

Fashioning the Future

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L'auteure suppose que les forces positives qui animent les affaires du monde ne sanctionnent en fin de compte ni l'anéantissement du globe ni l'assujettissement orwellien. S'appuyant sur cette confiance, l'auteur fait valoir que les êtres humains et notamment les personnes auxquelles l'article s'adresse — infirmières et éducateurs — peuvent faire face à l'avenir, confiants jusqu'à un certain point d'être en mesure de le modeler ou de l'influencer de façon significative. Cette donnée dépend toutefois des perspectives et de la compréhension qu'ils acquerront ainsi que de l'effort rationnel et soutenu qu'ils mettront à faire progresser leurs objectifs et rayonner leurs valeurs. Pour illustrer ce que sous-entend la réalisation des perspectives requises et l'acquisition des connaissances en vue d'une action efficace, l'article tire des exemples de la scène internationale et nationale de l'histoire de l'humanité au cours des 50 dernières années. Les exemples se rapportent en grande partie aux facteurs socio-économiques et culturels qui ont influencé le développement des systèmes de soins de santé et le rôle que les infirmières y ont joué. Sur la scène internationale, l'article évoque les politiques et les événements qui ont amené plus de 100 pays en développement à demander un nouvel ordre économique international, dont l'objectif central est de réduire ou, idéalement, d'éliminer la pauvreté. La pauvreté massive, comme le souligne l'article, est l'obstacle principal à la réalisation de l'objectif des Nations Unies qui vise la santé pour tous d'ici l'an 2000. Parlant des forces accumulées contre les politiques de santé rationnelles et humaines, tant sur le plan national qu'international, l'auteure conclut que les éducateurs dans le domaine de la santé doivent baser leur enseignement et leurs recherches sur le genre de problèmes planétaires et nationaux qu'aborde l'article.

The committee planning this conference of the Canadian Association of University Schools of Nursing, in choosing the theme *Fashioning the Future*, made two assumptions. One was that the human race has a future. The second was that human beings in general and nurse educators in particular can do something significant in fashioning it or at least those parts of it that concern us most: the health delivery system, the role of nursing within it, and most specifically, the responsibilities of the nurse educator.

How justified was the assumption that the human race has a future? The rise and fall of civilizations, Arnold Toynbee taught us, is the most persistent theme over the entire course of history (Toynbee, 1947). Even before the explosion of the atomic bomb in 1945, this century had surpassed all others in the toppling of empires, govern-

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ments, kings, and presidents and in the devastation and savagery of its wars and its genocidal massacres. What reasons, then, are there to suppose that, with an atomic, or rather a nuclear, arsenal burgeoning yearly in magnitude and menace, the human race has anything more than the ghost of a chance to survive through this decade, or the next, or the next?

The reasons are hard to come by. If humanity manages to escape nuclear annihilation, is not the most likely alternative the Orwellian world of total oppression of mind and body (Orwell, 1954)? A third and all-but-present threat is that of engulfment in the Tofflerian Third Wave of computer dominance (Toffler, 1981).

These and an array of other apocalyptic scenarios could be paraded to establish that humanity has either no future or one of such subjugation to seemingly uncontrollable forces as to make nonsense of the notion that it can be rationally and benignly fashioned.

Affirming the Future

Yet these prophecies of doomsday death, Orwellian oppression, and computer domination must be rejected. Despite the earlier references to the ever present nuclear peril and the historic record of social disintegration and collapsing civilizations, there are and always have been grounds for hope. History records not only human meanness but human greatness, not only hate but also love. It provides a basis for a faith that, through whatever forces are at work in the universe and in human society, the human race will survive and human beings will not give in indefinitely to forces that deprive them of the exercise of human rights and freedoms, including the right to fashion the institutions on which their daily well-being depends.

Clearly this is not the place to spell out the historical case for this assertion, the assertion that humanity in general, and our tiny portion of it in particular, can proceed to address the future with a determined confidence.

If our task is to look at the future, and if the surest guide to the future is a perceptive reading of the past, there is merit in looking back through half a century and identifying developments and trends within the period that will carry forward significantly into any imaginable future.

Before embarking on that retrospective journey let me indicate the general lines on which this paper is proceeding. I propose, first, to

discuss developments from the past both internationally and nationally that have relevance to the topic and, second, to comment on the current health care system in Canada. The comments will raise many questions about nursing and nursing education in the coming decades.

