political cultures scale, states with a homogeneous political culture are more likely to adopt the proposal than those with a heterogeneous or bifurcated political culture. Third, in all four focus states, the same types of interest groups were instrumental in the proposal's ultimate outcome. Fourth, in

states where the proposal was not adopted, opposing interest groups were able to reframe the issue successfully in their favor. And fifth, successful issue reframing by opposing interest groups significantly influenced public opinion in their favor. These factors do not represent stages or steps, as they do not occur in a specific order. Yet as the cases on each state reveals, they all played an essential part in the policy process, but at different times by different states.

## **CHAPTER 4: FOCUS STATES**

As noted in the last chapter, the American Nurses Association (ANA) chose four focus states as early implementers of the baccalaureate proposal: Maine, Montana, North Dakota, and Oregon. In effect, these states were to act as a legislative testing ground for the proposal. The ANA chose these states carefully, believing that the policy would be easily adopted in each.

### **NORTH DAKOTA**

#### **Cultural and socio-economic background**

North Dakota is located in the upper mid-western section of the country. Bordering the state is Minnesota on the east, South Dakota to the south, Montana to the west, and the Canadian provinces of Saskatchewan and Manitoba are to the north. It is the 19th largest state by area in the US and the 48th most populous. The state capital is Bismarck and the largest city is Fargo. Most North Dakotans are of Northern European descent. The six largest ancestry groups in North Dakota are: German, Norwegian, Irish, Native American, Swedish, and French (U.S. Census Bureau, 2000). This places the state firmly in Hero's Homogenous political culture category. Agriculture is the largest industry in the state, followed by petroleum and food processing.

State government in North Dakota is divided into three branches: executive, legislative, and judicial. The executive branch is headed by the governor. The North Dakota Legislative Assembly is a bicameral body consisting of the Senate and the House of Representatives. The five-justice North Dakota Supreme Court hears all appeals from the lower courts.

The political leanings of the state since its creation have been largely conservative. However, there is also a vein of political radicalism within the state's history. The liberal Non-Partisan League (NPL) was a strong political force during the first half of the 1900s with the election of many NPL candidates to government offices and the enactment of the party's largely socialistic programs. Today, the major political parties in the state include the Republican Party and the North Dakota Democratic-NPL Party. The state's Republican Party controlled the state government in its early days and still maintains a stronghold today, with 11 of the 12 statewide officers being Republican. In regards to policy innovation, North Dakota ranks 23<sup>rd</sup> among the 50 states on Walker's state innovation scale.

North Dakota has 11 public colleges and universities, five tribal community colleges, and four private schools. There are also a number of private colleges. Of these, 12 schools offer Associate and Bachelor degree nursing programs, and three offer Licensed Practical Nursing diploma programs.

As in most states, interest groups in North Dakota play a significant role the policy making process. However, according to Thompson and Hrebenar's classification of states by overall impact of organized interest, interest groups tend to play only a complimentary

role in the process in the state (Thompson & Hrebenar, 1996). As such, it should be noted that North Dakota was one of only two states the initially accepted the ANA proposal.

### **ANA Proposal**

The North Dakota, the North Dakota Board of Nursing (NDBM) has the ability to change nursing educational requirements on its own. The NDNA is the professional organization that represents Registered Nurses in North Dakota. As a regulatory board for nursing in the state, it has the power to initiate such a measure. In 1977, the board of nursing was given legislative authority to set the requirements for nursing education as a function of its regulatory power. Also at that time, registered and practical nurses came under the auspices of the same regulatory board.

Immediately after the 1977 legislative action giving the board rule making power, the NDBN and the North Dakota Nurses Association (NDNA) joined together to spearhead the drive to have the ANA proposal fully implemented in the state by 1990.

Subsequently, by March 1983, entry into practice had become the NDNA's major strategic plan priority. Bi-level entry into practice was reaffirmed during the 1983 annual NDNA convention, and a nine-member statewide Coordinating Committee was created (Rose, 2006).

By May 1984, the Coordinating Committee had conducted a number of meetings with a variety of state and local nursing and health care entities. At that point, the committee met with the NDBN to officially request that the board revise the rules to identify one level of education for Registered Nurses and one level of education for licensed practical nurses. The motion by the NDNA stated that: "the rules regulating schools of nursing be

revised to have the standards for schools preparing nurses on the professional level (RN licensure) and on the technical level (LPN licensure).” The Committee also made it a requirement that nursing education had to occur in an academic setting, and that all nursing programs had to provide transferable academic credit (Rose, 2006). After very little debate, the Board agreed to rewrite the rules to reflect two levels of nursing practice.

In 1984, the Board established the rules that called for the baccalaureate degree as the minimum level of education for Registered Nurses and associate degree as the minimum level of education for practical nurses. The new rules also gave the Board the authority to close any nursing program that did not comply with the new rules (Rose, 2006).

### **Policy Entrepreneur**

In 1978, a strong policy entrepreneur emerged when Karen Macdonald, a native of the state, was elected to the ANA Congress for Nursing Practice, the committee assigned with implementing the ANA baccalaureate proposal. From 1978 until 1984, Macdonald served two terms on the NDBN, including holding the position of president in her final year (1983-84). In 1983, she was appointed to the NDNA Entry into practice Coordinating Committee as the representative from the NDBN for 1983-84. In August 1984, she became the Executive Director of the NDBN and served in this position for several years. Subsequently, Macdonald proved to be in key positions at critical times during the national and state level evolution of the issue (Lambeth, 1992).

MacDonald spent much time and effort framing the issue in an educational context. She considered it a simple matter of upgrading the educational requirements needed to become a Registered Nurse (Lambeth, 1992). Unfortunately, her framing was often

misunderstood by others involved in the process. Key to this misunderstanding was the issue of transitioning, or “grandfathering” nurses who were already registered. Many nurses feared they would lose their license if the new educational requirements were put in place, and subsequently, demanded that a grandfather clause be added to the proposal. Although she worked very hard to make it clear that nurses under the old standards would not lose their license, and would in fact be grandfathered, this issue was never fully resolved.

It was MacDonald’s strategic position within the North Dakota nursing hierarchy that helped open the policy window long enough for the process to develop.

### **Issue Expansion**

Both the NDNA and the NDBN used a number of strategies to restrict the issue to nurses and not to the general public. Both groups believed that nurses would need to be mobilized before the issue could be expanded to the public. Therefore, they made it a priority to address the concerns of nurses on the entry issue (Lambeth, 1992; Rose, 2006).

From the beginning, the NDNA and NDBN believed that moving the issue to the public was unnecessary. When the board held statewide public hearings prior to voting for implementation, the input from the non-nursing public was minimal. In an analysis of the entry into practice arguments, researchers examined comments from 586 people who had expressed their views on the entry issue (Rose, 2006). They estimated that only 5% of the testimony was from the non-nursing public. Of the 129 pieces of written testimony favoring the baccalaureate proposal, only seven were from the public. Of the 72 letters opposing the proposal, 15 were from the public. With little interest expressed in the issue

by the public, the NDNA and the NDBN felt there was little need to direct the issue in that direction to sway public opinion.

Subsequently, the focus became the nursing profession itself. It was believed by both groups that since nurses would feel the impact of a change the most, they should be the major focus group. Nurses were also perceived as those who would most likely oppose the change since there was little unity within the profession. This fact was highlighted in an NDNA document outlining barriers that needed to be removed: "...The first of these barriers are nurses themselves. Nurses, like others, have a natural antipathy to change. Where nurses should be educated has been an issue since the mid-nineteenth century. Although the events surrounding the issue have changed, the issue remains alive (Rose, 2006)."

As described above, sponsors of the ANA proposal in North Dakota came from the NDBN and the NDNA. However, there were a number of groups opposing the proposal.

### **Opposition from Professional Groups:**

#### **Concerned Nurses**

The major professional group opposing the change was a group known as Concerned Nurses. In addressing and expanding the issue, the Concerned Nurses used a group-oriented strategy that involved mailing letters to every nurse in the state. By doing this, they were attempting to appeal directly to the members of the nursing profession (Lambeth, 1992; Rose, 2006).

Concerned Nurses took a novel approach to the issue by choosing not to discredit the leaders of entry movement. Instead, they brought in their own leader and used an "our

leader is better than yours” approach. Their framing of the issue was fairly simple: “yes...we agree there needs to be a change in the educational requirements for nurses in North Dakota, but...we can handle it better than the NDBN can.” However, they never clearly spelled out exactly how they would handle things differently.

The person they brought in to lead their opposition was Andrew Dolan, an attorney who represented the Federation for Accessible Nursing Education and Licensure (FANEL) at the public hearings. Dolan had previously written an article criticizing the attempt by the New York State Nurses Association to implement the bachelor’s degree as the educational requirement for RNs in New York and was considered an expert on the issue.

The main strategy used by the Concerned Nurses was to ask all North Dakota nurses to write to their legislators. Unfortunately, this strategy backfired. A few days after the letter mailing campaign kicked off, HB 1460, sponsored by FANEL and the Concerned Nurses was introduced in the North Dakota Legislative Assembly. This bill was an attempt to expand the entry into practice issue into the public arena by making it a legislative issue. It sought to remove the power to set nursing educational from the NDBN.

The major problem with the letter writing strategy was the content of their letter relative to the North Dakota legislation. Along with the explanation letter sent to the nurses was also a sample opposition letter that was to be sent to legislators. The letter was an example of a sample used in New York during the 1979-80 legislative session. It included a bill number and the names of senators and assembly members from New York. Most nurses simply did not realize this, and subsequently, sent letters to the North

Dakota legislature to non-existent individuals concerning a bill that also did not exist. Once the NDNA realized what had happened, they moved to capitalize on the error by make legislators aware of the opposition's unorganized nature. They did this by encouraging their members to call their legislators or by direct contact (Rose, 2006).

### **Opposition from Business Groups:**

At the institutional level, the major opposition to the entry into practice issue has been from institutions offering the associate degree for Registered Nurses. In the US, the associate degree is the major source of education for Registered Nurses. If the baccalaureate degree became the educational standard for Registered Nurses, these institutions would be the big losers.

In the early stages of the process, the NDBN attempted to gain the support of the American Hospital Association. However, the State Hospital Association had already expressed opposition to the proposal at both the national and state levels and remained in opposition throughout the process (Rose, 2006).

In North Dakota, the backers of the entry proposal faced serious opposition from two facilities within the state that sponsored associate degree nursing programs, Med-Center One Hospital and Trinity School of Nursing. In 1984, representatives of these facilities had a legislator request an Attorney General's opinion on whether the Board of Nursing had the authority to close diploma programs. The Attorney General's opinion stated that the Board of Nursing, via the 1977 legislative action, did have the power to set educational standards and could close nursing programs that did not meet those standards. In response, the diploma programs introduced legislation that would place

diploma and vocational programs within the Nurse Practice Act (NPA). The NPA, through statutes, requires that registered and licensed nurses meet minimal standards for practice and prohibits unlicensed individuals from practicing as registered or licensed nurses. This would remove the power of the Board of Nursing to set educational standards or close programs.

In January 1985, House Bill 1460 was introduced (HB 1460, 1985). The introduction of this bill resulted in an intense legislative battle pitting hospital administrators, diploma registered nursing programs, and their graduates against the NDNA and the NDBN.

On February 2, 1985, a large contingent of nurses attended the hearing on HB 1460 (Rose, 2006). The majority of the testimony centered on whether the Board of Nursing should be able to close nursing programs if the proposed changes were enacted.

Proponents of the bill that were present included representatives from Med-Center One Hospital in Bismarck, the North Dakota Hospital Association, Med-Center One School of Nursing, and Trinity School of Nursing in Minot. It should be noted that Med-Center One Hospital and Trinity School of Nursing were two of the three diploma nursing programs that existed in the state at that time (Rose, 2006).

Proponents testified that there were no other states that had adopted the ANA proposal and cited the failure of other states to initiate the changes. Terrence Brosseau, on behalf of the North Dakota Hospital Association, testified that his organization opposed entry into practice because it would drastically reduce the supply of nurses available in this country, and there was absolutely no evidence that graduates from hospital schools of nursing were any less competent than baccalaureate graduates. The new requirements

would drastically increase the cost of health care not only in North Dakota but across the country.

Opponents of HB1460 included the NDBN, the NDNA, the North Dakota Licensed Practical Nurses Association, and the University of North Dakota College of Nursing. In opposing the bill, the NDBN made it clear that the purpose of the proposed educational changes was to insure that nursing school graduates would be held to a high level of competency, thus maintaining the safe practice and provision of high quality nursing care for all North Dakota citizens. They maintained that the rule revisions concerning educational standards would apply only to nursing schools. As such, only the schools would be required to make the necessary adjustments. Currently licensed nurses would not be required to upgrade their educational credentials. However, this point was never made completely clear to many nurses in the state.

In January 1985 the combined lobbying efforts of the NDNA and the NDBN resulted in the defeat of HB1460. In November 1985, the NDBN adopted the new rules to the NPA implementing two levels of education for nursing.

### **The Law Suit**

On March 20, 1986, Med-Center One Hospital in Bismarck and Trinity Hospital in Minot served the NDBN with a restraining order temporarily stopping the Board of Nursing from enacting the new educational standards (Rose, 2006). The lawsuit claimed that law authorizing the NDBN to establish nursing education standards was the result of an unconstitutional delegation of legislative power, which violated the North Dakota Constitution. On April 24, 1986, a motion was filed to stop all further actions by the

NDBN. The motion also requested that the court certify two questions of law to the North Dakota Supreme Court. Over objections from the NDBN, the District Court accepted the motion. The two questions were:

1. “If the legislature establishes a licensed profession, and provides two separate levels of that profession, and sets out the general skills and body of knowledge to be utilized in each of the two separate levels, then is it constitutional for the legislature to create an administrative board to establish the contents of the test and the contents of the education (Trinity Medical Center and Med-Center One v. North Dakota Board of Nursing, 1986)?”
2. “Are the educational requirements established by the Nursing Board unconstitutional because of being unreasonable (Trinity Medical Center and Med-Center One v. North Dakota Board of Nursing, 1986)?”

In its findings on August 4, 1986, the Court stated that:

The advancement of professions by increasing the body of knowledge has long occurred in institutions of higher education. As a well educated body of nursing knowledge is developed through research, baccalaureate nursing programs will provide the education professional nurses need. We think the direction taken in North Dakota will serve the rest of the country as a prototype for advancement of both the nation’s health care and the nursing profession. (Trinity Medical Center and Med-Center One v. North Dakota Board of Nursing, 1986)

The law suit was the last legal hurdle the NDBN faced in its effort to adopt the ANA proposal. Within six months the proposal was full adopted and implemented in North

Dakota. However, over the next few years there would be many legislative attempts to rescind the new educational standards.

### **Entry into Practice Established in North Dakota**

On January 1, 1987, the NDBN officially established the new educational requirements, thus becoming the first state to formally enact the ANA proposal (Lambeth, 1992, Rose, 2006). The rules stated that new candidates for a practical nursing license must have an associate degree with a major in nursing granted by a postsecondary institution offering transferrable academic credit, and that all new candidates for a registered nursing license must have a baccalaureate degree granted from a postsecondary institution with an upper division major in nursing (North Dakota Administration Code Section 54-03.1-06-02 and 54-03.1-07-02). All nurses with an RN or LPN license who graduated from nursing programs before 1987 would not be required to obtain the new academic standards (Lambeth, 1992; Rose, 2006).

### **House Bill 1245: Entry into Practice Rescinded**

Between 1987 and 2001 (except for 1993 and 1999) a bill was introduced each year in the North Dakota Legislature with the intent of removing the new educational requirements for entry into practice. The backers of these bills, the North Dakota Long Term Care Association (NDLTCA) and the North Dakota Hospital Association (NDHA), had one single goal in mind: to rescind the new educational requirements. Their issue framing focused on the national nursing shortage and they made it clear to policymakers that North Dakota was the only state requiring a baccalaureate and associate degree for

entry into practice. They claimed that the new educational requirements were a key factor exacerbating the nursing shortage in North Dakota (Rose, 2006). Subsequently, this issue became the focusing event these groups used to lobby for rescinding the new educational requirements.

