Past Event: 2023 NCSBN Annual Meeting - Keynote: WHO Regulatory Guidelines Video Transcript

Event
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Presenter
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- [Jim] I've flown 14 hours to be here, and some of it in the airports, from Switzerland in Geneva to come to the Zurich room in the Swiss hotel. It's a bit of a thing and here we go. And we've got all the...similar to WHO, we've got all the country flags, the delegations, and everything else coming together.

So, it really is good to sort of feel as if I haven't really moved accordingly. And what I'm going to do is tell you a bit of a story if I may. You've had a lovely lunch, champagne, you have sweet desserts, so I'm going to try and keep the story entertaining as well. And there is no question mark at the end of the who here.

It's an update from WHO, it's not an update from who. Just to try and get...the story that I want to share with you is around some of the discussions that we're having in Geneva and in New York, including with your secretary Xavier Becerra, including with the American administration, around the sustainable development goals and the progress we're making.

I want to talk to you a little bit about that and the evidence base, and then bring it back to the field of regulation. Looking at the latest evidence that we have on regulation of all occupations, including the field of traditional and complementary medicine. Then bring that story to the nurses, which is your endeavor, and particularly then to bring it back to what you as nurse regulators in the United States could be doing to support this global agenda.

So, that's what we're going to be trying to do in the time that we have. And then hopefully, we'll get an opportunity to come through with a few questions and answers to come together. So, we heard the President talking about the history of the National State Boards of Nursing. Forty-five years ago in WHO, the discussion was the declaration of Alma-Ata, primary health care, and the commitment to health for all.

So, all people, irrespective of age, race, ethnicity would have access to health care without having to suffer financial hardship. That message is a core message still today as part of the principle of the

Sustainable Development Goals, Goal 3 on health and well-being, and the target in particular for universal health coverage and the commitment to that.

And the universal health coverage has two elements, it's care, access to care, with financial protection to come further forward. And WHO has a mandate globally to measure that progress, what are we doing and how are we getting to it?

So, on the first of July, just a few weeks ago, with some people may have been on holiday already, we celebrated the halfway point of the Sustainable Development Goals. So, what progress have we been making from 2015 to 2023? And what do we need to be doing differently in the second half of this 15-year period? Now, the first half, as you all know, dominated by public health emergencies of international concern.

COVID, the big one, the Ebola, which came to...where is Texas. Texas, where are you? Yep. Oh, they are, there's a few hands waving up there. Which came to the U.S. and, you know, tested the capacity of the healthcare system here. Zika virus, MERS, all continuously challenging. We've got record levels of climate-related disaster around the world, whether that's the fires in Canada, which are having impacts on your health, air pollution, environmental health.

Or whether that's the floods in Pakistan, the floods in China. We've got record levels of conflict, displaced populations, humanitarian issue. So, all of this is a major impact, let alone the COVID that comes forward. And where are we then with our data? Next month in New York, member states will look at the latest publication from WHO which says where are we at this halfway point, and the news is not good.

The news is life expectancy is in reverse. For the first time since we've had records, life expectancy is in reverse. Access to care is stagnated, the improvements that we've seen globally addressing sexual and reproductive health, maternal health, child health, immunization, HIV, all of those progress that we've made, stagnation, in COVID impact.

And so, we've got this ambition for universal health coverage that still continues to this day against stagnation, reversal, and financial protection in reverse at the same time as we've got more debt, we've got more investment requirements in health and care.

And so, what do we do differently? And what we must do differently is look at the people in our health care system. So, that's part of your job, looking at the people who access care and protecting them, but the people who deliver care through yourselves, the people, the experts in that policy negotiation. Because statistically, there's a correlation and association with the number, the quality, the quantity, and the quality of the healthcare teams in every single country and progress to universal health coverage.

And that's not new data, but it continues to be proved...the more data we get on an annual basis from around the world, it continues to be proven. Even during COVID, the single greatest barrier to progress on the COVID access care and treatment: health workers around all the countries in the world.

