Resolutions presented to the CNA Annual Meeting of Members
June 9, 2015

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RESOLUTION 1  Ensure the Autonomy of Canada’s Registered Nurses

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocates that registered nurses (RNs) in Canada not be subject to legislation that requires them to take direction/orders from other health-care professions that do not have a superior level of both academic and clinical preparation (that must include Canadian publicly accredited university graduate-level academic qualifications and substantial hospital-based education and training in their field).

Submitted by: Dr. B.M. Garrett, Delta, B.C.  Member of CRNBC and ARNBC

Rationale: Since 2009 in British Columbia, nurses have been regulated under naturopaths and required to take orders from them under the B.C. Health Professions Act (B.C. Ministry of Health, 2009; CRNBC, 2015). Naturopaths may employ nurses as privately paid practitioners and utilize them in clinics to manage therapies such IV chelation treatments.

Firstly, this is problematic in terms of educational preparation: university-prepared, hospital trained RNs in B.C. find themselves regulated beneath complementary and alternative medicine (CAM) professionals who have non-university and non-hospital based professional education and training. Most RN programs in B.C. are taught at universities and colleges that are members of the Association of Universities and Colleges in Canada (AUCC), which represents public and private not-for-profit universities and university degree-level colleges nationally. In B.C. these universities and colleges are established degree-granting institutions under the B.C. University Act or the B.C. College and Institute Act. In contrast, the recently opened B.C. school of naturopathy (the Boucher Institute of Naturopathic Medicine) is accredited by B.C.’s Private Career Training Institutions Agency, whose academic requirements are significantly lower than those of the AUCC. In terms of hierarchical status, the legislators (and CRNBC) may have considered the title of naturopathic doctor (ND) in their decision-making here. However, the title of ND is awarded on the basis of accreditation from the Council on Naturopathic Medical Education and the Association of Accredited Naturopathic Medical Colleges, which are both privately funded U.S. bodies (Garrett & MacPhee, 2015).

Secondly, all RN students are required to undertake significant hospital-based, supervised education and training in a variety of clinical areas to gain exposure to diverse clinical conditions and health issues. In contrast, naturopaths undertake all of their clinical training under the mentorship of other naturopaths in private clinics, so they have minimal exposure to acute care, diverse patient populations and emergency health-care interventions.
For nurse educators who prepare RNs for practice, nurse regulatory accountabilities to CAM practitioners become difficult to rationalize to student nurses when there is evidence that naturopaths do not adhere to current evidence practices (as in their opposition to national immunization policy (Cage, 2012; Wilson, Mills, Norman, & Tomlinson, 2005). Also, explaining that RNs should take orders from other health-care providers who have not undertaken substantial hospital-based education and training as a part of their preparation is likewise problematic.

Any form of legislation that places RNs beneath other health professionals with questionable and insubstantial academic and clinical preparation that is not at a significantly higher level than university baccalaureate entry for RNs (be they CAM providers, or otherwise) erodes the autonomy of nurses to control their professional development. Politically, this regulation supports the notion that the nursing profession should also be legislated beneath other newly recognized health professionals. The national situation varies as, apart from B.C., no other province has legislated RNs in this way. In Ontario, the only other province where naturopaths are recognized, the Nursing Act does not allow RNs to take orders from naturopaths (College of Nurses of Ontario, 2015). We therefore have a window of opportunity to prevent the further erosion of nursing professional autonomy across Canada by similar legislation elsewhere. As current provincial regulators (such as CRNBC) do not see it in their mandate to challenge existing legislation, and the new provincial professional association in B.C. (the Association of Registered Nurses of B.C.) does not recognize the significance of the issue nationally (as the legislation already exists here), national policy guidance from CNA is necessary.

Relevance to CNA’s mission and goals: This resolution will advance CNA’s mission to “unify the voices of registered nurses, strengthen nursing leadership [and] to promote and enhance the role of registered nurses [and] strengthen nursing and the Canadian health system.” It also has direct relevance to its efforts to “broadly engage nurses in advancing nursing and health.” In addition, this resolution will help shape and advocate for healthy public policy provincially, territorially and nationally. This is an opportunity for the nursing profession to demonstrate leadership in protecting the Canadian health system from market forces that drive private, professional practitioners into directing legislation that undermines public safety.

