Concerns over healthcare reform (HCR) and lowering the cost of health care are uppermost on the minds of Americans. They will play a major role in influencing the outcome of the 2020 U.S. presidential election. Nurses can anticipate questions from patients and the public who will want to know what nurses think about HCR. Due to the public’s trust and positive perceptions of nurses, when asked about HCR proposals, it matters what nurses say and how they say it.

Based on media coverage and public opinion polling, healthcare reform (HCR) is at the top of the public’s list of most pressing problems for presidential candidates to address (Pew Research Center, 2019). In particular, decreasing the cost of health care is foremost in driving the public’s support for HCR. At the time of this writing, the leading HCR proposals include Medicare for All, adopting a single-payer system, emphasizing market forces, and improving the Accountable Care Act (ACA).

Because public opinion polling also shows the public consistently trusts nurses more than any other profession (Brenan, 2019), nurses can expect people will want to know what they think about HCR and will value nurses’ opinions. Consequently, as the presidential election draws nearer, it is important for nurses to be knowledgeable about the leading HCR proposals. There are more than enough television talking heads commenting about HCR who, all too often, inject their personal views and partisan bias, which contributes to misrepresentation and confusion over the most crucial issue facing the country. By learning about the leading HCR proposals, nurses will be prepared to answer questions objectively and provide balanced appraisals of each proposal’s strengths and limitations.

Another reason for nurses to learn about HCR proposals is that, as citizens and as voters, it is desirable to be informed about how candidates would achieve HCR. And, knowing more about HCR proposals may even stimulate some nurses to get involved in supporting a candidate’s election or become active in state elections or local healthcare initiatives. Finally, as both consumers and providers of health care, nurses will be directly impacted by HCR. The ways they will be affected will depend, of course, on the particular HCR proposal that is implemented. Understanding the various plans helps clarify the benefits and potential risks to patients, to organizations that employ nurses, and to nurses themselves.
This article offers criteria to assess HCR proposals, summarizes the major concepts underpinning the four proposals currently attracting the greatest attention, and poses questions to consider when evaluating each plan. Learning more about each HCR proposal should not be taken lightly: Not only does health care account for nearly 20 cents of every dollar spent in the United States, but as the population ages, the need for behavioral and primary care increases, and maternal health outcomes worsen, pressures to achieve meaningful HCR will intensify.

Criteria for Assessing HCR Proposals

When considering HCR proposals, it is useful to have specific criteria to assess their intended outcomes. From a health economics and policy perspective, four criteria can be used to assess an HCR proposal. Applying these criteria to each proposal helps deepen understanding of a proposal’s merits and shortcomings and how proposals compare to each other. Four criteria to assess the leading HCR proposals are identified in Table 1 (the cells in the table are purposively left empty for the reader to fill in with their assessment).

The first criterion centers on whether and how the HCR proposal will improve healthcare delivery systems. Because efficiency is key to controlling costs and reducing waste, does the plan contain incentives to increase the efficiency with which services are produced and delivered using the least costly combination of human and non-human resources? Other areas where HCR can improve delivery system performance involve increasing care coordination, adopting virtual and digital technologies, and expanding community-based health care. Fundamentally, the proposal should be assessed for its likelihood of holding healthcare delivery systems accountable for their costs and quality.

A second criterion assesses the HCR proposal’s ability to increase access to health care. Access is affected by many factors, including culture, language barriers, geography, insurance coverage, price of health care, and the numbers and types of available healthcare providers. Accordingly, one can examine whether and how HCR proposals address each of these factors. Further, does the proposal describe the policy mechanisms by which increasing access will be accomplished? For example, will insurance coverage be extended to more people (or to everyone) by subsidizing the purchase of premiums charged by private insurers, or will Medicare or Medicaid eligibility be modified to expand access? Will health insurance plans cover people with pre-existing conditions at affordable prices? And, does the proposal identify what services people will have access to as well as those services that they will not?