The Last Half Century

Internationally

No one in 1933 could have foretold the nature and magnitude of the events and developments that were to occur internationally, nationally, and in all manner of our institutions, including the institution of health and the role of nursing in it.

The world in 1933 was in the depths of a depression in many ways like ours of 1983, with high unemployment and deep economic dislocations. Two new and very different figures were emerging on the international scene, where they would remain until their deaths some 12 turbulent years later. Hitler became Chancellor of Germany and opened the first Nazi concentration camp with all that implied for the subjugation of people. Roosevelt was inaugurated as President of the United States and, in contrast, within the year established the Tennessee Valley Authority, signalling thereby to the world a conviction that needs renewing in 1983, that governments need not cower helplessly before what are marketed as the immutable laws of conservative economics. The remainder of the 1930s were seven lean years in a world that could neither end the depression nor arrest the drift to war and to holocaust.

The 1940s, however, notwithstanding all the devastation of World War II, witnessed the regeneration of the human will and capacity for fashioning the future. The United Nations was born and the *Charter of Human Rights* adopted; the latter expressed humanity's finest aspirations and ideals, the former, together with its specialized agencies, offered structures for positive endeavours towards human well-being.

Among the range of international developments since the 1940s, four merit special attention: first, the birth of new sovereign nations from old colonial empires, raising the number of countries in the United Nations from 50 in 1945 to 157 in 1983; second, the vastly expanded world potential for producing and distributing wealth in the form of goods; third, the vastly increased potential for providing human services; fourth, the failure of the world's political and economic structures to utilize those potentials for social justice and human development.

The persistence and enormity of that failure, and particularly its effect on those new nations in the developing world, can be illustrated in many ways. One of the most telling for those of us whose professional commitments combine education and health is the international indicator of relative well-being, the Physical Quality of Life Index (North-South Institute, 1978, pp. 182–189). Combining data on life expectancy, infant mortality, and literacy, the Physical Quality of Life Index, indexed on a scale from 0 to 100, shows a world of rich northern industrialized nations with indexes in the 80s and 90s and of poor underdeveloped nations, largely in the southern hemisphere, with indexes in the 20s, 30s, and 40s.

Although the indications seem to stand as a testament of unjustifiable failure of our instruments of international action and of the exploitive policies of the multinational corporations they harbour, the story of the North-South relationship must not be depicted in wholly negative terms. Great, commendable, and partially successful efforts have been made by the United Nations and its associated agencies to grapple with the socio-economic problems of underdevelopment. Noteworthy among them is the success of the World Health Organization in the reduction, and in some instances the eradication, of communicable disease (although WHO's mandate goes well beyond the prevention of disease, as indicated later in this paper). Similar comments can be made about the multilateral and bilateral programs of developed countries such as Canada. Though these have been often misdirected or wasteful and sometimes harmful, they have had a positive impact on many Third World countries and those who seek to fashion the future must retain them and increase their effectiveness.

In the 1970s, two significant statements of purpose with implications for health and health personnel were made in the international community. The first was the Declaration of the Group of 77 (developing nations) made some 10 years ago to the General Assembly of United Nations. The Group demanded a New International Economic Order (NIEO). This challenge was a response from developing countries and new sovereign states to the failure of the programs of the United Nations and the industrialized countries to expedite solutions to the socio-economic problems of the Third World, notably the persistence of acute poverty and the deprivations that go with it. It was a concept aimed at establishing a more equitable balance of the world's goods and services between the developed and developing countries.

The reactions of developed countries to the New International Economic Order has been less than enthusiastic, although it has been

completely endorsed by WHO. The *Biennial Report of the Director General on the Work of WHO 1976-77* (World Health Organization [WHO] 1978b) indicates support for the aspirations expressed in the NIEO concept and states that WHO programs from that date will be developed with a concern for the role of health in promoting social and economic development. The acceptance of health as an integral part of development is described in this report as "a major stride in the direction of international social justice" (WHO, 1978b). The *Report* stresses that the determinants of health do not lie solely, or even primarily, in the field of health.

The second statement of purpose reflecting a new direction in the international field was proclaimed through the Declaration of Alma Ata, in 1978, from the International Conference on Primary Health Care sponsored jointly by WHO and the United Nations International Children's Emergency Fund (UNICEF). The global objective in this development was stated as "the attainment by all of the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO, 1978b, pp. 5). "Primary health care is the key to attaining this goal" (WHO, 1978a, pp. 17).

