

**A JOINT LEARNING INITIATIVE:
HUMAN RESOURCES FOR HEALTH AND DEVELOPMENT:**

Leadership Development for Global Health

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THE CONTEXT

There is no doubt that today we are at the cutting edge of scientific and medical advancement. More than ever, we have the knowledge, tools and the resources to promote health, prevent illness and fight disease. Global communication has and will continue to facilitate immediate transmission of vital information. Health is now a powerful political platform and, more than ever, there is recognition that it is central to sustainable economic development (the Commission on Macroeconomics and Health (CMH)).

Despite these facts, each year more than half a million women die from preventable causes during pregnancy and childbirth. This is unacceptable. Health infrastructures in the majority of countries have not been developed, and there are large underserved population groups where priority health needs are unmet. This is unacceptable.

Vitamin deficiencies, malnutrition, infectious diseases and anemia are widespread health issues affecting large portions of the populations of the developing world in spite of food surpluses, available technology and scientific breakthroughs. This also is unacceptable. New challenges of chronic disease, mental health, and accidents and injuries will require action.

In view of the multitude of activities that have already been undertaken, what is it that would make a difference and achieve results? Is it more of the same on a larger scale? Is it looking at problems in a different way? Or is it analyzing the environment in which we find ourselves today in a manner that compels us to come up with a different set of activities altogether? In the end, our work has been driven by these questions, especially the latter.

HUMAN RESOURCES FOR HEALTH SYSTEMS

It is hard to imagine any activity in the health sector that is not somehow dependent on people, but the topic of human resources for health (HRH) has been largely neglected. The Rockefeller Foundation has launched a major global “Joint Learning Initiative (JLI)” to address this gap because:

“Unless we focus on the human component of health systems development, it seems fair to predict that the goals of the global health community such as more equitable access to life saving vaccines and treatments, and the larger scale improvements reflected in the United Nations Millennium Development Goals will not be met.” (JLI, 2003)

*Excerpted from work for the Gates Foundation with their permission

Supported by multiple donors, the JLI project operates through seven working groups with global representation, including multilateral and bilateral donors and foundations. Its work covers the range of HRH concerns: supply (education, training and planning to meet health needs); demand (working conditions, incentives, migration); workforce modeling for priority diseases (HIV/AIDS, TB, injury prevention, tobacco); special HRH challenges for Africa (HIV infected workforce, loss of health professionals, needs for civil service reform, migration, resource constraints); innovation (social entrepreneurship and social franchising, complexity theory and health, business partnerships, leadership); and a coordinating group of working group chairs. The recommendations from the report will raise overall awareness of the central importance of HRH and assist policy makers at national and global level as well as donors to develop more robust HR plans and programs to strengthen the health sector. The work will be completed in mid-2004.

The World Health Organization is working closely with the JLI. In 2000, it was charged by member states (WHA 43/EB 44) to create a human resources development initiative in service of an urgent need to develop sustainable health systems, with special emphasis on developing countries, especially in Africa. A series of papers commissioned by WHO has underlined effective human resource development as fundamental to effective capacity building for health systems. (Milen, 2001, Leppo 2001)

There are enormous unmet needs in the area of human capacity building for health and major initiatives at country level and globally to address the adequacy of numbers, training, location and retention of formal and informal health workers, especially to meet the needs of the developing world to deliver personal and population oriented health services (JLI bibliog., World Health Report, WHO 2000). (See Note 2 at end of paper)

The World Bank has recently acknowledged its failure to address investments in human resources development for health systems, and new leadership in the health and development sector at the Bank is committed to addressing this gap in its loan and grants programs (Dussault, Baudouy, personal communication).