The third criterion focuses on whether the proposal con-

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### Table 1. Criteria for Assessing Healthcare Reform Proposals

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<th>Criteria</th>
<th>Medicare for All (or for More)</th>
<th>Single Payer</th>
<th>Greater Market Forces</th>
<th>Improve Affordable Care Act</th>
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<td>Improve delivery systems (efficient, care coordination, community and population health, accountable for costs and quality)</td>
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<td>Expand access to health care</td>
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<td>Increase emphasis on prevention education, social determinants of health</td>
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<td>Effect on payment systems (fee-for-service, value-based)</td>
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tains provisions that emphasize health education and disease prevention, and improvements in community and population health outcomes. Efforts to address the social determinants that worsen health and well-being are gathering momentum as providers and payers realize that much of the excess utilization and cost of health care are driven by inadequate housing, food, transportation, employment, social isolation, environment, and personal behavior. Does the proposal contain provisions that meaningfully increase public health education and incentivize healthcare providers, private organizations, and community organizations to address the social determinants that negatively affect health?

Because the way healthcare organizations and clinicians are paid and the amount they are paid influences their behavior, a fourth criterion concerns how the HCR proposal affects payment systems. It is well known that payment based on fee-for-service (FFS) is the most important contributor to overutilization of services, inefficiency, and rising healthcare spending. In recent years, the Obama and Trump administrations, with bipartisan Congressional support, have sought changes in federal payment systems that emphasize the value of healthcare services over the volume of services provided. Using a value-based approach means paying providers more (less) for achieving better (worse) patient outcomes taking into account the cost of resources used to produce the desired result. Does the HCR proposal continue a value-based approach to payment, or does it maintain historic FFS payment?

Beyond these health economic and policy criteria, HCR proposals can also be assessed by how they could affect the missions and financial security of healthcare delivery organizations and the workforce they employ, particularly nurses. As the largest health profession, nurses make decisions about the use of costly resources, are involved in patient care around the clock, are inseparably connected to the quality and safety of care, and are among the highest-paid health professionals. Therefore, nurses should consider how implementation of a HCR proposal could affect the well-being of their patients, their organizational environment in which they provide care, their relationships with physicians, and their employment and earnings.

Of course, there are other criteria one can use to assess HCR proposals. For example, a proposal could be examined for whether it contains provisions intended to increase access to behavioral and primary health care, particularly to those living in rural areas; improve maternal health outcomes; and address the myriad challenges facing providers who are caring for the nation’s 77 million aging baby boomers. The critical point is to select meaningful criteria to assess and compare HCR proposals which, in turn, can help guide discussions with patients and others who want to know what nurses think about Medicare for All, a single-payer system, using market forces to reform health care, or improving the ACA.

Healthcare Reform Proposals

As the presidential election heats up and candidates debate the issues, it can be expected candidates will modify many of the details underpinning their HCR proposal. Accordingly, to avoid misrepresenting a candidate’s HCR proposal, the discussion that follows focuses on conveying the main ideas behind each of the leading proposals, rather than describing specific details as they are known today. Also, because Medicare for All has attracted much of the media’s attention and several Democratic candidates have embraced this proposal, it will be helpful to briefly review the main features of the Medicare program before summarizing the plan itself.

The Medicare program was created in 1965 to provide health insurance for people age 65 and older. Later, people under age 65 with specific disabilities were eligible to enroll in Medicare, as were people of all ages with end-stage renal disease. Today the program enrolls approximately 60 million beneficiaries; about 12 million are enrolled in both Medicare and Medicaid (“dual eligibles”), and 9 million beneficiaries are disabled. Since 2010, Medicare enrollment has proliferated due to the aging of the baby-boom generation; spending in 2018 amounted to $731 billion (Henry
Medicare Part A provides insurance coverage for inpatient care provided in hospitals, skilled nursing facilities, and hospice care. Most people do not pay a premium for Part A because they or their spouse paid for it through payroll taxes. Part A is financed primarily (87%) by payroll taxes that are set aside in the hospital trust fund. However, the Part A hospital trust fund is projected to be depleted in 2026, which will require Congressional action to keep this component of Medicare sufficiently funded.

Medicare Part B covers physician and other clinician services and outpatient care and includes a few services not covered by Part A, such as physical and occupational therapy and some home health care. Beneficiaries pay Part B premiums starting at $134 per month, with premiums increasing according to beneficiary income, ranging from $189.60 to $460.50 per person per month in 2019. Part B is financed by general tax revenues (71%) and premiums (27%) paid by beneficiaries (Henry J. Kaiser Family Foundation, 2019b).