International developments during the recent past which have significance for health and health care systems can be found in the movements of ideas and peoples across international frontiers. The ideas include new concepts and practices which depart from the traditional Western concept of health and medical models and reflect those of other regions and more ancient cultures. Of equal significance is the movement of people, immigrants and refugees, transforming the ethnic composition of populations, such as Canada's. The refugee movement, which has every appearance of becoming a permanent phenomenon, will have a continuing and profound effect on population profiles and on health services throughout the world as the movement continues to grow.

Let me turn my comments on international developments in the last half century into two specific proposals as areas for consideration by nurse educators intent upon fashioning the future. First is the need for courses that deal with international health and international nursing. Such courses have, I believe, to deal with the kinds of socio-political concepts identified in this paper. It is only on the basis of some knowledge of international development and of factors that have been furthering and retarding it that students will comprehend and promote the international goals and objectives specific to the health

field. In this I am referring to the broad range of health and health-related matters that are vital to human survival with particular reference to the WHO-initiated objective to achieve health for all by the year 2000.

My second proposal relates to the need for programs which prepare nurses to provide transcultural health care. As the population in our country becomes increasingly multicultural, the need for health personnel who understand different cultural values, beliefs, and practices becomes more imperative. Canadian nurses have written with great sensitivity on their recognition of this needed change in nursing education (Davies & Yoshida, 1981).

These proposals for changes in Canadian nursing education flow directly from developments in the international field in the recent past and illustrate the importance of recognizing their significance in future planning at the national level.

Nationally

When we look at national developments of the last half century, we need first to recognize the primacy of political and economic factors as they influence the future. Let me first comment on the economic factors, in which I include where and by whom macro-economic decisions are made. Economic factors over most of the period have been favourable to Canada. By being strategically placed in the great trading area of the northern hemisphere, by becoming good at some economic activities and competent in others, and by finding markets for and selling off our natural resources, Canada has grown rapidly. All international comparisons testify that most Canadians have been able to enjoy a high standard of living.

For a while at least, during that period, good political decisions, from a social point of view, were made; they were good because of the emphasis placed on human service programs, programs which ensured that people would never suffer again as they had in the depression of the 1930s. This was the purpose of the great wartime social documents such as the Haegerty report, the Marsh report, and the Green Book Proposals for Health Insurance that formed the basis for post-war planning in health and social welfare (Taylor, 1978). These documents expressed the national will to build the kind of comprehensive nationwide social security system that the industrialized states of Western Europe had put in place long since.

tion to learn the intervention and to practise it repeatedly over the intervention and post-intervention periods.

A final example involves Drs. Jacqueline Chapman and Ellen Hodnett, whose research program focuses on normal and high-risk perinatal nursing care. Jacquie is facing the same situation as Ruth and those of us on the urinary incontinence study: she needs to train all the staff in the neonatal intensive-care unit in caring for extremely premature infants, using a new theoretical approach. This is very difficult in a stressful environment in which the nurses feel overloaded, where they frequently work "short," and where the vacancy rate is high. Dracup (1987) concluded, from her review of research on critical-care nursing, that the stress experienced by nurses, including those in neonatal units, was due to heavy workload as a result of inadequate staffing, rather than due to the nature of such patient-care demands as dying patients and worried families. Ellen could encounter problems trying to implement her proposed study, which involves trying to influence the behaviour of labour and delivery-room nurses to have them incorporate selected research findings into their practices, by using a significant peer who is respected by them. It is essentially a study of how to diffuse results from earlier studies of hers, but it, too, is dependent on a stable staff that can identify one of their peers as a model practitioner. Relief staff cannot do this, and if they do, they do not stay around to be influenced.

We could be in difficulty in trying to carry out all these studies.

I have been very worried about the crisis in nursing since it began to erupt into the media early last fall, but I have to admit that my major concerns were about its effect on our teaching programs and future recruitment of students. It was not until we were notified that we were funded and began to try to implement the urinary incontinence study that I recognized its impact on research. That, in turn, caused me to review the research programs to which we are committed on the faculty. I have been extremely proud of these programs because they are so clinically focused and because they are designed by nurse researchers with sound and current clinical skills. However, we have a real dilemma: just as we have the manpower and the funding to provide opportunities to undertake relevant clinical nursing research, we find the practice environments in crisis and unable to sustain research studies that involve the nurses. We are in a position to undertake descriptive studies of phenomena, but the studies that are being affected are those in which the descriptive phase has been done, the intervention has been identified and, for most, piloted, and now the test

lishment, over the next 10 years, of senior federal nursing positions to provide consultant services to the Department of National Health and Welfare and to the provinces in the developmental stages of the health care system. Significant to nursing was the appointment of a nurse to the Hall Commission in 1961, the Commission which produced the *Charter of Health for Canadians* (1964).