Key stakeholders: Key stakeholders who would benefit from this resolution are the College and Association of Registered Nurses of Alberta, the CRNBC, the Association of Registered Nurses of B.C., the College of Registered Nurses of Manitoba, the Association of Registered Nurses of Newfoundland and Labrador, the Nurses Association of New Brunswick, the Registered Nurses Association of the Northwest Territories and Nunavut, the College of Registered Nurses of Nova Scotia, the College of Nurses of Ontario, the Registered Nurses’ Association of Ontario, the Association of Registered Nurses of Prince Edward Island, the Ordre des Infirmières et Infirmiers du Québec, the Saskatchewan Registered Nurses’ Association, the Yukon Registered Nurses Association and the Canadian public.
**Estimated resources required or expected outcomes:** Resources other than advocacy from CNA will be minimal. With a strong response by the nursing community, working with the regulatory colleges, professional associations, the labour movement, civil society coalitions and especially the public, nursing will continue to be perceived as a treasured health profession rather than a trade that can be utilized as other health professionals require for their own practice needs.

**References:**


RESOLUTION 2
Increasing the Leadership Capacity and Engagement of all Aboriginal Nurses in Health and Nursing Policy Development

BE IT RESOLVED THAT no one organization or individual represents the breadth and depth of aboriginal nursing in every province, territory and region of Canada and that the Canadian Nurses Association (CNA) should work equally with the Aboriginal Nurses Association of Canada (A.N.A.C.), provincial/territorial aboriginal nursing groups and local or specialty aboriginal nursing groups to develop and advance aboriginal health nursing strategies at the national level.

And, BE IT RESOLVED THAT, to develop a better understanding of the data surrounding aboriginal nurses, CNA should conduct a national survey of aboriginal nurses and construct an updateable database that can be maintained for health administrators and planners.

Submitted by: Association of Registered Nurses of British Columbia (ARNBC) board of directors

Rationale: A.N.A.C. is a specialty group of CNA and therefore one of the key policy voices of aboriginal nursing in Canada. It is estimated that there are about 7,945 aboriginal registered nurses in Canada,¹ many of whom are not associated with either A.N.A.C. or CNA.

The voices, ideas and innovations of aboriginal nurses who are not part of A.N.A.C. could be brought forward to CNA by a myriad of other organizations, councils, subgroups and specialty groups that identify themselves under provincial/territorial associations, unions, aboriginal communities or umbrella health-care organizations. However, these organizations are not all known to CNA, nor do they have a formal relationship with CNA. In order to gain a full understanding of the current situation for aboriginal nurses, CNA needs to expand its network to include additional associations, organizations and groups working on behalf of aboriginal health nursing. By doing so, CNA would not only increase the leadership capacity of aboriginal nurses, but potentially increase their engagement in A.N.A.C. and CNA activities by aboriginal nurses.

Because there are numerous small groups and organizations that aboriginal nurses across Canada are affiliated with, a national survey is required to better understand where these nurses are working, how they identify themselves, what advocacy organizations they associate with, etc. Developing this survey into a permanent database would centre aboriginal health nursing information in one location, ensuring that CNA and A.N.A.C. have the best possible opportunity of engaging and hearing from all aboriginal nurses.

Relevance to CNA’s mission and goals: This resolution is particularly relevant to CNA’s mission to improve health outcomes in Canada’s publicly funded, not-for-profit
health system by strengthening nursing leadership. It fits all of CNA’s established goals for 2015, specifically to advance nursing leadership for nursing and for health; to broadly engage nurses in advancing nursing and health; and to shape and advocate for healthy public policy provincially/territorially, nationally and internationally. Strengthening leadership capacity in aboriginal nursing groups, including A.N.A.C., will help CNA meet their mandate of improving outcomes for all Canadians.

CNA has had a number of strategies related to aboriginal health including: the National Expert Commission;\(^2\) CNA’s 2012 Resolution 10\(^3\) (which resolved that CNA would work closely with ARNBC and has led to ARNBC selecting aboriginal health as a top policy priority, moving the aboriginal health policy work forward in British Columbia, out of which information has and will be shared with A.N.A.C. and CNA); the development of a CNA Aboriginal Health Nursing Advisory Committee; the collaboration with the 2014 North American Indigenous Games; and the delivery of webinars on nursing interests in aboriginal health. However, many of the aboriginal nursing resolutions put forward at CNA’s 2014 annual meeting have yet to be realized, and a more widespread engagement process with numerous aboriginal nursing groups would bring together the aboriginal voice and provide CNA with a broader basis from which to move policy forward.

