

What will it take to improve prevention of chronic diseases in Australia? A case study of two national approaches

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Abstract

Objective. Despite being a healthy country by international standards, Australia has a growing and serious burden from chronic diseases. There have been several national efforts to tackle this problem, but despite some important advances much more needs to be done. From the viewpoint of diverse stakeholders, the present study examined two approaches to controlling chronic disease in Australia: (1) the 2005 National Chronic Disease Strategy (NCDS); and (2) the 2008 National Partnership Agreement on Preventive Health (NPAPH).

Methods. Individual and small group semistructured interviews were undertaken with 29 leaders across Australia, reflecting a diverse cross-section of senior public health managers and program implementation staff from state and territory health departments, as well as academics, thought leaders and public health advocates. A grounded theory approach was used to generate themes relevant to the research.

Results. There is general support for national approaches to the prevention of chronic disease. The NCDS was viewed as necessary and useful for national coordination, setting a common agenda and serving as an anchor to align jurisdictional priorities and action. However, without funding or other infrastructure commitments or implementation plans, any expectations as to what could be meaningfully achieved were limited. In contrast, although jurisdictions welcomed the NPAPH, its associated funding and the opportunity to tailor strategy to their unique needs and populations, there were calls for greater national leadership as well as guidance on the evidence base to inform decision making. Key aspects of successful national action were strong Australian Government leadership and coordination, setting a common agenda, national alignment on priorities, evidence-informed implementation strategies, partnerships within and across governments, as well as with other sectors, and funding and infrastructure to support implementation.

Conclusions. Both the NCDS and NPAPH were seen to have overlapping strengths and weaknesses. A key need identified was for future approaches to focus on generating more sustainable, system-wide change.

What is known about the topic? Despite some important advances, chronic diseases remain Australia's greatest health challenge. In efforts to tackle this increasing burden from chronic diseases, several large-scale, national initiatives have been released in Australia over recent years, including the 2005 NCDS and the 2008 NPAPH.

What does this paper add? From the viewpoint of practitioners, policy makers, advocates, researchers and public health thought leaders, this paper examines the usefulness and significance of the NCDS and NPAPH as national initiatives for achieving improvements to the prevention of chronic disease.

What are the implications for practitioners? By better understanding how previous countrywide chronic disease initiatives were viewed and used at national, state and local levels, this research is well placed to inform current, planned and future large-scale, population-level health initiatives.

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Introduction

Australia is, by international standards, a very healthy country.¹ But this status is increasingly at risk from the growing epidemic of chronic diseases that affect almost half of all Australians² and are responsible for 85% of the total burden of disease.³

In efforts to control the increasing burden of chronic diseases, including heart disease, stroke and heart failure, chronic kidney disease, lung disease and Type 2 diabetes, the Australian Government has over the past decade released several strategies, including the Australian Better Health Initiative,⁴ Type 2 Diabetes Initiative⁵ and the National Healthcare Agreement,⁶ all of which fundamentally aimed to improve health outcomes and reduce pressure on the Australian health system. Several strategies specifically focusing on prevention were also released over this period, including, but not limited to, Eat Well Australia (EWA): An Agenda for Public Health Nutrition 2000–2010,⁷ National Tobacco Strategy 2004–2009: The Strategy,⁸ Be Active Australia: A Framework for Health Sector Action for Physical Activity 2005–2010⁹ and Healthy Weight 2008 – Australia's Future: The National Action Agenda for Children and Young People and Their Families.¹⁰ Importantly, across this period two large-scale national initiatives, the National Chronic Disease Strategy (NCDS)¹¹ and the National Partnership Agreement on Preventive Health (NPAPH),¹² were also released, both with overarching, country-wide approaches to addressing chronic disease.

The current landscape of national preventive health strategy and action looks comparatively bare compared with previous years. Arguably, the NCDS has lost currency and programs made possible through the NPAPH have lost momentum or ceased following its cancellation in 2014. However, chronic diseases remain Australia's greatest health challenge.¹³ As such, the current Australian Government is embarking on a new national strategy for chronic diseases.¹⁴

To ensure current, planned and future population preventive health initiatives, including the new national strategy, are informed by past experiences, it is important to better understand how the previous NCDS was used, whether it was relevant and whether it informed governments across Australia. In addition, it is important to consider how the NCDS and the NPAPH may have worked together as two different but complementary approaches to chronic disease prevention.

By analysing the NCDS and the NPAPH as a case study of national approaches to driving the preventive health agenda in Australia, the purpose of the present study was to explore the views of practitioners, policy makers, advocates, thought leaders and researchers with regard to: (1) the significance of the 2005 NCDS and its potential for achieving improvements to the prevention of chronic disease; (2) the approach to future national chronic disease strategies; and (3) the significance of the NPAPH and its potential for achieving improvements to the prevention of chronic disease.

