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## HEALTH CARE SYSTEM REFORM

*Sr. Mary Jean Flaherty, S.C.\**

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While no one can predict with certainty the pattern of health care delivery and financing at the end of this decade, traditional providers, physicians, and acute care hospitals are reorganizing and regrouping in anticipation of major change.<sup>1</sup> There is also evidence that large health insurers are developing networks which integrate payment and delivery systems.<sup>2</sup> This article discusses some potential effects of President Clinton's proposal to reform the delivery and financing of health care on contemporary nursing education. This article will also offer a historical backdrop for the nursing community's reactions to Clinton's reform proposal by comparing contemporary responses to the positions of nurse educators during the last major revision of the health care system in 1965.<sup>3</sup>

Nurses were early and eager sponsors of Medicare and Medicaid because governmental assistance to the elderly, the disabled, and the poor was compatible with the nursing ethos. A 1965 statement of the American Nurses Association (ANA) linked ANA's obligation to ensure the quality of nursing services to its consistent support of the principles contained in the Social Security Act of 1965.<sup>4</sup> In this statement, the ANA addressed three issues: education, economics, and utilization. The statement noted that Medicare's enactment would stimulate an increased de-

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1. Ron Winslow & George Anders, *Medical Industry Scrambles to Keep Up with Changes*, WALL ST. J., Sept. 13, 1993, at A7.

2. Rosalind D. Resnick, *Coalitions Make a Difference*, NATION'S BUS., Apr. 1992, at 21.

3. See *Challenges to Nursing in Medicare*, AM. J. NURSING, Nov. 1965, at 68; Fanny F. Siegel, *Medicare and Its Opportunity for Nursing Leadership*, NURSING F., Fall 1966, at 95.

4. *Nursing Concerns in Health Insurance for the Aged: A Statement from the American Nurses Association*, AM. J. NURSING, Sept. 1965, at 120.

mand for nurses, especially highly skilled practitioners, supervisors, administrators, and clinical specialists. This statement also endorsed an increase in public financing of basic, graduate, and continuing education, with special emphasis on geriatric nursing at the graduate level, and suggested that refresher courses could serve as a vehicle for encouraging mature nurses to return to practice.

There is little evidence in the literature which links nursing's advocacy for Medicare programs to a perception of financial gain. The opinions of Esther Peterson, Assistant Secretary of Labor and Vice-Chairman of the President's Commission on the Status of Women, may be a unique contribution to the economic implications of the dialogue.<sup>5</sup> Peterson suggested that nursing education design its programs for new audiences, including persons in need of continuing education and women who desire a second career. She also noted that the work life of women would be affected by the ANA position statement concerning levels of practice, and by the opportunity to join collective bargaining units.

The literature also acknowledged that nursing education should support new practice opportunities created by Medicare. It was noted that successful ventures into new practice areas required attention to nurse-physician relationships and communication,<sup>6</sup> and greater collaboration between nursing education and service.<sup>7</sup> Lambertsen recognized that Medicare would affect not only the patient population in acute care hospitals, but also the advocacy groups for quality health care:

A better informed public armed with prepayment plans, Medicare, and other means of financing, will expect and use more health services and will demand better health services. The old, the young, the retarded, the handicapped — all high risk groups — in past years had little service and little chance to survive or

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5. Gretchen Gerds, *The Status of Women Today and Its Effect on Nursing*, AM. J. NURSING, Nov. 1963, at 70.

6. See Florence M. Alexander, *The AMA Committee on Nursing Looks at Nursing Liaison Activities in State Medical Societies*, 99 HOSP. MGMT., Apr. 1965, at 110; Charles E. Lewis, *Home Care Revisited: An Experiment in Medical and Nursing Education*, 40 J. MED. EDUC. 84 (1965); Edmund D. Pellegrino, *The Communication Crisis in Nursing and Medical Education*, NURSING F., Spring 1966, at 45; Henry Pratt, *The Doctor's View of the Changing Nurse-Physician Relationship*, 40 J. MED. EDUC. 767 (1965); Rozella M. Schlotfeldt, *The Nurse's View of the Changing Nurse-Physician Relationship*, 40 J. MED. EDUC. 772 (1965).

7. See Edna Fritz, *Baccalaureate Nursing Education: What Is Its Job?*, 66 AM. J. NURSING 1312 (1966); Max R. Goodson, *Professional Education*, 66 AM. J. NURSING 798 (1966); Dorothy M. Smith, *Nursing Education and Nursing Service: A Dual or Separate Administrative Responsibility?*, 191 JAMA 416 (1965).

to become independent. Today, they are acquiring the knowledge about services and the means to pay for them.

