Response to the Canadian Nurses' Association

Toward 2020: Visions for Nursing

Registered Nurses' Association of Ontario

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The Registered Nurses' Association of Ontario (RNAO) is pleased to take this opportunity to provide feedback on the document *Toward 2020: Visions for Nursing* developed by the Canadian Nurses Association (CNA). This document is scheduled for discussion at CNA's upcoming Board of Directors (BOD) meeting in March.

We would like to address two key issues: process for paper development, and content.

Process Feedback

We see the document as a valuable starting point for an essential dialogue on the future of nursing, and we congratulate CNA for taking leadership in initiating this discussion.

Toward 2020: Visions for Nursing was developed by CNA staff by means of a literature review and an informal qualitative research methodology using a convenience sample and "snowball" recruitment of key informants. In our view, a serious shortfall in this process is that CNA BOD had no input into the development of this paper. As a result, CNA BOD members and advisors were not given the opportunity to comment on the very serious and complex content of this document before it was brought forward as a final product.. Indeed, the CNA BOD will have its first content discussion of *Toward 2020: Visions of Nursing* in March 2007, long after the document has been discussed by dozens of groups across the nation.

We are aware that *Toward 2020: Visions for Nursing* was developed before CNA adopted its new goals and strategic direction, and therefore would not fully reflect CNA's future vision.

Process Recommendations

1. RNAO recommends that a partner document to CNA's *Toward 2020: Visions for Nursing* be developed to reflect the rich feedback provided by multiple stakeholders during the presentations around the country, feedback from the CNA BOD meeting on March 2007, and other stakeholders' feedback as suggested in the pages ahead. This democracy-in-action approach will serve to empower nurses and nursing organizations who will see their voices reflected in the paper.
2. Given that the document is framed as a tool to trigger dialogue, RNAO believes it is vital that all presentations include ample time for discussion.

Content Feedback

The basic premise of *Toward 2020: Visions for Nursing* is that if nurses don't actively shape their future, other forces will not hesitate to do so. RNAO agrees that this approach may potentially galvanize nurses to become engaged to make their preferred future a reality. Conversely, nurses could take it as an indication that even the most unwise changes are inevitable. RNAO believes that there are many alternatives in all policy areas of importance to RNs, including nursing, health, social, and economic policy. Below, we will discuss how the paper could better help RNs to influence all these policy areas.

Mindful of our mandate to speak out for nursing, health care, and health, we will highlight key parts of the paper and advise further clarity on some and raise concerns about others.

Nursing

The paper articulates a future vision for nursing that is very different from today's reality: nurses would provide the bulk of primary care within a shared care model; there would be a major expansion of interdisciplinary health teams; 70 per cent of nurses would have access to full-time employment; and, the nursing profession would be strengthened.

As a national federation for registered nurses, CNA's contribution to addressing some of the confusion about nursing roles, scopes of practice, etc. is potentially valuable. However, the value of advocating a model of shared care that expands primary health care provider beyond registered nurses and physicians to allied health and human service workers is less clear. Scenario 1 includes: "every Canadian has a primary caregiver who may be a nurse, NP, family-practice physician, social worker or other health professional in a community health centre".[1] Scenario 2 claims: "The needs of the patient, family or community will dictate the primary care provider assigned."[2] .

While social workers and other health professionals provide essential service and care within their realms of professional expertise, they do not have the holistic perspective of primary care that is embodied by nursing and medicine. RNs, NPs, and MDs have the skills and expertise to assess both physical and mental health and therefore are ideal primary care providers and client-advocates. Assigning clients to social workers, nutritionists, occupational therapists, physiotherapists, pharmacists, psychologists, or other health professionals runs the risk of missing essential assessments or less efficient care as clients bounce around. There are potential equity concerns: who, for example, will be assigned a social worker as primary caregiver? Will it be those who are perceived as having "social problems"? Vulnerable populations who face social exclusion and poverty are also most at risk for having complex physical and mental health challenges that need careful monitoring. Assigning primary care providers to meet the needs of families or communities without privileging the needs of the clients first is a movement away from client-centred care.

