The emergence of global attention to health systems strengthening

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After a period of proliferation of disease-specific initiatives, over the past decade and especially since 2005 many organizations involved in global health have come to direct attention and resources to the issue of health systems strengthening. We explore how and why such attention emerged. A qualitative methodology, process-tracing, was used to construct a case history and analyse the factors shaping and inhibiting global political attention for health systems strengthening. We find that the critical factors behind the recent burst of attention include fears among global health actors that health systems problems threaten the achievement of the health-related Millennium Development Goals, concern about the adverse effects of global health initiatives on national health systems, and the realization among global health initiatives that weak health systems present bottlenecks to the achievement of their organizational objectives. While a variety of actors now embrace health systems strengthening, they do not constitute a cohesive policy community. Moreover, the concept of health systems strengthening remains vague and there is a weak evidence base for informing policies and programmes for strengthening health systems. There are several reasons to question the sustainability of the agenda. Among these are the global financial crisis, the history of pendulum swings in global health and the instrumental embrace of the issue by some actors.

Keywords Health systems strengthening, political priority, global health

KEY MESSAGES

- Organizations involved in global health have paid increasing attention to health systems strengthening over the past decade, driven by concerns over slow progress on the health MDGs, and the impact of global health initiatives on health systems.

- There are several reasons to question the sustainability of this attention, including a history of pendulum swings in global health, the global financial crisis, a weak evidence base on solutions and the instrumental embrace of the issue by some organizations.

- Health systems strengthening is predominantly a national issue, but the commitment of global actors is worth monitoring since they influence financing, national priority and policy approaches.

Introduction

In recent years the issue of health systems strengthening (HSS) has emerged on the agendas of many organizations concerned with global health. At their 2008 meeting in Japan, leaders of G8 nations discussed the issue for the first time. The World Health Organization identifies it as one of its top priorities. Bilateral donors claim to have devoted significant resources to HSS. Even global health institutions focused on specific diseases such as the Global Fund to Fight AIDS, Tuberculosis
and Malaria (Global Fund)—organizations one might expect to be wary of this agenda for fear funding may be diverted away from their priority concerns—have opened funding windows for the strengthening of health systems (GAVI 2005; Ooms et al. 2008; Naimoli 2009).

This level of attention among global health organizations is fairly new. From the mid-1990s to mid-2000s many organizations involved in global health focused on disease-specific ventures rather than health systems development. Three of the largest vertical programmes in the history of global health were established in this period: the Global Alliance for Vaccines and Immunizations (GAVI, established in 2000), the Global Fund (2002) and the US President’s Emergency Plan for AIDS Relief (PEPFAR, established in 2003).

This study examines how recent global attention for HSS emerged, and prospects for its continuation. We know attention is present when leaders of organizations express concern about the issue publicly and privately, and back up this concern by allocating resources. In the case of bilateral and multilateral donors, public–private partnerships and private foundations, those resources are predominantly if not exclusively material, in the form of financing. In the case of technical agencies, such as the World Health Organization, those resources are primarily ideational, in the form of policy and technical guidance.

Our focus is on the emergence of attention among organizations operating at the global level, rather than on national policy processes, preferred policy options or implementation barriers. Health systems are national systems, and dynamics within countries are the most critical facets of the issue. However, other studies have examined these national dimensions (Kruk and Freedman 2008; Logie et al. 2008; Coovadia et al. 2009; Atun et al. 2010; Lu et al. 2010; Paim et al. 2011), and there are important reasons for investigating global dynamics as well. Specifically, international organizations and donors influence national health systems by providing financing and policy ideas. In addition, HSS remains contested by some actors within global health organizations as an over-arching strategy for improving health outcomes among the poor, raising questions about the sustainability of attention.

In the sections that follow we present a widely used model of the public policy process to frame our analysis. We then lay out evidence on the emergence of attention. Thereafter we draw on the public policy model to identify factors that have shaped attention. Finally, we consider limits to the attention that has emerged and prospects for sustainability of the agenda among global institutions.