In response to this move, the North Dakota Nurses Association (NDNA) took an unusual route. Instead of directly addressing these issues, the group chose to create specific legislative language that they believed would remove the debate from the legislative arena. In 2003, the group had a bill introduced into the legislature (HB 1245, 2003) that was intended to amend the Nurse Practice Act. The bill would have removed the power of the NDBN to approve nursing programs and transfer that power to the North Dakota State Board of Higher Education (NDSBHE) (Rose, 2006).

In hindsight, it is apparent now that the NDNA Board of Directors did not fully understand the consequences of transferring the control of nursing programs to the NDSBHE. The NDNA also failed to explain the rationale for this move to the nursing community. The Board maintained that the reason for transferring the authority to approve nursing programs to the NDSBHE was simply to remove the debate on nursing education from the legislative arena. Unfortunately, they failed to realize that the NDSBHE, which is also a regulatory agency, is also subject to legislative oversight. This rationale simply made the issue even less clear and caused added confusion among North Dakota nurses (Rose, 2006). It also added to further fragmentation within the NDNA membership and the nursing community as a whole. This fragmentation resulted in several unfortunate consequences that influenced the ultimate outcome of HB1245.

Confusion and fragmentation within the nursing community could also be attributed to the fact that not all participants in the issue knew what each other were doing. This new move by the NDNA was an alien concept to the majority of the nursing community. Further exacerbating this confusion was the failure of the NDNA to explain the concept to its own membership and nursing community at large. The NDBN did not clearly explain how a new nursing program would be approved by the NDSBHE, or how moving the authority to approve nursing programs to the NDSBHE would affect a nursing graduate's ability to take the national licensing exam. All nursing students are required to take a national licensing exam after graduating from a nursing program that has been approved by a state's board of nursing.

To its credit, the NDNA did make an attempt to assure its membership via mass mailings and postings on its web site. They attempted to explain that they were not advocating lowering the educational requirement, and to further explain why schools of nursing should belong under the NDSBHE authority. They tried to explain that all nursing programs in North Dakota were in an institution of higher education where the nursing programs already meet the standards of higher education and they did not need approval of another state agency. The Board went on to cite a study that claimed conflict inevitably occurred when a state board of nursing has the right to exercise control of nursing programs that also falls under the jurisdiction of another state department (Hinsvark & Dorsch, 1979; Rose, 2006).

Unfortunately, the NDNA was not very successful with this rationale. The general mood and feeling among many NDNA members and the nursing community was that HB1245 was basically "giving away" entry into practice (Rose, 2006). Almost as an

after-thought, the NDNA indicated that there was a possibility that some North Dakota universities and colleges would withdraw their support of the new educational requirements if the authority to approve nursing programs was transferred to the NDSBHE (Rose, 2006). This only added to the confusion on the issue.

The division within the nursing community helped open a policy window of opportunity for opponents of the new educational standards. HB1245 allowed for the joining of the problem and political streams, thus facilitating the opportunity for policy change. This open policy window allowed the opponents of the new educational standards to advocate for a return to the old standards. The existence of the strong cooperation between the NDLTCA and the NDHA within the political stream kept the policy window open long enough for the HB 1245 to be approved.

The NDNA was simply unable to provide strong leadership needed to present a unified position. This lack of unity resulted in legislators (with the backing of the NDLTCA and the NDHA) creating and enacting a completely new policy that basically reestablished the old multi-level nursing education system. Long-term care facilities, community colleges and hospital welcomed the passing of HB1245 and the return to the old educational standards. As in the other three original ANA focus states, the same health care related interest groups were successful in defeating the proposed nursing education standards.

North Dakota was able to fully adopt the ANA proposal, if only for a few years. Maine, however, was not as successful. Although the proposal was adopted by the legislature in 1986, it was never fully implemented.

## **MAINE**

### **Cultural and socio-economic background**

Maine is located in the New England region of the country. The state is bordered by the Atlantic Ocean to the southeast, New Hampshire to the southwest, the Canadian provinces of Quebec to the northwest and New Brunswick to the northeast. It is the 39th largest state by area in the US and the 40th most populous. The state capital is Augusta and the largest city is Portland. The largest ancestries in the state are: English American, Irish, French or French Canadian, American, and German (U.S. Census Bureau, 2000). This places the state firmly within Hero's Homogenous political culture category.

The economy of Maine is based heavily on agriculture. Major agricultural products include poultry, eggs, dairy products, cattle, wild blueberries, apples, maple syrup and maple sugar. Maine's industrial products include paper, lumber and wood products, electronic equipment, leather products, food products, textiles, and bio-technology. Naval shipbuilding and construction are also major parts of the economy as well. Tourism and outdoor recreation play an increasingly important role in the state's economy.

Maine's state government is composed of three branches: the executive, legislative, and judicial branches. The Maine Legislature is a bicameral body composed of a 151 member House of Representatives, and a 35 member Senate. The executive branch is headed by the Governor who is elected every four years and may not serve more than two consecutive terms in this office. The judicial branch is responsible for interpreting state laws. The highest court of the state is the Maine Supreme Judicial Court.

The major political parties are the Democratic and Republican parties. In state general elections, Maine voters tend to accept independent and third-party candidates more

frequently than most states. Maine state politicians, Republicans and Democrats alike, are noted for having more moderate views than many in the national wings of their respective parties.

The University of Maine System consists of seven universities. There are also several community and technical colleges as well as a number of private colleges. There are 13 Registered Nursing Programs and five Licensed Practical Nursing programs.

As in most states, interest groups in Maine play a significant role in the policy making process. However, according to Thompson and Hrebenar's classification of states by overall impact of organized interest, interest groups tend to play only a complimentary role in the process in the state (Thompson & Hrebenar, 1996). As such, it should be noted that Maine was one of only two states that the ANA proposal was initially accepted.

### **ANA Proposal**

In the case of entry into practice in the four focus states, Maine was the only state in which the State Board of Nursing did not have the authority to change the nursing educational requirements on its own. Although it is a regulatory board for nursing in the state, it does not have the power to initiate such a measure. All such changes must be brought before the legislature.

The two groups that sponsored the entry drive were the state board of nursing (Maine Board of Nursing or MBN) and the state nurses association (Maine State Nurses Association or MSNA). The debate over the proposal began in 1984 after the members of the MSNA accepted a proposal for a bachelors and associates degree structure with

retention of the LPN title. The proposal called for entry level changes by 1985. Current license holders would be transitioned into the new levels of practice.

### **The Task Force**

In March of 1984, working with the grant from the ANA, the MSNA established a statewide task force to study the proposal (MSNA, 1984). The fifty-two member task force was chosen to represent the diverse interests and concerns of Maine's health community including the nurses and other health officials and workers. Its purpose was to explore the resources that were available in Maine, document any need for changes in educational standards for nursing licensure, establish competencies that would be necessary to meet the current and future health care needs, and determine what legal changes might be needed to raise educational standards for licensure (MSNA , 1984).

To accomplish the goals it set for itself and to make appropriate recommendations, the Task Force established six committees to study the major issues involved with the proposal. The leaders of these committees met with the Governor, key legislators, directors of schools of nursing, the Maine LPN Association, and the consortium and presidents of the specialty nursing groups. In all, over 47 informational sessions were held across the state by the following committees:

1. Baccalaureate Committee (nine members),
2. Competencies and Titling (nine members),
3. Licensing and Credentialing (nine members),
4. Legislative and Lobbying Committee (six members),
5. Public Relations and Press (eight members).

Legal consultation was also sought to establish what statutory changes, if any, would be needed to raise educational standards for licensure of future practitioners. This advice was incorporated into the recommendations from the Task Force subcommittee charged with the subject of legislative change. In addition, a concerted effort was made to achieve consistency with policies being developed at that time in other parts of the country, as well as with the ANA itself.

Based on the findings of the various committees, the Task Force made the following final recommendations:

1. By 1995 the educational requirements for two levels of licensure into nursing practice will be: a minimum of an associate degree in nursing for one level of licensure, and a minimum of a bachelor's degree in nursing for the other level of licensure.
2. The two levels of licensure will retain the current titles of Licensed Practical Nurse and Registered Professional Nurse, subject to change by the decision of the American Nurses' Association House of Delegates in June 1985.
3. The two levels of nursing practice will be defined by two sets of competencies, jointly developed by nursing education and nursing service representatives. Maine State Nurses' Association will convene and fund a committee to develop a set of preliminary competencies for each level of nursing by 1986, and a final set of competencies by 1987. All interested nursing parties will be invited to supply representatives of their own choosing to participate with the development of these competencies.
4. The future licensure exams should test the competencies specific to each level.

5. The National Council of State Boards of Nursing should develop exams as necessary to insure that minimum standards of safety and competencies appropriate to each level are examined.
6. A system will be developed by educational institutions to enhance educational mobility in nursing.
7. Financial assistance, private, corporate, state and federal, be made more available to qualified students for nursing education at all levels.
8. Sections 2201(3) and 2251(4) of the Law Regulating the Practice of Nursing be amended to reflect the associate degree requirement for licensure as a practical nurse and the baccalaureate degree requirement for licensure as a Registered Nurse. To provide sufficient lead time to educational institutions to make any necessary changes in the curriculum prior to the implementation date of 1995, the statute should be amended in 1985, if feasible.
9. A grandfather clause be added to the Law Regulating the practice of Nursing to insure that those licensed under the system in place prior to the effective date of change in educational requirements will retain their original Maine licensure after the effective date of change.

**Supporting Groups:**

**Maine State Nurses Association (MSNA)**

The major backer of the proposed changes was the MSNA (Munger & Vanderhorst, 1987). The group worked hard to frame the issue in terms of “better education equates to better nursing care.” They continually reiterated that the proposed changes would insure

that nurses would have the freedom to give consumers the highest possible care. Their reasoning was simple: the more complex a patient's condition, the more need for a better educated nurse. As patients become sicker, more advanced techniques are used to treat these patients. Nurses need to be more proficient in the skills needed with these techniques. Thus, for RNs to safely and effectively give high quality of care to the patient/consumer, a four-year education is necessary. Likewise, for an LPN to give the standard of care needed at their level, a two-year degree would be necessary.

This framing was clearly outlined in the findings of the Task Force: *“Upgrading educational requirements for entry into nursing practice will assure Maine citizens that they will continue to receive the highly skilled, quality nursing care they require in a variety of settings (MSNA, 1984).”*

Unlike in Montana and North Dakota, however, the MSNA did make an attempt to include not only the nursing community, but also the public at large. To aid the Task Force in its efforts, the MSNA's Commission on Nursing Education conducted six regional forums. Throughout the months of April, May, and June of 1984, nurses and the public were invited to hear presentations regarding the Task Force activities, and to have an opportunity to make known their concerns and suggestions. These ideas and issues were communicated to the various committees and became the basis for portions of their reports and recommendations. Noticeably absent from those targeted in this effort were the various interests representing the educational and health care industry. This oversight would later prove to be a major contributor in the proposals final outcome.

## **MSNA Public Relations Campaign and Public Opinion**

The Public Relations and Press Committee held several meetings in which it was discussed at length how to spread the MSNA's message concerning the proposed changes.

The Committee identified target groups whose values needed to be identified and explored if the proposal was to be successfully sold to them. They reiterated the need to reach as many groups as possible if unity and general consensus were to be achieved. It was clear from the beginning, however, that unity and consensus would not be an easy task. At one point the committee planned to set up a number of booths in a large shopping mall in Bangor. This was to have allowed various nursing groups to promote their unique aspects through the use of handouts, posters, photo displays, graphs, charts, etc. Each organization was to have been assigned a table of their own. The project was eventually cancelled due to the fact that many groups were against the bi-level entry issue and very little pre-interest could be generated. This lack of consensus would play a major role in the ultimate outcome of the proposal in Maine.

## **Maine Licensed Practical Nurses Association (MLPNA)**

Close behind the MSNA in its support for the changes was the MLPNA. Support from this group dated to 1983. In May of that year, the group endorsed a resolution supporting the traditional "Licensed Practical Nurse or LPN" title. During the next six months, the group was forced to take a hard look at itself and the patients it served. They determined that the health care climate in Maine was changing. Patients were sicker, requiring more technical expertise and were being discharged sooner. LPNs were assuming expanded

roles to meet the needs of the consumer and the employer in hospital, extended care facilities, and in homes. In November of 1983, MLPNA sponsored a symposium which brought together opposing viewpoints and reached a decision to expand practical nursing education from 12 months to 18, which at that time was considered associate degree level. The group endorsed the idea that a broader based education would be essential in the future for nurses at both the technical and professional levels. In their supporting statements to the Legislature, they concluded that, “It is our belief that expanding the curriculum of practical nurse education is simply part of the evolutionary process (McBrady, 1986).”

In their support of the proposal, however, the group issued a cautionary statement concerning the “grandfather” clause: “It is our opinion that the proposed new educational requirements apply to those entering the profession. Nurses licensed prior to the implementation date of the new educational requirements should be unconditionally grandfathered regardless of educational background. Anything other than unconditional grandfathering could cause undue hardship to those in the profession, who, for whatever reason, are not in a position to further their formal education prior to implementation (McBrady, 1986).”

### **Opposition from Professional Groups:**

#### **Consortium of Maine Nurses**

The major opposition to the proposal came from a group called the Consortium of Maine Nurses. This group consisted of 300 nurses who organized and campaigned state wide solely for the purpose of defeating the proposal. The Consortium framed their

opposition in terms of fairness and safety (Incze, 1986). Specifically, they identified three concerns they had with the proposed bill.

*A threat to the present nurses in Maine:*

Although a grandfather clause is included in this bill (LD 2061), it is no guarantee of mobility and employment for those nurses who are being grandfathered. Rather, the bill will provide an impetus for employers to regard the BSN as the only professional nurse thereby limiting career opportunities for those experienced non-BSN Registered Nurses to attain a degree. If this bill were to pass, serious discrimination against the nurses of the State of Maine would be mandated by law after 1995. Our nurses would be deprived of the freedom of choice to select that type of program which they deemed best since the two-year professional nurse program will be abolished. (Incze, 1986)

*A threat to the future of nurses of Maine:*

How will this (LD 2061) affect Licensed Practical Nurses from other states, (or) graduates from one year programs who wish to come to Maine? How can we expect to maintain an adequate supply of practical nurses in Maine when they can opt for a two-year program outside the state which will give them professional status rather than technical status....a professional status which they can never bring back to Maine since it will not be recognized under this new bill. (Incze, 1986)

*A threat to the people of Maine:*

As cost containment legislation proliferates, the acutely ill patient is sent home increasingly early to recover. The nurse who attends him/her must deal with less than optimal equipment and environment. The ability to improvise comes from a practical hands-on experience, not from theory. The ability to respond to an acute crisis comes

from observation of, and participation in, crisis intervention; not just from theory. Yet the BSN cannot with his/her limited clinical experience have integrated these skills. Again, as a result of cost containment, hospital staffing has been drastically altered. The presence of a worker who cannot carry the expected patient load due to inexperience can only negatively affect the intensity of care which patients will receive. (Incze, 1986)

When presenting their arguments against the proposal, the Consortium pointed out what they believed were several incorrect assumptions made by the MSNA. This included the assumptions that education on college campuses would improve by 1995, that clinical experience in college programs would be increased, that other states throughout the country would have approved the proposal, and that if other states did not approve the proposal, then the various State Boards of Nursing would have to come up with a miraculous solution to allow reciprocity between states without discrimination.

They further pointed out that in the 20 years since the ANA first began advocating the proposal the curriculum had not improved in terms of nursing theory, clinical experience had not been increased on campuses, no state legislatures in the country (as of 1986) had mandated such a bill. Since none of the above had occurred over those 20 years, they argued that it was illogical to assume that the needed changes would “magically” occur by 1995, a span of merely nine years.

They also noted that in New York the proposal had been rejected six times, and that it had been rejected in many other states. Further, they noted that: “The only state having such a law on its books is North Dakota. It was put there NOT by the legislature, not by mandate of the people, NOT by mandate of the nurses, but by nine persons: the Board of Nursing of North Dakota (Incze, 1986).”