The end of Chapter 5 uses a quotation from Donaldson to warn against "the insular behaviour of nursing and 'preoccupation with identity, boundaries, and process' that left unchecked would lead to a future she described as an 'expensive cocoon.'" One could argue that this attentiveness to identity, boundaries, and process is exactly the attribute required in order to practice client-centred care which respects "the client's autonomy, voice, self-determination, and participation in decision-making."[3] While collective self-reflection and self-criticism can be transformative, this document uses a language of crisis to urge change without clearly articulating the value that registered nurses have in this evolving health-care system. Given the speculation about collapsing registered nurses, licensed practical nurses, and registered psychiatric nurses into a single category of nurse; visions of a "general technical nursing category" that is a hybrid of nurse and technician; non-human robotic care partners; self-care, technology, and allied health workers replacing professional nursing care, it is not evident what will be missing when technology and technicians replace professional nursing care.

This document calls for nursing leaders "to focus on health and health systems, not on nurses and nursing".[4] If nursing leaders and professional nursing organizations are unable to articulate how nurses and nursing are integral to healthy public policy and a vibrant health-care system, it is difficult to imagine who else will make that argument.

RNAO's Recommendations on the Nursing Section

Nursing Shortages

Toward 2020 does a valuable service in drawing attention to the problems that are driving nurses out of the profession: "issues such as workload, overtime, scheduling, abuse and violence, and a lack of professional autonomy".[5] The document also acknowledges the growing problem with the pace and intensity of RNs' work.[6] It points out that failure to address these problems will guarantee a future nursing shortage.

Implicitly, the paper identifies a shortage of nursing positions, particularly full-time positions.[7] It also captures the complexity in determining whether there is a shortage.[8] However, there is a hesitance to accept that there is currently a nursing shortage until nurses have been redeployed to make better use of their time. Other CNA documents are less tentative. For example, a 2006 position statement cites an estimate of a 6.9 per cent shortage of nurses in Canada.[9] CNA is certainly attuned to the risk associated with shortages, as its website features key research that shows the health and economic cost of inadequate RN staffing.[10]

RNAO urges CNA to focus less on redeployment as a solution to nursing shortages in a partner document to the paper. We must address the inconsistent and often inadequate funding for nursing, which has made nursing employment unpredictable and nursing work environments needlessly challenging. CNA's own research has shown the toll of difficult work circumstances for RNs in Canada: illness and injury-related absenteeism

rates that far exceed those for all workers in Canada.[11] Stable and adequate funding would allow for secure and well-paid jobs for nurses in all sectors. Improving employment security and work environments would allow more nurses and aspiring nurses to commit to nursing. A commitment to educational funding is also a vital component to recruitment.

The report envisions an expansion of RNs' status and span of control, which should serve to enhance recruitment and retention. Potential shortages would be addressed by expanded nurse education programs. *Toward 2020* could have elaborated on the necessary nursing human resources steps, as outlined in the 2006 CNA position statement on national human resource planning in health.[12] We urge CNA to emphasize in a partner document to the paper the importance of political and financial commitment, with measurable deliverables. Ontario's recent experience with dedicated targeted funding for nursing shows that the right kind of commitment can make a significant difference.

70 Per Cent Full-Time Employment

The paper calls for 70 per cent of nurses in all categories to have access to full-time positions. All RNs should have access to full-time employment, and work conditions should be sufficiently sustainable that at least 70 per cent of RNs would accept full-time employment. Thus, RNAO's position calling for a realization of 70 per cent full-time speaks both to opportunity and to work conditions. RNAO urges CNA to revise this section by taking a stronger position on the issue, in line with that of the Canadian Nursing Advisory Committee.[13]

Scope of Practice

In envisioning a broad restructuring of responsibilities, the paper displays a readiness to accept replacement of RNs and other health professionals by lesser prepared caregivers, or by patients, or by robots. It takes the view that provider shortages will imply considerable upward drift of scope into areas where providers are in short supply.