Throughout this period, the record shows that the CNA has represented nurses well. A comparison of Association briefs to the first Hall Commission in 1962 (Canadian Nurses Association [CNA], 1962) and the second one in 1980 (CNA, 1980) reflects increased sophistication and skill in articulating nursing views as well as a decided change in perspective. The earlier brief contained 24 recommendations, 21 of which related to nursing. Its one specific reference to the health care system was in these terms: "No recommendations are made to the overall organization of health services and financing [which] are subjects for government and legislation" (CNA, 1962, pp. ii). The 1980 brief, in contrast, includes eight recommendations focusing on the health care system in terms of legislation, federal-provincial relationships, health care research, and health education. This document was described by Justice Hall as one of the best briefs received by the Commission and worthy of the closest attention from all levels of government.

National nursing leadership in the period under review has progressed in various ways, moving from a reactive to a proactive role in seeking input to policy decisions on national health, and advancing from a limited nursing viewpoint to a health system perspective. It demonstrates increasing competence in functioning in the broader field of national affairs.

Between 1967 and 1977 Canada's health system, though incomplete and flawed in certain ways, functioned in essential harmony with the principles of the *Charter of Health for Canadians* formulated in the *Report of the Royal Commission on Health Services* (Hall, 1964). Under the conditional shared cost provisions of federal legislation, the provinces were required to adhere to the principles of accessibility, universality, comprehensiveness, portability, and public administration.

For a variety of reasons, including declining economic growth which prompted federal financial authorities to wish to move away from open-ended shared cost programs, together with the pressure of some provinces to be freed of federal constraints, a decision was made in 1977 to place the funding of health and post-secondary education on a block funding basis, a decision that was formalized that year in the federal *Established Programs Financing Act*. It was not long before a

number of provinces began to abandon their undertaking to adhere to the principles that had prevailed under earlier arrangements. By 1980 extra billing by physicians and the imposition of extra charges for various health services had sufficiently eroded the health system to prompt the appointment of a second Hall Commission. The report of its findings and recommendations affirming the earlier principles and condemning extra billing have not arrested the deterioration of the system (Hall, 1980).

By the beginning of the 1980s there was no doubt that the health care system in Canada was in the process of change, real and potential change, through pressure from forces within and without governments. The system was subject to the constraints of an economic recession, the impact of a technological revolution, and the demands of a health-oriented population. Further, it was undermined by medical and commercial interests and was vulnerable as a political issue in the federal-provincial struggle over the division of powers.

Other changes began to appear in the health care field. Opposition to the medicalization of society, exemplified by Ivan Illich's (1975) *Medical Nemesis*, appeared in the mid-1970s, followed by the emergence of new patterns of care initiated by the women's movement and consumer groups. The holistic health movement appeared, emphasizing an appreciation of the whole person and reaffirming the importance of the mind and spirit in health and healing. There was a rediscovery of the significance of the environment, and *A New Perspective on the Health of Canadians* (Lalonde, 1974) gave lifestyle a new importance. New categories of personnel appeared as part of traditional health teams and the concept of health itself came under review and redefinition.

The Current Status of Health Care in Canada

As we moved into the 1980s the most significant change was the continuing deterioration, referred to earlier, in the national health insurance system. This began towards the end of the last decade, with an increasingly relaxed attitude in the provincial governments to the basic principles of accessibility and universality.

In response to calls for remedial action to arrest the erosion of the system and to recommendations of a Parliamentary Task Force on Federal Provincial Fiscal Arrangements (Government of Canada, 1981), the federal Minister of National Health and Welfare proceeded in May of 1982 to propose to the provinces a basis for federal-provincial collaboration to be incorporated in new legislation to be called the *Canada*

Health Act. The proposed Act would combine the *Hospital Insurance and Diagnostic Services Act* and the *National Medical Care Act* into one piece of legislation and, in the words of the Minister, would seek to ensure "100 percent universal entitlement to basic health insurance in Canada without financial or other barriers" (Bégin, 1982b, p. 13). However, this position is being strenuously attacked by medical associations, by the allied insurance industry, and by most provinces.