The patient's relationship with physicians, nurses, administrators of health service agencies, and other members of the therapeutic team also will change as he is expected to make more decisions about seeking and using care and as he becomes more involved with the therapeutic measures to be taken. To an unprecedented degree he will be cooperating greatly in his own therapy.<sup>8</sup>

Lambertsen also insisted that changes in nursing education would emerge from the practice arena, predicting that future practice would differ from that of 1966 because of drastic changes in health services, facilities, and patient populations.<sup>9</sup> Sleeper took the position that responsibility for planning educational programs for practitioners of the future is in the hands of nurse educators.<sup>10</sup>

During the early days of Medicare and Medicaid, the nursing community was preoccupied with its own professional issues, a nursing shortage<sup>11</sup> and an entry into practice dispute.<sup>12</sup> These professional issues may explain why authors of this period seemed to be more concerned with defending their educational viewpoints rather than envisioning new educational pathways. An editorial from the sixties attributes the nursing shortage of about 20,000 to attrition due to expense and marriage, other employment opportunities for women, low, non-competitive salaries, and a loss in prestige within the nursing profession.<sup>13</sup> Some observers cited the "excess education of nurses" as the cause of the shortage, while others argued that upgrading educational requirements was not the best method of addressing the lack of nurses at the bedside.<sup>14</sup> Although analysis of the nurse shortage was never entirely separated from the dialogue about the education of basic level practitioners, the debate about the

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8. Eleanor C. Lambertsen, *Changes in Practice Require Changes in Education*, 66 AM. J. NURSING 1784, 1785 (1966).

9. *Id.*

10. Ruth Sleeper, *Nursing Education in Evolution*, 271 NEW ENG. J. MED. 27 (1964).

11. See Eugene Levine, *Some Answers to the "Nurse Shortage,"* 12 NURSING OUTLOOK 30 (1964); Florence S. Wald, *Emerging Nursing Practice*, 56 AM. J. PUB. HEALTH 1252 (1966).

12. See Nancy Lipton, *Nursing Education as a Challenge to the Professionalization of Nursing*, NURSING F., Summer 1968, at 201; Verle H. Waters, *Distinctions Are Necessary*, 65 AM. J. NURSING 101 (1965); *What Nurses Say About Redefining Nursing*, RN, Oct. 1967, at 37.

13. *Nursing Education*, 271 NEW ENG. J. MED. 51 (1964).

14. See Thomas Hale, *Why the Nursing Shortage Persists*, 270 NEW ENG. J. MED. 1092 (1964).

most desirable education for entry into practice continued long after the shortage of the sixties was contained. Those who espoused the diploma as the certificate for practice insisted that continued support of traditional hospital-based programs was the best way to prepare nurses for bedside care.<sup>15</sup> Other advocates of diploma nursing programs pressed for a slow transition to collegiate-based education.<sup>16</sup> Supporters of the relatively new associate degree programs argued that a two year route to the practice of nursing offered the best of all possible worlds, a general and clinical education at community-based colleges, reasonable costs, and academic credentials to transfer to a four year baccalaureate program.<sup>17</sup> Baccalaureate educators, who influenced the direction of the American Nurses Association's position statement on nursing education, endorsed the view that a liberal education in a university setting should be the basis for professional nursing practice.<sup>18</sup> As time passed, discussion about the basic education of the nurse spread beyond the nursing community into the medical and hospital board rooms and the publications of those two groups.<sup>19</sup> When community college administrators realized the popularity of the associate nursing degree program, they joined the argument and advocated that associate degree education prepared people for the professional practice of nursing.<sup>20</sup>

Thirty years later, it is difficult to read this literature dispassionately. Arguably, nursing educators became so concerned with the preservation of their own fiefdoms that they ignored the obvious fact that a new delivery system requires a change in the way nursing is conceptualized and taught.<sup>21</sup>

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15. See Philip D. Bonnet, *Hospital Schools of Nursing in 1984: Two Forecasts*, HOSPITALS, Feb. 16, 1964, at 62; William K. Turner, *Nursing Education*, HOSPITALS, Apr. 1, 1964, at 113.

16. See Mary J. Erne, *Implications of Trends in Nursing Education*, NURSING OUTLOOK, Sept. 1966, at 36.

17. See Dagmar E. Brodt, *Education Today for Nursing Service Tomorrow*, 5 J. NURSING EDUC. 7 (1966); Dorothy E. Johnson, *Today's Action Will Determine Tomorrow's Nursing*, NURSING OUTLOOK, Sept. 1965, at 38.