Appropriate self-care and appropriate use of unregulated support staff such as personal health workers are essential aspects of client-centred care. Registered nurses and their organizations must be cautious, however, that they do not inadvertently sanction the movement of professional nursing services away from those most qualified to provide care to vulnerable clients, stressed family and friends, and lower-cost, unqualified workforces. Downloading the delivery of health-care services from the public sector to private households and community organizations has disproportionately increased the burden on women as health professionals, family caregivers, and community members.[14] [15]

In discussing different perspectives between RNs, LPNs, and RPNs with respect to scope of practice, the paper conveys an inconsistent message.: "Registered nurses face a different kind of vulnerability, being confronted with the claims of some LPNs and RPNs that their scope of practice mean they can basically replace RNs, or can practice with the same patients and across all domains of nursing. This frustrates RNs who have amassed a

growing body of evidence showing they have a positive impact on health and illness outcomes different from the other regulated nursing groups. Some research concludes for example, that more RNs and more hours of RN care correlate to better patient outcomes on a number of measures. Those kinds of findings should underpin decisions on who are the safest, most appropriate providers in any given setting. It should be noted that some physicians have made some of the same assertions about RNs that RNs have made about LPNs and RPNs."[16]

A casual reader who is unfamiliar with the health policy literature has no way of evaluating these conflicting assertions. Unlike other sections of this document, the "some research" on health outcomes by type of regulated nursing professional is not substantiated with any citations. Is this unreferenced statement then equivalent in veracity to "some physicians" who make the same claims about RNs? Given the strong resistance of some physicians[17] and medical organizations[18] to primary health care reform and utilization of advanced practice nurses, it is essential not to take this statement at face value without examining the evidence of quality of care provided by RNs and NPs. In imagining possible futures, it is essential that our national nursing organization be able to articulate and provide supporting evidence of RNs' contribution to client care and the health-care system. The document would be strengthened by providing evidence on staff mix and outcomes, including that of baccalaureate-prepared RNs [19] as well as evidence related to nurse-led clinics[20] [21] [22] and nurse practitioners.[23]

Health and the Health-Care System

Health

This paper demonstrates a progressive stance in acknowledging the significance of key aspects of primary care and population health. These include: moving resources to health promotion and the community from illness and hospitals; addressing poverty and the growing rich-poor divide; rebuilding "the balance for social care"; and, recognizing the link between environment and health. On the latter, the paper joins the great majority of scientists in warning of the perils of global warming.

A serious shortcoming of *Toward 2020*, however, is that it decontextualizes and depoliticizes broad social factors that impact health and health-care systems. For example, it suggests a simplistic, innocent narrative that "when the world and Canada were prosperous, there was more money for social programs, including health care. Bad times tightened the purse strings for all social programs…"[24] An alternative interpretation is that a neoliberal ideology of trade liberation, deregulation, privatization, and reducing the role of the state became the driving force behind globalization.[25] Reinforcing a notion that economic and political choices that become public policy are somehow external events over which we are powerless[26] does not empower nurses to become engaged in social change. Moreover, the document's overly sanguine discussion of globalization ignores its potential health impacts,[27] especially for the most vulnerable people of society. *Toward 2020* could do a better job of informing readers of the health

consequences of social and economic policy, which in turn would better empower them to advocate for healthy policies in all dimensions of political life.

Health-Care System

Toward 2020 uncritically uses the opinions and strategic communications of proponents of for-profit health care (such as Michael Walker, Executive Director of the Fraser Institute, and Irvine & Gratzer from the Atlantic Institute for Market Studies) as evidence for private, for-profit health care. A mention of peer-reviewed literature that demonstrates the increased cost and inferior quality of for-profit health care is shown as a side-bar point by a Rachlis quotation, but is not woven into the substantive discussion. Although it might have been an attempt to appear objective or neutral, a reader does not have any way to evaluate conflicting and contradictory side notes that represent divergent viewpoints. This section adopts a pejorative tone in stating that "the mantra in support of the public health care system, unaccompanied by critical debate and analysis, is not going to fix the system or make the problems go away"[28], while itself providing only a superficial discussion of this essential topic. It is especially disturbing to read "discussions about privately-owned and/or privately-delivered services, user fee or public-private partnerships, the reaction of many Canadians, their politicians, and certainly of many nursing organizations are ideologically based".[29] Political scientists would argue that proponents of for-profit health care are certainly no less ideological than proponents of not-for-profit health care. Important values and interests underpin public policy stances along the continuum. Trivializing support of not-for-profit health care as being ideologically based is disingenuous, especially when the redistributive agenda of market-based health-care reform has been well documented.[30]

Any CNA document should be consistent with the CNA position in favour of a single-tier, universally accessible health-care system, with services delivered on a not-for-profit basis, regardless of the opinions offered by various contributors to the consultations. The evidence is on CNA's side.

