Leadership and Governance for Enhanced HRH Contributions to Health Systems Strengthening

Insights. Imperatives. Investments.

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Introduction

This is a summary report from Work Group 5 which has been asked to focus on exploring strategies that strengthen the role of leadership, governance and stewardship for expanded human resources for health across the world. This is a work in process. We heard the Secretariat provide guidance: Fewer words. Bolder Actions. Less What? More How?

A set of slides is appended to this summary report to help facilitate reader reference to the broad array of resources from which we have drawn our conclusions and recommendations.

The HRH movement is at an important point of reflection and opportunity. Much has been done, but much remains for action by government and civil society, at the global, regional, country and institutional levels.

Our work must now drive both Civil Society and Governmental organizations to work together at the country level to accomplish the 2008 Kampala Declaration and Agenda for Global Action (KDAGA) vision:

"All people, everywhere, shall have access to a skilled, motivated and facilitated health worker within a robust health system".

HRH leaders then and now recognize that achieving significant and sustainable HRH gains is the cornerstone of an efficient and effective health system. Technical inputs like pharmaceutical supplies and appropriate funds have certainly been critical, but without a well-trained, responsive, reliable, and motivated workforce, these inputs would never reach the intended clientele[1].

Advocacy & Linking HRH Goals to National Development Goals

In an effort to avoid yet another stand-alone global health initiative, we now have an opportunity to link HRH goals to national, regional and international development goals. Strong HRH, is not simply a goal in and of itself, it is the essential driver for strong health system performance. A strong health system is the bedrock of universal health coverage, and contributes significantly to political stability, economic growth and overall societal well-being.

Insights, Imperatives, and Investment

We need to move beyond talk, resolutions and reports to actions and investments.

This short report presents the work of the GHWA's "**Technical Working Group on Leadership, Governance and Policy Alignment**". Its aim is to build upon the many prior recommendations, resolutions and studies calling for HRH strengthening. It seeks to provide insights regarding lessons learned that are judged to be essential for strengthening HRH leadership and governance at the global, regional and country-levels. The report defines three (3) critical **insights** about the HRH challenge; three (3) recommended **imperatives** or actions for the way forward; and three (3) areas of **investment** that governments, development partners and donors should support to ensure HRH success.

[1] *Human Resources for Health: Overcoming the Crisis*. Rep. Cambridge: President and Fellows of Harvard College, 2004. Print. Joint Learning Initiative.

A focus on leadership and governance highlights their contributions as the "great enablers"[2] of strong health systems. While technical approaches are certainly necessary to address global HRH issues, it is sound leadership and governance that sets the conditions for a functional and productive health system that is needed for efficient delivery of services and is too often overlooked when investments are made in health systems[3i]. Furthermore, expanded country-level actions are necessary and critical, as "…all global initiatives must be implemented, planned, and owned in specific national settings"[4].

Two further global forums and six years down the road after KDAGA a lot has happened. The visibility of HRH is much higher; several new resolutions have been adopted at the WHA and in the Regions. Importantly a WHO Code on the International Recruitment Health Personnel was adopted in 2010. Yet at the global level we have experienced challenges with governance and coordination of HRH initiatives.

The WHO Department responsible for HRH **is resource constrained** with GHWA losing staff and short of operational funds. In these circumstances we have seen uncoordinated movements among partners and a weaker global partnership. At the country level, while a few countries have made solid progress, the size of the HRH crisis cannot be said to be much better. Stewardship, leadership and governance shortcomings at global and country level have contributed to these challenges, yet stronger leadership and governance offer the most potent solution to successful implementation of the initiatives and investments needed to address the global HRH crisis.

Stewardship, leadership and governance is judged essential to achieve the other objectives in HRH being addressed by all of the GHWA Working Groups, including accountability and alignment; engagement with other sectors; scaling up transformative education; and providing a conducive environment for HRH with the right incentives, oversight and facilitating productivity.

[2] "Governance as an Enabler for Health Systems Strengthening and Country Ownership | LMG for Health." *LMG for Health*. Management Sciences for Health, 2014. Web. 06 June 2014. <http://www.lmgforhealth.org/pt/expertise/governing/governance-roundtable>.

[3] Francis Omaswa and Jo Bouford; "Strong Ministries for Strong Health Systems". www.achest.org

[4] *Human Resources for Health: Overcoming the Crisis*. Rep. Cambridge: President and Fellows of Harvard College, 2004. Print. Joint Learning Initiative.