Medicare Part A and Part B are often referred to as traditional Medicare or FFS Medicare. Importantly, there are three coverage gaps in traditional Medicare that have implications for HCR. First, there are no out-of-pocket maximums, which means that Medicare beneficiaries do not have an annual beneficiary spending limit (spanning deductibles, co-pays, and co-insurance across all services) beyond which insurance covers all additional costs. Consequently, beneficiaries are liable to pay for a catastrophic event. In contrast, qualified health plans offered through the ACA can charge an individual member no more than $6,700 for in-network services covered under Medicare Parts A and B (as of 2018). To protect themselves from catastrophic loss, more than 80% of beneficiaries have a source of supplemental Medicare coverage, ranging from enrolling in Medicare Advantage (discussed below), purchasing employer-sponsored plans, buying a Medigap insurance policy, or enrolling in Medicaid.

The second gap in traditional Medicare is that the program does not pay for long-term and other support services, such as dental services, eyeglasses, and hearing aids. The third gap concerns traditional Medicare’s 90-day limit on a hospital stay. If additional hospitalization is needed, the beneficiary can tap into their lifetime reserve days, which Medicare limits to 60 days. This means that after the 150th day of hospitalization, Medicare coverage ends, where-as qualified health plans offered through the ACA are not allowed to place such limits on covered services.

Medicare Part C is known as Medicare Advantage (MA) and provides beneficiaries with the option to receive services through nearly 3,000 private health plans, including Health Maintenance Organizations and Preferred Provider Organizations that are approved by Medicare, as an alternative to traditional FFS Medicare (Henry J. Kaiser Family Foundation, 2019c). MA plans receive capitated payments for Part A and Part B services, and two-thirds or more of beneficiaries receive extra coverage such as vision, hearing, dental, and health and wellness programs. In 2020, MA plans will have greater flexibility to offer nonmedical benefits, including transportation, healthy food options, and home improvements to chronically ill Medicare beneficiaries (Green & Zook, 2019). Currently, 22 million or 34% of recipients are enrolled in MA plans, with enrollment expected to increase to nearly 50% of all beneficiaries by 2030. In 2018, total MA spending was $232 billion.

Medicare Part D provides prescription drug coverage offered by private plans which are available to all Medicare beneficiaries. Most beneficiaries pay a monthly premium, which

J. Kaiser Family Foundation, 2019a). In 2030, the program is projected to enroll roughly 81 million beneficiaries; thereafter, growth will slow such that by 2050 there will be an estimated 92 million beneficiaries. As briefly summarized below (see Henry J. Kaiser Family Foundation website for a comprehensive overview of the Medicare program), the Medicare program consists of four parts, each of which requires separate premiums and relies on different sources of financing (e.g., payroll taxes, general tax revenues, co-payments, taxes on Social Security benefits, and transfers from states).

Medicare Part A is financed primarily (87%) by payroll taxes that are set aside in the hospital trust fund. However, the Part A hospital trust fund is projected to be depleted in 2026, which will require Congressional action to keep this component of Medicare sufficiently funded.

Medicare Part B covers physician and other clinician services and outpatient care and includes a few services not covered by Part A, such as physical and occupational therapy and home health care. Beneficiaries pay Part B premiums starting at $134 per month, with premiums increasing according to beneficiary income, ranging from $189.60 to $460.50 per person per month in 2019. Part B is financed by general tax revenues (71%) and premiums (27%) paid by beneficiaries (Henry J. Kaiser Family Foundation, 2019b).

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Medicare Part A is financed primarily (87%) by payroll taxes that are set aside in the hospital trust fund. However, the Part A hospital trust fund is projected to be depleted in 2026, which will require Congressional action to keep this component of Medicare sufficiently funded.

Medicare Part B covers physician and other clinician services and outpatient care and includes a few services not covered by Part A, such as physical and occupational therapy and some home health care. Beneficiaries pay Part B premiums starting at $134 per month, with premiums increasing according to beneficiary income, ranging from $189.60 to $460.50 per person per month in 2019. Part B is financed by general tax revenues (71%) and premiums (27%) paid by beneficiaries (Henry J. Kaiser Family Foundation, 2019b).