In the group's concluding remarks to the legislature, the following was recorded: "I ask you that the state of Maine not be made the guinea pig for this legislation which was found to be undesirable in all other states where it was introduced" (Incze, 1986).

### **Opposition from Business Groups:**

#### **Maine Health Care Association and Long-term Care Nursing Council**

The main opposition from business groups came from the Maine Health Care Association and the Long-term Care Nursing Council (Hamlin, 1986). These groups framed their opposition in terms of fairness and safety.

Their chief concern revolved around the supply of nurses, the lack of appropriate educational facilities, and the higher educational costs to potential nurses. They believed that if the proposal were to be passed by the legislature, it would further exacerbate the nursing shortage in Maine. Their justification for this fear was that the new higher educational standards would intimidate a large number of potential nurses, thus keeping them from entering the profession. They argued that fewer nurses would equate to lower standards of health care to the public.

In terms of availability and cost, they argued that even though there had been an increase in facilities offering a bachelors degree in nursing, it was still not sufficient. Many nurses who wanted to upgrade their education could not begin to consider a bachelors degree because the programs offered were costly and localized mostly in the south-central part of the state.

These groups were also concerned about the "grandfather clause" in the proposal. They believed that those who did not eventually upgrade to an associate (LPNs) or

bachelor's degree (RNs) would find themselves passed over for promotions and most likely not able to compete for other jobs regardless of the amount of experience and expertise they may have had. This concern over the "transition clause" shows up in each of the four target states and has a deciding effect on the ultimate outcome of the proposal in each.

### **Other Opposition**

Also opposing the proposal were several associates degree schools. They insisted that the second level title should reflect a new type of practitioner rather than the current LPN. In a position paper distributed at the MNA convention, the Council of Associate Degree Nursing Programs endorsed the two levels of professional and technical, but stressed that the titles ought to be Registered Professional Nurse (RPN) and Associate Registered Nurse (ARN).

When the ANA voted in July of 1985 for the associate title rather than the LPN title, the MNA surveyed 400 RNs and LPNs. Of the 41.8% who were "very" or "somewhat" opposed to the Associate Nurse (AN) title, the vast majority said they would be more likely to support it if assured that the transition clause and the 1995 implementation date remained in effect. In October of 1985, reassured with these results, the MNA members agreed to the new ANA proposed titles which included the grandfather clause and the 1995 implementation date (MSNA, 1984).

Other groups that had problems with the wording of the proposal as presented by the MSNA the Maine State Advisory Board of Health Occupations Education (Toto, 1986), the Maine Medical Association (Stred, 1986), the Maine Society of Anesthesiologists

(Flowerdew, 1986), the Maine Department of Human Services (Robbins (1986), Coastal Home Management (Watkins (1986), and the Maine Department of Business Regulation (DeVane, 1986)

The central concerns of these groups revolved mainly around reciprocity with other states and various technical definitions involving the scope of practice of nurses outlined in the proposal. These concerns would be a key factor in the legislature's decision concerning LD 2061 (MSNA, 1984).

### **Legislative Document 2061**

A BSN entry bill, LD 2061 (LD 2061, 1986), was introduced into the Democratic controlled legislature and supported by the Maine Board of Nursing, the LPN group, nine of 14 state nursing specialty groups, and the Democratic Governor. By this time, the number of BSN programs in the state had grown from one to five, two of the four diploma programs had closed, and the remaining two had announced closure plans. Universities had voiced a commitment to developing extension sites to expand BSN educational opportunities, and the five vocational-technical LPN programs were being upgraded to associate degree programs.

The bill updated Maine's "Law Regulating the Practice of Nursing" to reflect what was then considered contemporary nursing practice. The revision incorporated a broad definition of nursing to reflect ongoing changes in health care. The bill also included changes in future educational requirements for nurses to assure that future nurses would have the breadth and depth of educational preparation that justify entrusting overall responsibility for nursing services to the judgment of all Registered Nurses. The bill

provided a stimulus to strengthen nursing education by focusing on resources on the two clearly defined paths, the bachelor and associate degree. It was to serve to clarify future roles for nurses, and to distinguish the services they were to provide. It was also intended to bring the educational requirements for the professional nurse up to the minimal level already required by most health care professionals at that time.

The bill was passed with certain stipulations attached. The intense debate surrounding the bill led the legislature to conclude that certain provisions needed to be studied, and assurance achieved that these concerns would be addressed prior to implementation of the new educational requirements. Amendment “A” to LD 2061 was intended to address the concerns of several health care professionals and groups regarding wording, drafting errors, and scope of practice (LD 2016, Amendment “A”, 1986).

The bill’s statutory intent stipulated that there be two levels of entry into nursing practice. To ensure Maine’s readiness for the change and to understand its implications for Maine’s citizens and Maine’s health care institutions that depend on nurses, the legislature mandated the establishment of a Commission to study the law’s impact.

### **The Commission**

The Maine Commission on Nursing Supply and Educational Accessibility, which was appointed by the governor, was comprised of people representing the general public, the Maine Hospital Association, the Maine Community Health Association, the Maine Health Care Association, the Maine Board of Nursing, and nurses representing public, private and technical education, as well as nurses representing health care service organizations.

The Commission was assigned to study eight specific areas that were directly related to supply and educational accessibility with the intent of determining whether there should be two levels of nurses requiring either an associate degree or a baccalaureate degree and the provisions to be made relating to educational requirements that take into consideration the protection of those currently licensed, and the availability of nurses throughout the state.

The areas of study included the educational accessibility of approved courses for both the associate and baccalaureate degree throughout the state, the availability of education programs for upgrading all levels of nursing throughout the state, the extent that credits are transferable between vocational-technical institutes and the university system, and whether full credit for courses will be granted toward a baccalaureate degree, whether there will be a sufficient supply of both levels of nurses to meet needs throughout the state if associate or baccalaureate degrees are required, and the extent to which there is access to assessment of prior learning of nursing knowledge and transferability of nursing credits throughout the state, including areas that are geographically under-served;

1. Which titles should be used by each level of nursing and how each level should be defined;
2. Whether competency testing should be required and whether certain educational requirements should be waived if new levels of education are implemented; and
3. Whether nurses coming in from other states will or should continue to have endorsement from the state, and how this will affect the supply of nurses throughout the state.

The statutory amendment establishing the Commission required a report of its findings to the joint standing committee of the legislature having jurisdiction over business and commerce by January 1, 1990 and every two (2) years thereafter until the defined provisions had been implemented. The targeted implementation date was 1995.

### **Commission Findings and Recommendations**

In January, 1990 and again in January, 1992, the Commission reported their findings to the Legislature (Stone, 1993). In its report in 1990, the Commission shared its progress, but due to funding difficulties, was unable to make any recommendations at that time.

In 1992, the Commission was able to finish its study and determined that the criteria identified in 1986 had been satisfied. The legislature accepted this report and recommendation favorably. At that point the nursing community began to move forward toward defining a date and the necessary legal processes to support implementation.

### **Renewed Push for Passage**

Once the MSNA began to plan for a second legislative attempt, they adjusted the framing of the proposal to include cost efficiency. At a time when there was a growing call for health care cost containment, the MSNA seized upon this move in their attempt to persuade the Legislature to pass the proposal. In a letter to the legislature from the MSNA, they reiterated this new issue frame by stating that: “Better educated nurses, working in newly defined levels of nursing will make a bigger contribution to more efficient, cost effective delivery of health care services (Sossong, 1993).”

In early 1993, LD 1471, entitled “An Act to Amend the Licensure Requirements for Nurses,” was introduced into the legislature. The bill was the implementation suggestions put forth by the Commission on Nursing Supply and Education Accessibility. In sponsoring the bill, Representative Peggy Pendleton noted that: “This bill assures protection of those currently licensed and assures the availability of nurses throughout the state (Pendleton, 1993).” However, the inability to persuade many in the nursing and health care industry that these stipulations could and would be met ultimately proved to be the downfall of the bill.

### **Legislative Testimony**

While the MSNA continued to be the main supporter of the bill, the number of those opposing or expressing reservations had grown considerably since 1986. Although the state LPN Association endorsed the 1986 bill, its growing concern over a lack of clarity of the grandfather clause was sufficient enough for the group to oppose the current bill. In the end, the testimony for and against the bill proved to be a mixed bag. While a number of groups came forward to support the bill, many more had serious reservations about it. Most of these reservations revolved around the same issues. These issues included the concern that the transition clause was still too vague, the change in nursing titles, and a continued concern over the impact the new educational requirements would have on the supply of nurses, especially in long-term care.

Major groups expressing concerns with the bill included the Maine Long-Term care Association (Hamlin, 1993), the Maine Health Care Association (Fisher, 1993), the Maine State LPN Association (Wursthorne, 1993), the National Federation of Licenses

Practical Nurses, Inc. (Wursthorne, 1993), the National Association of Practical Nurse Education and Services, Inc. (NAPNES, 1992, 1993), the Federation for Accessible Nursing Education and Licensure (FANEL, 1992a, 1992b, 1992c, 1993a, 1993b), the National Organization for Associate Degree Nursing (Singer, 1992, 1993), Northern Maine Nurse Managers (Getchell, 1993); and the Organization of Maine Nurse Executives (Hourigan, 1993).

### **Legislative Document 1471**

Legislative Document 1471 was submitted to the 116<sup>th</sup> Legislature in May of 1993 (LD 1471, 1993). By this time the membership of the joint standing Business Legislation Committee had changed significantly since 1992, thus the proceedings did not build from the work of the Commission, but rather followed the regular hearing and workshop process. The Commission's work was never fully presented or brought into evidence during the process. In fact, the Commission was identified as an advocacy group when it had attempted to be factual in its analysis. Some of the individual testimony during the hearings imparted a different perspective on the Commissions' findings than what the Commission actually intended. This, combined with the growing concern over the above outlined issues resulted in a frustrated Business Legislation Committee, a frustrated Commission, a frustrated coalition of nursing organizations and many frustrated individuals and organizations with vested interest. The Business Legislation Committee directed the nursing community to try to resolve its differences and recommended that the bill be carried into the next legislative year.

Over the next few months, numerous meetings were held in an effort to address the areas of particular concern raised during the legislative process. The Commission had a number of interested parties attend these meetings, however, the legislative representatives named to participate were unable to attend.

An educational forum focusing on the Commission's work and the proposed legislation was held in September of 1993 via the statewide interactive television network. Individual commissioners also spoke at numerous meetings throughout the state.

The political process which was managed by the MSNA was never able to achieve a consensus. In December of 1993, the Executive Director of the MSNA, Ann Sossong, left her position with the organization. Ms. Sossong had been acting as the main policy entrepreneur working with the legislature and others to get the bill passed. This left a power vacuum within the MSNA that crippled the organization's entry efforts. The MSNA was not able to find a replacement with the experience and knowledge that Ms. Sossong possessed.

On December 30, 1993, the Commission issued its final report and recommendations on LD 1471. It concluded that changes at the MSNA warranted a revision in the plan for moving toward two levels of nursing in the state of Maine. The Commission recommended that further dialogue was needed, and that a legislative presence was essential to address concerns that might arise as the bill advanced through the process. The report also stated that nursing could benefit from additional time to address this difficult issue.

The Commission's final recommendations stated that (Stone, 1993) it believed the most appropriate action at present was to suspend the legislative process by requesting an "Ought not to pass" action on LD 1471. It recommended that the legislation be resubmitted in the near future. The Commission planned to update the data related to the specific provisions and to revise its recommendations if indicated. It further stated that it remained open to input from interested parties and, if supporting factual data could be provided that supported an alternative finding, the Commission would integrate that information into its data base, deliberations, and recommendations. Its final recommendation stated that professional nursing organizations should address the political process and the Commission should remain as objective as possible. At that point the bill died and the issue has not been resurrected.

## **MONTANA**

### **Cultural and socio-economic background**

Montana is located in the upper western section of the country. It is the fourth largest state in the US and the 44<sup>th</sup> most populous. To the north, the state borders the Canadian provinces of British Columbia, Alberta, and Saskatchewan. The state is bordered on the east by North Dakota and South Dakota, while to the south is Wyoming, and to the west is Idaho. The state capital is Helena and the largest city is Billings. German ancestry is the largest reported European-American ancestry in most of Montana, followed by Scandinavian ancestry. This places the state within Hero's homogeneous political subculture. There are also a number of predominantly Native American counties, mostly

around each of the seven Indian reservations. The economy is based heavily on agriculture, although lumber, mineral extraction and tourism are also major industries.

The government of Montana is composed of three branches: the Executive, Judicial, and Legislative. The executive branch is headed by the governor. Montana has a bicameral legislature composed of two chambers: a 100-member House of Representatives and a 50-member Senate. House members to four two-year terms and Senate members are limited to two four-year terms. The Montana State Legislature meets only on odd numbered years, and for 90 day periods. The highest court in the state is the State Supreme Court.

Historically, Montana is a swing state of cross-ticket voters with a tradition of sending liberals to the state capital and conservatives to Washington. However, there have also been long-term shifts of party control. During the 1970s, the state was dominated by the Democratic Party, with Democratic governors for a 20-year period, and a Democratic majority of both the national congressional delegation and during many sessions of the state legislature. Overall, since 1889 the state has voted for Democratic governors 60% of the time and Democratic presidents 40% of the time, with these numbers being 40/60 for Republican candidates.

Montana has three state financed community colleges and four tribal colleges. The state has two major state-funded four-year colleges, the University of Montana and Montana State University. There are also a number of private colleges. There are nine registered nursing programs and five licensed practical nursing programs.

As in most states, interest groups in Montana play a significant role the policy making process. According to Thompson and Hrebenar's classification of states by overall impact

of organized interest, interest groups tend to play only a dominant/complimentary role in the process in North Dakota (Thompson & Hrebenar, 1996). As such, it should be noted that Montana was one of the two states that the ANA proposal was outright defeated.

### **ANA Proposal**

In the case of entry into practice in Montana, the Montana Board of Nursing (MBN) presumed it had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it was assumed by the organization that it had the power to initiate such a measure. It was to later find out it did not. As in the other focus states, the state board of nursing and the state nurses association (Montana Nurses Association or MNA) worked in conjunction to get the ANA proposal adopted in that state.

Discussions within the MNA concerning the entry issue began in 1977 (Munger et al., 1987). These discussions resulted in the introduction and adoption of the first entry resolution by the MNA's House of Delegates in 1978 (Munger et al., 1987). The resolution asked that two categories of nursing practice be identified, that the new educational standards be in place by 1985, and that a plan for implementation be developed (Munger et al., 1987).

A forum concerning issues surrounding the entry question was held at the MNA's 1979 convention. A document from MNA's Council on Practice comparing the competencies of nursing with two-years of preparation with those nurses having four-years of preparation was distributed and discussed (Munger et al., 1987).

The MNA was represented at the 1980 ANA entry meetings in Portland, Oregon and Pittsburg, Pennsylvania. MNA's representatives at the ANA meetings conducted sessions at MNA's Annual Nursing Fair that year, and provided participants with a written summary of actions taken to date by MNA and ANA (Munger et al., 1987).

A long-term goal adopted by the MNA House of Delegates in 1982 read as follows: "Implement the baccalaureate as the basic educational level of entry into practice by 1987." Attached to the goal were existing assumptions, assignment of functions to various structures within MNA related to the goal, a proposed time frame for progress reports, and a budget allocation (Munger et al., 1987).

In 1983, a steering committee was appointed by the MNA Board of Directors to establish the general direction of the implementation process for the proposal (Munger et al., 1987). The committee represented clinical, educational, and administrative concerns in nursing, as well as each type of nursing education programs: diploma, associate, and baccalaureate. Also included in the committee were a member of the Montana Board of Nursing and an MNA Board member. After two meetings in 1983, the ad hoc committee recommended the appointment of a special committee to develop a plan for implementation.