Section One: Insights

We share three (3) key insights for the GHWA Board's considerations regarding the need for enhanced leadership and governance for HRH Success.

1. Dimensions of the HRH Challenge are Complex and Well Known
2. The Importance of Political Leadership at Country Level
3. The Role of Technical and Professional Leadership is Critical

1. Dimensions of the HRH Challenge are Complex and Well Known (See attached slide deck)

Today's frustration with HRH shortages still draw upon the landmark assessments in the 2006 World Health Report, when the world faced a shortage of approximately 2.4 million health service delivery professionals comprising doctors, dentists, nurses, and midwives[5]. In just seven short years, this figure jumped to 7.2 million and is expected to rise to 12.9 million by 2035[6]. This shortage is calculated by estimates that the proper threshold for an effective HRH supply lies somewhere between 2.3 to 2.5 health workers (physicians, nurses and dentists only) per 1,000 population, with an estimated global health workforce of approximately 100 million people. Unfortunately, approximately one third of the global population (2.5 billion people) lives in a country where this minimum health service provider to patient ratio remains unmet[7].

Unfortunately, after all of this past work, HRH's value in most countries (rich and poor) is not yet well appreciated enough by parliaments and heads of state. In the UK and Europe they are moving beyond shortages to consider cross border migration (See Slide 30) and new competencies needed to cope with the challenges not only of today, but of the health care systems of 2035 (See Slide 15).

Proportionally, the region most severely affected by the health worker shortage is sub-Saharan Africa, which has a provider to patient ratio that is equivalent to one tenth of Europe's ratio. To wit, "Ethiopia has a fiftieth of the professionals for its population that Italy does"[8]. In strict numerical terms, however, Southeast Asia is also experiencing a significant health worker deficit due to its exponential population growth[9].

It is important to note, however, that current and future workforce shortages are not unique to, nor inherent, in the developing world. Forty percent of nurses serving in high-resourced countries are expected to transition out of

[5] Global Health Workforce Alliance. *Country Coordination and Facilitation (CCF): Principles and Process*. Geneva: World Health Organization, 2010. Print.

[6] World Health Organization. Global Health Workforce Shortage to Reach 12.9 Million in Coming Decades. WHO. N.p., 11 Nov. 2013. Web. 05 June 2014. <http://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/en/>.

[7] *Human Resources for Health: Overcoming the Crisis*. Rep. Cambridge: President and Fellows of Harvard College, 2004. Print. Joint Learning Initiative.

[8] *Human Resources for Health: Overcoming the Crisis*. Rep. Cambridge: President and Fellows of Harvard College, 2004. Print. Joint Learning Initiative.

[9] Global Health Workforce Alliance. *Country Coordination and Facilitation (CCF): Principles and Process*. Geneva: World Health Organization, 2010. Print.

the health industry by 2020[10], creating a vacuum in countries that are already dealing with the effects of an aging population and also acting as the impetus for international recruitment from southern countries. Conversely, both the Philippines and Argentina have a surplus of nurses and doctors, respectively[11].

Workforce Imbalances

Compounding the interrelated issues of workforce shortages and poor worker distribution are five commonly identified workforce imbalances. Even with the right amount of health professionals at the recommended provider to patient densities, adequate healthcare cannot be achieved if the following imbalances are left unaddressed[12]:

1. Profession/Specialty: The balance between professions and skills such as of doctors to nurses/midwives, as well as the shortage or surplus of certain types of specialists
2. Geographic: The distribution of health workers where they are needed in rural versus urban areas, as well as migratory practices that tend to favor rich working environments to socioeconomically disadvantaged regions/within and between countries
3. Institutional: The imbalance of resources available among health facilities in a given region or country
4. Public/Private: The difference in resource allocation among public and private health facilities within a given region or country
5. Gender: Gender imbalance in nursing and specialties that are conventionally related to women and children (i.e. gynecology, pediatrics, family practice, etc.)

The scope and nature of the HRH challenge remains a persistent burden in low resourced countries as they struggle to deal with both non-communicable diseases as well as the challenges of HIV-AIDS, Malaria, TB, Ebola, and poor maternal health issues of unsafe deliveries. Low resource countries face complex and persistent problems not just in the shortages of workers, but workers unable to expand their skills due to low pay, poor recognition for hard work, demoralized by corruption and poor workplace conditions, and under prepared HRH managers and health system leadership in general. (See Slides 25, 28-29). A short list of the challenge dimensions is in Slide 100.