A model of the public policy process

John Kingdon’s streams model of the public policy process is one of the most widely applied in the field of public policy analysis (Kingdon 1984). Kingdon argues that issues emerge on policy agendas when three independent streams—problems, policies and politics—flow together (Kingdon 1984; Shiffman and Ved 2007). Considerable activity may occur in any given stream, but not until they couple is attention likely to appear. Individual policy entrepreneurs play a crucial role by helping to bring the streams together. Although developed to analyse national policy processes, the model is relevant for understanding global policy-making. It identifies how problems come to be perceived as appropriate subjects for public action, how policy alternatives are generated, and how external political factors shape agenda-setting—all dynamics present at the global level.

The problems stream is the flow of broad conditions facing societies, some of which become identified as problems that require public attention (Kingdon 1984). A condition is a situation in society, but a problem is a condition that commands attention and comes to be perceived as an issue for which organized action is possible and appropriate. This distinction is critical (Stone 1989). There are hundreds of conditions floating around in society, from HIV/AIDS to violence against women, many causing serious harm. Only a handful receive major attention and come to be labelled as problems. Kingdon identifies three elements within this stream that influence officials to pay attention to particular issues and therefore increase the likelihood that conditions will come to be perceived as problems. Feedback on the operation of existing programmes serves to alert policy makers to performance deficiencies. Indicators provide evidence of the magnitude of and change in severity of a condition, making the issue salient to policy makers. Focusing events, such as disasters, crises and forums, give a condition public visibility.

The policy stream produces the set of alternatives proposed to address problems (Kingdon 1984). The primary actors in this stream are policy communities, groups of experts who spend time and resources developing solutions to problems in particular issue areas. They include academics, career bureaucrats and donor officials, among others, who are connected by their shared interest in a particular problem. They advance ideas through various forums, including seminars and journal articles. Kingdon notes that rarely are policy ideas entirely novel; rather, new policy alternatives are almost always combinations of old ideas.

Finally, there is a political stream (Kingdon 1984). The political stream consists of elements such as national elections, social protests and international political developments—large-scale happenings that arise largely independently of developments surrounding problems and policies. While researchers and others in the policy stream are relatively hidden, actors in the political stream are publicly visible. They include prime ministers, political parties, parliamentarians, UN agency heads and the leaders of large advocacy organizations, among others.

In sum, issues are most likely to emerge on policy agendas when they have acquired status as problems, policy communities have generated consensus on workable solutions and political windows have opened, creating opportunities for policy entrepreneurs to link the three streams.

Methods

We used three kinds of sources to conduct our study: internal documents from organizations involved in global health, published studies on HSS and interviews with senior officials from various global health organizations. We reviewed and analysed approximately 150 documents in total. Approximately 100 were...
internal documents from a number of organizations involved in
HSS, including bilateral donors, multilateral donors, private
foundations, public–private foundations and United Nations
agencies. Also, we conducted a search of published scholarship
on HSS, reviewing and analysing approximately 50 works
referenced in Medline and other databases.

In addition, we conducted 20 in-depth semi-structured
interviews with senior officials from a number of organiza-
tions involved in HSS: the Global Fund, GAVI, the Joint United
Nations Programme on HIV/AIDS (UNAIDS), the Norwegian
Agency for Development Cooperation, the Government of
Japan, several departments of the World Health Organization
(WHO), the World Bank, the Doris Duke Foundation, the
Rockefeller Foundation, Harvard University, Johns Hopkins
University, the London School of Hygiene and Tropical
Medicine and the Center for Global Development. These
interviews lasted between 45 and 90 minutes. We identified
respondents through consultation of peer-reviewed literature
and snowball sampling, with the aim of reaching many of the
most senior officials directing efforts in HSS at key institutions
involved in global health. We asked some common questions of
each respondent, such as his or her perception of the level of
attention HSS is receiving globally. However, we did not employ
a uniform survey instrument since our aim was to elicit the
unique knowledge that each respondent held. We informed
respondents that the interviews were confidential and anonym-
ous, but that we may use some of their statements in the report
in ways that would not reveal the original source. With the
consent of respondents we recorded all interviews, and then
had them transcribed.

We chose a case study design because of the need to examine
underlying processes shaping the emergence of attention to
HSS. The case study approach is better suited than other
research methodologies, such as a structured survey or quan-
titative analysis, to achieve this objective (Yin 1994). This is
true because the defining feature of the case study is that it
considers a phenomenon in its real-life context.