**Key stakeholders:** A.N.A.C., provincial/territorial aboriginal nursing groups, regional nursing groups, aboriginal communities

**Estimated resources required or expected outcomes:** Costs would include the development and administration of a survey and survey tool, creation and maintenance of a database as well as engagement and oversight from CNA’s aboriginal support programs.

**References:**

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) take steps to work with the federal government to amend legislation and regulations in order to remove barriers to full scope of practice for nurse practitioners (NPs).

Submitted by: Shannon Spenceley, president, College and Association of Registered Nurses of Alberta (CARNA)

Rationale: Legislation and a number of regulations at the federal level contain clauses which identify the need for a medical examination or consultation with a physician. Examples include completion of the medical assessment forms for the purposes of EI (Employment Insurance Act); the Canadian Pension Plan Disability (CPPD) form (Canada Pension Plan Act and Canada Pension Plan Regulations) and the Disability Tax Credit form or the Disability Tax Credit Certificate (Income Tax Act).

These acts and regulations were initially formulated at a time when NP practice was uncommon except for rural remote areas where Health Canada had established nursing stations.

NPs are now well-established health-care providers who work in a wide variety of diverse settings, ranging from rural remote to urban nationwide.

Clauses that identify physicians as the only medical practitioner who can provide medical examinations, consultations or sign forms act as a significant barrier to full scope of practice for NPs.

Removing legislative and regulatory barriers to NP practice will increase access to services for Canadians and decrease unnecessary referrals and wastes of time and scarce health-care resources by both clients and health-care providers.

Relevance to CNA’s mission and goals:
- It is an object of CNA to advance nursing excellence and positive health outcomes in the public interest.
- It is an object of CNA to promote profession-led regulation in the public interest.
- It is a goal of CNA to promote and enhance the role of registered nurses to strengthen nursing and the Canadian health system.
- It is a goal of CNA to shape and advocate for healthy public policy provincially, territorially, nationally and internationally.

Key stakeholders:
Canadian NPs, provincial and federal governments and the Canadian public
Estimated resources required or expected outcomes:
- Resources: manageable within current resources. CARNA has completed an initial review of federal legislation and regulations and can provide a summary of changes needed.
- Expected outcomes: Barriers to NP practice will be removed enabling full scope of practice for NPs and increased access to services for Canadians.

References:
CNA bylaws

Examples of federal legislation specifically referring to medical practitioners (attached)
BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for Canada to set and realize greenhouse gas emission targets.

BE IT FURTHER RESOLVED THAT that CNA advocate for all measures necessary to meet those targets, including aggressive carbon pricing and comprehensive measures aimed at each emitting sector.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: As the Intergovernmental Panel on Climate Change concluded: the global climate system is warming and the cause is anthropogenic greenhouse gas (GHG) emissions. Natural and human systems are impacted, and the impacts are likely to be severe, pervasive and irreversible if emissions continue. These emissions have radically changed the composition of the atmosphere. The carbon dioxide concentrations have risen steadily since the start of the industrial era, when they were about 280 ppm. Recent estimates have put concentrations over 400 ppm. That is a 43 per cent increase. The jump is unprecedented, and the levels of carbon in the air far exceed those at any time in the last 800,000 years; the previous high over that period was 300 ppm about 330,000 years ago. When other greenhouse gases besides CO₂ are factored in, the increase is even more alarming: about 60 per cent from the start of the industrial era to 2012.

Effects in most vulnerable parts of the globe can be very serious: low-lying areas, drought-prone areas, areas vulnerable to extreme weather events, and the far north — where warming has been much greater than areas farther south. Nevertheless, many parts of Canada have experienced century events like crippling flooding and ice storms. Canada is experiencing related woes like West Nile Virus and devastation of forests by pine beetles that would not survive normal winters.

In recent years, Canada’s performance has left much to be desired. It fell dramatically short of its Kyoto commitment to reduce GHG emissions to six per cent below 1990 levels by 2012. In fact, 2012 GHG emissions were 18 per cent above 1990 levels. Facing a requirement to buy carbon credits to meet its targets, Canada withdrew from the Kyoto accord in December 2011. Critics accused it of being deliberately obstructive.