2. The Case for HRH Investment is a matter for Political Leadership at the Country-Level

In addition to having a positive effect on health, smart HRH policies contribute to societal stability, national security, and economic dividends to those who invest in them – these benefits need to be articulated more effectively to Heads of State and country governments. It is desirable and important for them to appreciate that the health system is a critical source of employment, capital investment, contributes to economic growth via a healthy workforce that is more productive, and to national security. The lessons learned from national security frustrated by transnational disease such as avian flu and by HIV and AIDS and Ebola are illustrative. (See http://www.who.int/bulletin/volumes/85/3/06-036889/en/ and also http://www.georgetown.edu/news/avian-flu-symposium-2014.html

[10] World Health Organization. Global Health Workforce Shortage to Reach 12.9 Million in Coming Decades. WHO. N.p., 11 Nov. 2013. Web. 05 June 2014. <http://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/en/>.

[11] Zurn, Pacal, Mario Dal Poz, Barbara Stilwell, and Orvill Adams. Imbalances in the Health Workforce. Tech. Geneva: World Health Organization, Evidence and Information for Policy Health Service Provision, 2002. Print.

[12] Zurn, Pacal, Mario Dal Poz, Barbara Stilwell, and Orvill Adams. Imbalances in the Health Workforce. Tech. Geneva: World Health Organization, Evidence and Information for Policy Health Service Provision, 2002. Print.

It has been strongly argued that a healthy population correlates with a more productive and less restive population[13]. This fact presents a remarkable opportunity to mobilize political and economic resources for all regions of the world, including sub-Saharan Africa in particular. Economic production and growth in Africa is projected to increase to 5.9% during 2014 – combined with improvements in child mortality rates and a decrease in fertility, sub-Saharan Africa could benefit from a significant demographic dividend in coming decades[14]

The observations are still relevant from The Joint Learning Initiative, a consortium of 100 health leaders studying HRH strengthening, who put it simply: "Today's dramatic health reversals risk more than human survival in the poorest countries – they threaten health, development, and security in an interdependent world"[15]. Dimensions of labor economics should be factored into this "Business Case for HRH" including insights from the International Monetary Fund (see Slide 28).

Clearly, global, regional and country level political leadership is needed to make resolution of the HRH crisis a top priority for legislative action, particularly among heads of state and parliaments. Political commitment can be developed from a well prepared and communicated "**Business Case for HRH**". This political ownership must reside within the most senior and influential leaders of a country's parliament, executive branch and across Ministries of finance, health, economic development and education. Political commitment that can be supported and strengthened through consistent, coordinated, and well reported gains in health sector performance and resulting in the availability of the right health workers in the right place, at the right time, with the right tools, skills, knowledge and attitudes to deliver value for money at all levels of the country' health system. This requires a careful alignment of policy across countries, within global partners, and with the ministries of a country and across both public and private producers and employers of health workers.

Political leadership is needed that can be used to demand plans and budgets from public and private educators and employers of health workers to use innovative processes and technologies for more effective and efficient services delivered to protect, promote and restore health at optimal levels.

Political leadership is needed to ask for targeted technical and financial assistance from regional and global donors, and to require donor aid to be harmonized and targeted to meet priority health system needs as defined by countries.

Communities through their various organizations should hold political leaders to account by raising the provision of quality essential health care and HRH to a matter of high priority over which elections are won and lost.

3. The Role of Technical and Professional Leadership is critical

Committed political leadership on its own is not sufficient; there is a critical role for managers, administrators, and academia and professional associations in providing the political leaders with quality information for policy formulation; program planning and development; resource allocations for HRH; and to drive the performance of systems in which HRH function. In some countries, there is a dearth of qualified and motivated HRH managers and administrators; the professional associations are weak; and academia is not involved enough in health systems governance.

[13] "Conflict and Health." *Conflict and Health*. BioMed Central, n.d. Web. 05 June 2014. <http://www.conflictandhealth.com/>.
[14] *Africa Health Forum: Finance and Capacity for Results*. Summary Report. Washington: World Bank, 2013. Print.
[15] *Human Resources for Health: Overcoming the Crisis*. Rep. Cambridge: President and Fellows of Harvard College, 2004. Print. Joint Learning Initiative.