Let me identify some of the issues. Speaking before the Canadian and American Public Health associations' meeting in Montreal in November 1982, Monique Bégin, the Minister of National Health and Welfare, described the complexities involved in deciding on future courses of action for health within the federal-provincial structure. In response to her rhetorical question "Where, then, are we going?" she described the alternatives for a choice of direction, their potential impact on the health of Canadians, and the problems inherent in their implementation. The Minister pointed out that, in times of economic growth, the development of alternatives had been encouraged with funding from federal and provincial governments. This initiative had resulted in many imaginative programs which allowed a wider choice of health care for providers, consumers, and policy-makers (Bégin, 1982a). Nursing examples of these are well documented by the Canadian Nurses Association in its 1980 brief (CNA, 1980) "Putting 'health' into health care."

Madame Bégin identified a number of alternatives but focused particularly on the proposal "to use the nurse as the point of first contact and the doctor as the final point of referral" (Bégin, 1982a, pp. 3-4). Acknowledging the potential in this proposal for more efficient and effective resource allocation, she identified two conditions necessary to implement it: the support of both senior levels of government, and the support of other provider groups and consumers.

In expanding on these proposals, the Minister identified two major problems. First, increasing nurse utilization would affect the current growing supply of physicians in the country by virtue of reducing the role of physicians. The Minister stated that the opposition of the medical associations to such change has been expressed publicly in a variety of ways and that such opposition creates political difficulty in facilitating this change. Second, in the absence of a strong ground swell of public support for utilizing the nurse in an alternative role, she pointed out that it would be extremely difficult to carry it through. As indicated, the *Canada Health Act* proposal is strongly opposed by the Canadian Medical Association. The CMA favours its own privatization

scheme, which would move Canada away from universality and return Canadians to the two-tier system which we had up to the late 1960s. This would divide Canadians again into those who could pay for services and those who could not. Other opposition comes from the insurance companies and from provincial governments on the basis, in the first instance, of the profit motive, and in the second, that it represents a violation of provincial rights.

The nursing profession, through the CNA, has declared its position on the proposed Act in a brief to the Minister of National Health and Welfare (CNA, 1982). It expresses support for the proposals in the areas of universality, comprehensiveness, portability, and the maintenance of standards in the system. It affirms, however, its earlier position that the proposed legislation should provide nursing services in an extended role as an entry, and perhaps the most cost-effective entry, to the system (CNA, 1980). The Minister's comments of November 1982 (Bégin, 1982a) identifying problems associated with the CNA proposal bear careful examination. Madame Bégin indicated that to implement the proposal that the nurse be an entry to the health care system would require the support of four separate groups: the federal government, the provincial government, the other health care providers, and the consumers, or public.

The current status of support from the four groups can be summarized as follows: the federal Minister's expressed public interest in the proposal might be interpreted as a positive reaction from the senior level of government; the position of provincial governments remains unclear; among other health providers there is some support from organizations such as the Canadian Health Coalition while, according to the Minister, there is declared opposition from the medical profession; from the public, there is relative silence. That score shows tentative support from one group; no reading on the second; a divided position in the third, including opposition from the major medical providers; and limited response from the fourth.

What significance can be drawn from that reaction? My attempt to analyze it has raised questions which I believe must be answered by nurses themselves. The first relates to the public. How can the public's silence be interpreted? Is it lack of information or lack of interest? If it is the former, why does the public not know of the proposal? Who should have told them? Since it is a nursing proposal that would affect how the public enters the health system, is it the responsibility of members of the nursing profession to interpret it?

This line of reasoning leads to the question of how well informed and committed to the idea are nurses themselves. Is the profession united on this issue? To gain support for any major change requires interpretation by an informed and committed membership working individually and collectively at all levels. If lack of unity or commitment exists within nursing itself, then the priority becomes the development of strategies to correct that situation. Among the already committed, what new initiatives can be taken by nurse practitioners, nurse educators, and nurse administrators? Can they, and should they, promote and facilitate progress towards involving membership in supporting the proposal to make the nurse an entrance point into the system?

With regard to the attitude of provincial governments, what additional measures should be taken in the political arena to achieve support from this level of government, which is responsible for the health care system in its own province? Finally, the opposition from the medical profession, with which nurses have traditionally had the closest ties, gives cause for concern. The two professions, medicine and nursing, are already at odds on the basic issues of universality and accessibility in the health care system. Despite these divergent views are there new approaches that should be made to achieve understanding, if not agreement, on positions to ensure that future working relationships do not jeopardize the provision of health care to people?