While Canada isn’t a large emitter, it is a high emitter per capita and could be playing a leadership role. Its current Copenhagen commitment of a 17 per cent reduction in emissions from 2005 levels by 2020 is woefully inadequate, as 2005 emissions were near Canada’s high water mark. The Climate Action Network has estimated that if Canada were to decarbonize its economy by 2050, it would have to cut its current emissions by one third below 2012 levels by 2025 (equivalent to 21 per cent below 1990 levels).
For registered nurses (RNs), greenhouse gas emission targets are important not simply because they will help avoid climate catastrophe, but because the health and environmental co-benefits will be substantial: air quality will improve dramatically; communities will become more liveable; and the natural environment will be better protected.

**Relevance to CNA’s mission and goals:** This resolution seeks to unify the voices of Canadian RNs for healthy public policy provincially, territorially and nationally, in one of the defining challenges of our time: climate change. It seeks to strengthen the leadership that RNs have provided in this area, and in so doing, change public policy in a way that protects and enhances health and the environment.

**Key stakeholders:**
- CNA’s jurisdictional members and their interest groups
- Federal and provincial governments
- Other interest groups with a stake in reducing climate change, including self-identified health, environment, labour, civil society and business organizations

**Estimated resources required or expected outcomes:** The outcome of implementing this resolution will be advocacy that responds to the threats of climate change. CNA would be expected to maximize its current policy/political action resources and to expand where necessary.

**References:**


BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for universal access to comprehensive palliative care in every corner of this country and call for a principled framework to translate the Supreme Court decision on assisted death into a policy and practice framework.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: Registered nurses and nurse practitioners are experts in providing end-of-life care as indicated in our nursing best practice guideline, *End-of-Life Care During the Last Days and Hours*.¹ At RNAO’s annual general meeting in 2014, a resolution was passed urging a principled public discussion at the provincial and federal levels regarding end-of-life care that brings in the voices of RNs, NPs and nursing students.² RNAO identified universal access to palliative care in every corner of this country as a top priority in this dialogue. Along with universal access, RNAO wants to see a principled framework that reflects recent judicial and legislative developments, such as the Supreme Court of Canada decision in *Carter v. Canada (AG)*³ and the passing of Bill 52, *An Act respecting end-of-life care*⁴ in Quebec.

Advancing universally accessible palliative care and developing a principled framework that translates legal developments into policy and practice, demands strong nursing leadership at the federal and provincial levels. Much of the attention to date among media and policy-makers has been on physician involvement at the end-of-life; however, this responds to only one aspect of care delivery. RNs and NPs are often found at the bedside, delivering round-the-clock care for Canadians in their last days and hours. Moreover, RNs and NPs are actively involved in advance care planning and supporting decisions regarding end-of-life care.

CNA, the Canadian Hospice Palliative Care Association and the Canadian Hospice Palliative Care Nurses Group are to be commended for drafting a joint position statement on palliative care. However, the draft circulated for consultation in March 2015 fell short of the aforementioned objectives: expanding universal access to palliative care and developing a principled response to translate legal developments into practice and policy.

Relevance to CNA’s mission and goals: The intent of this resolution is to unify the voice of RNs and NPs to provide leadership that serves the public interest. There is a public dialogue underway regarding end-of-life care, and it is important that nurses demonstrate visible leadership to promote the best interests of Canadians and to signify the contributions of nursing expertise in end-of-life care.
Key stakeholders:

- CNA’s jurisdictional members and their interest groups
- Federal and provincial governments
- Canadian Hospice Palliative Care Association
- Canadian Hospice Palliative Care Nurses Group

Estimated resources required or expected outcomes: The outcome of implementing this resolution will be movement toward universally accessible palliative care and development of a principled framework that responds to recent legal developments. CNA would be expected to maximize its current policy/political action resources and to expand where necessary.

References:

3 Carter v. Canada (Attorney General), 2015 SCC 5.
BE IT RESOLVED that the Canadian Nurses Association (CNA) work with nursing, health and human services, and civil society allies to stop the decline in overall federal housing investments while continuing to advocate for the development of an integrated, comprehensive, national housing strategy.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: In their nursing practice and daily lives across Canada, registered nurses, nurse practitioners and nursing students witness the premature deaths, adverse health outcomes and suffering that accompanies poverty. As documented by the CNA-commissioned paper Better Health, four major and intersecting health determinants that generate and reproduce health inequities across the life span are income, food insecurity, housing and social exclusion. Because CNA members understand the evidence and consequent importance of healthy public policies to address the root causes of health inequities, resolutions on affordable housing, homelessness and poverty were passed at CNA’s annual meetings in 2005, 2009, 2010 and 2011.