MNA's Special Committee on Implementation, appointed in June 1983, met five times that year. Soon thereafter, the Committee was notified of a special meeting being called by ANA's Cabinet on Education scheduled for July 1983 (Munger et al., 1987). Anticipating an invitation from MNA to attend the meeting, the special committee drafted a tentative implementation plan. MNA was invited to the meeting and subsequently presented MNA's proposed plan. The initial plan was broad in scope, and

provided a framework for the evolution of the detailed plan, which came to fruition in June 1985 (Munger et al., 1987).

Encouraged by the positive feedback from the meeting, the MNA Board of Directors voted to allocate \$5,000 for implementation of the entry goal as its good-faith share of a grant proposal submitted to ANA in November 1983 (Munger et al., 1987).

A position paper on nursing education was prepared by the special committee and adopted by the MNA Board of Directors in October 1983 (Munger et al., 1987). The statement outlined official actions taken by the MNA regarding nursing education in support of baccalaureate preparation for professional nursing practice. It was sent to state agencies that had been discussing the development of an additional associate degree program in the state to prepare Registered Nurses. Several factors, including MNA's position paper, contributed to the decision not to proceed with the program.

### **Framing by Support Group**

From the beginning, the MNA framed the issue in terms of a need to improve nursing education in order to provide superior health care services (Munger et al., 1987). This assumption was attached to the 1982 long-term goal which stated MNA's rationale for the promotion of entry: "Baccalaureate education is the basic preparation of all health care professionals. Consistency in educational preparation of the professional nurse will aid in alleviating the great divergence presently operating within the organization. The baccalaureate-prepared nurse has the best basic education to deliver comprehensive care to clients."

In March 1984, the organization again reiterated this point in a position statement: “The purpose of this concept is to insure that future nurses are educated in a system that will best prepare them to meet the ever increasing technology and complexities of health care. Similar concepts have been adopted by many other professionals. It is now time for the nursing profession to accept the responsibility and be responsive to the health care needs and demands of the future (MNA, 1984, March 13).”

### **Steering Committee**

MNA’s Board of Directors appointed the Steering Committee in January 1984 to “overview the activities of the grant (Munger et al., 1987).” One member of the 1983 Special Committee was appointed to the Steering Committee along with seven others chosen for their individual skills and MNA affiliation. The composition of the committee changed during the years due to resignations, inability to attend frequent meetings, and conflicts about the educational goal. Of a total of 14 nurses who served on the Steering Committee periodically from January 1984 through April 1987, five participated in the final phase of the entry campaign (Munger et al., 1987).

In one of its first reports to the MNA Board of Directors, the Steering Committee described the time and effort expended in forming a cohesive, knowledgeable, committed group and in determining its relationship to the MNA Board, MNA staff, and other MNA structures (Munger et al., 1987).

Minutes were recorded for 28 meetings of the Steering Committee, in addition to joint meetings of the committee, various other MNA committees, and other groups, during the three year campaign (Munger et al., 1987). Individual members of the committee were

active on the statewide Speakers Bureau and represented the Steering Committee at meetings with other organizations or individuals.

### **Policy Entrepreneur**

When choosing an individual to lead the effort for adoption of the proposed changes, the MNA selected someone whom they believed had the greatest respect and influence both within the state nursing community and at the state capital. Mary Munger was chosen as the Steering Committee Coordinator to work with nurses and legislators. Munger was a seasoned Registered Nurse who had a proven track record of successful nursing legislative activities. She worked to help the ANA develop a national salary goal in 1965, convinced the organization to support the Equal Rights Amendment, assisted in the development and subsequent publication of guidelines for the development of Education and General Welfare programs by state nurses associations, and advised ANA staff on issues affecting the economics of nursing.

Munger also served as the executive director of the MNA for a number of years. In that role she was instrumental in writing and lobbying for legislation that would protect the right of Registered Nurses and licensed practical nurses to bargain collectively. Proving to be diligent, Munger lobbied throughout several legislative sessions in 1961, 1963, 1965, 1967 and 1969. The bill was passed and vetoed in 1965, passed and signed in 1967 and then made permanent in 1969. Legislators nicknamed the bill the "Blue-eyed Nurse Bill" in honor of Munger.

When the MNA found itself battling to ensure that nurses could engage in collective bargaining, they called on the expertise of Munger. She was honored by the

establishment of the Mary Munger Award, which recognizes a nurse for leadership in the interest of legislative, social, or economic needs of the nurses in Montana. Assisting Munger was Barbara Booher, the MNA's Executive Director, and Trudy Malone, the MNA's President. Both women were well known and respected in the nursing community with both being well experienced with legislative activities. As a matter of fact, Malone received the Mary Munger Award in 1979.

### **Issue Expansion**

An overriding concern of the Steering Committee was the acceptance of, and support for, educational changes among nurses and the public, that should be promoted across the state.

Sixty-two persons attended a forum on April 3, 1984, representing every nursing organization in the state, MNA structural units, districts, and guests (Munger et al., 1987). The purpose of the forum was to begin statewide dialogue regarding implementation of the educational changes. Small groups, with the assistance of professional facilitators, discussed issues related to entry such as the impact on education, careers and employment, and quality of care.

Nurse supporters from across the state were invited to serve as members of a speaker's bureau. In November 1984, approximately 20 nurses participated in a one-day training session arranged by the Steering Committee (Munger et al., 1987). The session was conducted by a consulting firm. Speakers Bureau members arranged speaking engagements with local nursing groups and other interested organizations to inform them, encourage their support of the proposed changes, and to relay reactions to the steering

committee. Correspondence was the principle means of maintaining contact between the Steering Committee and the Speakers Bureau. In October 1985, a second state wide meeting was held to evaluate, coordinate, and refine implementation efforts (Munger et al., 1987).

Employment of a part-time coordinator in July 1985 enabled the Steering Committee to develop other structural features of its detailed implementation plans. In August 1985, five area coordinators were appointed to establish area-wide networks of supporters, and to coordinate entry activities in preparation for the 1987 legislative session (Munger et al., 1987).

At the state level, four sub-groups composed of MNA members and non-members were activated to collect data regarding educational access, use of nursing personnel, impact of entry on employment opportunities, and impact of entry on the cost of nursing education (Munger et al., 1987). Final reports and recommendations from each of the subgroups were given to the Steering Committee, and relevant recommendations were forwarded to appropriate MNA structures for information. A summary of the data from the subgroups work was featured in a special entry newsletter, *NEWSALERT* (Munger et al., 1987). Because access to education was a major issue with members of the 1987 legislature, copies of the sub-committee's reports were made available to the 18-member House committee to which H.B. 36, MNA's entry legislation, was referred (H.B. 36, 1987).

A monthly newsletter was started in August 1985 and was published through December 1986 (Munger et al., 1987). Initially, the newsletter, *NEWSALERT*, was a photocopied separate page in MNA's official publication, *PULSE*. Later, it was printed as

a part of the publication. The newsletter was sent to MNA members and to 35 business, labor, agricultural, and health-related organizations. The newsletter described entry activities including statements of support from various nursing organizations, highlighted national trends in nursing education and practice, and responded to questions about the impact of entry.

The services of a private consulting firm were used to finalize a questionnaire and an informational brochure sent in September 1984 to all Registered Nurses and licensed nurses licensed in the state (Munger et al., 1987). The purpose of the mailing was twofold: (1) to provide accurate, consistent information to all nurses and interested parties in the state, and (2) to collect data regarding opinions and concerns from these groups. Results indicated that Registered Nurse supporters outnumbered opponents by three-to-one and that more than twice as many licensed practical nurses supported the changes as opposed them. Also included in the summary report were many concerns and issues expressed by nurses about the changes. This data provided valuable input about issues the Steering Committee would focus on for the next two and one-half years.

In July 1986 a second survey was conducted by the same consulting firm. Representatives of the Steering Committee and its subgroups identified the need for a survey to collect current data about staffing patterns, and about predicted needs for nursing personnel, and to get the perspective of nursing service administrators on the impact of the entry proposal on the quality and cost of care (Munger et al., 1987). Two hundred seventeen questionnaires were mailed to nursing administrators in hospitals, nursing homes, convalescent centers, extended care facilities, county health departments, home health care agencies, and college-based health services. The 57 percent response

indicated strong support for the entry proposal. Among all types of health care settings across the state, 62.7 percent of the respondents supported the proposed changes in education. Close to 75 percent of the nurse administrators related higher standards for education to improvement in key components of nursing practice such as independent decision making and ability to meet emerging needs of special populations. Copies of the executive summary from the July survey were sent to all nursing service administrators surveyed, to nursing organizations, and to key state agencies and legislators.

### **Public Relations**

Several means were used to disseminate information about MNA's proposal for changes in education (Munger et al., 1987). This included the use of public relations materials available from ANA. "Nursing 21" campaign badges were also made available in 1984. Two separate posters were prepared to accompany a special promotional pamphlet in 1986. These visuals were distributed throughout the state by area coordinators who arranged to have them posted in public places. News releases were sent to all newspapers and radio and television stations whenever activities focusing on entry were held.

At a news conference in August 1986, MNA's legislative intentions were publicized along with key items from the survey (Munger et al., 1987). However, television, radio, and news coverage of this event emphasized the division within the nursing community.

### **Opposition from Professional Groups:**

Two nursing groups opposed the proposal: the Concerned Nurses of Montana and the Montana LPN Association. While the Concerned Nurses were instrumental in getting the “entry” legislation defeated, the LPN Association eventually made peace with the MNA and withdrew its opposition to the legislation.

### **Concerned Nurses**

The Concerned Nurses of Montana (CNOM) was a group of Registered Nurses who framed their opposition to the proposal in terms of fairness and job discrimination. January 1983 is the date given for the official start of the organization (Munger et al., 1987). The Concerned Nurses believed that higher educational standards for nurses weren’t necessary, and would actually contribute to educational discrimination by limiting nursing jobs to those who could afford to obtain a four-year diploma (Wilke, 1986, December 4; “Change in Nurse Rules,” 1986). They attempted to convince legislators that the cost, duration and availability of four-year nursing programs would make nursing as a profession an impossibility to some, especially female heads of households and minorities.

The Concerned Nurses also believed that the new standards would contribute to a nursing shortage and to the closure of some small and rural Montana hospitals (Munger et al., 1987). They stated that because the new requirements would make out-of-state nurses with a two or three year education ineligible to practice in Montana, the state would face a shortage of nurses, particularly in rural communities that were already having difficulty

attracting and maintaining nursing staff. They believed this would lead to the closure of some rural facilities.

The MNA countered these claims by stating that the proposed new standards were strictly intended to make nursing education more standardized, and that those nurses already practicing in the state prior to the proposed implementation date would be exempt from the new requirements (Munger et al., 1987). The MNA stated that Montana was a provider state where nursing is concerned. This is because many nurses who are educated in Montana leave the state to practice elsewhere. This fact was considered by the MNA as a major contributor to the nurse shortage. The group acknowledged that some rural communities were having difficulty attracting not only nurses but also physicians, but that this did not justify relaxing educational standards for either profession.

In response to the Concerned Nurses claim that a four-year degree did not provide a superior education, the MNA countered that four-year programs give nurses a broader base of education to meet a variety of needs (Munger et al., 1987). The MNA also countered that many nurses earn two-year degrees at community colleges, which are institutions whose credits often cannot be transferred to other institutions when those nurses want to further their education.

Members of the Steering Committee met with officers of CNOM in May 1985 (Munger et al., 1987). The CNOM officers re-emphasized the organization's support for all four of the existing types of nursing education programs, and stressed the need for easier access to baccalaureate programs. The organization's written and verbal testimony was critical of BSN graduates and supportive of the scope and quality of care provided by diploma and A.D. graduates. Newsletters from this organization often quoted information

from the national organization Federation for Accessible Education and Licensure (FANEL).

Representatives of CNOM attended meetings of the Nurses Council to express opposition to entry. Its members were active, effective opponents both before and during the 1987 legislative session. They employed a full-time lobbyist who held a doctorate in education and was the wife of a local congressional candidate.

### **House Bill 409**

In 1985, CNOM initiated H.B. 409 (H.B. 409, 1985). The intent of its proposed legislation was to prevent the Montana State Board of Nursing from changing educational requirements for nursing practice through its rules.

During the legislative debate on H.B.409, the lobbyist for the Montana State Licensed Practical Nurses Association (MSLNPA), with support of CNOM, persuaded the Department of Commerce, which has administrative authority over the Montana State Board of Nursing, to arrange a meeting to discuss a memorandum of understanding proposed by CNOM (Munger et al., 1987). Attending were representatives of MNA, MSLPNA, CNOM, and the board of nursing. The memorandum of understanding was a proposal to the four nursing groups to establish an advisory task force to advise the board of nursing on “entry level” change. The proposed task force was to have broad-based representation from the four organizations to which the memorandum of understanding was addressed, the Montana Nursing Home Association, the Montana Medical Association, the Montana Hospital Association, a vocational-technical center offering a program for practical nurses, and an associate degree nursing program. Money to finance

the meetings was to come from board of nursing funds with staff assistance from the Department of Commerce.

According to the minutes of its March/April 1985 meeting, the MNA's Board of Directors voted not to participate in the advisory task force for the following reasons (Munger et al., 1987):

1. MNA had in place an implementation plan which included joint meetings to discuss mutual concerns with all organizations and groups impacted by the educational preparation of nurses,
2. MNA was concerned with the use of taxpayer dollars to fund a coalition in light of the history of a prior task force which was formed and studied the Entry into Practice issue in 1978 and,
3. MNA felt that the Association was being held hostage via House Bill 409.

Ultimately, the proposed legislation was defeated. One of the results of the legislative debates was that conflicts among nurses and their employers about educational preparation were identified for legislators and the public.

In May 1985, the Board of Nursing took a neutral position about MNA's proposed educational changes, thereby negating the need for the proposed task force (Munger et al., 1987).

### **Attorney General's Opinion**

Also during the 1985 legislative session, the Montana Board of Nursing requested an opinion from the state Attorney General regarding the Board's rule making authority on educational requirements. On August 7, 1985, the Office of the Attorney General of the

State of Montana issued its opinion on the matter. In its opinion, the Board did not have the authority to change educational requirements for nursing practice through its administrative rules (Munger et al., 1987).

At that point, the administrative option to address the proposed change was closed and plans proceeded to present the proposal to the legislature for consideration.

### **Montana State Licensed Practical Nurses Association (MSLPNA)**

The second nursing group that opposed the proposal was the MSLPNA (Munger et al., 1987). This group initially approved of the proposed changes but technically reversed their stand in 1986. The LPN Association also framed their opposition in terms of fairness. They had serious concerns about the grandfather clause of the proposal, specifically that those educated prior to the implementation of the new standards would be forced to upgrade their educational credentials, or leave nursing all together. Although the MNA made it very clear that this was not the case, this issue proved to be the major divisive point between the MNA and the LPN Association. This division resulted in the LPN Association requesting that LPN educational requirements be left as they were, with the stipulation that if this was done, the organization would not oppose the RN changes. As with the Concerned Nurses, this group also felt that increasing the educational standards for nurses did not necessarily lead to superior patient care.

Efforts of the Steering Committee and the MNA Board of Directors to involve MSLPNA in discussions on entry are well documented in MNA's record (Munger et al., 1987). The MSLPNA was represented at the first statewide forum for nurses on entry in April 1984. In September of that year, all licensed practical nurses were sent the

descriptive brochure explaining the proposal for changes in education, along with a survey form to complete. At MNA's request, a licensed practical nurse was appointed by MSLPNA to the Steering Committee. This representative served from October 1984 to April 1985.

LSLPNA joined forces with CNOM against MNA during the 1985 legislative debate over H.B. 409 (Munger et al., 1987). Requests to meet with representatives of the licensed practical nurses organization to discuss the position of that group were made by MNA in April 1985 and again in July 1985. Responses to both requests indicated unwillingness to hold such a meeting. MSLPNA was represented at the three meetings of the Nurse's Council.