Methods

Data collection consisted of individual and small group semi-structured interviews undertaken by an independent consultant recruited to minimise potential bias due to existing professional relationships between the research team and respondents.

Published standards for designing, undertaking and reporting qualitative research guided the methods and reporting of the research, including elements such as who the research team were, what the context of the study was, how participants were recruited, the use of a discussion guide and the reporting of quotations in the results.¹⁵

Participants were recruited using a combination of purposive and snowballing sampling techniques, whereby invitees were individually identified by the research team on the basis of their likely ability to provide an informed contribution to the study, or to nominate other suitable candidates from their organisation. Participants included senior public health managers and program implementation staff from state and territory health departments senior academics; as well as thought leaders and public health advocates from key agencies across the country.

In all, 33 individuals were invited to participate through a personally addressed email from the Director of the Australian Prevention Partnership Centre (<http://www.preventioncentre.org.au>, accessed 5 January 2016), a national centre investigating approaches to building an effective, efficient and equitable system for the prevention of lifestyle-related chronic disease. The email invitation was followed-up by the research team. To ensure the study captured informed perspectives, all respondents needed to have relevant experience of at least 2 years. Further, all respondents were ≥ 18 years of age and provided informed verbal consent for both their participation in the research and for the recording of the interviews before participation. Interviews were undertaken between June and August 2015 and, where possible, were conducted face to face and audio recorded.

Interviews were supported by a semistructured discussion guide, developed to elicit views across three broad themes: (1) perceptions on the 2005 NCDS, in particular its significance to the prevention of chronic disease; (2) views on future national strategies; and (3) perceptions on the NPAPH and its significance for achieving improvements to the prevention of chronic disease. The discussion guide was developed initially by the research team and then revised following feedback from a Project Steering Committee, academics, practitioners and policy makers with extensive awareness of and experience in Australia's chronic disease prevention environment.

Consistent with a grounded theory approach responses were anonymised and reviewed by the research team, and analysis of the text undertaken to generate themes and subthemes. The research was reviewed and approved by the Sax Institute low-risk research assessment committee (R2015/05/03).

Results

In all, 29 individuals participated in the research. This included 17 people who were sent the invitation email and 12 others who responded in place of the original invitee or else alongside the original invitee. Interviews were approximately 1 h in duration and were conducted face to face and by telephone. All eight of Australia's state or territory health jurisdictions participated in the research, along with an additional 10 individuals (four researchers and six advocates or thought leaders).

National Chronic Disease Strategy

Endorsed by Australian Health Ministers in 2005, the NCDS provided high-level policy guidance for action at every level of government and all parts of the healthcare system for the prevention and management of chronic disease. Based on overarching best-practice approaches that recognised the importance of prevention and integrated care, the document identified key guiding principles and identified four action areas: prevention across the continuum; early detection and early treatment; integration and continuity of prevention and care; and self-management. Five disease-specific National Service Improvement Frameworks (NSIFs) were also produced to accompany the Strategy. For both the Strategy and the NSIFs, implementation was the responsibility of each jurisdiction according to local priorities and needs. No specific funding was provided to jurisdictions for implementation.

Policy impact of the 2005 NCDS

Almost all respondents were aware of the 2005 NCDS. When asked about the use they had made of it and its centrality to a national approach to chronic disease, particularly chronic disease prevention, views varied. A few respondents, particularly those from smaller jurisdictions, reported that the NCDS was quite central in guiding state or territory strategy. Other respondents, however, thought that the NCDS had served only little function in the work of policy makers and practitioners, as the following comments illustrate:

I've given it as close to zero consideration as you can get.
(Advocate/thought leader)

Never looked at it. (Advocate/thought leader)

The 2005 strategy was virtually entirely irrelevant to our work. There was a failure to include, recognise or engage the [non-governmental organisation (NGO)] sector as providers of health services. (Practitioner/policy maker)

Although some respondents saw value in high-level strategic statements of intent, for those critical of the 2005 NCDS the most common observations were that it made no funding or other infrastructure commitments, had no implementation plan and was not binding in any way. The following quotes are typical of this view:

A national strategy is only as good as the dollars attached to it. It failed to provide resources, an implementation strategy, an accountability framework, and goals and targets. (Practitioner/policy maker)

National strategies are pretty useless unless they come with financial muscle – otherwise why would the states and territories do anything, let alone convince other portfolios to do anything. (Advocate/thought leader)

Despite the cynical views raised throughout the discussions with regard to the 2005 NCDS, most respondents agreed that there is value in having a national strategy. As one informant aptly noted:

When they're well put together they serve as an anchor for everything that happens. It helps to prioritise research

and programs – everything can be tied back to the Strategy.
(Researcher)

In terms of prevention, informants were asked about the prominence that prevention was given in the 2005 NCDS and the way that prevention was 'oriented'. Generally, it was acknowledged that although prevention was recognised as important in the document, like other aspects of the Strategy it lacked detail and specified actions. In other words, the document 'said all the right things' about the importance of prevention but provided no clear direction (and did not earmark funds) for the pursuit of national prevention initiatives.