While the public health and public policy rationales for transformative action on poverty and affordable housing become more clear, people’s health deteriorates and federal government policy is moving in the wrong direction. The loss of the long-form mandatory census and other data gaps make it increasingly difficult to precisely understand the full scope of the problem. It is estimated that over 35,000 Canadians are homeless on any given night and over 235,000 different Canadians experience homelessness in a year. An estimated 733,275 renter households (18 per cent of all Canadian renter households) experience “extreme housing affordability problems” such that they are at risk of homelessness, as they have low income and are spending more than 50 per cent of it on rent.

Where we do have reliable information, the situation is getting worse. To use Ontario as an example, the most recent Ontario Non-Profit Housing Association statistics indicate that, at the end of 2013, there were 165,069 households waiting for rent-g geared-income housing. Average provincial waiting times for rent-g geared-to-income housing continue to increase, from 3.2 years in 2012 to 3.89 years in 2013. Peel region has the longest overall waiting time at 8.39 years. For every household occupied, two cancel their applications and three more apply.

Over the past 25 years, Canada’s population has increased by almost 30 per cent, while the annual national investment in housing has decreased by over 46 per cent. In 1982, all levels of government combined had funded 20,450 new social housing units annually, which steeply dropped to around 1,000 units annually in 1995. While the number of new social housing units increased to 4,393 annually in 2006, the cumulative impact of cancellation of funding for affordable housing means more than 100,000 units of supportive housing have not been built over the last 20 years. Federal per capita spending on low-income housing (adjusted for inflation in 2013 dollars) dropped from an average of $115 per person in 1989 to just over $60 per person in 2013. While there
has been time-limited, federal housing investments in recent years (such as $1 billion for affordable housing in 2010 and $2 billion for new housing and homelessness initiatives as part of the 2009 stimulus spending), the overall trajectory is a “downward slide.”

With a federal election on the horizon in 2015, addressing the basic human right and need for decent and affordable housing must remain an advocacy priority for CNA. Without action, federal operating agreements that support rent-g geared-to-income subsidies for low-income households in cooperative, non-profit and social housing, which are scheduled to end over the next 20 years, will put 365,000 additional Canadians at risk of homelessness. At present about 36 per cent of Toronto Community Housing’s residential portfolio is considered to be in poor or critical condition. Without substantive investments by federal, provincial and municipal governments to repair this housing stock, over 90 per cent of these residential units will be in poor, critical or closed condition by 2043. Investing in good to fair housing stock would have economic, social, environmental and health impacts, including preventing 544,000 instances of resident illnesses over 30 years with better housing conditions. Every $10 spent on housing and supports for chronically homeless individuals results in a $21.72 savings related to health care, social and housing supports and involvement with the justice system. Investing in housing is the right thing to do for health, human rights, public policy and economic reasons.

Relevance to CNA’s mission and goals: Advancing this resolution will serve CNA’s mission of advocating for healthy public policy and serving the public interest. It will assist with the goal of advancing leadership for nursing and for health and will shape healthy public policy at all levels of government. This resolution is consistent with CNA’s belief that RNs “have both a professional and ethical responsibility to promote health equity through action on the social determinants of health.”

Key stakeholders:
- CNA’s jurisdictional members and their interest groups
- Federal and provincial governments
- Health and human services providers and their organizations
- Civil society groups and movements
- The general public

Estimated resources required or expected outcomes: The Alternative Federal Budget 2015 has recommended stopping the sharp decline in overall federal housing investments by increasing federal spending by $2 billion annually for affordable and social housing programs with related programs. Researchers at the Homeless Hub have proposed increasing federal spending from projected commitments of $2.09 billion to $3.75 billion in 2015-2016, with a total investment of $44 billion over ten years, in order to drastically reduce chronic and episodic homelessness. This proposal would raise per capita federal investment in housing to approximately $106 per Canadian annually, which is still less than what was invested in 1989. CNA would be expected to maximize its current policy/political action resources and to expand where necessary.
References:


9 Gaetz et al., p. 5.


11 ONPHA, 2014.

12 ONPHA, 2014.

13 ONPHA, 2014.

14 Gaetz et al.

15 Gaetz et al.

16 Gaetz et al.

17 Gaetz et al.

18 Gaetz et al., p. 4.

19 Gaetz et al.


22 CCEA.

23 Gaetz et al.


26 CCPA.

27 Gaetz et al.

28 Gaetz et al.
BE IT RESOLVED that the Canadian Nurses Association (CNA) support the World Health Organization’s (WHO) classification of ketamine as an essential medicine and so advocate against efforts to schedule ketamine as a profound threat to global health and equity.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: Historically, CNA has worked to improve global health and support national nursing associations. For 37 years, until federal funding from the Canadian International Development Agency was stopped in 2012, CNA “built partnerships in more than 45 countries to strengthen the nursing profession’s contribution to global health.” Within the global health file, CNA liaised with international organizations on social justice and equity, global nursing leadership, and disaster response, and it considered itself “a dynamic voice in promoting and advocating for maternal, newborn and child health.”