18. AM. NURSES ASS'N COMM. ON EDUC., EDUCATIONAL PREPARATION FOR NURSE PRACTITIONERS AND ASSISTANTS TO NURSES: A POSITION PAPER (1965).

19. See Thomas Hale, *Problems of Supply and Demand in the Education of Nurses*, 275 NEW ENG. J. MED. 1044 (1966); Lambertsen, *supra* note 8.

20. See Virginia D. Allen & Connie Sutton, *Associate Degree Nursing Education: Past, Present and Future*, 2 NURSING & HEALTH CARE 496 (1981); Adebisi O. Fabayo, *Nursing and the Community College Movement*, 19 NURSING F. 181 (1980).

21. See Katharine D. Dreves, *This I Believe about Nursing in a Changing World*, NURSING OUTLOOK, Feb. 1964, at 50; Lambertsen, *supra* note 8.

## I. HEALTH CARE IN THE MID-SIXTIES

After the enactment of Medicare, the delivery of medical services centered around acute care. Hospitals were remodeled, beds were added, and high technology specialty care became the state of the art.<sup>22</sup> The patient mix in hospitals changed as the population aged and more people sought care under the entitlement program. The therapeutic expectations and outcomes of patients and providers increased. Medicare was not the only social force contributing to the growing importance of health care in society. Simmons, a leading sociologist of the period, described other social forces which influenced health care in the period after Medicare: increased population mobility, greater public sophistication, better communication systems, improved standards of living, growth in communication among the professions, change in disease prevalence as people lived longer, a transition from a religio-philosophical view of life to materialistic and scientific values, and the emergence of special interest groups.<sup>23</sup>

The wars on heart disease, cancer, and stroke were also important political battles for Medicare recipients and their providers because of the incidence of these diseases among older people and because federally sponsored research programs spawned new technologies to aid in diagnosis and treatment.<sup>24</sup> Medicare payments also encouraged doctors and hospitals to become more aggressive in looking for and treating the diseases of the aged. Manpower training programs and Medicare's support for graduate medical education contributed to the growth of specialization in medicine and nursing.<sup>25</sup> New paramedical groups also emerged to address both the clinical concerns of an aging population and the conviction that good patient care, especially high technology care, required more than a physician-patient relationship.<sup>26</sup> Then, too, there was the bureaucratic factor of the federal government's significant involvement in

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22. See Margaret L. McClure & M. Janice Nelson, *Trends in Hospital Nursing: Nurses' Roles in Hospitals*, in *NURSING IN THE 1980S: CRISES, OPPORTUNITIES, CHALLENGES* 59 (L.H. Aiken & S.R. Gortner eds., 1982).

23. See Leo W. Simmons, *Change in the Social Order: As it Affects Health Service*, 45 *HOSP. PROGRESS* 81 (1964).

24. See Shizuko Fagerhaugh et al., *The Impact of Technology on Patients, Providers and Care Patterns*, 28 *NURSING OUTLOOK* 666 (1980).

25. See Stuart H. Altman, *The Growing Physician Surplus: Will It Benefit or Bankrupt the U.S. Health System?*, in *THE COMING PHYSICIAN SURPLUS: IN SEARCH OF A POLICY* (Eli Ginzberg & Miriam Ostow eds., 1984).

26. See Lucie Y. Kelly, *Health Care Delivery: Who?*, in *DIMENSIONS OF PROFESSIONAL NURSING* (1985).

health care financing, and the documenting, reporting and accounting functions which evolved and became integrated into hospital nursing practice. Simmons asserts that it would be impossible for traditional modes of practice to fit the comprehensive agenda which evolved after the enactment of Medicare.<sup>27</sup>

Nurse educators responded to Medicare's revolution of the health care system with a vigorous advocacy for funds for nurse training in general and graduate studies in particular<sup>28</sup> and for the development of a new system of associate degree education.<sup>29</sup> Prior to the sixties, graduate programs in nursing prepared administrators and teachers. There were also a few programs which offered advanced training in public health and psychiatric mental health nursing.<sup>30</sup> When hospitals emerged as centers for diagnosis and treatment of the acutely ill, nursing faculty created clinical specialist programs which led to master's degrees.<sup>31</sup> These early initiatives tracked federal interest in heart disease, cancer, and stroke.<sup>32</sup> Nurses learned that Weller's insight that health is a political commodity made sense.<sup>33</sup> The more mature educational programs based their curricula on the health needs of specific populations, and expanded specialty nursing practice into practitioner practice.<sup>34</sup> Nurse educators, emphasizing that only thirty percent of the teachers held master's degrees,<sup>35</sup> also launched doctoral programs to prepare researchers and future faculty members.

