
TECHNICAL WORKING GROUP (TWG) #5

This paper serves as a background report to inform the Global Strategy for Human Resources for Health. The development of this paper has been coordinated through a thematic working group (TWG), comprising of 2 co-chairs and a group of experts drawn from various Global Health Workforce Alliance (GHWA) constituencies, operating under the oversight of the GHWA Board working group. The views expressed in the paper, do not necessarily reflect the official position of GHWA. All reasonable precautions have been taken by the co-chairs to verify the information presented in the papers.

By Technical Working Group No. 5 Co-Chairs:

**Dr. Francis Omaswa, MD**  
Executive Director  
African Centre for Global Health and Societal Transformation

**Dr. James A. Rice, PhD**  
Project Director  
Leadership, Management, and Governance Project  
Management Sciences for Health

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With research and drafting assistance from:

**Katie Susette Martin**  
Management Sciences for Health
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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.

In 2008, the Global Health Workforce Alliance (GHWA), convened over 1500 government officials, donors, civil society organizations, and technical experts, in Kampala, Uganda for the First Global Forum on Human Resources for Health (HRH) and adopted The Kampala Declaration and Agenda for Global Action (KDAGA) that has guided the HRH movement up to now. At that time, having already surpassed the halfway point of the Millennium Development Goals’ implementation timeline, many countries, both high and low-resourced, were still struggling to make significant gains in universal health coverage. They developed a vision for HRH that stands today:

“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.

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”. By “policy alignment” we mean that policies and funding for HRH development within the Ministry of Health and the whole of government are not only positively balanced with words, but with essential funding that encourages good HRH development. 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.

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 health 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\(^3\). 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 are 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.

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\(^3\) Francis Omaswa and Jo Bouford; “Strong Ministries for Strong Health Systems”. www.achest.org

\(^4\) Strong Ministries for Strong Health Systems

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 Case for HRH Investment is a matter for Heads of State
3. The Importance of Political Leadership at Country Level

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 4.3 million health service delivery professionals comprising doctors, dentists, nurses, and midwives. In just seven short years, this figure jumped to 7.2 million and is expected to rise to 12.9 million by 2035. 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, midwives, 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.

Unfortunately, after all of this past work, HRH’s value in most countries (rich and poor) is not yet well appreciated enough by the two ministries of health and education, as well as 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”. In strict numerical terms, however, Southeast Asia is also experiencing a significant health worker deficit due to its exponential population growth.

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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 the health industry by 2020\textsuperscript{11}, 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\textsuperscript{12}.

**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\textsuperscript{13}:

1. **Profession/Specialty**: The balance between professions and skills such as doctors to nurses/midwives, as well as the shortage or surplus of certain types of specialists and paramedical teams.
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 including those where minority groups reside within and between countries.
3. **Institutional**: The imbalance of resources available among different levels of services and health facilities (both public and private and of all levels of service) 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**: The overrepresentation of women 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 remain 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 maternal and reproductive health challenges including 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, weak career and training opportunities, low motivation, 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.

**The Case for HRH Investment is a matter for Heads of State and Political Leadership at the Country-Level**

In addition to having a positive effect on health, smart HRH policies contribute to societal stability, through attaining health equity, national security, and economic dividends to those who invest in them – these benefits need to be articulated more effectively to Heads of State and governments as well as some senior civil servants, policy makers, and economists. 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)

It has been strongly argued that a healthy population correlates with a more productive and less restive population. 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.

The observations are still relevant from The Joint Learning Initiative (JLI), 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.” Dimensions of labor economics should be factored into this “Business Case for HRH” including insights from the International Monetary Fund (see Slide 28). The JLI also calls for multi-disciplinary approaches to consider social determinants of health in HRH development.

Clearly, global, regional and country level leadership is needed to make resolution of the HRH crisis a top priority for political decision-making, legislative and executive action. It takes a “whole of government” approach, led by Heads of state and supported by parliaments. Political commitment can be developed from a well prepared and communicated “Business Case for HRH” that emphasizes how wise HRH development contributes in a positive way to overall society development. 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 must 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’s health system. This requires a careful alignment of policy across the ministries of a country, across both public and private producers and employers of health workers, among countries and among global partners

Political leadership is needed

• to establish the national business case for HRH, to support it by necessary regulations and to use it for demanding 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.