Once we had collected the internal documents, published
studies and interview transcripts, we went through each,
triangulating among multiple sources of information in order
to minimize bias and assess patterns of causality. In particular,
we checked information from respondents against published
works, as interviewees in some instances did not remember
accurately the timing of events. We developed a timeline of
the history of attention to HSS, and grouped together evidence
on the effects of various factors in order to evaluate evidence on
their causal impact. We shared the draft with several external
reviewers who have familiarity with the history of HSS in
global health, including several in organizations involved in
HSS, in order to check for accuracy of the history and the
causal accounts, and incorporated their feedback into the
document.

Results

Evidence of attention

A number of major actors involved in global health currently
are engaged in HSS (Table 1), including the World Health
Organization, the World Bank, the G8, and several global health
initiatives and private foundations. Many have come to pay
attention to the issue only in the past few years.

World Health Organization (WHO)

WHO attention to the issue has grown over the past decade.
The 2000 World Health Report focused on health systems
performance and was a catalyst for global debate on that issue
(Interview no. 8 (I-8); Navarro 2000; Almeida et al. 2001;
Murray and Frenk 2001; Musgrove 2003). In 2005 the WHO
hosted the Montreux Challenge, a meeting to develop a shared
framework for HSS (WHO 2005b). The Global Health Systems
Action Network, a platform to share ideas and practices for
HSS, emerged from this meeting. The WHO—with funding
from the Italian government, the hosts of the 2009 G8 summit—
also convened meetings to find ways to exploit the
complementarities between global health initiatives and HSS
(WHO 2008a). HSS also has been the focus of several WHO
regional ministerial summits. Member states of the WHO
European Region drafted the Tallinn Charter on Health
Systems in June 2008, and African member states made a
similar declaration in Ouagadougou, Burkina Faso in April that
year.

The WHO has promoted a framework with the aim of
creating a common understanding of HSS. The WHO regards
the health system as the collection of organizations and actors
whose main intent is to promote, restore and maintain health.
There are six building blocks in its framework: service delivery,
a well-performing health workforce, good health information
system, access to medical products and technologies, financing,
and leadership and governance to ensure and monitor per-
formance (WHO 2007). Global health actors including PEPFAR,
GAVI and the Global Fund have adopted this definition (WHO
2008a).

In addition, the WHO and other actors have promoted both
primary health care and universal coverage as anchoring ideas
for HSS (Walley et al. 2008; Garrett et al. 2009). Responding to
member state concerns during her candidacy for the post, WHO
Director-General Margaret Chan used the idea of primary
health care to bring coherence to organizational priorities, and
made it the theme of the 2008 World Health Report (I-13; WHO
2008b). The 62nd World Health Assembly passed a resolution
in 2009 on ‘Primary Health Care, Including Health Systems
Strengthening’ (Resolution WHA62.12). The idea of primary
health care had been brewing for several years, especially in
the Americas region of the WHO, which had great influence on its
renewed rise to prominence (I-13). Universal coverage was the
focus of the 2010 World Health Report.

The World Bank and the Health Systems Funding Platform

The World Bank also has been a purveyor of ideas for HSS
through its Flagship Program on Health Sector Reform and
Sustainable Financing. Since its inception in 1997, the Flagship
Program has trained approximately 20 000 individuals on
improving health system performance (Shaw and Samaha
2008). The content of the course is based on a framework
developed by Roberts and colleagues, published in Getting
Health Reform Right: A Guide to Performance and Equity (Roberts et
al. 2008). More recently, the Bank has prioritized HSS in its
revised Health, Nutrition and Population strategy and has taken.
on a large role in mobilizing resources for HSS (World Bank 2007). The Bank cites HSS as one of its comparative advantages and has outlined a 5-year action plan for increasing synergies between HSS and priority disease interventions. The Bank also has collaborated with the WHO in developing a toolkit for assessing HSS (WHO 2010).

In addition, the World Bank has partnered with GAVI and the Global Fund in the Health Systems Funding Platform, a mechanism intended to increase co-ordination and streamlining of international resources for national health programmes. The Funding Platform was initiated in 2009 on the recommendation of the Task Force on Innovative Financing for Health Systems, an element of the International Health Partnership (IHP+). Former British Prime Minister Gordon Brown was one of the initiators of the IHP+, whose aim has been to enhance donor co-ordination for the Millennium Development Goals (MDGs) (1-13; IHP 2008; Hill et al. 2011).