There are several explanations for the responses of nurse educators to

27. See Simmons, *supra* note 23.

28. See Rena Boyle, *Federal Legislation: Its Impact on NLN's Accrediting Programs*, NURSING OUTLOOK, Mar. 1965, at 34; Ruth B. Freeman, *Public Funds for Nursing*, AM. J. NURSING, Nov. 1963, at M-28; James E. Snyder, *Congress Unleashes Dollars for Nursing Education*, HOSP. MGMT., Oct. 1964, at 77.

29. See generally Patricia T. Haase, *Upheaval Within: The Politics of the Profession*, in THE ORIGINS AND RISE OF ASSOCIATE DEGREE NURSING EDUCATION (1990); Lucie Y. Kelly, *THE NURSING EXPERIENCE: TRENDS, CHALLENGES AND TRANSITIONS* (1992).

30. See generally Jean Campbell, *MASTERS EDUCATION IN NURSING: REPORT OF A STUDY CONDUCTED IN SPRING, 1963* (1964); Loretta E. Heidgerken, *The Graduate Curriculum Study* (1962) (Nursing School curriculum, The Catholic University of America); Janice Marcia Brown, *History of Masters Education in Nursing in the United States, 1945-1969* (1979) (unpublished doctoral dissertation, Columbia University).

31. See Brown, *supra* note 30.

32. See Philip A. Kalisch & Beatrice J. Kalisch, *THE ADVANCE OF AMERICAN NURSING* (2d ed. 1986).

33. See Thomas H. Weller, *Questions of Priority*, 269 NEW ENG. J. MED. 673, 674 (1963).

34. See Kalisch & Kalisch, *supra* note 32.

35. See Florence M. Alexander, *Education for a Career in Nursing*, 195 JAMA 591, 593 (1966).

the enactment of Medicare. It can be argued that professional disputes about the basic education for the practice of nursing were so intense that, with the notable exception of associate degree educators, reform of the traditional curriculum was ignored or delayed. It can also be asserted that the underlying assumption of the ANA position statement directed nurse educators to focus their attention on the reform of graduate education and the relocation of educational programs into the colleges. In any case, graduate and associate degree education prospered in the wake of Medicare.<sup>36</sup>

## II. HEALTH CARE IN THE NINETIES

It is anticipated that integrated delivery systems will replace individual hospitals and solo practitioners as the providers of health care services.<sup>37</sup> However, while everyone understands acute care hospitals and fee for service medicine, there is an ambiguity and anxiety about the growth of managed care networks and the emergence of local integrated delivery systems.<sup>38</sup> Some analysts insist that ideal integration will be achieved through a collaborative linking of existing facilities, tertiary hospitals, community-based hospitals, clinics, and nursing homes.<sup>39</sup> Others suggest that networks need to include physician practices and social services agencies if they are to be comprehensive, cost-saving, and effective.<sup>40</sup> Other models emphasize price and cost. In these formulations, insurance groups dominate, initiating contracts with individual hospitals, physicians and/or integrated networks to deliver services to their enrolled populations at the most economical price.<sup>41</sup> The goal of each model of integration is to weave together and control an array of preventative, medical, ambulatory, and, if necessary, in-patient providers and services to meet the health needs of a defined population and be competitive on quality

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36. See KELLY, *supra* note 29; see generally Patricia T. Haase, *The Federal Government Lends a Hand*, in *THE ORIGINS AND RISE OF ASSOCIATE DEGREE NURSING EDUCATION* 67 (1990).

37. See Winslow & Anders, *supra* note 1.

38. See Susan B. Garland, *Health Care Reform: It's Insurer vs. Insurer*, *BUS. WK.*, May 4, 1992, at 62, 66.

39. See Emily Friedman, *Managed Care: Where Will Your Hospital Fit In?*, *HOSPITALS*, Apr. 5, 1993, at 18, 19; Trish Riley & Robert Mollica, *To Cut Costs, States Develop Networks of Care*, *BUS. & HEALTH*, June 1993, at 72.