At the request of WHO, Glenngard and Anell (2003) attempted to gather data through literature reviews and direct interviews of key leaders in USAID, World Bank, SIDA, DfID, IHSD, NORAD and DANIDA on the kinds and amounts of donor investment in human resources development for health (HRH) and, within that category, leadership development. Only SIDA was able to identify specific budgets for support of HRH programs, as most are integrated into overall project budgets. It was not possible to break out specific programs on leadership development in this work, and in other literature of international programs, there is little documented evidence of investment in

leadership development for broader health systems effectiveness, and virtually none on leadership for global health (Appendix A2, theme #20).

Their data does show that most donor support is for short term education and training to address shortages and imbalances in technical areas or to staff vertical programs. There is a shift occurring towards more practical education (vs. theoretical) and from donor driven programs to those owned developed and managed by the recipient countries. The Nordic donors are increasingly pooling funds for coordinated investments.

THE NEED FOR LEADERSHIP DEVELOPMENT FOR HEALTH SYSTEMS AND HEALTH

Leadership development should not be supported for its own sake, but because it contributes to the achievement of a goal—in this case, improvements in global health.

There is evidence on specific needs for leadership at country and global level, and there are two additional ways in which leadership development is critical—in addressing the uncertainty involved in delivering technical and policy solutions to improve global health in complex health systems and in leading innovation. The following sections will briefly discuss the important needs for leadership in each area.

Leadership at Country Level

As part of its HRH initiative, WHO commissioned a series of papers and consultations with senior health systems leaders on priority needs for effective and sustainable health systems. The results of an extensive literature review (Leppo et al, July 2001) and broad consultation was the identification of huge gaps between capacity and need for leadership in strategic management and policy development at country level, especially

in developing countries (Leppo, August 2001). The report called on WHO to mount a major initiative to strengthen its own capacity at central, regional and country level to assist countries in these efforts.

A series of articles and reports discuss the need for individuals who possess knowledge and skills commonly associated with leadership in the literature. The CMH calls for the building of country capacity for stewardship, intersectoral action and monitoring of performance (CMH); NEPAD speaks to the same concerns as does the World Development Report 2003. Mills (2001) calls for individuals with the skills to manage change, address organizational cultures, and cope with external constraints. A significant number of experts interviewed for this project called for improved country level leadership for health within all sectors (government, civil society and business) working together to increase the effectiveness of current vertical programs and to strengthen health systems (themes # 4,5,10,14 in Appendix A2).

Individual leadership effectiveness is closely related to the availability of institutional support for their efforts. Because institutions are often weak, the leaders that do exist, especially in developing countries, have great difficulty implementing viable solutions that would make a difference in the health of their population. This is due to a variety of factors, but among those that were considered most crucial by expert advisors are:

1. Rapid turnover of leadership interrupting prior agendas.
2. The failure to create the context surrounding health leaders that would enable them to devise and implement strategies to achieve their goals, including:
 - the lack of access to up-to-date knowledge and technology;

- the lack of capacity to collect and present convincing evidence on the health situation at the national level that would enable them to make the case for resources among competing priorities;
 - donor driven agendas that alter national priorities, are short term, and fail to build sustainable health systems.
3. The lack of sustainable institutional mechanisms that enable potential leaders to draw on the wealth of expertise at the country, regional, or global level, including:
- the lack of alliances with critical groups, e.g., politicians, consumer groups, academia, NGOs, etc.;
 - the lack of understanding of and involvement in issues of a global nature that impact health at the country level, e.g., global financial decisions, treaties, trade, commerce, etc.

These factors have prevented effective, sustained leadership for health that could have contributed significantly to the unfinished global health agenda.

It takes leadership, individual and institutional, to develop the evidence of need; design effective interventions; create effective policies; argue for resources; mobilize the public and political will to act for health; and address inequities globally and within countries. It takes effective leadership to create a vision for an effective health system and to negotiate effectively with donors and funding agencies. It takes effective leadership to coordinate and integrate what may be disparate vertical programs into an effective and flexible health system capable of responding to crisis and meeting basic needs. It is this leadership that can make a difference in country and at a global level.