The G8

Leaders of the G8 nations also have taken up the HSS issue. Prompted primarily by the host government, they discussed HSS for the first time at their annual summit in 2008 in Toyako, Japan, where they endorsed a Framework for Action on Global Health with health systems as the core priority (Reich and Takemi 2009). Keizo Takemi, Senior Vice Minister for Health, Labor and Welfare at the time, was a key domestic political champion, meeting with the Japanese Prime Minister and the Ministers of Finance, Foreign Affairs and Health to encourage them to make health systems a priority at the summit (1-11). He was also instrumental in the launching of the Working Group on Challenges in Global Health, which helped to develop the Framework for Action adopted at the 2008 summit. The Italians, the host of the 2009 G8 summit, also included the issue on the agenda, and funded the WHO-directed initiative to build positive synergies between global health initiatives and HSS. Maternal and child health was the primary health issue at the 2010 G8 summit; however, HSS was prominently identified as necessary for achieving progress.

Private foundations

Among private foundations, the Rockefeller Foundation has offered considerable support for HSS. In 2002, the Foundation launched the Joint Learning Initiative on Human Resources for Health. This initiative was instrumental in bringing attention to the health worker crisis (Chen et al. 2004; Narasimhan et al. 2004). In 2008 the Foundation also launched programmes on private sector health, eHealth and health sector capacity building (Lagomarsino et al. 2009; Rockefeller Foundation 2008, 2010). The Foundation further developed these programmes into a Transforming Health Systems Initiative in 2009 that promoted health systems research and universal health coverage (Rockefeller Foundation 2011). The Doris Duke Foundation has also supported HSS, launching a US$100 million African Health Initiative in 2007 (1-7).

Global health initiatives

Three major global health initiatives—GAVI, the Global Fund and PEPFAR—have launched funding windows for HSS (Table 2). Between 2007 and 2010, GAVI approved US$568 million and disbursed US$315 million for HSS programmes in 53 countries (GAVI 2011). Funding allocations for HSS reached a maximum of US$137 million in 2008, representing 23% of total GAVI disbursements for that year. The Global Fund launched a separate window for HSS in 2005. It has disbursed

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**Table 1** Evidence of recent attention to health systems strengthening (HSS) from several organizations involved in global health

<table>
<thead>
<tr>
<th>Organization</th>
<th>Primary form of resources</th>
<th>Evidence of attention</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization</td>
<td>Policy guidance</td>
<td>Recent World Health Reports focus on health systems</td>
</tr>
<tr>
<td></td>
<td>Technical advice</td>
<td>World Health Assembly passes 2009 resolution on HSS</td>
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<tr>
<td>G8</td>
<td>Declarations of national commitment</td>
<td>WHO develops six building block framework for HSS</td>
</tr>
<tr>
<td>World Bank</td>
<td>Financial</td>
<td>HSS a major theme of 2008 summit</td>
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<tr>
<td></td>
<td>Policy guidance</td>
<td>HSS considered at 2009 and 2010 summits</td>
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<td></td>
<td>Training</td>
<td>Participation in Health Systems Funding Platform</td>
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<tr>
<td>Global Fund</td>
<td>Financial</td>
<td>US$170 million approved, US$83 million disbursed for HSS since 2005</td>
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<td>Participation in Health Systems Funding Platform</td>
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<tr>
<td>GAVI</td>
<td>Financial</td>
<td>US$568 million approved, US$315 million disbursed for HSS from 2007 to 2010</td>
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<td></td>
<td></td>
<td>Participation in Health Systems Funding Platform</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Financial</td>
<td>US$520 approved for HSS programmes in 2009 and 2010</td>
</tr>
<tr>
<td>Rockefeller Foundation</td>
<td>Financial</td>
<td>Initiative on Human Resources for Health launched in 2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transforming Health Systems Initiative launched in 2009 with an initial US$100 million funding commitment</td>
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US$83 million of US$170 million in approved funding for HSS, although this represents less than 5% of total disbursements. PEPFAR approved US$20 million for HSS programmes between 2009 and 2010. In 2009, the Obama administration reorganized its global health programmes, launching the Global Health Initiative with an emphasis on improving health outcomes through HSS. PEPFAR was selected as the flagship programme for the initiative and has since developed a strategic framework tool using the WHO’s building block model as a template.