So, we've got to look at what we do about people. And the thing is that when we start talking about people, just as you bring all your representatives from your states together, we have to look at these within-country differences. It's not just the global number, it's not just the USA data that we want to look at, we got to look at below that into the administrative levels.

And what we see is huge variation, this health care for all access to care changes as soon as you go from the state to the next level down. We see that across low-income countries as you see on the charts, but also in high-income countries. I looked at the data here for...this is a study which is published a few years ago, and Dr.

Carey McCarthy is former staff member at the national state boards, now working with WHO. Dr. Carey McCarthy published this looking at this access to a nurse within different countries. And if you look at the U.S. state's information today, it's still the same. I think you've got the sort of two-fold difference between your top three states and your bottom three states.

So, if you're in North Dakota. Dakota? Dakota is there. South Dakota. DC. Where is Es? Es is over there now.

Hello. You know, a huge difference compared to being in Georgia or Utah, two-fold difference in these workforce densities, and how does that impact on the staffing issues? How does that impact on access to care? We looked at all these issues and the role of people in a publication which we took to the United Nations General Assembly here in the U.S. in New York, and looked at the impact that people have not just on health outcomes, but on these broader Sustainable Development Goals.

So, looking at poverty, nutrition, looking at gender equality, SDG 5. Now, we are the world's largest women-led workforce in the health and care economy. Out of all the industries or sectors, we employ more women than any other economic sector.

We have an impact on gender equality if we pay people properly. California? California. Hello, California. Decision this summer in the Senate, your Senator, Maria Elena Durazo, minimum wage for health and care workers, $25 an hour, the impact of that on wages and economics proven already.

That sort of have an impact around health, jobs, decent work, decent wages, impact on gender equality. No healthcare system anywhere in the world should be subsidized by poor wages for women at all, that's a WHO position.

So, we're really looking at all these impacts. And what we see is an evidence base here across the SDGs, that regulation, when it's dynamic, when it's agile, when it's flexible, has this broader impact on the supply, on the education, on the distribution, on the employment, on the wages.

It creates good practice, it creates the appropriate environment for these people to work and deliver services to the people that we wish to protect. So, this real added value role, which isn't necessarily the fundamental role of protecting the public, but it's this added value role, the evidence is steering us towards these are some of the things that we should be doing better in the second half of the SDGs.

Because any improvement, whether it's a 1%, 2%, 3% improvement in our industry over the next seven years, cumulative that's 10%, that's 15% improvement in that period of time, which has an impact on access to care. So, what we started with a process was to say, "Okay, what is the latest evidence base on health practitioner regulation?"

We started this in 2019. We convene member states and experts from around the world, nurses, medicine physicians, pharmacists, different occupations to come together and say, "Where are we going and what's the direction of travel?" That meeting was held late 2019 and then COVID hit early 2020, and so there was a period of diversion of resources into the pandemic.

But we picked this work up again in 2021 and looked at it and said, "Right, now we've got a bit more capacity again, what are the issues? What we don't do?" So, we have four major objectives, to look at what is documented in the evidence around the different models, the diversity that's happening around the world. Looking for those innovations, what's happening out there which is giving us this 1%, 2%, 3% improvement?

What's happening out there, which is protecting people, but giving us these co-benefits? Trying to see whether those innovations have been measured and studied, and we could look at the sort of cost implications of some of those issues. Because as WHO, we're trying to collect experience from around the world to give guidance to our member states to the regulators about what could be the key considerations that you could then look at and say, "Okay, here's the evidence base, can I translate that evidence base into practice in Arizona?"

Wherever you may be, will that work here accordingly to do it? And to get member states invested in that evidence base. To do that, WHO is a weird and wonderful organization, it's 100...how many members in your...fifty-one, I presume? Fifty-nine?

Okay. I can't count states, there's a few other territories. Okay, so you've got 80? Eighty. We've got 197. So, of course, everyone's got some slightly different experience of process and interventions and what we need to do, so we have to be sure that we have a robust evidence policy guidance process to come through.