Leadership at Global Level

A more recent influence on country level health progress is the issue of globalization.

Certain key factors of globalization that influence health are:

- People Flow – travel, migration (forced and voluntary), patient movement, movement of health workers
- Information Flow – ideas/popular culture, commercial health information, health education, scientific/medical evidence
- Technology – information and e-technologies and direct telemedicine links; biomedical and scientific technologies
- Commerce –movements of goods and services, regulatory frameworks (food, drug and blood quality; health care standard setting; intellectual property) and capital markets (including trade policy)
- Environment
- Diseases
- Wars, Violence, and Crime
- Religion and Culture

These have been loosely defined as transnational factors not fully subject to national governmental/political control. Country leaders for health will need to increase their understanding of the role that global factors play as determinants of health in their own country.

The effects of globalization are superimposed on the national factors influencing health. For example, international trade policy affects food safety and availability of pharmaceuticals; a global labor market contributes to migration of key health

professionals from developing countries to the developed. These are all factors outside the exclusive control of nation states. The consequences of decisions made at the global level - especially those related to trade and commerce - very often escape health leaders at global and national level. What is more serious is that ministers of finance and heads of state make decisions in global forums without being aware of their health consequences.

The need for stronger national leadership on global health issues is identified by several authors. It is needed to make country level health systems more effective in the face of global determinants of health (Kaul et al, 1999; Johnson et al, Koop 2000)—to create the ability to take the “outside” into account -- and to ensure that the health effects of global initiatives are clear and that these respond more effectively to country needs (CMH; Chen, 1999; McKee et al, 2001; Mills, 2002).

Kaul (2002) identifies three gaps in public policy making that inhibit the sharing of global public goods—one of these is the “participation gap” where global policy making is essentially intergovernmental but some governments are not represented or, if present, do not have the capacity either to participate fully or follow-up effectively on commitments made due to lack of experience, resources, or power. Rao and Stiglitz both agree on the problems of global governance being dominated by wealthy industrial countries and the equity issues this raises. Mills (2002) calls for a “leveling of the playing field” to create a global partnership based on shared responsibility and mutual interest. Many of those interviewed stressed the importance of better preparation and linkage of leaders in developing countries with global decision-making to put them on a more equal power footing (themes #5, 6, 7, 8, 14 in Appendix A2)

Buse et al (2002) cautions that absent this level playing field, there may be a false policy convergence due to inequities in power of those at the table. He provides a case study of a recent global health debate dominated by a “transnational managerial class” of US consulting firms, multilateral donors, foundations, WHO and private sector interests—a phenomenon he calls “elite pluralism”.

Leadership in Complex Adaptive Systems

Complexity theory (Plsek, 2000) provides insights into the leadership challenges in today’s health systems. Great advances in the development of technical solutions to health problems have emerged from the traditions of science —the idea that further study of systems can lead to deeper understanding and greater predictability of outcomes. We can develop drugs for particular diseases, and we can create protocols, with a high degree of agreement among experts about how they should be delivered (e.g., DOTS). If the protocols are followed and adequate resources provided, we can expect certain outcomes with a high degree of certainty. Yet we see time and again, failure to deliver interventions that have been proved effective. Sometimes the workforce is inadequate, health systems are not robust, or country experts resist change to traditional methods.

There are more complex interventions like delivery of ARV therapies, where, in addition to the problems in the earlier example, uncertainty can be high because the “the parts” of the system—human beings—have the freedom and ability to respond in many different ways and there may be low agreement on the one right way. There are many different models for action —some may work well in one place and fail in another. The solutions to such problems in complex environments with uncontrollable factors and high degrees of uncertainty require creation of the conditions for “self organizing systems” to

move in the desired direction, try the preferred approach, gather data, and adapt. These are situations in which leadership can make a difference. The leadership challenge is developing effective strategies to deal with the uncertainty in these complex adaptive health systems in countries and at global level to create the conditions to deliver better health results.