RNAO's Recommendations to the Health and Health Systems Section

The Role of the Private Sector

In places, *Toward 2020* is tentative and ambiguous on the role of the private sector in health care, both with respect to the evidence and with respect to the preferred role. For example, it says, "Physicians and other caregivers are divided about private versus public care," without elaborating on who the other caregivers are.[31] This ambiguity about the role of the private sector is in contrast to a lengthy series of CNA resolutions that: endorse the principles, spirit and conditions of the *Canada Health Act*; endorse the extension of those principles to other sectors such as home care and pharmacare; and, call for moratoria and bans on for-profit delivery and finance of health care.

Toward 2020 is clear on some issues around the role of the private sector: wait times are not an argument for privatization, and Canadians want a publicly-funded health system not driven by profit. RNAO urges , in the partner document, to take a clear, consistent and unequivocal position in favour of not-for-profit delivery as stated in CNA's mission, goals and strategic directions in the following areas.

The Chaoulli Decision. The paper correctly identifies the Chaoulli decision as occasioning urgent action, but in response only calls for action to improve access to timely and appropriate care.

The paper would be strengthened by expanding its discussion of the Chaoulli decision and wait times, along with the threat these issues pose to Medicare. Additionally, the report should include the following: that the split 4-3 decision was highly controversial and bitterly contested, and that the majority position has been vigorously criticized by the Court minority and by some well-respected experts for its handling of evidence.[32] The partner document to *Toward 2020* should include the findings of the Federal Advisor on Wait Times, which elaborate a comprehensive client-centred strategy that would enhance health care within the public system[33] (these findings were released after *Toward 2020).*

The paper should also speak to the elements that will be needed to save Medicare from the impact of the Chaoulli decision; amendments to provincial legislation restricting second tiers of health care,[34] and rigorous federal enforcement of the *Canada Health Act*.[35]

RNAO urges CNA to include in the partner document a call to all politicians, and especially the Prime Minister and Premiers of the nation, to take all necessary steps to prevent the further growth of multiple tiers of health care, including implementing comprehensive wait-times strategies, strengthening restrictions on transacting in essential medical services, and enforcing the *Canada Health Act*.

User Fees. User fees for medically necessary services are a violation of the *Canada Health Act* – an act CNA was instrumental in realizing. There are two significant concerns about user fees: they may deter essential use of health services, and they disproportionately impact lower income people. *Toward 2020* suggests evidence on the adverse impact of user fees is inconsistent, and provides references from the Atlantic Institute for Market Studies, a market-oriented think tank. The importance of contextualizing different claims and evaluating evidence carefully is demonstrated in this example. In their historical analysis of proponents of user fees, Robert Evans and his colleagues have found that provincial medical associations, self-employed medical practitioners, and the business sector have traditionally advocated for user fees while citizen's groups, salaried health workers, and nurses' associations have advocated against them.[36] Based an analysis of this issue by the independent Canadian Health Services Research Foundation confirming that user fees inevitably create advantages for the rich and healthy while harming the sick and the poor,[37] RNAO urges CNA to remain steadfastly against user fees.

For-Profit Delivery. At one point, the paper suggests that Canadians don't want "a health system…driven by making a profit from illness."[38] Yet on the next page, the paper laments ideology that it says risks losing lessons from other countries, without ever specifying which ideologies and which lessons.[39] This has been the language of proponents of a stronger role for the market in health care, including private payment for health care and for-profit delivery. RNAO urges CNA to take an unequivocal position, consistent with CNA's vision, mission and goals, in calling for a moratorium on any expansion of for-profit delivery of health care, using the weight of evidence on outcomes and cost to support this decision.[40 41 42 43 44 45 46 47 48 49 50 51 52].