MNA's delegates to ANA's 1985 convention unsuccessfully opposed changing the title for the technical nurse category because agreement had been reached with licensed practical nurses in the state to retain the title *licensed practical nurse* (Munger et al., 1987). Subsequently, on the recommendation of the Steering Committee, a resolution on titling was approved by MNA's 1985 House of Delegates to retain in Montana the title *licensed practical nurse* for the AND-prepared technical nurse. Copies of the resolution of ANA's House of Delegates on titling for licensure and of MNA's resolution were sent to MSLPNA. Members of the Steering Committee presented information about entry to the 1985 and 1986 annual conventions of the MSLPNA.

On October 31, 1986, MSLPNA's executive director telephoned MNA's executive director asking for a meeting November 3 with MNA representatives (Munger et al., 1987). MNA's executive director and a project coordinator represented MNA at the meeting, with four licensed practical nurses and their lobbyist present. On November 14,

1986, MSLPNA's lobbyist sent a letter asking MNA to delete any proposed changes affecting licensed practical nurses in its proposed legislation. MNA's Board of Directors acceded to this request at the recommendation of a joint meeting of MNA's Committee on Legislation and Steering Committee. A licensed practical nurse testified against HB 36, MNA's entry proposal, but did not represent herself as a representative of MSLPNA. A licensed practical nurse, an active member of CNOM, was elected to the 1987 Montana legislature and was a member of the House committee that heard HB 36.

### **Opposition from Business Groups:**

#### **Montana Hospital Association**

The Select Committee on the Nursing Entry Level was formed within the Montana Hospital Association in April 1986 (Munger et al., 1987). MNA's Steering Committee co-chairman and project coordinator were invited to the first meeting of the group to discuss MNA's goals and plans. The same opportunity was afforded groups opposing entry and for representatives of Montana's nursing education programs. A similar meeting was held to present and discuss results of the July 1986 survey of nursing service administrators.

The Select Committee submitted a recommendation to the 1986 MNA House of Delegates in support of the concept of entry after 1995, but only if the educational programs for both categories of practice were in place (Munger et al., 1987). The resolution was not accepted by the MHA delegates, who voted to oppose MNA's legislation because of cost concerns and perceived difficulty in recruiting baccalaureate-prepared nurses to Montana's rural hospitals. Testimony by MHA representatives during

the legislative hearing reiterated the views of MHA's House of Delegates and raised doubt about the authority of the North Dakota Board of Nursing to implement changes in education in that state.

### **Montana Medical Association**

MNA's executive director and project coordinator met with the Montana Medical Association's executive director, lawyer lobbyist, and legislative committee chairman in November 1986 to share a copy of the final version of the entry legislation (Munger et al., 1987). The MMA representatives informed the MNA representatives that a decision had been made within MMA not to take a position on MNA's entry legislation. They advised against having the bill introduced because of the controversy about the issue among nurses. However, individual physicians contacted legislators both in support of and in opposition to H.B. 36.

### **MNA's Grant-Supported Entry Campaign, 1984-87**

ANA awarded money to MNA based on three separate grant requests submitted from January 1984 through April 1987. Funds from the ANA were used to (Munger et al., 1987) inform and involve as many organizations and nurses about entry as possible, purchase the services of consultants in developing implementation plans and conducting surveys purchase and distribute newsletters and other promotional materials, collect data through statewide surveys, and employ a part-time coordinator and a part-time clerical assistant in July 1985.

In November 1984, Steering Committee members and MNA board members attended meetings with administrators and directors of nursing from four colleges conducting nursing education programs. Meetings were held a day later with administrators and directors of nursing from five vocational-technical centers conducting practical nursing education programs. MNA's proposal for changes in education was discussed and input was requested. During the discussions, the presidents of Montana State University and Carroll College, which had baccalaureate nursing programs, offered strong support for the changes in education. Administrators of the two colleges conducting associate degree programs acknowledged the need for the changes.

Opposition to the proposed changes in the educational base for practical nursing came, both during and after the meeting, from the vocational-technical centers. However, opposition from the centers was weakened when the legislation was changed to delete proposed changes in practical nursing education. Miles City Community College vigorously opposed entry at legislative hearings and in the press.

Following the defeat of H.B. 409 in 1985, and in discussions with legislators and other state officials, MNA agreed to call a meeting of all nursing organizations in the state to discuss issues of common concern and to determine interest in forming a statewide coalition (Munger et al., 1987). Seventeen nursing organizations were contacted and a meeting was arranged for October 1985. Two additional meetings were held with representatives of 11 nursing organizations attending one or both meetings. The group took the form as the Nurses Council. Entry was the main topic of discussion at the first two meetings of the group, but agreement was reached that the format and content of future meetings would include additional agenda items. In the afternoon following the

first meeting of the nursing organizations, representatives of organizations supporting entry met with members of the Steering Committee to encourage resolutions of support from each state group and to enlist participation in entry efforts.

In July and September 1985, the co-chairman of the Steering Committee met with the Commissioner of Higher education to discuss MNA's proposed changes in education (Munger et al., 1987). Because of his expressed interest, another meeting was held with the Commissioner in January 1987 to discuss the outcome of MNA's entry legislation, and to provide him with current reports about trends in nursing education (Munger et al., 1987).

A meeting was held in 1985 with the administrator of the Vocational Education Division of the Department of Public Instruction (Munger et al., 1987). He had expressed his opposition to the entry proposals on several different occasions and did so again at the 1986 MSLPNA convention.

Forums on entry were conducted during MNA's 1984, 1985, and 1986 annual conventions (Munger et al., 1987). Reports on entry activities were included in the association's annual book of reports for those three conventions.

### **MNA's Legislative Experience**

Historically, MNA enjoyed a great deal of credibility for its legislative endeavors (Munger et al., 1987). In 1942, MNA employed its first executive. Since that time, that person has served as official lobbyist for the association during legislative sessions and between biennial sessions, and has monitored legislative outcomes and relevant activities at the state capital. In recent years, the chairman of MNA's Committee on Legislation

and MNA's director of economic and general activities have also served as lobbyists. A student intern was employed to collect and sort legislative documents and to track the status of bills. Day-to-day decisions about legislative positions were, and continue to be, based on a legislative platform adopted by the MNA House of Delegates.

Nurses in Montana gained prominence for their political and legislative involvement during the 1960's. The association initiated and, after three legislative sessions, was successful in getting legislation passed in 1967 regulating collective bargaining for Registered Nurses and licensed practical nurses.

It had been the pattern for the MNA's Committee on Legislation to meet frequently during each legislative session to review legislation, determine MNA's positions, and make arrangements for testimony. Telephone messages to MNA's districts activated calling trees of local nurses who contacted their respective legislators as needed,

In 1985-86, several changes took place within MNA altering its legislative pattern. MNA employed a new executive director in December 1985. The responsibilities of the MNA board, staff, lobbyists, and Committee on Legislation were studied and changed so that the committee was enlarged to include area coordinators, who were also responsible for organizing area networks for the promotion of entry. MNA's executive director was employed to serve as both coordinator and lobbyist for the promotion of entry. A part-time staff person working with the MNA's economic and general welfare program joined MNA's staff in 1986 and assisted with legislative workshops and lobbying during the 1987 session. With this staff person, MNA had a total of four registered lobbyists. The work of the intern was assigned to another part-time employee.

## **Early Warning Signs**

Most organizations, when stuck on an issue, bring together representatives for the groups most affected. These representatives often negotiate tenaciously until they find a solution all sides can accept. Unfortunately, this does appear to have been the case when the MNA was preparing to take the proposal to the legislature.

As early as 1985 there were signs that the MNA would have difficulty convincing the legislature to approve the proposed changes. In a letter to the Steering Committee, Sharon Dieziger (Dieziger, 1985, August 29), a member of the MNA's Nurse Advisory Committee, indicated that some members of the legislature had already made up their minds concerning the proposed change. She states: "I have some grave concerns that I need to share with you regarding a recent conversation I had with Representative Bergene. She told me that the Legislature is very committed to not dealing with the educational issues of entry. The committees she worked with feel that they fund boards for this purpose, and if boards do not deal with controversial professional issues of education, etc., that their purpose will come under serious scrutiny. She tells me that it has already been discussed that a committee mechanism is in place to go through the Audit Committee to request sunseting the Board of Nursing."

She further stated that there is much talk throughout the state concerning the supposed turmoil within the MNA and that certain interest groups were watching closely (Dieziger, 1985, August 29). Although there are no records to indicate that such "turmoil" was going on within the MNA, the fact that such a rumor was circulating undoubtedly diminished the MNA's reputation and credibility in this issue, both with the public at large and within government circles.

## **1987 Legislative Effort**

Area coordinators tried to have nurses involved in legislative campaigns and to have at least one nurse supporter assigned to each legislator for contact during the session. In some areas of the state, nurse supporters were assigned to legislators with whom they maintained regular contact regarding H. B. 36, but without much success.

Representative Dorothy Bradley, Bozeman, a seasoned legislator and consistent supporter of professional nursing, agreed to sponsor the legislation. In early 1986, Senator Judy Jacobson, Butte, authorized the Montana Legislative Council to draft the bill for MNA but was unwilling to sponsor it when asked to do so by MNA.

On January 5, H.B. 36 was introduced (H.B. 36, 1987). It was assigned to the House Committee on Human Services on Aging and a hearing was scheduled for January 15, giving MNA much less time than anticipated for lobbying the bill (Munger et al., 1987).

Six new legislators were serving on the House committee, including the licensed practical nurse member of CNOM. A holdover committee member had sponsored H.B. 409 in the 1985 session. The committee met only three times before hearing MNA's entry legislation and members had just begun to get acquainted with one another.

Caught in the confusion that exists at the start of a legislative session, all four of MNA's lobbyists concentrated on getting additional sponsors, in contacting the 18 House committee members and other legislators, in activating the telephone tree to get support from nurses across the state, and in preparing for the hearings. This process was further complicated because MNA's lobbyists and MNA's executive did not know many legislators or their history in regard to MNA's legislative interests.

MNA's detailed testimony, present by MNA's president, was based on data collected from surveys, nursing literature, and facts about Montana's nursing situation (Munger et al., 1987). Other speakers supporting H.B. 36 included the president of the Montana Consortium of Schools of Professional Nursing, a nursing service administrator from a large hospital, a hospital staff nurse, and a school nurse. The presidents of the Montana Student Nurses Association and the Montana Public Health Association were ready with supporting testimony, but time constraints placed on the hearing by the committee chairman limited the number of persons testifying. Written testimony from other nurses and health-related organizations, along with a scroll of more than 700 names from baccalaureate nursing students across the state, was given to committee members in a packet of supporting documents.

The opposition had representatives from CNOM, MHA, the Montana Health Care Association (representing nursing homes), a nursing service director, a licensed practical nursing educator, a licensed practical nurse, the director of Miles Community College's associate degree nursing program, and a rural hospital administrator. Content of the opposition statements followed the same arguments as those publicized before the session (Munger et al., 1987).

There were in attendance almost 200 individuals. When queried by the chairman, approximately two-thirds of them indicated support for the bill. The committee voted to delay executive action on the bill for another week (Munger et al., 1987).

The following week, every member of the committee was contacted by the MNA's entry lobbyist, who provided additional information to each, based on expressed need. Hundreds of letters poured in from supporters and opponents.

In executive session January 22, 1987, the committee approved a motion not to pass the bill by an 18-2 vote after an attempt by a supporter to move the date from 1992 to 1995 and another motion to table it (Munger et al., 1987). The influence of the licensed practical nurse committee member and of the member who raised the issue during the 1985 session was very significant, as were telephone calls from local hospital and nursing home administrators. Sponsor Bradley advised against trying to mount a campaign to overturn the committee's action. All but 18 members of the House accepted the committee's recommendation not to pass H.B. 36.

Defeat of H.B. 36 can be attributed to strong opposition from nurses and employers, MNA's internal problems, and MNA's inability to clearly explain the "grandfather" clause to the state's licensed practical nurses.

## **OREGON**

### **Cultural and socio-economic background**

Oregon is located in the Pacific Northwest region of the country. The state is located on the Pacific coast between Washington to the north and California to the south. Nevada is southeast of the state and Idaho is to the east. It is the 9th largest state by area in the US and the 27th most populous. The state capital is Salem and the largest city is Portland.. The residents of Oregon are primarily of European ancestry with the largest reported ancestry groups being German, English, and Irish. There is also a sizeable African American and Hispanic population (U.S. Census Bureau, 2000). The places the state within Hero's heterogeneous political subculture.

Oregon is one of the largest producers of timber and has one of the largest salmon industries in the world. The state is also home to a number of large national and international corporations.

The government of Oregon is comprised of three branches, the Executive, Judicial, and Legislative. The three branches are referred to as departments by the state's constitution. Governors serve four-year terms and are limited to two consecutive terms, but are not limited to a number of total terms. Oregon has no Lieutenant Governor. If the office of Governor is vacated, the Oregon Constitution specifies that the Secretary of State is first in line for succession. The Oregon Legislative Assembly is made up of a thirty-member Senate and a sixty-member House. The state Supreme Court has seven elected justices.

For the first half of the 20th century, Oregon was consistently Republican. This began to change in 1954 with the election of a Democratic Governor and a Democratic majority in the legislature. Today, Oregon clearly leans Democratic as a state, with both U.S Senators from the Democratic Party, as well as four out of Oregon's five U.S. Representatives.

The Oregon University System consists of seven public universities and one affiliate. There are also a number of private colleges and 17 community colleges. Of these, there are 17 Registered Nursing programs and seven Licensed Practical Nursing programs.

As in most states, interest groups in Oregon play a significant role the policy making process. According to Thompson and Hrebener's classification of states by overall impact of organized interest, interest groups tend to play only a dominant/complimentary role in

the process in the state (Thompson & Hrebenar, 1996). As such, it should be noted that Oregon was one of the two states in which the ANA proposal was outright defeated.

### **ANA Proposal**

Of the four states in this study, the least amount of information concerning the entry issue could be found on Oregon. Neither the Oregon State Board of Nursing (OSBN) nor the Oregon Nurses Association (ONA) was able to supply this researcher with any pertinent data on the issue (other than the OSBN's official positions). What information that could be located is as follows.

In the case of entry into practice in Oregon, the OSBN had the ability to change the nursing educational requirements on its own. As a regulatory board for nursing in the state, it had the power to initiate such a measure. With this ability in mind, discussions within the OSBN concerning the entry issue began in 1977. On March 3, 1982, these discussions resulted in the OSBN adopting two motions relating to the requirements for licensure of Registered Nurses and Licensed Practical Nurses (Hicks, 1985, March 26). These motions called for RNs to hold a minimum of the baccalaureate degree in nursing and LPNs to hold a minimum of the associate degree in nursing. The motions read:

“Effective January 1, 1990, an applicant for initial licensure as an RN shall be a graduate of an approved program of nursing, with at least a baccalaureate degree in nursing. Any person holding a license to practice as an RN, which is valid on January 1, 1990, shall be deemed to be licensed as a RN under the provision of this act and shall be eligible for renewal of such license under the conditions prescribed by renewal of license requirements.”

“Effective January 1, 1990, an applicant for initial licensure as a LPN shall be a graduate of an approved program of nursing with at least an associate degree in nursing. Any person holding a license to practice nursing as a LPN under provision of this act shall be eligible for renewal of such license under the conditions prescribed by renewal of license requirements.”

### **The Study**

In 1982, the ONA, working in conjunction with the OSBN, initiated a systematic study to ascertain the views of Oregon nurses towards the proposed change and its related issues (Morton, 1983). The study was to determine the extent of support or opposition toward the two levels of practice and the inclusion of a “grandfather clause.” Also to be examined was the degree of support for a ladder mechanism of articulation among various types of nursing education programs; one educational alternative for nurses who, under the proposed change, may not be content to merely be “grandfathered.”

Three hundred Oregon Registered Nurses, randomly selected from the Oregon Board of Nursing’s mailing list of license holders residing in Oregon, were invited to participate in the study through mailed questionnaires. The response rate to the mailed questionnaires was 84 percent.