Drivers of attention

Factors shaping the rise of attention to HSS correspond to dynamics in Kingdon’s three streams. In the problems stream, facilitating factors include emerging evidence of a health workforce crisis, global health initiative concerns that weak health systems have hampered achievement of organizational objectives, and growing criticism of the adverse effects of these initiatives on health systems. In the policy stream, factors include a legacy of attention to horizontal strategies in the health sector and the emergence of a health systems policy community: both of these developments have spurred the creation of policy alternatives. In the politics stream, factors include slow progress on the health-related MDGs, and donor moves toward aid co-ordination, a thrust in line with the HSS strategy.

Problems stream: identification of a health workforce crisis

One factor contributing to attention for HSS was an influential report on a health workforce crisis in low-income countries. As noted above, in 2002 a Joint Learning Initiative on Human Resources for Health was launched with support from the Rockefeller Foundation. The initiative published its findings in a 2004 report. The report estimated the global shortage of health workers at 4 million, noting that the Sub-Saharan Africa region had only 3% of the world’s health workers while carrying 25% of the world’s disease burden (Joint Learning Initiative 2004). The report influenced the adoption of a series of World Health Assembly resolutions on the impact of health worker migration on health systems (Resolutions WHA57.19 and WHA58.17) and the need for scaling up health workforce productivity (Resolution WHA39.23). The health worker crisis was the topic of the 2006 World Health Report (WHO 2006). A key outcome of the Joint Learning Initiative was the creation of the Global Health Workforce Alliance in 2006 as a common platform for accelerating action to address the crisis (Chen et al. 2004; Omaswa 2008). The Alliance convened the first Global Forum on Human Resources for Health in February 2008, where a Global Action Plan for Human Resources for Health was launched.

Problems stream: problematic relationships between global health initiatives and health systems

Problems connected to global health initiatives also have shaped attention. These initiatives have embraced the issue of HSS for two reasons (I-6; I-9; I-10). First, they came to believe that weak health systems presented bottlenecks to achieving their own organizational objectives, such as the uptake of anti-retroviral drugs for HIV/AIDS and the expansion of child immunization. Secondly, they were sensitive to criticism on possible adverse effects of global health initiatives on health systems.

The GAVI board commissioned a series of studies in 2003 and 2004 to investigate ways in which it could improve the impact of its immunization programmes (McKinsey and Company 2003; GAVI 2004; GAVI 2005). The studies concluded that financial and human resource weaknesses were hampering immunization coverage (GAVI 2004). They recommended that GAVI expand its mandate to include HSS to improve coverage rates (McKinsey and Company 2003; GAVI 2005). The Global Fund also faced calls to address the health workforce crisis (Dräger et al. 2006; Ooms et al. 2007). Ooms and colleagues noted that ignoring the crisis could lead to a ‘medicines without doctors’ situation in countries supported by the Fund. The Global Fund followed GAVI’s lead and launched a separate window for HSS in 2005. It removed that option in subsequent rounds because of the poor quality of the proposals (I-9), but in 2007 resumed HSS funding (Ooms et al. 2008).

Concern also emerged that global health initiatives were affecting health systems adversely. Global health analysts argued that global health initiatives were contributing to the fragmentation of health systems, distorting national health priorities and placing undue reporting and co-ordination burdens on the governments of low income countries (Msuya 2004; High-Level Forum on the Health Millennium Development Goals 2005). Critics warned that these initiatives were creating ‘islands of excellence in seas of under provision’ (Buse and Waxman 2001, p. 750). Some critics went so far as to call for the Global Fund to Fight AIDS, Tuberculosis and Malaria to be replaced with a global fund for health (I-9; I-10; Ooms et al. 2008).

Leaders in developing countries were also concerned that global health initiatives and donors were harming health systems and distorting priorities (I-1; I-6; I-7; I-9). Brugha and colleagues report the comments of one official on burdensome reporting requirements:

“We spent 7 months last year on the Global Fund, 8 months on the Clinton Foundation, and 3 months on MAP… it is not surprising we talk of capacity shortfall.”