Summary

CNA is to be commended for initiating a vital discussion on possible futures for nursing. RNAO recommends that a partner document be developed , and the following points, consistent with CNA's stated mission, six goals and new strategic directions, be clearly stated and expanded:

- The looming nursing shortage is an important challenge, but not an insurmountable one, that could justify deskilling the provision of health care. The paper should reflect proposed policy and an aggressive health human resources strategy to avoid RN shortages.
- Support for the CNAC position calling for at least 70 per cent full-time employment for nurses.
- Any changes in scope of practice must be made on the strength of the best evidence on the likely impact on clients, and not driven by potential shortages.
- It will call on CNA to explicitly foster the political commitment essential to solving the looming nursing shortage by promoting targeted conditional funding for nursing.
- It will show unequivocal support for Medicare congruent with CNA's BOD vision, mission, goals and strategic directions. There is solid evidence in favour of a single-payer, universally accessible health care system delivered by not-for-profit providers. CNA must use this evidence, and present a clear, consistent and unequivocal position. This inconsistency in messages is a concern that RNAO has raised with CNA on past occasions.
- It will call on the federal and provincial governments to take all measures necessary to protect the *Canada Health Act* from the Chaoulli decision, including making all legislative changes needed to prevent the emergence of a second tier in health care, implementing a comprehensive wait-time strategy, and enforcing the Act.
- It will speak against user fees using the evidence summarized in the Canadian Health Services Research Foundation document.
- It will take an unequivocal position, consistent with CNA's vision, mission and goals, in calling for a moratorium on any expansion of for-profit delivery of

health care, using the weight of evidence on outcomes and cost to support this call.

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[1] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, p. 96.
[2] Ibid., p.97.
[3] Registered Nurses' Association of Ontario (2002). *Client Centred Care*. Toronto: Author, p. 12.
[4] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, p. 84.
[5] Ibid., p. 11.
[6] Ibid., p. 53.
[7] Ibid., p. 52.
[8] Ibid., p. 56.
[9] Canadian Nurses Association (2006).. *National Planning for Human Resources in the Health Sector*, citing a 2004 OECD study.
[10] See http://www.cna-nurses.ca/CNA/issues/research_summaries/nurse_staffing/default_e.aspx. Accessed July 26, 2006.
[11] 7.9 per cent per week vs. 5.0 per cent per week. Informetrica (2006). *Trends in Illness and Injury-Related Absenteeism and Overtime among Publicly Employed Registered Nurses*, Canadian Nurses Association, p. 14.
[12] Canadian Nurses Association (2006). *National Planning for Human Resources in the Health Sector.*
[13] In 2002, the CNAC called for 70% full-time employment for nurses.
[14] Glazer,N. (1993). *Women's Paid and Unpaid Labor: The Work Transfer in Health Care and Retailing*. Philadephia: Temple University Press.
[15] Armstrong, P. C. Amaratugna et al. (2002). *Exposing Privatization: Women and Health Care Reform in Canada.* Aurora, Ontario: Garamound Press.
[16] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, pp. 62-63.
[17] Dr. Granger Avery, past president of the British Columbia Medical Association, for example, said: "Our GP system is an excellent primary care system. To substitute that for something less—which, be definition,is what nurse practitioners are—is unnecessary and retrogressive." Teasdale, C. (1999). Family Practice on the Cusp: Government Controls Focus More on Cutting Costs than Serving Patients, Some GPs Warn" Medical Post. February 23, 1999.
[18] Examples of scepticism about collaborative interdisciplinary teams and the value of care provided by nurse practitioners may be found in Ontario College of Family Physicians (2005). Family Physicians and Public Policy: The Light at the End of the Tunnel. Toronto: Author.
[19] The evidence shows that increased RN staffing improves outcomes both in Canada and internationally. Hospitals with higher RN nursing staffing mixes had significantly lower mortality rates (Tourangeau, A. E., Giovannetti, P., Tu, J. V., & Wood, M. (2002).. Nursing-related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research*, 33*:* 71-88.). In other research, a higher proportion of care provided by registered nurses is associated with shorter length of stay, lower rates of urinary infections, and upper gastrointestinal bleeding. A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia, shock or cardiac arrest, and failure to rescue – death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis (Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine*, 346*:* 1715-1722.). Higher proportions of RNs/RPNs were associated with better clinical outcomes in teaching hospitals (McGillis Hall, Linda, Diane Doran, G. Ross Baker, George Pink, Souraya Sidani, Linda O'Brien-Pallas, and Gail Donner (2003). Nurse Staffing Models as Predictors of Patient Outcomes. *Medical Care, 41*(9): 1096-1109). More RN direct care per resident was associated with better outcomes in long-term care (Horn, Susan D., Peter Buerhaus, Nancy Begstrom, and Randall Smout (2005). RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents. *American Journal of Nursing*, *105*(11): 58-70). In teaching hospitals, an inverse correlation was observed between proportions of professional nursing staff on a unit and the number of medication errors and the number of would infection (McGillis Hall, Linda, Diane Doran, and George Pink (2004). Nurse Staffing Models, Nursing Hours, and Patient Safety Outcomes. *Journal of Nursing Administration, 34*(1): 41-45.) Increased patient workloads for RNs in hospitals were associated with increased risk of patient mortality (Aiken, L. H., Clarke, S. P., Sloane, D.