The data gathering instrument included a four item questionnaire related to the proposal. Subjects were asked to respond to four declarative statements, using a forced choice, four-point Likert-type scale:

1. Nursing should be divided into “Regional Technical” nurses with two distinctive types of educational preparation, instead of the present system of B.S., Diploma, A.D., for R.N.s and Practical/Vocational for L.P.N.s/L.V.N.s.
2. When the proposal is implemented, the Bachelor’s Degree should be required for licensure as a “Registered Nurse.”
3. Legislation implementing the proposal should not include a “grandfather clause.”
4. When the proposal is implemented, a “Registered Technical Nurse” should be allowed to enter any educational program with full credit for previous nursing education.

The findings (see Tables 4.1 and 4.2) indicated that Oregon nurses were divided on two issues associated with the proposal. Approximately one-half of the respondents expressed varying degrees of support for a differentiation in the levels of practice and licensure, and one-half expressed their opposition. The vast majority of respondents indicated they supported inclusion of a “grandfather clause” in implementation of the proposal and the development of a career ladder mechanism of articulation among various types of nursing education programs.

**Table 4.1: Percentage of Nurses by Type of Basic Nursing Preparation Expressing Support for Resolution Items**

<b>Resolution Item</b>	<b>Diploma</b>	<b>A.D.N.</b>	<b>B.S.N.</b>
Professional/Technical Split	40%	31%	84% ***
Bachelor's Requirement	39%	31%	86% ***
Grandfather Clause	94%	97%	76% ***
Ladder Mechanism	90%	97%	86%

\*\* alpha .01

\*\*\* alpha .001

Source: P.G. Morton. 1983. *Oregon's View of Entry into Practice*

**Table 4.2: Percentage of Nurses With and Without Advanced Nursing Education Preparation Supporting Resolution Items**

<b>Resolution Item</b>	<b>Basic Prep Only</b>	<b>B.S.N.</b>	<b>Master's</b>
Professional/Technical Split	39%	79%	93% ***
Bachelor's Requirement	36%	86%	93% ***
Grandfather Clause	95%	75%	86% ***
Ladder Mechanism	95%	85%	71% **

\*\* alpha .01

\*\*\* alpha .001

Source: P.G. Morton. 1983. *Oregon's View of Entry into Practice*

Respondents prepared in the three types of basic nursing education programs were found to differ significantly in their views of three aspects of the proposal. Baccalaureate nurses more frequently supported the differentiation of two levels of practice than either diploma or associate degree nurses. The majority of baccalaureate prepared nurses agreed the bachelor's degree should be required, while only a minority of diploma-prepared nurses and associate degree nurses supported this requirement. Baccalaureate nurses were significantly less supportive of a protective "grandfather clause" than were either diploma or associate degree nurses. Subjects with the three types of basic nursing preparation were found not to differ significantly in their views of the ladder mechanism of articulation in nursing education.

Subjects were found to differ significantly on all items when advanced nursing educational preparation was taken into account. Nurses who had continued their education to earn either a bachelor's or master's degree in nursing were more supportive of both the differentiation of levels of practice and the bachelor's requirement than nurses reporting no nursing education preparation beyond their basic program. Ninety-five percent of the nurses without advanced nursing education preparation supported inclusion of a "grandfather clause" in the proposal, while significantly fewer bachelor's degree holders and master's prepared nurses did so. Support of the ladder mechanism was significantly greater among nurses without advanced nursing education preparation than among nurses who had continued their educations to earn bachelors or master's degrees.

The report concluded (Morton, 1983):

“There is strong agreement among Oregon nurses that a “grandfather clause” should be an aspect of enabling legislation. Failure to include protective language could seriously erode support of the resolution.”

“Oregon nurses overwhelmingly endorse a system of articulation among nursing education programs which makes a career ladder possible. If such a mechanism was accessible to nurses across the state, opposition to the resolution may lessen. It would provide an option not now readily available to non-baccalaureate nurses who view the resolution as adversely affecting their own career advancement.”

“The investigation revealed that the type of basic nurse education completed and the level of advanced nursing education achieved are associated with the degree of support expressed for resolution items. The findings suggest that nurses’ values and beliefs, at least as they are reflected in their stances on aspects of the resolution, differ in relation to educational preparation.”

“Perhaps no professional group remains so divided in its views of what should constitute the educational and practice requirements of its profession. The challenge before the profession is to define not only what future nursing practice will be and the educational preparation necessary for that future role, by educational and career mobility for current practitioners.”

Based upon the findings of this study, on November 30, 1982, the ONA began the entry drive by establishing five subcommittees to carry out a five year plan of implementation (Kelly, March 30, 1983). The subcommittees were to gather information from other states involved with the ANA proposal in order to develop a statewide plan. In February 1985, after reviewing the findings and recommendations of each of the

subcommittees, the OSBN established a task force to develop implementation plans for the proposed changes. The initial draft of the plan was completed in the fall of 1985. In framing the issue, the group emphasized the now familiar idea that a better educated nurse results in better health care services.

### **Supporting Groups:**

#### **Oregon Society of Nursing Administration (OSNA)**

Other than the OSBN and the ONA, the only other major professional group on record that supported the proposed changes was the Oregon Society of Nursing Administration (Widder, March 26, 1985). They based their support on the commonly held belief that a better educated nurse leads to better health care delivery. Interestingly, this group used the nursing shortage argument to favor the proposed changes. In testimony before the House Education Committee in 1985, they pointed out that there were a sizeable number of associate degree nurses (two-year nurses) who were unable to find jobs because they could not compete against their better educated baccalaureate degree nurses (four-year nurses). They also stated that those two-year graduates who did find a job were often at a disadvantage in competition and promotion. Of the four states in this study, this is the only incidence where the nursing shortage was used to support the proposed changes.

### **Opposition from Professional Groups**

Unfortunately, the move by the OSBN and ONA was viewed by many in the state's health care community as too much too fast. Many felt left out and/or ignored. There was

a widespread feeling within the community that the changes were being made without enough consultation with those the changes would affect the most: nurses.

### **Oregon Federation of Nurses (OFN)**

The OFN is a union organization which is a member of the American Federation of Teachers, AFL-CIO. At that time, the group represented 500 nurses in the Willamette Valley of Oregon. It is also affiliated with the Oregon Federation of Nurses, which at that time represented 4,500 members.

This group's major concern revolved around the possible financial costs of the changes to both the citizens and the health care industry in Oregon (Schmidt, 1985, March 26). They pointed out that health care cost containment was a major concern of the current legislature, and as such, the proposed changes would almost assuredly increase those costs. They stated that it was their firm belief that the legislature was the only body appropriate to research the proposal and the impact of its implementation.

### **Concerned Nurses of Oregon**

Concerned Nurses of Oregon was established in March of 1984 with the single goal of halting plans to require the Bachelors degree for beginning professional nursing practice (Zerzan, 1985, March 26). The group claimed over 1,500 members representing every major health care facility in Oregon. They framed their opposition in terms of a lack of consensus within the nursing community on the proposal. To support their opposition, the group quoted a number of national surveys showing that the majority of RNs in Oregon and across the country were opposed to the move. In testimony before the House

Education Committee in March 1985, they produced a national survey done in 1981 showing that 80% of RNs polled were against the changes.

### **Opposition from Business Groups:**

#### **Oregon Community College Association (OCCA)**

#### **Oregon Council of Associate Degree Nursing Programs (OCAP)**

Founded in 1962, OCCA is an association whose purpose is to support Oregon's community colleges before policy makers. The group represents seventeen publicly chartered community colleges across the state. Similarly, the OCAP represented the various schools of nursing across the state that offered an associate degree in nursing.

In 1985, these professional business organizations joined forces to defeat the proposed changes. Both groups had serious objections to the proposed changes based on the following concerns (Ruff, 1985, March 26):

1. There was a basic lack of empirical evidence supporting the need for change (Rose, 1985). Exhaustive literature reviews showed no consistent difference between Associate Degree Nurses (ADN) and Baccalaureate Degree Nurses (BSN). At that time, RN licensing exam data showed ADN graduates consistently scored higher both in state and nationally.
2. A concern that the proposed licensure change would have an adverse effect on nursing supply, especially in rural locales. Data reviewed included the preponderance of BSN schools in the Portland metro area, and also the fact that 71% of Oregon RNs graduates were educated in non-baccalaureate programs (Oregon State Board of Nursing, 1984, September).

3. A concern that a licensure change would adversely affect the cost of education and the cost of health care. Yearly tuition and fees were significantly higher for baccalaureate and other types of nursing programs ((National League of Nursing, 1984). The question raised was, “who will share the increased cost of nursing education?” Possible candidates included the taxpayer and the health care consumer.
4. A concern about preserving access to a career as an RN for “typical” candidates of community college programs. These included a greater percentage of older and married students, single mothers, divorced or widowed people, and a higher percentage of men than other programs (Tilton, 1983).

### **House Bill 2928**

In early 1985, in the belief that the proposed changes would deny two-year nursing graduates (Associate Degree Nurses) access to Registered Nursing, the OCCA, with backing from the OCAP, sponsored HB 2928 (H.B. 2928, 1985). The main affect of this bill was to remove the authority to change nursing education requirements from the OSNB. HB 2928, however, did not preclude the future implementation of the proposed changes. According to the OCCA, its intent was to insure legislative review of any future proposed changes and, because of that, would assure adequate discussion involving all parties of interest to the future of nursing in the health care setting (Bassett, 1985, March 26).

In testimony supporting the bill, the OCAP highlighted the following facts (Ruff, 1985, March 26):

1. That this was not a new issue to the legislative arena. On the national level the issue had formally surfaced in 1965 with the ANA recommendation for a change in nursing education for the professional nurse. They pointed out that several states had attempted legislation in this area, and that significantly, no state had thus far moved to legislate a change in nursing education or licensure.
2. Nursing leaders within Oregon had attempted to resolve the issue within their own ranks but had reached a stalemate. The OCAP did not foresee the issue being resolved before 1990.
3. The issue not only affected the 24,496 licensed RNs in Oregon, but also many areas outside of nursing: those desiring a nursing career, those who deliver health care throughout the state, those who fit into Oregon's educational system, and those who fund it. Because of this tremendous and varied impact, the group believed that the issue needed to be addressed by an elected rather than an appointed body.

The bill was amended (Anderson, 1985, May 15) as a result of numerous discussions between interested parties, including representatives from baccalaureate nursing programs, licensed practical nursing, the OSBN, the ONA, the Oregon League of Nursing, the OSNA, the OCCA and, the OCAP. The amendments addressed the following concepts:

1. The creation of a statewide master plan for nursing education to involve all interested parties.
2. The need for accurate Oregon data for making well founded conclusions concerning nursing education.

3. The need for the OSBN to pause before embarking on a study, and to share publicly its plans for doing so in 1987.
4. Agreement that any future changes in entry level nursing education or licensure must go before the legislature.

In April of 1985, the legislature passed HB 2928 with the following two amendments (H.B. 2928, 1985):

1. The Oregon State Board of Nursing shall appoint a state wide master planning commission to act as an advisory body to the board on matters relating to nursing education;
2. The Oregon State Board of Nursing shall present to the Sixty-fourth Legislative Assembly a plan for a study addressing the current and future scope of nursing practice, nursing educational needs and responsibilities for providing nursing education.

In May 1985, a representative of the OSBN appeared before the legislature with the following statement (Schweickart, 1985, May 15): “In a series of meetings held in March and April, a compromise agreement was reached which would establish a statewide Master Planning Commission to deal with matters relating to nursing education. With or without passage of any legislation, it is the intent of the Board of Nursing to gather all interested parties together to discuss this complex issue and hopefully gain a consensus regarding future nursing education needs for our state.”

In April of 1987, based on the recommendations of the commission, the Board adopted the following official position statement: “The Baccalaureate of Science Degree

in Nursing shall be required for entry into professional nursing and the Associate Degree in Nursing shall be required for entry into technical nursing.”

In February of 1989, the Board reaffirmed the above position minus a specified implementation date (Oregon State Board of Nursing, 1989, February 9): “The Oregon State Board of Nursing reaffirms the position statement adopted in 1987 (concerning entry into nursing practice). The Board has adopted this position in the belief that in order for nurses to provide quality health care well into the next century, nursing education at the baccalaureate and associate level is needed to provide the knowledge and skills necessary to meet the increased complex and technological challenges facing the health care delivery system.”

“The position statement of the Board differs from the 1987 position statement in that an implementation date is not specified. The Board believes that an implementation cannot be established until a new national licensure examination(s) is available to states. The availability of a national examination, which is psychometrically sound and legally defensible, is an essential component for maintaining the interstate licensure endorsement system currently in place.”

“Until an implementation date is established, the Board’s resources and activities will be focused on the following strategies in order to continue long range planning and to progress toward the goal delineated in the position statement:

1. Encourage state nursing education programs to provide nursing curricula which maximize articulation among all nursing education programs.

2. Maximize educational opportunities for all nurses throughout the state by encouraging accessibility of current nursing education programs through outreach programs.
3. Encourage nursing service to develop demonstration sites of differentiated practice, based on educational levels and competencies via differentiated job descriptions and utilization in the clinical practice settings in order to generate a data base on the effects of differentiated practice on patient outcomes of quality and cost effective nursing care; and nurse satisfaction, retention and recruitment.
4. Maintain close communication with the National Council of State Boards of Nursing regarding the development and availability of a national examination for baccalaureate graduates.
5. Maintain a comprehensive data-base regarding statistics on state nurse manpower characteristics and nursing education statistics to be available to interested parties.”

To this date there has been no further action by the OSBN to pursue the ANA proposal.

## **CONCLUSION**

More than four decades have passed since the ANA first proposed the bachelor's degree as the minimum educational requirement for professional nursing practice. Unfortunately, debate over the issue has long been at a standstill, thanks mainly to the efforts of opposing interest groups. Yet there have been some changes in nursing education since 1965—most noticeably the almost total disappearance of the hospital-

based diploma programs and the explosive growth of associate degree-granting community college programs.

At the level of public policy, there has been little perceptible change in licensure requirements for basic nursing practice (with the exception of North Dakota, the first state to adopt a requirement for new RNs to hold a bachelor's degree in nursing—a requirement that was recently rescinded). Working independently and together, state level health care interest groups have been highly successful at stifling any efforts to implement the proposal.

So what can be learned from this experience, and how can current and future nursing education reformers use lessons from this case to avoid the same mistakes? In the next chapter, I discuss each research question and hypotheses. I also identify the obvious errors made by the original backers of the ANA proposal and make suggestions for future policy efforts.

## **CHAPTER 5: FINDINGS**

It has been forty four years since the American Nurses Association (ANA) published its entry into practice position paper. During that time period, only one state, North Dakota, was successful at getting the proposal fully implemented. And even there it was rescinded in 2003. This study examined how and why the issue was derailed in four focus states.

A comparative case study approach was used to examine the strategies used by proponents and opponents of the proposal in their efforts to influence the nursing community, the public at large, and the various state legislatures. In examining the entry into practice issue, I specifically looked at how the issue made the policy agenda in each of the four focus states, the various policy entrepreneurs involved, and the tactics used by supporters and opponents of the proposal. I also examined what the cases say about each research question and hypotheses.

### **IT SHOULD HAVE WORKED**

So why did the proposal fail? In theory, it should have been easy: a simple proposal to increase nursing education requirements. The ANA chose four states, North Dakota, Montana, Maine, and Oregon as early implementers due to their perceived ability to change educational standards without direct legislative action. Further, according to the

models, each of the four states met the required criteria that identified them as policy innovators.

### **Review: Model, Research Questions, and Hypotheses**

#### **Model A: More likely to adopt ANA policy**

1. A higher ranking on Walker's state policy innovation scale
2. Homogeneous political culture
3. Weaker organized interest group influence on policy making
4. Strong internal cohesion among supporting groups
5. Stronger issue framing by supporting groups

#### **Model B: Less likely to adopt ANA proposal**

1. A lower ranking on Walker's state policy innovation scale
2. Heterogeneous or bifurcated political culture
3. Stronger organized interest group influence on policy making
4. Weak internal cohesion among supporting groups
5. Stronger issue reframing by opposing groups

**Question 1:** Based on Walker's state innovation scores, did the outcome of the proposal in each state accurately reflect the ranking of each?

**Hypothesis 1:** Ranking the states according to their innovation scores, those in which the proposal made the legislative agenda will have a higher ranking than those that did not.