Section Two: Imperatives

We recommend three (3) key imperatives for the GHWA Board's considerations on the need for enhanced leadership and governance for HRH Success in countries:

- Support and Sustain Coordinated Political Leadership at Highest Levels of Government
- Establish a Multi-year and Evidence Based HRH Financing Strategy
- Implement Evidence Based Education, Recruitment and Retention Strategies

Imperative 1: Support and Sustain Coordinated Political Leadership at Highest Levels of Government

"Governments are stewards, or protectors, of the public interest and have the ultimate responsibility for assuring conditions that allow people to be as healthy as they can be. Heads of state and Ministries of health and the ministers who lead them must be able to perform a set of core stewardship functions within the ministry and across government"[ii]. There is evidence to show that in Sub Saharan Africa it is the countries with strong governments that are making the most progress as they are able to design and implement policies within country context and to marshal country and partner resources towards agreed strategies. These governments need to call for leadership across all ministries, especially health, education, finance and economic development. There also needs to be collaborative planning with civil society organizations, professional associations and academic institutions.

Supporting and sustaining political leadership and health system stewardship and governance is the single most critical intervention that holds potential for implementing needed HRH solutions at country and global level. Identifying and implementing HRH solutions is complex and needs committed, bold and supported leadership at all levels.

We recommend that the GHWA Board with partners engage directly with selected top global and country political leaders. Individual meetings should be conducted with these leaders. Examples include the UNSG who showed keen interest and addressed the First HRH Global Forum, the AUC Chairperson, and other regional leaders. This can be done through the work of recognized champions similar to the ones deployed for HIV efforts. These should be well funded and have defined deliverables.

Political leadership needs to be backed by technical and management capacities at country and global levels. The capacity to convene multiple stakeholders, and resources that are needed for HRH development, calls for the establishment of **structures and forums for continuing genuine and coordinated dialogue among key stakeholders**.

Many countries have already recognized the need for a coordinating body that plans and regulates HRH activities, and have established various forms of HRH committees or councils to advocate for and oversee HRH work. These "councils" typically align policies, coordinate legislation and regulation, and technical approaches to resolving the HRH crisis. In countries that have not already taken this step, it is desirable that such an entity be created at the highest level by the Ministry of Health[16] and as a multi-sector agency reporting to the parliament and head of state. A multi-sector membership in such bodies is critical because of the diverse nature of the factors that drive HRH supply and demand (See Slides 101, and 82-84). A starting agenda for these bodies can be seen in prior Joint

[16] Global Health Workforce Alliance. *Country Coordination and Facilitation (CCF): Principles and Process*. Geneva: World Health Organization, 2010. Print.

Learning Initiative recommendations in Slide 36, and in slides 49-54. Samples of good country level HRH action plans can be seen in slide 37 from Sudan, Rwanda slides 109-112, and from South Africa in slide 14.

Imperative 2: Establish Multi-year and Evidence Based HRH Financing Strategy

The need for funds is extensive for such items as enhanced pay, better working conditions, transformational education and other cited below in the investment section. The HRH financing strategies developed and managed by a new "HRH coordination governing body" must extend beyond traditional 2-3 year planning horizons to 10-15 years. Domestic resources should be mobilized following evidence based recommendations from the national "councils". Country based HRH leadership must also be more focused and assertive in their requests for support from international donors. Bold forums must be convened now, similar to the sophistication and scale of the GAVI and Global Fund initiatives, to more clearly define the scope of investments needs and alternate sources of funding these investment requirements. **Strong HRH is an essential prerequisite for gains in the Global Fund and GAVI type campaigns.**

Formal transition plans are also essential, but to move this funding from foreign donors to the host countries will face some of the same capacity development challenges that the PEPFAR program of US Government support for HIV and AIDS and the Global Fund, see e.g. : http://www.pepfar.gov/documents/organization/217767.pdf

Imperative 3: Build A Suite of Recruitment and Retention Strategies

Leadership, governance and stewardship are required to put in place policies, practices and resources that are needed to recruit and retain HRH where they are needed in each country. Because the factors that shape the supply and use of health workers are so varied, a comprehensive suite of tools and strategies must be advocated for and used by those who govern and lead the HRH initiatives in each country. The array of strategies are shown in slides 53-56, 70-76, 81, in 123-126 and in the work of CapacityPlus seen in slides 121-126. The new governance for HRH will need to review and act upon the work of the other GHWA Working Groups addressing such important issues as:

Proper incentive mix*: Tuition reimbursement, flexible hours, bonus, clinical ladders, shared governance, child care, transportation (Imbalances in the health workforce)*
Address Portability of qualifications*: "Improving recruitment and retention requires either higher reward that makes alternative employment less attractive or making qualifications less 'portable' – that is, less likely to be recognized in other countries. The development of new health professions in many countries is a way of reducing the portability of qualifications, thereby reducing the opportunity cost of jobs at home" (Health Workers: Building and Motivating the Workforce)*

Enhanced skills mix for task-shifting. *"Most developing countries have new categories of staff that do not match internationally recognized professions…Examples include nurses with extended training and roles and people working at sub nurse levels with training of a few weeks to three years…Training is for specific roles without the generic training in conventional professions. Typically, such employees are mobile nationally, but they do not transfer easily across countries" (Health Workers: Building and Motivating the Workforce)*

Those who govern and lead the next generation of HRH capacity building will need to invest in and master new workforce planning tools, such as those highlighted in slides 61-66.

The supply shortage can also be partially met by having HRH training programs, and HRH managers implement strategies to support the workforce to be ***more productive*** and to ***rely more on community health workers***.

Studies in the US, UK and Europe suggest the promise of new techniques for enhanced efficiency in the reports by leading global HR consulting firms. (See Australia in slides 17-19, Hay Group in slide 20, Slide 27, and KPMG in slides 70-76)

Section Three: Investments

Resolution of the HRH challenge requires substantial financial investments that exceed the current levels of spending among the World's low income countries. Considering the competing priorities for financial resources facing many governments (health and education and finance ministers), it is committed and strong leadership at the highest levels of government that will mobilize the evidence, economic and social- equity arguments that are needed to persuade parliaments and private sector organizations (CSOs, universities, employers) to allocate additional resources needed to support HRH. At the country level, these financial resources are not just new investments from external public and private donors, but a re-allocation of domestic resources for HRH within the countries themselves.

We recommend three (3) critical investments for the GHWA Board's considerations to support enhanced leadership and governance for HRH Success:

- **Build Health Human Resource Management as a Profession for Talent and Quality Development**
- **Improve Working Conditions for Health Workers**
- **Enhance HRH Planning and Monitoring Information Systems**

Those who govern and lead a country's pursuit of smart levels for the supply and quality of human resources for health, should assertively build and nurture coalitions of public and private sources for the billions of dollars needed to address the HRH funding. These coalitions must embrace such diverse sources as:

Country Level:

1. The General budget
2. Social health insurance
3. Dedicated, ear-marked, ring-fenced excise taxes
4. Corporate Social Responsibility (CSR) funding from extractive industries (Mining, Petroleum and Chemicals)
5. Enact tax reduction incentives for companies that support HRH improvement initiatives
6. Enhanced performance based payments to health providers that develop and implement successful HRHG enhancement initiatives.
7. Enhanced budget sharing among health and education systems for targeted development of all health professionals, including community health workers.

Global level: public and private donor organizations should be encouraged to pool and harmonize their investments at the regional and country levels similar to the inter-sectoral coordinating governance in GAVI and Global Fund structures and strategies. Some of this resource pooling can be accomplished in various regional bodies, such as the European Union, the Asian and Pacific HRH Alliance, the African Platform on HRH, the East African Community, ECSA and WAHO and others. Administration of these funds can be supported by World Bank related trustees. Donor investments, however, should complement and coordinate into country defined needs, priorities, and plans.

Investment 1: Build Health Human Resource Management as a Profession for Talent Innovation and Quality

On top of supporting and sustaining political leadership, there is also the need to cultivate and develop technical and professional leadership for health systems and for HRH. These HRH professionals can provide political leaders with the information, analytical, and managerial support needed to advance HRH policy, regulatory and investment gains. At present, health workers, managers who work in health systems, and human resources for health are undervalued, under prepared, under supported, and under paid. Reducing the HRH crisis demands better human resources planning and management (HRM) professionals. Better HRM demands the availability of an enhanced and strengthened profession, the Human Resources Manager. (See this web portal: http://www.ashhra.org/about/index.shtml)

OECD countries have strengthened the performance of and results from their health systems not just by investing more of their GDP into their health sectors, but by intentionally supporting the development of a cadre of professional managers and policy analysts dedicated to HRH. These professional HR managers are needed to perform such key duties as:

- Advocate for the value of HRH development
- Champion better working conditions for health workers
- Lead short and long range health workforce planning and development policy and regulations
- Engage in analyzing and guiding labor economics considerations at the highest levels of government
- Guide the design, development, and delivery of pre- and in-service transformational education of formal and informal health workers, as well bolder skill mix-shifting among health workers
- Support the development and strengthening of health professional associations that advocate for the needs of the health professions (working conditions, fair pay, and continuous knowledge development), as well as the people and communities they serve
- Design more effective performance management and reward systems, and the policies and regulations to require their use
- Monitor and evaluate HRH policy and regulatory interventions at national, regional and global level

The GHWA Board must call for increased investments into the professionalization of HR Managers, and the support of health professional associations for all cadres of health workers. These professional associations play an essential role in defining performance standards for each profession; undertake peer learning and evaluation, and amplifying the voice of the health workers for better service quality, working conditions, performance management and fair compensation. Advanced degree programs in labor and health economics, policy analysis, regulations for licensure and performance support, HRH management, and health systems management are investments that should be funded by development partners and country HRH employers.

The professionalization of HRH managers should help ensure that those who lead and govern HRH systems cause higher levels of investment into health professional education, including new curricula, faculty, new educational facilities and methods, new digital supported and web enhanced teaching systems.

HRH governance must also seek enhanced policy and regulations that enable and strengthen wise health worker and health facility licensure and results oriented certification of continuous performance improvements and life-long, continuous education as a requirement of licensure.

Investment 2: Improve the Conditions for Health Workers to Deliver Needed Services.

The majority of HRH in low resourced countries, especially those from sub-Saharan Africa, are often not able to work and live in dignity among the people they serve due to low pay; poor work place conditions (especially for women) and cultures too oriented to *criticism* and not enough to *celebration* of progress, productivity innovations and professionalism. HRH managers often do not have appropriate equipment and materials needed to do their work. They often have to subsidize their wages by undertaking additional activities that take them away from the core roles expected by their employers.

Those who govern the health sector must ensure that leaders and managers at all levels need to be more cognizant of the difficult conditions in which health worker operate. Without an enabling work environment it is unrealistic to expect high performance from health workers. Such poorly supported health workers are often the subject of unfair criticism when they rightly devise coping mechanisms to support themselves and their families. High productivity cannot be demanded and expected from poorly supported HRH. Those who govern and lead health systems must call for improved working conditions for health workers, from rural primary care health posts to urban hospitals, and in ministries of health, such as for:

1. Enacted and enforced regulations demanding gender equity in employment for all types of health workers;
2. Health facilities that are clean, safe, and well maintained;
3. Medical technologies that are appropriate, well maintained and wisely used

HRH should be able to work and live in dignity among the communities they serve on the compensation from one job for which accountability and high performance should be demanded and facilitated by modern talent development and effective performance management processes. Expanded base pay and benefits are essential for all health workers, including workers engaged in health protection and promotion, as well as frontline primary care services delivery.

Country level policies and regulations should encourage CSOs and government employers to support innovative recognition and merit pay for health workers that consistently improve health services access, quality, effectiveness and efficiency.

Investment 3: Enhance HRH Planning and Monitoring Information Systems

HRH governance and leadership demands enhanced work force planning and monitoring systems. But HRH leaders must also advocate for expanded investments into the development of new cadres of health systems managers and leaders who know how to effectively use these systems; managers and leaders who in turn reinforce the call for HRH management and a drive for health systems strengthening and universal health coverage.

Effective leadership and governance of HRH is underpinned by evidence and robust health workforce information systems. Many countries do not know the number or types of health workers engaged and employed in their health systems. Maldistribution of health workers exposes vulnerable populations to poor health services access and quality. Weak IT systems frustrate the use of modern HR personnel administration and yield counter-productive policies and systems for performance planning and management. These weaknesses in HRH systems

make it very difficult for heads of state and other political leaders to fully appreciate their need for enhanced HRH development and investment, and also difficult to attract and support professional HR managers.

Substantially expanded investments are needed to enable more effective forecasting of health workforce needs and investment levels by profession, by geographic distribution and by places of employment. See slides 113 from KPMG, the IHRIS resource in slide 31, and the work of Deloitte in slides 114-117. New HRH web portals are needed to support those who lead and govern to better monitor and influence HRH management, as illustrated by New Zealand in slide 118.

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[i] Strong Ministries for Strong Health Systems
[ii] Strong Ministries for Strong Health Systems