40. See Janice Spillane, *PPO Gaining Wide Acceptance in Care Plans*, *PENSION WORLD*, May 1991, at 18.

41. See Martha Glaser, *N.J. Blues Managed Care Threatens Small Providers*, *DRUG TOPICS*, Aug. 16, 1993, at 60; Alfred G. Haggerty, *New Mega-Managed Care Company in California*, *NAT'L UNDERWRITER*, July 12, 1993, at 3.



and cost. The ongoing rearrangement and realignment of health providers and insurers is an effort to gain a competitive edge, or to put it more succinctly, to stay in business in an environment where managed care groups, the federal government, and private insurers have already begun to insist on using the least expensive health services and on limiting visits to specialists.<sup>42</sup> It also represents a plan which anticipates health care alliances and the accountable health care plans outlined in Clinton's reform agenda.<sup>43</sup> In communities with too many acute care beds and physician specialists, there are mergers, bed closures, and new agreements among rival hospitals.<sup>44</sup> Specialists are joining existing managed care programs or are banding together with family care practitioners to form new groups.

There is a striking and disconcerting parallel about the self-preserving reaction of the medical and hospital industry to health care reform and the response of the nursing community to Medicare. Acute care hospitals and specialist physicians are clearly on the defensive; they are not the driving force in managed or integrated care delivery networks, where primary and preventative health services and providers dominate.

Medicare required the development of sophisticated management information systems for its enrollees. Navigating the management potentials of health care reform requires that comprehensive information about health problems, risks, use patterns, health behaviors, and habits of the defined population, the "market," be integrated with provider behaviors and price. Traditionally, the assessment of actuarial data and the management of large data sets has been the forte of insurance companies, while hospital and physician information systems have captured the experience of individual patients. Managed care environments already have elements of both data sets. However, because health care reform guarantees universal coverage, prescribes managed care, and promises to hold insurance plans accountable for quality and cost containment, the integrity, availability, and sophistication of an information system which can track persons across time and setting is critical to effective and competitive performance.

In the Clinton proposal, individuals will select among three options: a basic health program, a program of choice among providers and services,

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42. See Winslow & Anders, *supra* note 1.

43. See Laura Souhrada, *Three Experts, Three Visions of the Future*, *HOSPITALS*, Apr. 5, 1991, at 41.

44. See M. Mary Conroy, *Physician, Cut Thy Costs*, *BUS. & HEALTH*, June 1991, at 38; Wendy Zellner et al., *And Now, Monolith Hospital*, *BUS. WK.*, June 28, 1993, at 33.

the so-called point of service program, and the traditional fee for service program.<sup>45</sup> In this framework, if a person chooses the basic package, most or all of the costs will be borne by the employer. If a person elects a more comprehensive benefit package or opts for greater choice among services and providers, there will be an out-of-pocket payment.<sup>46</sup>

Most public attention is directed to the proposed organization of the health reform systems and the plan to pay for universal coverage. Meanwhile, the business and health literature reflects a preoccupation with restructuring because, as some put it, reform is already underway in the field.<sup>47</sup> In the Clinton scenario, there is a critical link between the ability to "capture" the health care contract of an identified population and the ability to control the presentation and utilization of a wide range of services. Because it is thought that solo practitioners, specialists, and isolated acute care hospitals cannot compete on unit price, there is a mad scramble to link together or join some network or "balanced" cooperative. While the activity in the field may not be a reform, it is certainly reorganization.

### III. THE RESPONSE OF EDUCATORS TO HEALTH CARE REFORM, 1994

As noted earlier, the responses of nurse educators to the impact of the 1965 Social Security Act on the practice or delivery of nursing services were mediated by professional concerns. However, the Clinton proposal has stimulated such a lively debate that Sprayberry is concerned that nurses might engage in the rhetoric of access or consumer advocacy and ignore the interests of nursing.<sup>48</sup> Chinn argues against compartmentalizing knowledge, research, and practice and compares this tendency to little boys playing with boxes in which everything fits neatly and safely.<sup>49</sup> She calls for creative educational reform, not the rearrangement of new models in old boxes or the creation of more boxes.

In response to the Clinton proposal, two major nursing organizations, the American Nurses Association (ANA) and the National League for

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45. See Ann Devroy & Dana Priest, *Clinton Health Bill Opens Hill Debate*, WASH. POST, Oct. 28, 1993, at A1.

46. See WHITE HOUSE DOMESTIC POLICY COUNCIL, *THE PRESIDENT'S HEALTH SECURITY PLAN: THE COMPLETE DRAFT AND FINAL REPORTS OF THE WHITE HOUSE DOMESTIC POLICY COUNCIL* (1993).