( Brugha et al. 2004, p. 98)
The Rwanda government, commenting on donor priorities, noted ‘a gross misallocation of resources’ in the health sector, stating that ‘the main problem is the development partners’ (Republic of Rwanda 2006, p.8).

At both GAVI and the Global Fund, the decision to invest in HSS has been controversial (I-1; I-6; I-10; Hill et al. 2011). Some GAVI board members wonder what HSS means in practice and how results can be tracked (I-6; Naimoli 2009). A major debate for the board of the Global Fund was whether to establish a separate tranche for HSS or instead integrate this with the three diseases (I-10). The deeper tension in both organizations has been whether supporting HSS alters their basic missions. As one Global Fund official puts it:

“There was a fear that a separate window was modifying the mandate of the Fund...a big hole that could swallow nearly all the resources of the Fund that were destined...to actually be for HIV, TB and malaria.” (I-10)

And a GAVI official says:

“It’s still controversial whether GAVI itself should be involved with health system strengthening. I think there are various board members that question that maybe we have overstepped the mark and health system strengthening should be left [for] the World Bank or other regional investment banks or domestic resources should be used for that.” (I-6)

Policy stream: legacy of attention to strengthening health sectors

In the policy stream, historical legacy influenced attention. Global health actors have promoted a horizontally-oriented approach to health sector development at several points over the past four decades, making the strategy of HSS more a re-combination of old ideas (in line with Kingdon’s analysis of how policy ideas emerge) than a new approach for addressing health problems.

The primary health care movement, launched in 1978 at Alma Ata, sought to build health systems with the aim of achieving health for all by 2000 (WHO and UNICEF 1978). The movement was plagued from the outset by debates about the practicality of this goal (Rifkin and Walt 1986; Cueto 2004), but over time various organizations involved in global health became convinced that some level of investment was required to address health problems.

Another wave of horizontalism emerged with the World Bank’s entry into health in 1980. During this period, neoliberal macroeconomic policies dominated global development policy, pushing many developing countries toward structural adjustment programmes and health sector reforms (World Bank 1993). The World Bank also proposed a different way of conducting donor–government business in health at the country-level, advocating for a sector-wide approach (SWAp) (Peters and Chao 1998). The emphasis in SWAp, at least in theory, was on local ownership and partnership between the government and donors, and the holistic development of the health sector rather than numerous, independent projects (Cassels and Janovsky 1998).

By the mid-1990s, another vertical wave emerged with the proliferation of initiatives and public–private partnerships dedicated to addressing specific health problems in the developing world. GAVI, the Global Fund and PEPFAR—three of the largest such initiatives—appeared during this period. This trend was due in part to the emergence of a major new funder for global health—the Gates Foundation—which emphasized a technologically driven approach to health development and provided billions of dollars of funding for disease-specific initiatives. The HSS idea emerged in part in reaction to this latest vertical wave, and represented the third post-World War Two appearance of a horizontal strategy among organizations involved in global health.

Policy stream: influence of a health systems research policy community

The growth of a policy community of health systems researchers also influenced attention by making available policy options. This community has had difficulty coalescing (I-1; I-2; I-3; I-14; I-15); however in recent years networks of researchers such as the Alliance for Health Policy and Systems Research based at the WHO have played important roles in pushing global health actors to see HSS as a necessary means for improving health outcomes (Alliance for Health Policy and Systems Research 2004; Bennett et al. 2008). Ministerial forums on health research were held in Mexico and Mali, both calling for a significant increase in research on health systems. More recently, the WHO convened the first global symposium on health systems research in Montreux in 2010 to facilitate knowledge sharing. This led to three articles in PLOS Medicine by health policy and systems researchers outlining a research agenda for the field (Bennett et al. 2011; Gilson et al. 2011; Sheikh et al. 2011).

Political stream: pressure to achieve the MDGs

In addition to developments in the problems and policy streams directly concerning HSS, several larger forces in the political stream influenced attention. Most importantly, in 2001 the world’s nation-states unanimously approved the Millennium Development Goals, a set of development objectives with a 2015 target date. The MDGs have become the dominant global framework for development and have shaped national policy priorities (Fukuda-Parr and Hulme 2011). A number of organizations involved in global health became convinced that some of the MDGs could not be achieved without stronger systems.