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Medicare Part D provides prescription drug coverage offered by private plans which are available to all Medicare beneficiaries. Most beneficiaries pay a monthly premium, which
varies by program and by beneficiary income. Part D is financed by general tax revenues (73%), premiums (15%), and transfers from states (11%).

Medicare for All

Under this proposal, the Medicare program would become the core framework for achieving HCR. However, presidential candidates embracing this approach have modified the proposal in important ways (Oberlander, 2019). Some would eliminate private insurance plans immediately or phase them out over time, while others would retain private insurers, particularly to manage Part D prescription drugs. Medicare for All proposals also vary by whether premiums and beneficiary out-of-pocket expenditures will be eliminated and whether everyone will be eligible to enroll in Medicare. For example, under Medicare for More, people between the ages of 50-64 would have the option to enroll in Medicare (Levitt, 2019).

Should Medicare for All (or for More) become the backbone for HCR, nurses might consider several questions to assess this proposal.

For example:
- Will Medicare for All replace Medicaid, the Children’s Health Insurance Program (CHIP), Indian Health Service, coverage for military veterans provided by the Veterans Administration, and other federal or state health programs?
- Will the coverage gaps in traditional Medicare identified above be closed?
- If Medicare does not provide some services, will beneficiaries be able to purchase private Medigap insurance?
- Will the increasingly popular private sector MA plans (Part C) be eliminated?
- Does Medicare for All imply “Medicare prices and payment for all” services and therapies provided by all clinicians, hospitals, and other healthcare delivery organizations? Because Medicare payments usually reimburse at amounts that are less than provider costs, and should private insurers be eliminated, providers will not receive commercial payments, which are typically higher than Medicare payments. To fill the gap between Medicare payment and provider costs, will healthcare delivery organizations and clinicians increase the number of billed services, use more “higher-margin” and hence more profitable services to treat patients, or up-code the intensity of patient conditions to receive higher payments (Song, 2019)?
- Finally, how much would Medicare for All (or for More) cost, and how would this HCR proposal be financed?

Single-Payer System

In a true single-payer model, the government is the only payer for healthcare services. This means there are no private insurers, which should decrease overall administration costs. Everyone would have health insurance under a single-payer system. Throughout the world, only North Korea and Cuba have true single-payer systems as all other countries with single-payer-like systems allow people access to private health insurers for services not paid for by the government.

In the United States, some states have sought to adopt a single-payer system. On several occasions, advocates in California have attempted to enact legislation enabling the adoption of a single-payer system but without success. In 2011, the Vermont legislature passed and the governor signed a single-payer system bill into law, but within months abandoned implementation given the high taxes needed to finance its single-payer system. In 2016, Colorado citizens voted against a ballot measure that would establish a single-payer system. Between 2010 and 2016, legislators in 20 states have proposed 59 single-payer bills (Brown & McCuskey, 2019).

Should a single-payer system become the means for achieving HCR, nurses might consider several questions to assess this proposal, including:
- How much will a national single-payer system cost, and how would it be financed?
- Because the federal government would be the only payer of healthcare services, will the power to set prices lead to a reduction in innovations in producing and delivering health care?
- What healthcare services will be paid for by the government? How will the prices for services be determined?
- Will all healthcare services be available to everyone, or will
only certain services be available and paid for by the federal government? Who will make these decisions?
• Will people have access to private insurance for services not paid for by the government?
• Will the Medicaid program, CHIP, Indian Health Service, and other federal and state insurance and care delivery programs be eliminated?

Greater Use of Market Forces

The overall goal of market-oriented proposals is to stimulate competition over the price and quality of services produced by providers. Market-oriented proposals are favored by those who view competitive forces as the best way to increase the number of choices available to consumers and thereby promote consumer shopping for healthcare insurers and providers. Proponents also believe market forces are especially useful in pressuring providers to be more efficient in providing care, which, in turn, will help lower costs and prices faced by consumers. Also, market forces are viewed as hastening the development of usable information on prices and quality and stimulating innovation in the production, distribution, and delivery of health care (Adams & Markowitz, 2018).