**Question 2:** Using Hero's political cultures scale, did the outcome of the proposal in each state accurately reflect the political culture category assigned to each?

**Hypothesis 2:** States with a homogeneous political culture are more likely to adopt the proposal.

**Question 3:** In the states where the proposal made the policy agenda, was overall interest group strength a factor in it's doing so?

**Hypothesis 3:** In the states where the proposal made the policy agenda, overall interest group strength was weak.

**Question 4:** In states where the proposal was not adopted, was reframing an effective tactic used by opposing groups?

**Hypothesis 4:** In states where the proposal was not adopted, opposing interest groups were able to reframe the issue successfully in their favor.

**Question 5:** How did issue reframing affect public opinion?

**Hypothesis 5:** Successful issue reframing by opposing interest groups significantly influenced public opinion in their favor.

**Table 5.1: Hypotheses Confirmation**

<b>Hypotheses</b>	<b>North Dakota</b>	<b>Montana</b>	<b>Maine</b>	<b>Oregon</b>
<b>1</b>	Yes	No	Yes	---
<b>2</b>	Yes	No	Yes	---
<b>3</b>	Yes	No	Yes	---
<b>4</b>	---	Yes	Yes	Yes
<b>5</b>	No	Yes	Yes	Yes

Source: Author.

### **WALKER'S STATE INNOVATION SCORES**

As identified on Table 5.2, the two states that either adopted or came close to adopting the proposal, North Dakota (#23) and Maine (#20), are both in the upper half of Walker's state innovation scale. Montana (#38), where the proposal was defeated, has a

low ranking on the scale. Oregon (#8) had the power to adopt the proposal without legislative action, and was well on its way to doing so. Unfortunately, with the passage of HB 2928 (sponsored by the Oregon Community College Association), the Oregon Board of Nursing (OBN) was stripped of its ability to set educational standards for nurses. Even with this setback, the OBN still has plans to implement the proposal once a standardized national nursing exam for the new educational requirements is established.

**Table 5.2 Walker’s Innovation Scores of the States\***

<b>State</b>	<b>Score</b>	<b>State</b>	<b>Score</b>
New York	.656	Kansas	.426
Massachusetts	.629	Nebraska	.425
California	.604	Kentucky	.419
New jersey	.585	Vermont	.414
Michigan	.578	Iowa	.413
Connecticut	.568	Alabama	.406
Pennsylvania	.560	Florida	.397
<b>Oregon</b>	<b>.544</b>	Arkansas	.394
Colorado	.538	Idaho	.394
Wisconsin	.532	Tennessee	.389
Ohio	.528	West Virginia	.386
Minnesota	.525	Arizona	.384
Illinois	.521	Georgia	.381
Washington	.510	<b>Montana</b>	<b>.378</b>
Rhode Island	.503	Missouri	.377
Maryland	.482	Delaware	.376
New Hampshire	.482	New Mexico	.375
Indiana	.464	Oklahoma	.368
Louisiana	.459	South Dakota	.363
<b>Maine</b>	<b>.455</b>	Texas	.362
Virginia	.451	South Carolina	.347
Utah	.447	Wyoming	.346
<b>North Dakota</b>	<b>.444</b>	Nevada	.323
North Carolina	.430	Mississippi	.298

Source: Walker, Jack L. “The Diffusion of Innovation among American States,” in the *American Political Science Review*. September, 1969, Vol. 63, No. 3, 880-899.

\* Alaska and Hawaii were omitted from the study because data for their years of adoption were often missing.

## POLITICAL CULTURE

All four focus states fall into political subculture categories which make them good candidates for implementation of the baccalaureate policy. With the exception of Oregon, three of the focus states directly addressed the issue at the legislative level. In two states, North Dakota and Maine, the proposal was actually adopted, while in Montana it was defeated. In Oregon, though the issue was cut derailed mid-process, there are still concrete plans to initiate the new educational requirements at some point in the future. A closer look at several socio-economic factors reveals the overriding homogenous nature of these states, thus making them good candidates for a smooth adoption process (see figures 5.3 through 5.7).

**Table 5.3: White versus Non-White Population Percentage**

	Maine	Montana	North Dakota	Oregon	<b>Four State Average</b>	<b>U.S.</b>
White	98.4%	92.7%	94.6%	92.8%	<b>94.6%</b>	<b>80.3%</b>
Non-White	1.6%	7.3%	5.4%	7.2%	<b>5.4%</b>	<b>19.7%</b>

Source: 1990 US Census

**Table 5.4: Northern/Western European Ancestry**

Maine	Montana	North Dakota	Oregon	<b>Four State Average</b>	<b>U.S.</b>
72.1%	73.1%	82.0%	66.0%	<b>73.3%</b>	<b>46.7%</b>

Source: 1990 U.S. Census

**Table 5.5: Median Household Income**

Maine	Montana	North Dakota	Oregon	<b>Four State Average</b>	<b>U.S.</b>
\$27,854	\$22,988	\$23,213	\$27,250	<b>\$25,326</b>	<b>\$30,056</b>

Source: 1990 U.S. Census

**Table 5.6: Poverty Level**

Maine	Montana	North Dakota	Oregon	<b>Four State Average</b>	<b>U.S.</b>
10.5%	15.6%	13.8%	12.1%	<b>13.0%</b>	<b>13.5%</b>

Source: 1990 U.S. Census

**Table 5.7: Educational Attainment Levels**

	Maine	Montana	North Dakota	Oregon	<b>Four State Average</b>	<b>U.S.</b>
Less than H.S. Diploma	21.2%	19.1%	23.3%	18.5%	<b>20.5%</b>	<b>24.8%</b>
H.S. Diploma Only	37.1%	33.4%	28.0%	28.9%	<b>31.9%</b>	<b>30.0%</b>
Less than Bachelors Degree	23.0%	27.7%	30.6%	32.0%	<b>28.3%</b>	<b>24.9%</b>
Bachelors Degree or higher	18.7%	19.8%	18.1%	20.6%	<b>19.3%</b>	<b>20.3%</b>

Source: 1990 U.S. Census

Compared to the national average, the population of the four focus states is whiter, has a stronger Western/Northern European ancestry, is more rural, has a lower median household income but with a lower poverty level, and is slightly better educated than the rest of the country. Maine, North Dakota, and Montana fit very well into the homogeneous political culture category, while Oregon is a definite fit for the

heterogeneous category. In fact, all four states fit well into each of the political subculture discussed (see Figure 5.1).

**North Dakota:**

- A. Hero: Homogeneous subculture: High probability of addressing and adopting the baccalaureate policy
- B. Elazar: A mixture of Moralistic and Individualistic political subcultures with a slight leaning to the Moralistic subculture. Good to high probability of addressing and adopting the baccalaureate policy.
- C. Lieske: Nordic subculture: Good to high probability addressing and adopting the baccalaureate policy.

Final Outcome: Baccalaureate policy adopted and implemented in 1987.

**Maine:**

- A. Hero: Homogeneous subculture: High probability of addressing and adopting the baccalaureate policy.
- B. Elazar: Moralistic subculture: High probability of addressing and adopting the baccalaureate.
- C. Lieske: Anglo-French subculture: High probability of addressing and adopting the baccalaureate policy.

Final Outcome: Baccalaureate policy adopted in 1986 but not implemented; readdressed in 1993 and defeated.

**Montana:**

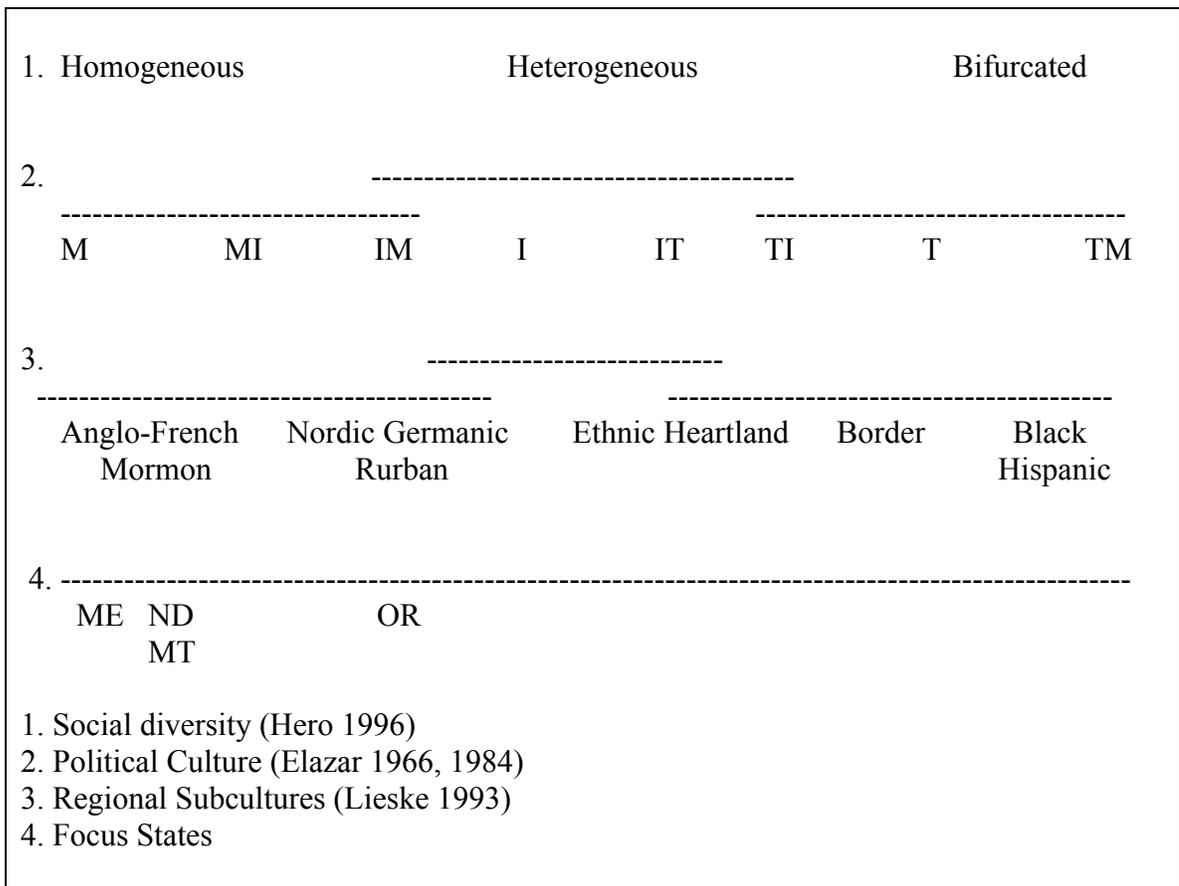
- A. Hero: Homogeneous subculture: High probability of addressing and adopting the baccalaureate policy.
- B. Elazar: A mixture of Individualistic and Moralistic subcultures with a slight leaning to the Individualistic subculture. Good to high probability addressing and adopting the baccalaureate policy.
- C. Lieske: Nordic subculture: Good to high probability addressing and adopting the baccalaureate policy.

Final Outcome: Baccalaureate issue addressed and defeated in 1987.

**Oregon:**

- A. Hero: Heterogeneous subculture: A good to fair probability of addressing and adopting the baccalaureate policy.
- B. Elazar: Moralistic subculture: High probability of addressing and adopting the baccalaureate policy.
- C. Lieske: Rurban subculture: A good to fair probability of addressing and adopting the baccalaureate policy.

Final Outcome: Baccalaureate issue not directly addressed, however, plans are in place for future implementation.



**Figure 5.1 Focus states groupings according to Hero, Elazar, and Lieske**

## INTEREST GROUP INFLUENCE

In examining the interest players in this study, it is obvious that Wilson’s Niche Theory is very much a reality in the four focus states; health care policy is heavily influenced by hospital and nursing home associations while education policy is heavily influenced by higher education groups, and in some instances (as in the baccalaureate issue), by the same hospital and nursing home groups. Each of these groups has staked a claim on their own distinctive area of policy expertise that exclusively serves a particular clientele or membership, i.e. the health care and higher education industries. Each of these groups has also used their positions on legislative committees to effectively shield their interests.

The two states where the proposal was adopted, North Dakota and Maine, have complementary interest group influence. The two states where the proposal was not adopted, Oregon and Montana, have dominant/complimentary interest group influence (see table 5.8).

**Table 5.8 Thompson and Hrebendar’s Classification of States by Overall Impact of Organized Interest**

Dominant	Dominant/ Complementary	Complementary	Complementary/ Subordinate	Subordinant
	Montana Oregon	Maine North Dakota		

Source: Clive S. Thompson and Ronald J. Hrebendar, “Interest Groups in the States,” in *Politics in the American States*, 6<sup>th</sup> ed., ed. Virginia Gray and Herbert Jacob (Washington, D.C.: CQ Press, 1996), 152.

## ISSUE FRAMING, REFRAMING AND PUBLIC OPINION

According to my model, all four focus states were ideal fits as policy innovators. Yet the issue was defeated in all four. In the end, the manner in which a policy is presented (issue framing/reframing and publicity) to the public most likely has far more to do with its chances of success than demographics or political culture theories.

In North Dakota, the only state that was able to fully implement the ANA proposal, the positive manner in which the issue was framed by supporters was one of the keys to its success. Adding to that was the extremely positive publicity the effort received when the state's Supreme Court ruled in favor of the state board of nursing concerning whether it had the authority to set nursing education standards. The Court noted:

The advancement of professions by increasing the body of knowledge has long occurred in institutions of higher education. As a well-educated body of nursing knowledge is developed through research, baccalaureate nursing programs will provide the education professional nurses need. We think the direction taken in North Dakota will serve the rest of the country as a prototype for advancement of both the nation's health care and the nursing profession. (Trinity Medical Center and Med-Center One v. North Dakota Board of Nursing, 1986)

Though no public opinion polls were conducted before or after the ruling, this one piece of positive publicity most likely had the greatest influence on public opinion than did the combination of all the other activities surrounding the effort. In neighboring Montana where the state's Supreme Court ruled that the board of nursing did not have the authority to set nursing education standards, the proposal was defeated. As in North Dakota, there were no opinion polls taken on the issue, so there is no way of knowing for sure if the

ruling had much sway on public opinion. Yet in reviewing the activities surrounding the entry drive in both states, the only major difference that stands out is the rulings by the two supreme courts.

What lessons can be learned from North Dakota's success? First and foremost, the victory can be placed almost entirely on the unity and vision of the nursing profession in the state. North Dakota nurses exhibited a clear sense of unity highlighted by an acute awareness of the importance of statewide involvement in the development of social policy, combined with an understanding of the consequences of higher levels of education. This display of unity and vision, along a well placed policy entrepreneur and good issue framing, brought respect and recognition from legislators and other leaders throughout the state. Testimony before boards, committees, and the legislature along with presentations to a variety of professional and civic organizations, resulted in nursing being considered a reliable source on health care and an advocate for the public. There was a unity of purpose and pride in the efforts to get the proposal adopted, and later, from having accomplished what no other state had been able to do.

Clearly then, the early success of North Dakota nurses can serve as a positive example for future reform efforts. Though superior in their access to financing and other vital resources, the interest groups representing the health care industry were no match for the positive public opinion generated by the unity within the nursing community. This single fact illustrates the vital nature of public opinion in the creation of any public policy. Issue framing and/or reframing, along with the overall perception by the public of the key players in the process ultimately helps decide a proposal's outcome. If, as in the case of the North Dakota nursing profession, the public perceives a true sense of unity and

dedication to a cause (policy), it will most likely be more supportive of that cause. The support by the public on any policy issue has a direct bearing in a legislator's support of the issue. In fact, it was only after the public became aware of a growing sense of disunity within the North Dakota nursing community that the opposition was able to get the policy rescinded.

### **WHY IT FAILED**

In reviewing the historical data concerning the entry issue in each of the four focus states, two problems can be identified with the way the issue was handled: (1) problems with setting the agenda, and (2) the failure to anticipate serious outside opposition.