And we have to go through proper process of structured systematic review, expert engagements, making sure that there's consultation with member states from around the world, getting case studies, grey literature to really be able to produce a WHO policy guidance, WHO recommendations.

And so, we've done that process. And David has been one of those global experts along with U.S. CDC has been represented, Morris from Minnesota, Minnesota, who's an expert on occupational regulation, not particularly on nursing, but looking at much broader elements.

So, the U.S. was well represented, and bringing some of those papers that David writes on aeroplanes into those discussions to come further forward. And we've looked at that systematic review, and just some of the figures that we've got, what did it reveal?

Nine hundred articles...no, 850 articles come through across peer-reviewed publications, grey literature, largely coming from five countries. The high-income OECD economies, where you have capacity, where your science and your engagement and your regulation.

You've built capacity over 45 years to be able to do that. You've got the funding, the resources, you're constantly looking at the evidence base. So, 50% of the evidence base from those five countries, which should...can we give global recommendations on the basis of the experience from five countries? No, we can't, but let's qualify in terms of what that is.

That mean it's 5 countries out of nearly 200, but it's actually nearly 20% of the workforce around the world when we look at the physicians, doctors, and nurses. So, you know, it's an evidence base from 1/5 world, so it gives us some level and degree of confidence that it may have some bearing on the other things.

And then we added to that country case studies and we added a much more broader discussion, looking at the experts from around the world, to bring that basis in. And just as David was saying in terms of his Space Odyssey, regulatory Odyssey, you know, very hard to do justice in a PowerPoint in a few minutes.

But this is the work of, you know, a whole group of people, a testimony to their engagement with WHO over several years and we're trying to condense that down into about six slides. The publication, you're getting an advanced notification of this, the publication will be available in November when it will be fully published online as WHO.

But just some heads up on the emerging themes and the emerging policy considerations. What we're seeing is some issues around definitional ambiguity, uncertainty around the world, the maturity of systems, some of the things has got 45 years of experience in the anglophone culture as against something from a lusophone or a Hispanic trend, maybe a colonial influence in a low and middle-income country.

So, very differences around the world, first and foremost, when we look at some of these issues, and that's normal when you're looking at a global perspective. But then we do see that the types of systems and issues, whether that's coming from a professional-led perspective, whether it's emerged out of what may have been hierarchical medicine first and then other occupations as they were professionalized coming forward has an impact.

We're seeing that very little of that evidence, though, is mainly descriptive, is mainly descriptive about the system that exists, very little evidence telling us about the outcomes that may come with it. So, as a result of the work that you've done, as a result of those historic perspectives and professional perspectives, how that may also translate into impact?

Which is, don't forget, we were looking for the areas around innovation and some of the costs of that innovation to try and understand, but the evidence base is a little light on that. The functions and the mechanisms, though, nonetheless...and David may have a perspective on this, which we can come back to in the questions as well.

But the functions and the mechanisms, protecting the public as the primary purpose, then looking at education, accrediting, licensing, looking at issues around competence and quality, most systems around the world are starting to group some of those things together in a very, very coherent way.

However, what we did find...just a couple of issues just as a highlight, we did find that most of that descriptive analysis is still blind to the men and women, the people that are in the workforce.

Very, very few of those studies actually even looked at the regulatory impact beyond the occupation. So, what's the impact on women in the workforce as against men? Are there some differences? Those gender dynamics, which we see in many other issues, including gender pay, the gender pay gap, that is real, gender occupational segregation, harassment and violence at work, all of these issues that are real for the people that are part of your nurse workforces not necessarily coming out in the publications and the evidence coming further forward.

So, that's something that we're sort of thinking about as we go into the next step. The public interest in the republic form, this is some of David's work. Like I said, the stuff he writes on the plane, we do use it

at WHO. This word that he published four years ago, just before COVID, really looking at this 21st-century perspective, which we now have the 2050 perspective to take on board.