Because the President and the Republican party have yet to make available their proposal for HCR, one can only speculate about the elements of a market-oriented proposal, and when such a plan might be introduced. Based on media reports and recent documents (Trump, 2019), it can be expected that a market-oriented HCR proposal will seek to stimulate the sale of health insurance across state lines, give states more flexibility in financing and organizing healthcare delivery, expand health savings accounts, increase price transparency, and link prices to quality metrics. Of particular interest to advanced practice registered nurses (APRNs), in November 2018, the Department of Health and Human Services, Department of Labor, and the Department of Treasury sent the President the jointly developed document “Reforming America’s Health Care System Through Choice and Competition.” This document contains several pages calling for the elimination of state-imposed scope of practice restrictions on APRNs and other nonphysician providers.

What questions might nurses consider when examining market-oriented proposals? For example:
• Will people with pre-existing conditions have access to health insurance provided by insurers, and at what price?
• What will prevent insurers, healthcare organizations, and clinicians from obtaining regulatory benefits or government relief and protection from the pressures imposed by competitive market forces that will likely threaten the survival of some insurers and providers?
• How will market forces be used to lower the cost of prescription drugs?
• How will quality of care be measured uniformly and compared across providers, and how will information on quality and prices be provided to consumers so they can shop?
• What is the role of the federal and state governments in a market-oriented system, especially in expanding access to health care and addressing the needs of vulnerable populations?

Improving the Affordable Care Act

Signed into law by President Obama in 2010, the ACA ushered in the most significant change in health care since the passage of Medicare and Medicaid. While the law contains provisions intended to address numerous deficiencies in producing and delivering health care (including initiatives to advance the use and role of APRNs), the overriding goal of the ACA is to increase access to health care.

To achieve this goal, the ACA has implemented a combination of private market strategies (namely, creating both state and federal insurance marketplaces and encouraging private plans to offer insurance coverage) and public strategies (mandating everyone purchases health insurance or face penalties, subsidizing people with low incomes so that they can purchase health insurance, expanding the Medicaid program, and requiring certain preventive services be provided at no out-of-pocket cost to nearly all insured people). While estimates vary, these strategies have resulted in expanding health
insurance coverage to approximately 20 million people. Further, 36 states plus the District of Columbia have expanded their Medicaid programs. Despite the ACA’s success in expanding health insurance coverage to more Americans, its main criticism is that insurance premiums have risen for many people, and the cost of health care has not been controlled.

Because attempts to repeal and replace the ACA have not been successful, the ACA remains the organizing framework driving the federal government’s approach to health care. However, depending on which candidate is elected president and which party controls the House and Senate following the 2020 election, it is conceivable that none of the other HCR proposals discussed here will be adopted, leaving the ACA as the status quo framework. At the same time, it is crucial to realize the ACA could be invalidated, or upheld by the U.S. Supreme Court, which agreed to review a federal appeals court decision that found part of the law unconstitutional. A decision is unlikely until 2021, after the presidential election. Therefore, due to these uncertainties surrounding the ACA, nurses need to pay attention to the legal actions that will determine whether the ACA remains a viable option for HCR, and to the specific details for how the law can be improved.

Conclusion

Concerns over HCR and lowering the cost of health care are uppermost on the minds of Americans and will play a major role in influencing the outcome of the 2020 presidential election. Nurses can anticipate questions from patients and the public who will want to know what nurses think about HCR. Due to the public’s trust and positive perceptions of nurses, when asked about HCR proposals, it matters what nurses say and how they say it. By using specific criteria to assess HCR proposals and by being able to explain the strengths and limitations of each plan objectively, nurses will be able to live up to the public’s expectations.

Everyone gains by being informed about health care: patients who receive care, taxpayers who finance government programs, organizations that are in business to provide health care, people who earn their livelihood in health care, innovators who seek to improve care, community and public health organizations, and advocates who work to ensure vulnerable people obtain needed care. To be sure, as the presidential election approaches, HCR proposals will be modified and debated, come under media scrutiny, and inevitably be misrepresented. Will nurses be prepared to cut through the fog and confusion that will engulf the election by providing impartial and helpful explanations of each HCR proposal to patients, concerned stakeholders, and the public? $