Leadership for Innovation

Promoting innovation, defined as the introduction of an idea or action into social or economic systems, (Pickstone, 1992) is a fundamental goal of the Foundation's work. Berwick (2001) discusses the science of innovation in three domains—the perception of the innovation; the characteristics of the adaptors; and the context in which the innovation takes place.

While the early innovators are often mavericks, operating outside the system, the individuals central to the change process needed for innovation are the “early adaptors”—the opinion leaders who are well connected, have access to resources/authority and are tolerant of risk. These are the real “leaders” in the spread of innovation because they are watched by the early majority who can tip the momentum of the system in the desired direction. It is important to find and support the early innovator, but it is just as critical to invest in the early adaptors among individuals already in positions of authority and influence to prepare them to mobilize others inside and outside their organization to act for health.

THE MODEL FOR LEADERSHIP DEVELOPMENT

The literature on leadership and approaches to leadership development is voluminous. (For example, a bibliography on collaborative leadership, a currently popular approach, commissioned by the Turning Point Leadership Development National Excellence Collaborative in the United States (2000) identified nearly 300,000 citations on “collaborative leadership in public health”. About 35,000 were reviewed for their project.).

The word “leadership” is attached to programs ranging from short courses in a specific disease or other technical area to graduate degree granting fellowships to mid-career and “in-practice” executive programs. Most programs seem to use the term to imply that anyone who participates in “their” program will, by definition be a leader. To some degree, the prestige, the kinds of exposures outside the person’s experience or “upgrades” in their knowledge and skills from a course or receipt of a degree may put them in a leadership position back in their home environments. However, the actual time spent specific to the leadership development process is highly variable if present at all, and the contribution of the program to participants’ leadership effectiveness is rarely measured.

The public health community in the United States, lead by the Centers for Disease Control and Prevention (CDC), has long supported investments in public health “systems” leadership development in the US through the National Public Health Leadership Institute (NPHLI), now at the University of North Carolina, and internationally through its own Sustainable Management Development Program (SMDP). The Epidemiologic Intelligence Service (EIS) and its international counterpart the Field Epidemiology Training Program (FETP) produce elite technical cadres of leaders for public health. However, a recent evaluation of the FETP program by Battelle (2001) makes the point that “when these programs fail, they almost always fail because of lack

of leadership skills and team building”. In recent years, more content has been added on leadership to the FETP programs adapted to the specific country context (see Note #3 at end of paper).

In the international arena, the Fogarty Center at NIH has a long history in the area of international leadership development for biomedical research, and they have recently extended this work into areas of epidemiology and clinical research. They also emphasize the importance of leadership abilities to fellows’ success when they return to their countries (Koesch, Personal Communication, 2003).

Leadership development is a major focus of the top Fortune 500 companies. Melum (2002) notes that leadership development is big business. In 1993, US companies spent \$17B annually to develop leadership skills in their staff. The health care industry has been slow to invest in leadership—spending about 1.25% of payroll on overall training and leadership development each year compared to 4% in the top 100 companies in 2002.

Chief Executive magazine, in cooperation with Hewitt Associates, (a global human resources firm) annually ranks the top 20 companies for leadership development. Criteria include self reported data gathered by Hewitt from the firms, financial performance data, and the judgment of an external panel of experts from business and academia. Johnson and Johnson, IBM and GE are the top three. Their approaches vary depending on their corporate culture, structure (centralized vs. decentralized), and strategy. But they all emphasize growing their own top leaders and supporting “up and comers”. Most develop their own list of preferred leadership qualities, even definitions of leadership, to match their strategy and culture and train to those. Webster (2003) writes

of companies in the developing world who see leadership as a critical risk factor in global success. She also notes the importance of an organizational culture that supports the use of the techniques learned by leaders.