Three goals—4, 5 and 6 on child survival, maternal survival and infectious diseases, respectively—are health-related. By 2005 global development actors were expressing growing concern that poor countries, particularly in Sub-Saharan Africa, were not on track to meet these health-related goals (Wagstaff and Claeson 2004; Fay et al. 2005; WHO 2005a; Countdown Coverage Writing Group 2008). One respondent, connecting this outcome to HSS, speculated on why progress was slow:

“Targets are wonderful but...why are we not making it? We can in principal stop everybody who is suffering from HIV/AIDS of dying because we have anti-retroviral treatment. Where is it? ...It cannot get there because the whole
logistical system, procurement system, etc. is not there to guarantee that it’s getting where it should be.” (I-9)

Several studies, including one from the WHO (WHO 2005a), also attributed slow progress to poorly functioning health systems (High-Level Forum on the Health Millennium Development Goals 2004; Task Force on Health Systems Research 2004; Travis et al. 2004). Travis and colleagues argued that actors had embraced a suspect premise, noting that the ‘drive to produce results for the MDGs led many stakeholders to focus on their disease priority first, with an implicit assumption that through the implementation of specific interventions the system will be strengthened more generally’ (Travis et al. 2004, p. 900). The Health Systems Funding platform, mentioned above, emerged as a direct result of concern over slow progress on the health MDGs. The platform essentially sought to reverse the causal arrow: strengthen health systems; then the MDG health objectives might be reached.

**Political stream: Paris Declaration emphasizes horizontal solutions**

Aside from the MDGs, another external influence on the agenda was growing concern by donors in the early 2000s over fragmentation in the provision of aid, leading in 2005 to the Paris Declaration (High Level Forum 2005). Endorsed by major bilateral and multilateral donors, UN agencies, national governments and other institutions, it included pledges to harmonize donor aid and to align aid with national government priorities, thrusts in line with the holistic approach of the HSS agenda. The Health Systems Funding Platform specifically invokes the Paris Declaration as a foundation for action.1

**The coupling of streams**

In the Kingdon model an issue emerges on a policy agenda when the problems, policy and politics streams couple, a process facilitated by policy entrepreneurs. Developed based on evidence from the United States, the model examines a limited number of venues where agenda-setting takes place, with a special emphasis on the United States Congress.

The coupling process was more complicated in the case of global attention to HSS. The G8, the World Health Organization, the World Bank and the various private foundations and public–private partnerships represent separate venues. The same basic elements in the Kingdon model shaped attention in each: political developments (especially pressure to achieve the MDGs); policy dynamics (including existent horizontally-oriented strategies that the organizations could draw on); problems (slow progress in achieving organizational objectives); and policy entrepreneurs helping to bring these streams together (for instance Keizo Takemi in the case of the G8). However, the specifics of the coupling process varied by organization.

**Limits to attention**

While organizations involved in global health have augmented attention to HSS over the past decade, difficulties in the policy, problems and politics streams raise questions about the sustainability of their commitment.

**Politics stream: the global financial crisis, pendulum swings and aggregate funding levels**

The present global financial crisis places constraints on donors. Commitments for HSS have been lower than expected (Glassman and Savedoff 2011; Hill et al. 2011), and debt reduction negotiations in the United States pose a threat to funding from the Obama administration’s Global Health Initiative. In addition, long-standing pendulum swings in the priorities of organizations involved in global health, moving from vertical to horizontal approaches and back again, raise the question of whether the most recent wave of attention truly has altered historical patterns of instability in the agenda status of global health issues. Moreover, despite donor rhetoric surrounding the importance of the issue, aggregate donor funding for HSS has not grown rapidly in recent years (Figure 1).2 From 2004 to 2009, commitments for HSS grew at an average annual rate of 7.1%, considerably slower than that for total health and population funding (13.1%) and only slightly exceeding the rate of increase for all donor aid (6.2%). As a percentage of total funding for health and population, HSS funding declined markedly from 1998 to 2009, from 63.5% to 27.6%, as HIV/AIDS and other infectious diseases grew to receive more than half of all commitments.