But looking at that and sort of saying, "Well, these changing dynamics, how do you stay..." Because we've got 200 jurisdictions around the world. David mentioned 300 or something in terms of different regulators that you looked at...

- [David] [inaudible 00:21:24.234]

- Yep. So, in some of those jurisdictions and territories, multiple people involved. Some of those are still building their minimum capacity to an international standard, others are already advancing further forward. So, how do you keep abreast of some of those issues, critical for some of the conversations that we've been having? COVID-19 pandemic, we've been looking at this with interest.

And one of your team members is speaking tomorrow on the COVID-19 impact on nurse education and the nurse licensing examination. We've seen WHO has published on this as well, the disruption to health professional education, the impact of this sort of shift to online learning.

What's the global perspective on that? Canada has published...Andrei Geriatti [SP] has published a study into the latest examination results in Quebec, looking at the deterioration in results for the latest examination coming further forward and whether there was some challenges in the examination or in the education disruption or the examination.

So, looking at some of that, so look forward to hearing the results of that tomorrow. Because that's something that we've only just scratched that, being truthful. The impact on education, and then immediately going into practice, the mental health impacts of uncertainty, anxiety, imposter syndrome may be going into the workplace, not fully assured that you have all the competencies to practice into an environment, which is constantly changing as well.

What's the impact of that in the longer term? Is it going to result in these higher levels of intention to leave? I see in your latest publication that you've got with your workforce survey, you're already reporting this increase in intention to leave here in the United States. There's more people in the workforce, but there are also more people with mental health challenges in the workforce today.

So, really, to understand that, and like I said, trying to disaggregate this across high-income and low-income countries accordingly. And then one of the key issues that came out is that there may be good intentions, there may be good practice, but that isn't always followed through into the delivery.

So, we may have regulatory frameworks that really put in place quality, competence, and fitness to practice. But these may be evaded or avoided by professions of different occupations because the overall governance just doesn't have the same investment in governance to try and give that...they're understaffed, under-resourced.

Regulators trying to deal with the growing workforce with the privatization of education, a huge acceleration in medical schools, nursing schools around the world, which are privately funded, not state-funded. And so, the regulators are really struggling with this burden and it means there's a practice gap coming further forward.

With all that evidence base, then the expert group, David, in addition to watering plants, looking after the office, writing papers, he's also been one of the WHO experts in the world and really helping us look at that evidence base and then say, "Well, where can we be confident of making policy recommendations?"

Because it comes back to, again, you as the practitioners, you as the people who are doing this as your day job, if WHO is going to make it relevant to you, how do we translate the evidence base into some of the policy considerations? And we've ended up with a provisional grouping here of 15 policy considerations in 4 areas and that's digestible.

We hate reports from...WHO, you know, writes reports like a traffic warden writes parking tickets. You know, we've got an evidence group on just about everything coming to give you different pieces of information and knowledge. COVID, as you've all seen, the documentation, you need a Ph.D. or three years of a Ph.D. to be able to read everything.

And then by the time you finish that, it's going to be out of date. So, how do we make sure that it's digestible for practitioners to come further forward? So, we've looked at four key areas. The regulatory...statements which are overarching and considered to enable action, that's what we want to communicate, the evidence base to communicate an action into practice.

So, looking at the regulatory systems to protect the public to really get further forward. And what we're seeing around the world is based on some of the work that David and yourselves have been doing, but looking at this right-touch regulation, this dynamic, agile, flexible, engaging, you know, to be fit for purpose in a very dynamic changing world.

Regulation, which is very restrictive, in terms of its priorities to protect the public is not going to give you the agility to come further forward. So, making sure that we've got systems, structure, and governance in place to enable that innovation, to enable the adoption, you know, whether it's artificial intelligence or other things coming in, so that you're able to keep pace with some of that work to come further forward.

And whether or not you go for a single occupation or a multiple occupational group...regulator in South Africa, for instance, has over 80 occupations under an umbrella framing as against, you know, single occupation in some of the nursing regulators around the world, some of the medical regulators.