• to negotiate 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.

**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, service users from the population, academia and professional associations in proving the political leaders with quality information for policy formulation and resource allocation and in driving the performance of systems in which HRH function. In some countries, there is a need for more health services managers in general, and there is an even greater dearth of qualified and motivated HRH managers and administrators. In addition, the professional associations are fragmented and academia is not involved enough in health systems governance.
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 links for effective health systems governance coordinated with political leadership at highest Levels of Government
- Establish Multi-year and Evidence Based HRH Financing Strategy for health gains
- 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”\(^{17}\). 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.

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 governance dialogue among key stakeholders.

Many countries have already recognized the need for a body beyond the Ministry of Health 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

\(^{17}\) Strong Ministries for Strong Health Systems
an entity be created at the highest level by the Ministry of Health \(^\text{18}\) 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 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. This funding should reflect the value of effective HRH to the country’s economy by embracing worker productivity in several service, manufacturing, education sectors, including tourism. The HRH financing strategies developed and managed by a strengthened and inclusive HRH 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 in structure, 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.

Such forums would need the convening power to link up international HRH funding opportunities, including global initiatives with the sophistication and scale of GAVI and the Global Fund.

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](http://www.pepfar.gov/documents/organization/217767.pdf) Three steps are essential for this transfer of ownership from donors to host country:

- Host country and donors must enter into an agreement where the needs of all parties are clearly defined with sensible timetables linked to the respective roles and objectives for expanded responsibilities of all;
- The host country needs to establish an all government Country Coordinating Council for HRH planning and resource mobilization. This body needs a formal terms of reference with support from secretariat staff provided by the Ministry of Health; and
- A bold resource mobilization plan must be mutually defined by donors and host country leaders that defines sources and uses of funds over a multi-year period.

**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. Donors can help invest in comprehensive capacity development for these country based HRH leaders. Host country leaders must acknowledge the value of this capacity development and make some of their own commitments and investments to make it happen. 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 Board of GHWA 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 (imbalance 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)

“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 managers explore ways to support the workforce to be more productive and to find effective ways to optimize the contribution of community health workers and other front line 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 health ministers, it is committed and strong leadership that will mobilize the evidence, economic and social-equity arguments that are needed to persuade parliaments to allocate 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 low resourced countries themselves. This investment should, however of course be made in ways that enhance not compromise health services delivery.

We recommend the GHWA board call for three (3) critical investments by countries 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. The health and education systems of each country should allocate funds into a pool that supports more targeted development of community health workers.

Global level: public and private donor organizations should be encouraged to pool and harmonize their investments for HRH, including at the regional and country levels. National Sector Plans, such as used for IHP+ and increasingly used to set out GAVI and Global Fund funding commitments should serve as a basis for harmonization of domestic and international HRH investment. The potential for resource pooling through various regional bodies,
such as the European Union and various regional intergovernmental structures should be explored. Sub regional structures may also serve such a purpose, such as the East African Community, ECSA, WAHO and others, as well as alliance structures such as the Asian and Pacific HRH Alliance, the African Platform on HRH etc. Special attention should be given to how the World Bank and the Regional Development Banks could engage in aligning domestic and international funding and in the administration of pooled funding for HRH.

**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 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). 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](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 dedicated to HRH, as well as be a core competency of general managers. 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
- 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, as well as the people and communities they serve
- Design more effective performance management and reward systems
- Monitor and evaluate HRH interventions at national, regional and global level

The GHWA Board must call for increased investments into: the professionalization of HR Managers by both the ministries of health and health care institutions; for expanded engagement of academic institutions in resolving HRH shortages; and for enhanced 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 health economics, HRH management, Health systems are investments that should be funded by development partners.
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 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. 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. As the health sector challenge of posting and retention parallels teaching, the two sectors should engage in more collaborative dialogue for knowledge and experience sharing.

Support for 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**

Effective leadership and governance of HRH is underpinned by evidence and robust health workforce information systems and the analytical skills and products that inform robust policy making. 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 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.

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 its contributions to health systems strengthening and universal health coverage.

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.
Bibliography


Francis Omaswa and Jo Bouford; “Strong Ministries for Strong Health Systems”. www.achest.org