#### **Agenda Setting Approach**

As noted earlier, Cobb, Ross, and Ross (1976) identified three distinct approaches to agenda setting, the outside initiative model, the mobilization model, and the inside initiative model.

In each of the four focus states, the State Nurses Association (a non-governmental entity) approached the Board of Nursing (a governmental regulatory agency) to place the issue of nursing educational standards on the policy agenda. On the surface, this would appear to be an outside initiative approach. However, there were several key individuals actively involved in the process who were directly associated with both groups. In fact, a number of these individuals had dual responsibilities as either chairpersons or committee members in both. In most states, these two groups have a very close working relationship when it comes to policy making. In reality, a state's nursing association is often nothing

more than the “civilian” arm of its board of nursing. Therefore, the approach used to get the entry issue on the policy agenda can be best described as an inside access approach.

Although this approach is often the easiest way for a group to achieve its agenda, it requires a minimum of participants to achieve success. However, the expansion phase of this process opens the door for widespread criticism and attack due to its perceived exclusiveness to other groups. In reality, the issue expansion techniques used in this approach are very limited. Generally, only identified and selected attention groups are included. The groups originating the policy (the various state boards of nursing) did not make a very strong effort to expand the issue to the public agenda. They chose instead to mainly focus on the nursing community. In reviewing the historical documents available, it seems clear that the originating groups in each state did not fully grasp the need for outside support. As such, they did not make sufficient effort to include key outside players in the process. Specifically, the lack of a well coordinated effort to entice the support of various health care and education interest groups proved to be the major fatal flaw in the entry effort. This was especially true in Montana, Oregon, and North Dakota where the focus remained on the nursing community throughout the proposal effort. In contrast, Maine gets credit for attempts at inclusiveness for making some effort to include non-nursing groups in its adoption efforts. However, even there it was still a case of too-little too-late. Groups representing the nursing home, hospital, and community college industries were ultimately responsible for the defeat of the issue in all four states.

Another problem in the agenda setting process was the historical lack of internal cohesion within the nursing community. Cobb, Ross, and Ross (1976) point out that groups who use the inside access approach tend to be more homogenous than other

groups. In the nursing community, this is not necessarily true. The nurses that comprise most state boards of nursing do tend to be a fairly homogenous group. They are mostly female, with bachelor or higher degrees, and from upper management or semi-independent settings. However, this is not reflective of the nursing community as a whole. While the originating groups tended to be homogenous, the community they represented was not. This fact helped distance the issue from the average nurse.

This lack of diversity and equal representation continued to be reflected throughout the entire process. Although in each state there were a wide variety of individuals included in the committees assigned to develop the new educational requirements, each committee was heavily populated by nurses with advanced degrees that were known to favor the new educational standards. There were very few associate degree RNs or LPNs on any of the committees. As such, this most likely fostered a feeling among the lesser educated nurses within the community that the issue was an “elitist” movement in which they were being dictated to by the upper echelons of the nursing community.

Even the choice of policy entrepreneur most likely added to the elitist image of the process. In each of the three states where the issue was actively addressed, a well placed and influential policy entrepreneur was chosen. These individuals tended to be from the upper levels of the nursing hierarchy and have a bachelors or higher degree. It is easy to see how those at the lower echelons of the nursing community and those with lesser education could view the process in a less than positive light. This is a tough situation for proponents of the entry issue: you must have a strong policy entrepreneur to get the issue passed while at the same time you run the risk of alienating some of your core constituents. It is in reality a “damned if you do” and “damned if you don’t” situation.

Montana, for example, had a well placed, highly educated and experienced policy entrepreneur as the leader of its adoption efforts. Mary Munger was highly regarded within both the upper echelons of the nursing community and in the legislature as a knowledgeable and reliable nurse leader. However, it was this same notoriety that alienated her from the “average” nurse within the Montana nursing community; she simply wasn’t viewed as “one of us”. This was most likely a major contributor to the issue’s lack of support from many within nursing community.

Adding to this lack of cohesion was the top-down decision making process used by the supporting groups. A top down approach is one in which the decision to make a change is made at the upper levels of an organization. This approach is disseminated to the lower levels in the hierarchy, who are, to a greater or lesser extent, bound by them. If reforms are perceived to be imposed “from above,” it can be difficult for lower levels to accept them.

The entry issue was not brought about by any type of crisis, but instead by the upper echelons of the nursing community at the national level. This group simply decided that nursing education should be upgraded. There was never any ground-swell of support for the issue among the nursing community as a whole or from the general public. As stated earlier, the entire process was controlled and dictated by the various boards of nursing, which did not truly reflect or represent the nursing community as a whole. The attitude taken seems to have been one in which those at the top were telling those at the bottom “don’t worry, we know what’s best for you, so just trust us!” This attitude did not go over well with the average nurse. The feelings and attitudes of many nurses on the issue were best summed up during legislative hearings in Maine by opponents of the new

educational standards: “The only state having such a law on its books is North Dakota. It was put there NOT by the legislature, not by mandate of the people, NOT by mandate of the nurses, but by nine persons, the Board of Nursing of North Dakota” (Incze, March 5, 1986), and “I ask you that the state of Maine not be made the guinea pig for this legislation which was found to be undesirable in all other states where it was introduced” (Incze, March 5, 1986).

Adding to this lack of cohesion within the nursing community was the concern over the “grandfathering” issue, which can also be attributed to the top-down approach to agenda setting used.. The boards of nursing and the nurses associations did not make enough effort to explain this issue in detail to the nursing community. This seeming lack of real concern from entry supporters most likely was a further contributor to the “elitist” image many held of the entire process. As stated, it was well known in the nursing community that those behind the entry effort were either bachelor or masters level nurses. These were nurses that the entry proposal would have little or no effect on. Thus, the perception of the way that the grandfathering issue was handled was most likely seen by some as a situation where those with a higher education telling those with less education that they know what’s best for them.

In all four states, a lack of cohesion and anger among the nursing community was reflected in the presence of well organized nursing groups opposed to the entry issue. Although these groups had varying names in different states (in Oregon, Montana and North Dakota they called themselves “Concerned Nurses” while in Maine they were known as the “Consortium of Maine Nurses”), they each expressed the same concerns and anger over the manner in which the entry issue was being handled. Also, in North

Dakota and Montana, the states' Licensed Practical Nurses Associations joined forces with these groups to fight the entry issue.

### **Failure to anticipate serious outside opposition**

In addition to problems with agenda setting and internal support, there is no solid evidence that any of the supporting groups completely understood the threat from outside interests. In each state there were initial efforts to enlist support from some or all of these groups, but no well-formed consistent enlistment campaigns. By focusing too exclusively on the nursing community, supporters both alienated these groups and gave them time to mount a counter offensive against the proposal.

Over the last two decades, interest groups have evolved from close knit alliances into diverse, large and powerful players in state policy making (Hrebenar & Thompson, 2004). The entry into practice issue involved a number of interests outside the nursing community: strong and influential interests representing hospitals, nursing homes and two year degree institutions. To this researcher, it seems amazing that none of the supporting groups understood this threat. Anyone working in health care at any level cannot help but be keenly aware of the power these interests wield. Those in charge of the entry drive were all highly educated and well placed within the health care industry. For them not to have anticipated resistance from these outside groups is hard to understand. One can only assume that since all but one state had the power to establish the new educational standards on their own, there was belief that they could basically slip the new educational standards into place without much notice. How wrong they were!

Many interest groups occupy narrow “niches” in policy and also participate in coalitions that allow them to pool their efforts to effect or deflect broad policy change. Wilson (1973) noted that some groups develop autonomy, or a distinctive area of competence in a clearly demarcated area of policy expertise that exclusively serves a particular clientele or membership. These groups tend to have a clear and undisputed jurisdiction over certain functions, services, goals, and/or causes. In most states, groups representing dominant economic interests are by far the most numerous and most influential. And nowhere is that more true than in the health care and education industries.

The three major business opponents of the entry proposal in all four states were (and are) the nursing home/long-term care industry, the hospital industry, and the junior/community college industry. Over the years, each has come to dominate policy at the state and national level in its own particular niche area. The following is a recap of each group and their niche area of interest and control.

### **Hospital Industry**

The hospital industry has remained strongly opposed to the entry proposal. Their major problems with the issue revolve around cost concerns and the perceived difficulty in recruiting baccalaureate-prepared nurses. In reality, it is most likely their profit margin that concerns them the most. It would obviously cost more to employ higher educated nurses; something they are not anxious to do in light of spiraling health care costs.

The industry is represented at the national level by the American Hospital Association (AHA), with each state having its own sub-unit. The AHA is composed of nearly 5,000

hospitals, health care systems, networks, other providers of care in all 50 states. Via its advocacy activities, the AHA represents its members' perspectives in national health policy development, legislative and regulatory debates, and judicial matters. Advocacy efforts include the legislative and executive branches and include the legislative and regulatory arenas at the national and state levels. Along with the AMA and the NCHA, the AHA is part of a much larger group of interests that dominate U.S. health care policy.

### **Nursing Home/Long Term Care Industry**

The nursing home industry also strongly opposed the entry proposal. They also frame their concerns with the entry issue in terms of cost and recruiting difficulties. Again, as with hospitals, the true reason for their concern, most likely, has more to do with profit than anything else. Most nursing homes are staffed by diploma educated LPNs who are generally paid much less than RNs (which are mainly associate degree nurses). Nursing home owners would be required to pay much more for associate degree LPNs.

The nursing home industry is the third most powerful health association in most states, after hospitals and physicians. In terms of power, nursing home associations are highly organized, collecting large contributions for political campaigns and political lobbying activities. The major efforts of these associations are toward influencing the development of administrative regulations, rates, licensing activities, and also focus on legislators and their legislative activities. This lobbying activity has promoted weak regulation of the industry. Litigation has also been used as an effective tool by the nursing home industry to promote favorable public policies. The industry is able to invest substantial sums in such activities and to hire talented individuals for legislative, administrative, and legal

actions. Nationally, the American Health Care Association (NHCA) is the largest and most influential nursing home organization. Most, if not all state nursing home/long term care associations, are members of this group.

### **Community College Industry**

Community colleges are the primary source of new Registered Nurses in the United States and are represented at state and local legislative levels by the American Association of Community Colleges (AACC). As of 2007, AACC's membership represented almost 95 percent of all accredited U.S. two-year community, junior and technical colleges. The group touts itself as the primary advocacy organization for community colleges at the federal level. The organization also works closely with directors of its state offices to influence state policy.

The AACC has taken a position against the baccalaureate issue from the beginning. Over the years, they have adamantly stood by their position that adopting the baccalaureate degree as the minimum level for entry into professional nursing would further exacerbate the nursing shortage in this country. The truth, however, has much more to do with control and money than the AACC is willing to admit. If adopted, the baccalaureate proposal would effectively end the Associates Degree Program for Registered Nurses. This would be a huge blow to community colleges both in enrollment numbers of nursing students and to the associated financial windfall of the ADN programs. In effect, it would end a monopoly that they do not want to give up.

## **POLICY IMPLICATIONS**

This study examined why the entry into practice issue proposed by the ANA in 1965 failed in four focus states. I specifically identified the two reasons I believe were the major causes of the issue's demise: an agenda setting model based on exclusiveness, and a failure to anticipate serious outside opposition.

So what are the implications for health care policy? With health care reform being one of the major issues in Washington, there is little doubt that the groups identified in this study will continue to have an impact on health care policy. This is true at both the national and state levels. What happened with the entry issue in the four focus states is indicative of what supporters of national health care reform can expect from these and other organized health care interests; resistance, resistance, resistance.

This study highlights a stark reality that many policy makers already understand: the pluralist system of interest group influence has evolved into a subtle form of neocorporatism. This model of interest group theory describes a form of informal cooperation between governments, be it state or local, and certain powerful interest groups (Thomas, 1993). Accordingly, this cooperation serves to maintain stability in the processes of developing and implementing policies. The neocorporatist model is primarily focused on economic policies in which three sectors of society, business, labor, and government are involved in negotiations about questions of policy.

Under the current system, the government (federal and state) has basically granted a monopoly to certain interest groups in exchange for their cooperation in developing policy. Anyone familiar with the power the long term care and hospital industry wields in

the policy arena can attest to this fact. It is no stretch to say that in most states, and indeed nationally, the policies hospitals and nursing homes support, almost always become law.

How did the system get this way? There are two reasons. First, the last eight years of a market-based approach to health care policy is partly to blame, although in reality, the trend started much earlier.

Under the Bush administration, reform attempts included incentives for health care spending accounts, tax relief, and increased buying power of small businesses towards health insurance. Though touted as providing greater consumer choice, health care savings accounts have been characterized as nothing more than a disguise for further reductions in coverage with cost shifting away from the young and healthy to those who can least afford it: the old and sick. This trend basically undermines the concept that health care costs should be spread out evenly among the healthy and unhealthy alike. Though the Bush proposals for making coverage more affordable entailed a limited expansion of government health programs, in general, they were designed to reinforce the private sector's capacity to expand health coverage.

Prior to the Bush years, Bill Clinton's attempts at health care reform were shot down due to both industry and Republican opposition. The Republican Party (GOP) has consistently opposed a single-payer universal health care system, believing such a system constitutes "socialized medicine" and is in favor of a personal or employer-based system of insurance, supplemented by Medicare for the elderly and Medicaid. The GOP has a mixed record of supporting the historically popular Social Security, Medicare and Medicaid programs, all of which Republicans initially opposed. Most all efforts by

Democratic Administrations to expand government sponsored health care services have been vehemently opposed by the Republican Party.

Second is the demise of the public as an independent force in policy making. Instead of initiating policy, Americans take little or no direct part in the action. Citizens have become increasingly alienated and estranged from politics. This is the inevitable consequence of important decisions being made at the highest levels. People lose interest to the degree that they lose control. Since relatively few people participate actively in this process, power has become concentrated in fewer hands. As a result, policy influence has fallen into the laps of certain powerful interests. This fact is quite evident in the outcome of the entry issue.

The top down approach used by entry backers reflects how a great deal of public policy is dictated in this country. It also highlights the apathy that many Americans feel towards their government. The backers of the entry proposal lost credibility and support from the nursing community when it did not involve them in the decision making process. They felt dictated to and subsequently disenfranchised from the entire process.

So what can be learned from this experience? First, it is important to involve the entire community in any decision making process. There must be always be a consensus and an understanding of what is happening within the affected group. Citizens who feel like they are part of the process are much more likely to be supportive of a cause than those who feel left out or dictated to. There must be inclusion.

Second, opposing interests must not be ignored or underestimated. All efforts must be made to include these groups in the process. Obviously there must be a certain amount of give and take on any issue, however there can be no progress made without compromise

from both sides. Health care reform advocates in this country must understand that the dream of universal health care or even universal health insurance will not happen overnight. It will take years of compromise and negotiation with the health care industry before real reform can happen.

It is hoped that the research presented will contribute to the understanding of how agenda setting plays a key role in policy failure or success, and the role that interest groups play in the policy process.

### **RECOMMENDATIONS FOR FURTHER RESEARCH**

In reviewing the findings of this report, there are several questions that come to mind. How have other professions been able to successfully increase their educational requirements? What opposition did they encounter, and what strategies did they use to counter that opposition? What can health care reformers learn from these examples?

One of the main arguments used by opponents of the entry issue revolved around the national nursing shortage. With the shortage now entering its third decade, could it now be used in favor of raising educational standards for nurses? With no relief in sight, wouldn't a better educated (and thus better prepared) nurse be able to handle a heavier work load?

Has the current neocorporatist system become too entrenched in our policy making system to be reversed? What, if anything can be done to reestablish a pluralist system highlighted by more equal representation from all interests?

In recent years, the entry issue has resurfaced in several states, most notably in New York, New Jersey, and California. What strategies are supporters of the issue using this

time around? How are they different from those used previously? Also, have the strategies used by opponents of the issue changed? What can health care reformers learn from the current entry drive?

There were other questions raised within this study that could be used as a basis for communication, decision making, and group interaction among those seeking to reinvigorate the entry issue, and perhaps within health care reform movement itself. Hopefully this could enable a more productive dialogue between supporters and opponents of both issues.

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