**Policy stream: lack of solutions and policy community fragmentation**


**Figure 1** Health and population funding commitments for all donors by issue. Notes: Columns show the total commitments for each issue in billions of constant US dollars, 2009 base year. The trend line shows the percentage of total health and population funding commitments directed toward health systems strengthening (HSS).
“The level of understanding, the sophistication of the evidence, the strength of the measures, and the credibility of strategies and interventions to strengthen health systems remain at a very primitive state and it’s frustrating that we’re not advancing more quickly on these fronts…”

Several factors may stand behind this state of affairs. One is that research on health systems has been chronically under-funded (1-9; 1-5; Bennett et al. 2008). Travis and colleagues note that health systems research has an ‘image problem’ and is perceived to be ‘fluffy, pedestrian and applied’, in contrast to other research areas such as drug discovery which are viewed as prestigious and science-driven (Travis et al. 2004). Another is that HSS inherently involves managing complex relationships among multiple moving and inter-related elements—governance, finance, human resources and information management to name a few—and solutions depend on context. In addition, the policy community has had trouble coalescing into a tight grouping with a shared identity that could facilitate collective action to promote attention and research on the issue (1-1; 1-2; 1-3; 1-14; 1-15). Actors concerned with HSS acknowledge this situation:

“I think it’s very fragmented, scattered…I don’t feel that I have a community to which I belong.” (I-1)

“I wouldn’t say they identify themselves as a tribe…one of the things we tried to do was strengthen the sense of community amongst health systems researchers because it’s a very heterogeneous group and the strong feeling was they needed to self-identify under a more common umbrella.” (I-14)

Problems stream: definitional issues
A consequence of the fragmented nature of the policy community is the lack of consensus on what HSS entails and what indicators should be used to measure progress and generate evidence for future programming (WHO Maximizing Positive Synergies Collaborative Group 2009; Fryatt et al. 2010; Shakarishvili et al. 2010). Moreover, definitional issues hamper implementation and assessment. There is much variation in the HSS activities pursued by the different actors (Biesma et al. 2009; WHO Maximizing Positive Synergies Collaborative Group 2009), leading to the risk that HSS is becoming a catch-all phrase to be used instrumentally in advancing pre-existing organizational goals. On the other hand, the lack of clarity surrounding the concept may have helped in one sense: bringing together multiple constituencies. As one respondent puts it:

“I am not sure clarity of ideas…is either a necessary or even sufficient notion for mobilization… it may even be…that you need the concept to be fuzzy in order to generate and mobilize support.” (I-4)

Conclusions
This paper has analysed how, why and the extent to which over the past decade the issue of health systems strengthening has emerged on the agendas of organizations involved in global health. Attention has increased, and developments in the problems, policy and political streams explain this emergence. Among the most influential factors:

- in the problems stream, concerns that global health initiatives are harming health systems, and that without stronger health systems these initiatives may not achieve their organizational objectives;
- in the policy stream, the availability of alternatives generated by HSS policy communities; and
- in the political stream, worries surrounding slow progress on the health-related MDGs.

The level of attention should not be over-stated. While some organizations have augmented funding for HSS, aggregate donor commitments do not match the rhetoric surrounding the issue. Also, the HSS policy community has yet to emerge as a potent political force pushing attention for the issue, and the evidence base on what works for HSS is weak. An additional issue is that commitment to the issue by some, if not all, of the actors within global health initiatives is instrumental: a concern for achieving organizational objectives, rather than a deeply held belief that HSS is an optimal strategy for achieving health outcomes for the poor.

Health systems reside in nation-states, and prospects for the agenda will ultimately be determined by country-level dynamics. However, the global actors we have analysed in this study influence national agendas, control considerable financing and are sources of policy ideas. As such, their behaviour is worth monitoring, as their future decisions concerning organizational priorities will shape the agenda’s future.

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Conflict of interest
We declare that we have no conflict of interest.

Endnotes
1 See Health Systems Funding Platform website, online at: http://go.worldbank.org/0D4C6GPQU0, accessed 2 September 2011.
2 These data are from the credit reporting system database of the Organization for Economic and Cooperation and Development, which reports official development assistance from the world’s leading multilateral and bilateral donors. We divided all health and population funding into four historically prominent categories: health systems strengthening, infectious disease control, population and reproductive health, and HIV/AIDS. 2009 is the latest year for which comprehensive data are available.