In March 2015, at the 58th session of the Commission on Narcotic Drugs (CND), China asked the CND to review a proposal that would place ketamine in Schedule I of the UN Convention on Psychotropic Substances, 1971, alongside LSD and mescaline. Ketamine has significant therapeutic value within Canada and in jurisdictions around the world. Ongoing research suggests that it has promise as a treatment for severe depression, psychosis and post-traumatic stress disorder. While used recreationally in some jurisdictions as a ‘party drug’, the critical fact is that WHO lists ketamine as an essential medicine. It is the “only available anaesthetic for essential surgery in most rural areas of developing countries, home to more than 2 billion of the world’s people.” Ketamine is so widely used as an anaesthetic in human and veterinary medicine because it is readily available, easily and safely administered, and inexpensive.

WHO’s Expert Committee on Drug Dependence (ECDD) evaluated ketamine in 2006, 2012 and 2014, and each time it concluded that scheduling was not warranted. Weighing the accumulated evidence on non-medical use, diversion and relatively lower public health harm against the evidence of ketamine’s therapeutic value, it is clear that CND should not schedule ketamine under the 1971 convention. Associations working in health, medicine, pharmacology and veterinary science, as well as civil society groups from around the world, support WHO’s work and have urged state parties to abide by the ECDD’s recommendations. RNAO supported this position as well under the procedural concern that placing ketamine on the CND agenda contravenes the terms of the 1971 convention.

Decreasing access to ketamine is indeed a “potential disaster for the world’s rural poor,” as this safe anaesthetic agent will not be available for emergencies and surgeries, including emergency Caesarean sections. Ketamine is particularly useful when anaesthetizing patients in shock, as it raises the blood pressure. This can be particularly helpful in obstetrical emergencies — as can the dissociative state properties...
of ketamine, which makes people unaware of what is happening to them but protects their vital cough and gag reflexes.\textsuperscript{16}

Scheduling ketamine contradicts sound public health policy and contravenes human rights and the rule of law by ignoring WHO’s ruling that ketamine should not be scheduled.\textsuperscript{17} On March 13, 2015, the Chinese delegation deferred its resolution on this issue for a year pending further study.\textsuperscript{18} Canada is one of 53 CND members but refused to disclose its position and how it would have voted.\textsuperscript{19,20} Although Canada did make a statement on March 13, 2015, on the “importance of ketamine as an anesthetic in the developing world,” the response was inadequate compared with the principled public stands taken by Germany, the Netherlands and Switzerland.\textsuperscript{21} Canada’s stance on this issue is neither consistent with the government of Canada’s articulation of an “unequivocal commitment to saving the lives of the world’s most vulnerable women and children,” nor with its statement that “maternal, newborn and child health is Canada’s top development priority.”\textsuperscript{22}

**Relevance to CNA’s mission and goals:** This resolution is consistent with CNA’s position statements on global health and equity\textsuperscript{23} and global health partnerships.\textsuperscript{24} It is a way to serve CNA’s public interest mission and meet the goal of shaping and advocating for healthy public policy provincially/territorially, nationally and internationally. This resolution provides an opportunity for action to realize CNA’s belief “that achieving equity in health is a nursing obligation that crosses national borders.”\textsuperscript{25}

**Key stakeholders:**
- CNA’s jurisdictional members and their interest groups
- International Council of Nurses (ICN)
- Civil society allies on this issue
- University of Ottawa researchers Jason Nickerson and Amir Attaran, who have played prominent roles in this campaign\textsuperscript{26}

**Estimated resources required or expected outcomes:** Through advocacy by CNA as well as health, health-care and civil society allies, access to ketamine will be safeguarded by supporting the work of WHO in its ruling that this essential drug not be scheduled. CNA would be expected to maximize its current policy/political action resources and to expand where necessary.