And whether you do either one, still these fundamental principles apply around agility and innovation, allowing for innovation to come further forward. We see on scope of practice...and David talked about that again, earlier, you know, scope of practice is not something that's new to many of you in the room today, but we're constantly looking at.

Because, you know, if you go back 45 years to the Ama-Atta declaration, it was about primary health care teams, multidisciplinary teams working together so that each of their different competencies, their education, their scope of practice, enables those overlaps to really work and go further forward. That's going to be something that continues to shift the dynamics in every jurisdiction.

And yet, we've got professional silos coming further forward. In the UK, David is going to head back to Scotland to take up his semi-retirement, I already heard him talking about supervising more Ph.D. students. But if you go back into the United Kingdom at the moment, they've got a new workforce strategy, which talks about a real shift over the next seven...they want to double the number of

physicians, they want to double the number of nurses to try and catch up with the problems that they've had exposed and exacerbated by COVID-19.

But they're also bringing in new scopes of practice for physician assistant, for advanced practice nursing, for different roles and already there's an outcry. If you go in the newspapers, the social media, if you go to different interlocutors, there's an outcry already about territory, how this is not going to serve quality to the patient because it's very much a professional scope or turf coming further forward.

And yet, the reality is, these are what governments are considering and they're calling on the regulators to help them enable them to come further forward as well. The issue also becomes how do you look at promoting the safety and the competence in the scope when today's practitioner, today's nurse, today's physician is likely to have many different jobs in many different jurisdictions.

You know, one in six of healthcare professionals around the world, they're now practicing in a jurisdiction other than where they had their first education, their first qualification. One in six. Migration and mobility within countries. Your labor market here in the U.S., as we saw, recovered, constantly changing, constantly moving as people would, you know, putting in different wages, different incentives to attract people into that COVID response.

So, you see people voting with their feet looking at those opportunities. This is a highly educated, tertiary educated workforce, who are making decisions about careers, which are going to cross-jurisdiction. So, how do you look at some of those scopes?

You know, what you're doing here around the compact work and being able to cross jurisdictions, that's going to cascade into Canada and North American markets, other the labor markets. We've got the same in the European context, we've got the same in the African context. The African passport is going to come forward for nurses and physicians and pharmacists and others to enable them to work in every jurisdiction.

So, how do we look at some of those issues that come further forward? But this fourth area here, the policy considerations, really, around this potential, this explored potential that we're seeing in some of the evidence is something that I am thankful to the expert group to really highlight in the evidence base, is that the co-benefits of your role that you do as regulators can have the substantive impact on what we talked about right at the beginning.

Health for all, equity, universal health coverage, if we can get an evidence into practice, into policy, into investment decision-making to come further forward. And that's really...therefore, using the evidence base to look at where's our practice gap?

Where's that evidence-knowledge practice gap that's happening? And this is particularly...maybe you will all have internal challenges, issues, complexity in your relations, in your stakeholders, and everything else coming further. But nonetheless, you are still a high-income country setting with huge benefits compared to many of your regulatory professional colleagues around the world.

So, how do you help look at some of these regulatory practice gaps in your own system, publish around that evidence-based, look at some of the other gaps that are not there, the cost, the knowledge, the innovation, the gender, so that people like me can take that evidence base and help others around the world to do it? Because they're still focusing on other elements of that stepping, that progressive implementation because of their capacity.

So, how do we get further forward on that? Which now I'm going to pivot from that evidence base into this particular practice perspective from nursing. Because WHO...I saw Stephanie Ferguson at lunchtime, I haven't seen her since the COVID hit. Hey.

Stephanie, another person who's worked with WHO for many, many years on this nursing/midwifery agenda. We've really tried to...I said I've been working with David for 15 years, we've been doing work on nursing and midwifery together, looking at the evidence base for all of the MDG period and the SDG period.