M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*: 1987-1993.).
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[21] Sciamanna, C., Avarez, K., Miller, J., Gary, T., & Bowen, M. (2006). Attitudes toward nurse practitioner-led chronic disease management to improve outpatient quality of care. *American Journal of Medical Quality, 21*(6): 375-381.
[22] Denver, E., Barnard, M., Woolfson, R. & Earle, K. (2003). Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patient with type 2 diabetes. *Diabetes Care, 26*(8): 2256-2260.
[23] In addition to integrating resources from the Canadian Nurse Practitioner Initiative, literature directed to the general public is also helpful. See, for example, the Canadian Health Services Research Foundation (2002). Myth: Seeing a Nurse Practitioner Instead of a Doctor is Second-Class Care. Ottawa: Author. http://www.chsrf.ca/mythbusters/pdf/myth8_e.pdf
[24] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, p. 19.
[25] Steger, M. (2001). *Globalism: The New Market Ideology*. New York: Rowman & Littlefield Publishers.
[26] McQuaig, L. (1998). *The Cult of Impotence: Selling the Myth of Powerlessness in the Global Economy.* Toronto: Penguin Books.
[27] Yong, J. & Millen, J. (2000*). Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, ME: Common Courage Press.
[28] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, p. 45.
[29] Ibid., p. 49.
[30] Evans, R. (1997). Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform. *Journal of Health Politics, Policy, & Law*, 22(2): 427-465.
[31] The paper does correctly acknowledge that nurses are generally strong supporters of publicly-funded and publicly-delivered health care, on page 45.
[32] E.g., see Flood, Colleen. M., Mark Stabile and Sasha Kontic (2005), inding Health Policy 'Armibrary': The Evidence on Waiting, Dying, and Two-Tier Systems", *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada*, pp. 296-320; and Flood, Colleen M. (2006) "Chaoulli's Legacy for the Future of Canadian Health Care Policy", forthcoming, *Osgoode Hall Law Journal*
[33] Postl, Brian (2006), *Final Report of the Federal Advisor on Wait Times*, Health Canada, June 30. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2006-wait-attente/index_e.pdf, accessed July 27, 2006.
[34] For specifics, see Marchildon, Gregory P. (2005), *The Chaoulli Case: Two-Tier Magna Carta?,* Longwoods Publishing. http://www.longwoods.com/product.php?productid=17190&page=1 accessed July 27, 2006.
[35] Ibid.
[36] Barer, M., Bhatia, V., Stoddart, G. & Evans, R. (1993). The Remarkable Tenacity of User Charges: A Concise History of the Participation, Positions, and Rationales of Canadian Interest Groups in the Debate over 'Direct Patient Participation' in Health Care Financing. Vancouver: University of British Columbia Centre for Health Services and Policy Research.
[37] Canadian Health Services Research Foundation (2001). *Myth: User fees would stop waste and ensure better use of the healthcare system.* Author.
[38] Canadian Nurses Association (2006). *Toward 2020:Visions for Nursing*, p. 48.
[39] Ibid., p. 49.
[40] Devereaux PJ, Choi PT, Lacchetti C, Weaber B, Schunemann HJ, Haines T, et al. (2002). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal, 166* (11): 1399-1406.
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[51] Rosenau, P. V., and Linder, S.H. (2003). Two decades of research comparing for-profit health provider performance in the United States. *Social Science Quarterly, 84*(2): 219-241.
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