Notwithstanding our desire to have the support of the medical profession in this struggle to see nursing more fully and appropriately utilized in the provision of health care, it is important to recognize where the real power on public issues resides. On at least two previous occasions involving major national issues, the *Health and Diagnostic Services Act* of 1958 and the *National Medical Care Act* of 1966, it was political will, the voice of the people, which determined the outcome in those struggles rather than the views of the medical profession or the commercial interests, both of which opposed the legislation. Using those precedents as a guide, the nursing profession must develop new strategies to gain public support for its proposals — strategies that should involve membership at every level.

Conclusion

The purpose of this paper is to provide a broad framework for charting the future for nursing education in Canada. It will be apparent that I have dealt only with certain broad policy issues, internationally and nationally. There are other questions of immense importance: entry to

the practice of nursing; new and extended ways of maximizing the technological and information systems to provide continuing education and baccalaureate programs beyond the university setting; the impact of technological change on future students and faculty; and the moral and ethical aspects related to high technology. These examples could be described as among the professional, technological, and ethical imperatives of both today and tomorrow.

Without diminishing their importance let me end on the note with which I began. I would describe it as an expression of faith — faith that we can have a future and that we can play a part in fashioning it. But it is a contingent or conditional faith. It holds that humanity's future depends on the nature of our perspectives and understandings. It holds further that we, as educators in the health field, have special responsibilities and opportunities to undergird our teaching and research with a continuing appreciation and understanding of the kind of global and national issues this paper has touched on.

What I aspire for this conference are fruitful deliberations as we seek to fashion a future, a future in which such global objectives as health for all people by the year 2000 may, in fact, be attained; a future in which we, in Canada, have developed to the optimum the role that nursing can play in a health care system that truly honours the principles set out in the *Charter of Health for Canadians*.

References

- Bégin, M. (1982a, November 15). Address to the meeting of American Public Health Association and Canadian Public Health Association, Montreal, QC.
- Bégin, M. (1982b, May 26). Address to the Conference of Federal-Provincial Ministers of Health, Ottawa, ON.
- Canadian Nurses Association. (1962). *Statement to the Royal Commission on Health Services*. Ottawa: Author.
- Canadian Nurses Association. (1980, p. 15). Putting "health" into health care. *Health Services Review '79*. Ottawa: Dept. of National Health & Welfare.
- Canadian Nurses Association. (1982, August). *A brief to the Honourable Monique Bégin, Minister of National Health and Welfare, on the Federal Proposals for a Canada Health Act*. Ottawa: Author.
- Davies, M., & Yoshida, M. (1981). A model for cultural assessment of the new immigrant. *Canadian Nurse*, 77(3). (This issue features four other articles on Canada's multicultural health needs.)
- Government of Canada. (1981). *Fiscal federalism in Canada: Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements*. Ottawa: Queen's Printer.

- Hall, E.M. (1964). *Report of the Royal Commission on Health Services: Vol. 1*. Ottawa: Queen's Printer.
- Hall, E.M. (1980). Canada's national-provincial health program for the 1980's. *Health Services Review '79*. Ottawa: Dept. of National Health & Welfare.
- Illich, I. (1975). *Medical nemesis*. Toronto: McClelland & Stewart.
- Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document*. Ottawa: Government of Canada.
- North-South Institute. (1978). *North-South encounter: The third world and Canadian performance*. Ottawa: Runge Press.
- Orwell, G. (1954). *Nineteen eighty-four*. London: Penguin.
- Taylor, M.G. (1978). *Health insurance and Canadian public policy*. Montreal: McGill-Queen's University Press. (Reference to Haegerty report, p. 18; Marsh report, p. 21; Green Book Proposals, pp. 1, 52-53.)
- Toffler, A. (1981). *The third wave*. London: Pan.
- Toynbee, A.J. (1947). *A study of history*. Abridgement of volumes 1-4 by D.C. Somerwell. London: Oxford University Press.
- World Health Organization. (1978a). *Primary health care: Report of the International Conference on Primary Health Care (Alma Ata, USSR, September 6-12)*. Geneva: Author.
- World Health Organization (1978b). *The work of WHO 1976-77: Official Records No. 243*. Geneva: Author.