And we've really looked at...and partly through David's influence as a particular regulatory specialist, we've tried to make sure that this regulatory discussion is part of everything WHO in Geneva does with all the healthcare professions. Whether in the International Year of the Nurse and the Midwife that we managed to get the WHO to celebrate for our 70th anniversary, for the work that we did on the midwifery, "The State of the World's Nursing."

And a document called "The Strategic Directions on Nursing and Midwifery," which sets out what is the evidence base on the policy practice priorities that we want the professions, educationalists, the deans, the associations, the presidents of the associations, the regulators and the government, the quants, there's different stakeholders at national level or sub-national level, state level, what is it that they can be doing to make a difference.

And in the latest evidence that we've published, adopted by your Secretary of State, the U.S. has adopted this in the World Health Assembly with resolution, you know, one of the champions of that resolution looks at four priority areas around education, jobs, leadership, and service delivery.

And within that service delivery sector, the particular issue about the role of regulators, to drive practice, to drive the evidence base to come further forward. And this is where as a policy priority from WHO, we hope that empowers and enables you of the dynamics of how you work with your legislators, the dynamics of work both at the state level and the federal level, very different.

But how it can also enable regulators in other settings which maybe don't have the same capacity and the same parliamentary processes, to enable them to really drive that process twinning with guidance from yourselves as well to go further forward. Because we think, we being the evidence base that WHO looks at with the countries, with member states, the ministers in the governance think that if we can get this right, this has an impact on equitable access to care.

So, that's the opportunity that we're asking you to look at. And maybe that's just the sort of closing of this to say that, you know, I didn't just come to celebrate David's departure. We're looking to...David has been a fantastic partner for many, many years with the World Health Organization representing your organization.

But with Joy and Philip, we want to extend that partnership and through the board and through yourselves to really go into this continuing second half of the SDGs. Can you, with your capacity, look...as this publication comes out in the context of this issue, if you look at your workforce survey that you're publishing in your journal and some of the issues that you have, can you look at...with your partnerships with other professional associations, with other regulators, look at some of these research gaps.

What are you doing around some of these questions in some of these issues? Because what you look at and research and publish here has this co-benefit: global public goods. As one of the wealthiest economies, as one of the strongest regulators, one of the biggest workforces occupation-wise that you are dealing with, that is a global public good that we would ask you to provide to the world, not just for yourself.

Share it. Publish, publish, publish, share it, but ask the right research questions. And there are plenty of research gaps that David and the expert group have identified that need to be filled. The other issue, and we're seeing...you know, Hank was...Hank's in the audience?

Yep. Yep. We're seeing, you know, there's great collaboration with other healthcare professional associations here. That's not a given in every jurisdiction around the world. So, how can you work with others to really empower and enable that? Going back to this primary health care philosophy 45 years ago, the declaration of Alma-Ata, primary care teams, how do we really drive that further forward?

And then, in addition, your data is...you know, congratulations to the unique ID program that you have, NursingSys? Nursys. Nursys and NNCLEX, is it NNCLEX? NGN, Next-Generation NCLEX.

You have data, you have intelligence, you have strategic intelligence there. How do you use that to take action both on the strategic directions for nursing and midwifery here in the United States and every state, and how do you use that data to get your spokespeople in Washington, whether that's your foreign affairs people, whether that's your health people, your CDC representatives around the world to be sharing what you know through your intelligence as global goods in the policy dialogue?

The resolution that we got in the World Health Assembly took nearly three years of diplomacy to get people to commit to that agenda. But now we need them to implement it and we need leadership on that agenda, which you as a well-resourced setting can help my team. One of your own, Terry McCarthy from...one of your team members here for many years leads our portfolio in Geneva.

So, you're helping one of your own to help change the world to come further forward using data to drive decision-making and to drive investment. So, that's my final remark. It's a pleasure to be here in Zurich, down the road from Geneva. It's a pleasure to be next to David again on this, his last gathering as the chief exec, but it's also a pleasure to be with you and your board leadership going further forward.

Thank you very much.