**References:**


8 Chen & Malek.


12 TNI, 2015.

13 TNI, 2015.


16 Boseley, 2015.


RESOLUTION 8  Protecting Medicare

BE IT RESOLVED THAT the Canadian Nurses Association (CNA) seek intervener status in Cambie Surgeries Corp. v. British Columbia to provide the voice of registered nurses (RNs) and nurse practitioners (NPs) in rejecting attempts to privatize Canada’s health-care system and threaten universally accessible, publicly-funded and not-for-profit health services.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: In 2005, the Supreme Court of Canada issued a landmark 4-3 split decision in Chaoulli v. Quebec (AG) holding that prohibitions against private health insurance violated rights under the Quebec Charter of Human Rights and Freedoms. Three of the seven justices also held that the prohibition violated the Canadian Charter of Rights and Freedoms. This case paved the way for privatization of health care within Quebec and carries national implications in the face of future court challenges.

At present, Cambie Surgeries Corporation is a private hospital in British Columbia led by Dr. Brian Day and offers sport medicine surgical procedures as well as pediatric dental services, colonoscopies and needle aponeurotomy. Cambie Surgeries has launched a legal challenge against the government of British Columbia (Cambie Surgeries Corp. v. British Columbia) alleging that prohibitions against holding private insurance and private payment for health-care services, violates constitutional rights. The case will begin before Supreme Court of British Columbia and is anticipated to commence in late 2015. If successful, this would not only put medicare in British Columbia at risk, it would also be a very dangerous precedent for the rest of the country:

“I don’t see anything immoral, unethical or illegal for a person in a democratic society to be able to spend their own money on the health care of themself or a loved one.” – Dr. Brian Day

Canadians cherish their universally accessible and publicly-funded health-care system and consider it a source of national pride. Private payment restricts access to health-care services, based on income, meaning that access to health care for lower income people without private insurance gets delayed, reduced or erased. Private payment results in higher costs, due to limited buying power, higher administrative costs and skewed usage for insured versus uninsured services. The American health-care system is an example. As of 2013, 13.2 per cent of Americans had neither public nor private health insurance for the entire calendar year; this number has mercifully been dropping due to the introduction of Obamacare. In part due to its multi-payer nature, U.S. health expenditures exceed those of the rest of the OECD, but health outcomes are comparatively poor.

Profit incentives turn out to be perverse in health care because they harness human ingenuity in ways that inflate costs and deliver worse outcomes. Health care is particularly vulnerable because it is very difficult to assess and monitor quality of care; the incentive to cut corners is very powerful, and the penalty for not cheating may be
loss of market share. A review of four decades of experience of U.S. privatization, with a combination of public funding and private health-care management and delivery, found that “for-profit health institutions provide inferior care at inflated prices.”5 For-profit provision leads to cherry-picking of profitable services and clients, leaving the public sector to deal with high-cost clients.6,7 An abundance of literature points to poorer outcomes from for-profit health care8,9,10,11,12,13,14,15,16 at higher costs.17

Given the growing privatization agenda in Canada, along with the federal government’s decision to distance itself from health care and not renew the Canada Health Accord, the stakes are very high. The fate of medicare may rest in the hands of the courts and it is imperative that RNs and NPs be at the forefront in speaking out against the disastrous impacts that a private and/or two-tier approach to health-care financing would have on this country.

Relevance to CNA’s mission and goals: This resolution aligns directly with CNA’s mission to improve health outcomes in a publicly-funded and not-for-profit health system by advocating for healthy public policy and a quality health system. Simply put, if medicare is dismantled, the quality of the health-care system will diminish.

Key stakeholders:
- CNA’s jurisdictional members and their interest groups
- Canadian Federation of Nurses Unions
- Federal and provincial governments
- Other relevant stakeholders

Estimated resources required or expected outcomes: The intent of this resolution is to protect medicare and reject for-profit attempts to privatize Canada’s cherished health-care system. CNA would be expected to maximize its current policy/political action resources and to expand where necessary. This resolution will involve seeking legal counsel; however, RNAO would encourage CNA to procure pro bono support.

References:


4 Organisation for Economic Co-operation and Development. (2013). OECD health statistics 2013 – Frequently requested data. Retrieved from http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm. In 2011, U.S. health expenditures consumed 17.7 per cent of GDP; the next highest was 11.9 per cent for the Netherlands, while the OECD average was 9.3 percent. In spite of the elevated costs, American health outcomes lag behind the OECD: U.S. infant mortality is 6.1 per thousand vs. 4.1 average for the OECD
and 0.9 for Iceland. Life expectancy is lower in the U.S. at 78.7 years vs. 80.1 years (average) for the OECD. Correspondingly, the U.S. performs poorly on potential years of life lost per 100,000: 5,814 vs. 4,633 OECD (average) for males and 3,447 vs. 2,415 OECD (average) for females.