47. See Mike McNamee, *Health-Care Reform: It's Already Here*, BUS. WK., June 14, 1993, at 114; Richard W. Osborne, *Now Is the Time*, BEST'S REV., Apr. 1992, at 43.

48. See Lynn D. Sprayberry, *Nursing's Dual Role in Health Care Policy*, 14 NURSING & HEALTH CARE 250 (1993).

49. See Peggy L. Chinn, *The Politics of Little Boxes*, 41 NURSING OUTLOOK 6 (1993).

Nursing (NLN) have developed position papers on health care reform. The 1991 ANA proposal,<sup>50</sup> which has been well received by consumers, calls for diminished emphasis on a "sickness-oriented system," and attitudinal change about the organization, financing and delivery of health care.<sup>51</sup> It notes, and this insight may be its greatest contribution to the debate, that agenda building is not an end in itself, but a place to clarify and develop health policy. Commentators on NLN's proposal, *An Agenda for Nursing Education Reform in Support of Nursing's Agenda for Healthcare Reform*,<sup>52</sup> predict that all nurses will be educated for community-based practice.<sup>53</sup> Consequently, they endorse the development of faculty prepared to work in the community, an increase in the number of advanced nurse primary care practitioners, the building of more community health centers, and greater emphasis on health promotion research focused on communities.<sup>54</sup> Hillary Rodham Clinton, the architect of health care reform, identifies a need for staff nurses, advanced practice nurses, and primary care providers if reform is to bring about health care for all Americans.<sup>55</sup> Thelma Schorr, an old hand at nursing roundtables, agrees but adds an important caveat.<sup>56</sup> She says that if health care is to be really available, accessible, and affordable, nursing must be accepted as first class health care and not second class medical care. Anderson, recognizing that change is underway, fears that nurses will not restructure the way they deliver care.<sup>57</sup>

It is apparent that nursing's practice and educational models built around Medicare are out of synch with health reform proposals.<sup>58</sup> Primary and preventive services will replace most tertiary care. The population to be served is more significant than physicians and hospitals. Health

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50. AMERICAN NURSES ASSOC., *NURSING'S AGENDA FOR HEALTH CARE REFORM* (1991).

51. *Id.*

52. NATIONAL LEAGUE FOR NURSING, *AN AGENDA FOR NURSING EDUCATION REFORM: IN SUPPORT OF NURSING'S AGENDA FOR HEALTHCARE REFORM* (1992 draft).

53. See C. A. Tanner, *Nursing Education and Health Care Reform*, 32 *J. NURSING EDUC.*, Apr. 1993, at 147.

54. *Id.*

55. See Hillary Rodham Clinton, *Nurses in the Front Lines*, 14 *NURSING & HEALTH CARE* 286 (1993).

56. See Thelma M. Schorr, *The Term Is "Health Care,"* 14 *NURSING & HEALTH CARE* 294 (1993).

57. See Carole A. Anderson, *Restructured Organizations: Traversing Hills and Valleys*, 41 *NURSING OUTLOOK* 198 (1993).

58. See Steven Findlay, *Health Care Group Aims at Community-Based Delivery Systems*, 10 *BUS. & HEALTH* 42 (1992); G. Rodney Wolford et al., *Getting to Go in Managed Care*, 18 *HEALTH CARE MGMT. REV.* 7 (1993).

care services will be provided in more comfortable, less expensive, community-based settings. Generalists or balanced panels of primary care practitioners and specialist physicians will be the providers. The delivery of care will be integrated with the payment of care to assure good utilization, quality, and cost control. Education and the use of self help and support groups will go hand in hand with traditional therapy. Individuals, not employers, will choose their health insurance plans. Consequently, people must know the benefits and quality of the competing products as well as their costs. Wise choices will also require the consumer to be informed about personal states of health, to take responsibility for adopting healthy behaviors and lifestyles, and to make the best use of health care services.

If even half of these values are incorporated successfully into the reform package, the delivery system of the future and nursing's role in it will be very different. Rheba deTornay's questions, such as "What will nursing's role be in a changed system; what skills and competencies will nurses need?" and "How must schools and programs of nursing change, and are we really ready for sweeping changes?" provide nurse educators with a personal and communal agenda for the reform of nursing education.<sup>59</sup>

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59. Rheba de Tornay, *Nursing Education: Staying on Track*, 14 *NURSING & HEALTH CARE* 302 (1993).