Calculating the return on investment (ROI) in leadership development is an issue critical to institutions across the public, non-profit and corporate spectrum. Anecdotal information abounds in the business sector, but it has been a challenge for them to develop quantitative measurement tools. Most of the work done on ROI and Benefit/Cost Ratios has looked at different types of training, not specifically called leadership development. The studies done have tended to focus on employee groups (supervisors) whose work can be directly related to financial returns. Phillips (1996) notes studies of supervisor/manager training with ROIs of 400% (B/C of 5:1), 215% (B/C of 3:1) 1400% (B/C of 15:1).

Phillips (1996) has developed the most sophisticated model to date for evaluating ROI. It requires data collection at five levels: participant reaction and plans to use training; demonstrated learning; applied learning on the job; did on the job application produce measurable results; did the monetary value of the returns exceed the cost of the training. He discusses the challenges of gathering good data on each, especially the last item. When financial outcome is less relevant than social outcome, the metrics are even more challenging.

There is no agreed definition of "leadership".(One author cites over 300 different definitions in the literature.) Much of this variation is because of the increasing understanding that leadership occurs in context; and, as noted above, organizations have the flexibility to create their own definition to fit their strategy and culture.

In a meeting at the Foundation in early December, we began to explore the definition of leadership that might best reflect the BMGF's culture and agenda and how to integrate leadership development into existing disease programs (Appendix F).

A paper commissioned for this project from the Office of Public Management (Leadership for Global Health-Appendix G) traces the evolution of thinking in the general literature on leadership theory and practice and its importance to organizational change. Its development is traced from the "Great Man Theory" of the mid 20th century to the more current notions of collaborative leadership, where the challenge is to strengthen and mobilize the leadership potential of all actors within an organization to work with their collaborators outside to achieve a defined goal.

There is, however, an emerging agreement (OPM paper; Packard; bibliographies on leadership by the Leadership Learning Community; Turning Point; the Kellogg Foundation; and business literature) that working with individuals in positions of authority and responsibility will lead to faster results. There is also agreement that the characteristics of effective leadership development programs include:

- programs built around the process of solving the problems faced by individuals (leadership for what?)
- programs sensitive to the environments in which the participants operate
- models involving several short term engagements over a 12-18 month period interspersed with specific commitments to on-site project work
- a cohort model providing the opportunity for peer learning during and after the program
- a team experience/approach

- mentoring and/or technical assistance in longer term programs, especially in highly technical areas or with less experienced professionals
- brief outside exposures, but emphasis on support in the home site (Fogarty, Rockefeller and others offer re-entry grants and stipends to the individuals)
- long term continuity of support through networking, resource sharing and periodic reunions

Virtually all experts interviewed with experience in this area emphasized the need for leadership development built around real problem solving for results (#9 in Appendix A2) and that, in programs seeking health result, the participants must come from multiple sectors and not be limited to health professionals (#10 in Appendix A2).

Taking into consideration the literature, experience and expert advice in the area of leadership development to achieve results most quickly, we recommend an emphasis on “practice based” leadership development for certain key groups of individuals currently in (or likely to be in future) positions of authority and responsibility for achieving better health outcomes at national level and in global organizations. The goal of these programs would be to increase the individual’s effectiveness in their current roles, strengthen their organizations, and prepare them for global health leadership.

The model below, taken from the OPM paper, provides the conceptual framework for such an approach. Individuals enter the program with different personal qualities, knowledge and skills, and experience. Through specific learning modules including structured lectures and discussions with experts, readings, case studies (including technical content as appropriate), study visits and peer learning, they increase their ability to create/articulate a vision for stronger health systems and improved health

results. This vision will guide the formulation of a leadership agenda that is uniquely suited to the environment in which they work. Through strengthening of behavior and judgment, they learn to mobilize others to work for the defined goals, including a focus on the development of leadership capacity within the organization to achieve and sustain the identified outcome. Mentorship and peer learning permit reflection on their work and modification of their strategy and actions.