6 Himmelstein & Woolhandler, 2008.

7 Himmelstein & Woolhandler, 2008.


BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for increasing registered nurse (RN)/nurse practitioner (NP)-to-population ratios to better meet the need for optimal health outcomes, patient/client safety and timely access to care.

Submitted by: Registered Nurses’ Association of Ontario (RNAO)

Rationale: On a national level, CNA (2009) warns that Canada may suffer a shortage of 60,000 full-time equivalent RNs by 2022 if current trends continue. This situation arose because RN employment has not only failed to keep up with growing acuity — it has even failed to keep pace with population growth. In fact, RNs suffered employment cuts in recent decades. For example, budget cuts of the early 1990s were so severe that the RN workforce in 2002 was still below its 1993 level. In 1993, 235,738 RNs were employed across Canada; however, that number continued to fall and in 2002 remained below the pre-recession totals at 230,957 employed RNs. Unfortunately, since 2002, minimal progress has been made. Between 2003 and 2013 the RN supply only grew by 15 per cent (296,029 RNs including nurse practitioners) compared to a growth of 50 per cent of licensed practical nurses (LPNs) (106,447) and an 8 per cent increase in registered psychiatric nurses (RPNs) (5,617).

There has been a marked shift from RN to LPN employment across the country. Between 2009 and 2013 alone, the LPN share of the nursing workforce has risen from 23.3 per cent to 26.2 per cent. The trend of a shifting mix away from RN employment to LPN employment is concerning. While all nurses learn from the same foundational knowledge, RNs study for a longer period of time and form a greater depth and breadth of information resulting in differing clinical outcomes. Studies indicate that, when RNs are more directly involved in patient care, have lower nurse to patient ratios and smaller workloads, patients experience more positive outcomes. Furthermore, RNs cannot simply be replaced by less qualified providers. A cross sectional study found that a one per cent increase in the ratio of LPN to total nursing time was associated with a 4 per cent increase in the odds of mortality and a 6 per cent increase in the odds of sepsis in trauma patients. Similarly, increased RN hours per patient day is associated with a decrease in medication errors, whereas the opposite is true when LPN hours are increased.

In 2012, CNA developed its Staff Mix Decision-making Framework for Quality Nursing Care, in collaboration with the Canadian Council for Practical Nurse Regulators and the Registered Psychiatric Nurses of Canada. One of the guiding principles of that document is that “decisions concerning staff mix respond to clients’ health-care needs and enable the delivery of safe, competent, ethical, quality, evidence-informed care in the context of professional standards and staff competencies.” Considering the increase in client complexity across Canada, evidence is clear and consistent that decreasing RN employment has enormous implications for patient outcomes, continuity of care, workforce stability and healthy work environments. Furthermore, there is a need
to increase the numbers of nurse practitioners to promote innovative care-delivery models across all health sectors.

Similarly, the NP to population ratio should be increased across Canada. According to the Canadian Institute for Health Information, the Canadian NP workforce has increased from 1,990 in 2009 to 3,477 in 2013. However, given the evolving needs of Canadians and opportunities to strengthen health system effectiveness, more NP positions are needed. Across all areas of the system, NPs increase patient access to care, improve continuity in care and provide health services in a cost-effective manner by increasing efficiency and decreasing duplication. Funding models are frequently cited as a barrier to creating new NP positions. Person-centred funding models that enable the creation of sustainable NP positions, including fair compensation, will transform the public’s access to NPs across the country.

Relevance to CNA’s mission and goals: This resolution is directly related to CNA’s mission of being the national professional voice of RNs and advancing the profession to improve health outcomes. Within the context of an RN shortage, there is a lack of RN positions to improve the health-care outcomes of Canadians. This resolution also aligns with CNA’s goals. Action on this resolution will not only enhance the role of the RNs and NPs, but also strengthen the Canadian health-care system.

Key stakeholders:
- CNA’s jurisdictional members and their interest groups
- Federal and provincial governments

Estimated resources required or expected outcomes:
The outcome of implementing this resolution will be advocacy to address the national shortage of RN and NP positions. CNA would be expected to maximize its current policy/political action resources and to expand where necessary.

References:


18 Frith, K. H. et al., 2012.


20 CIHI, 2013.