Perspectives on a new national strategy for chronic diseases

Repeatedly, the comments raised by respondents echoed views that: (1) the new strategy should genuinely underpin a coordinated effort to meaningfully address chronic disease; and (2) the process for its development should be significantly different to earlier efforts, otherwise it is likely to yield similar results to previous strategies. As two informants said:

The Commonwealth has been absent on health prevention and now they want to develop a national strategy?
(Advocate/thought leader)

The risk is that the next strategy is just a set of motherhood statements without any implementation plans. It needs to be funded, planned and coordinated with the states and territories. (Practitioner/policy maker)

It was clear that informants, whether they were practitioners, policy makers, advocates, researchers or thought leaders, wanted to see a chronic disease strategy that would guide a genuine effort to address the root causes of chronic disease. They wanted to see government leadership to drive environmental or systemic change, for example in reducing the amount of sugar, salt and fat in food and drink and addressing the social acceptability of alcohol consumption. It was commonly noted that there had been some 'good wins' in terms of tobacco control, plain packaging and widening no smoking areas for example, but that the same leadership had not been directed to addressing other root causes of chronic disease.

Several respondents also expressed frustration that governments tended to adopt a 'personal responsibility' approach to chronic disease prevention. Rather than addressing environmental or systemic factors, it was felt that governments often take the view that 'people should be able to choose' and that prevention activities should be aimed at 'encouraging people to make healthier choices'. It was noted by several respondents that people are not always able to make 'healthy' choices, whether due to their knowledge, social background, geographic location or available income. Government has an important role, it was thought, in addressing environmental factors to make it easier for people to make healthier choices. The following are indicative comments from respondents:

It's important to have national strategies but they usually don't have a systemic foundation. They're usually based on what people think the strategy should be. (Researcher)

It's inequitable to simply say that individuals should take responsibility. Clearly, not everyone is equal in their ability to stay healthy. (Advocate/thought leader)

You need governance and leadership to address systemic issues – unless that's there, there's no point. (Practitioner/policy maker)

National Partnership Agreement on Preventive Health

With funding in the vicinity of A\$645 million allocated by the Australian Government to states and territories across Australia, the NPAPH was an unprecedented, national, coordinated framework to tackle the growing burden of chronic disease through prevention. Initially covering the period 2008–14, but in 2012 extended until June 2018, and then in 2014 cancelled prematurely,¹⁶ the NPAPH broadly set out to improve the prevention of chronic disease through a collection of policy priorities and funding arrangements across four distinct components: (1) settings-based programs, including the Healthy Children Initiative, the Healthy Workers Initiative and the Healthy Communities Initiative; (2) whole-of-population social marketing strategies; (3) the establishment of partnerships across sectors; and (4) enabling infrastructure to support the partnership.

Effect of the NPAPH on government-led preventive health policy and practice across Australia

When asked about the potential of the NPAPH, respondents overwhelmingly agreed that it created a strong platform for the national roll-out of programs supporting healthy lifestyles. The strength of this platform was described in three main ways by respondents: (1) supporting multiple and layered strategies; (2) allowing for the expansion and scaling up of existing programs; and (3) creating opportunities for developing and testing innovative ideas.

All respondents also agreed that core infrastructure was developed under the NPAPH, which elevated the rigour and sophistication of their preventive health activities. The key themes that arose throughout the interviews focused on achieving stronger governance, creating enhanced data collection capabilities, establishing a more skilled workforce and implementing improved program evaluation standards and accountabilities. Comments reflecting these views included:

Having access to that data is embedded now in people's expectations. So yes, the money was useful to us in advancing our collections program. (Practitioner/policy maker)

The focus on evaluation was a significant thing – to have it formalised as it was in the NPAPH was very good. (Practitioner/policy maker)

We've ended up with a large workforce of people who now understand how the systems approach works and how to make it work. (Practitioner/policy maker)

Respondents had mixed views about the extent to which the NPAPH was successful in building partnerships. Some respondents felt that the NPAPH created positive opportunities

for them to better collaborate with other state and territory government agencies, primarily within health, but occasionally outside of health. Two comments indicative of this view were:

The technical network was really useful. . .there's no other forum. (Practitioner/policy maker)

There is definitely a legacy of continued cross-government communications. The development of some personal working relationships has been a real benefit. (Practitioner/policy maker)

Other respondents questioned the extent to which the NPAPH facilitated a partnership between state and territory governments and the Commonwealth Government. Some felt the NPAPH improved these communications, yet others were of the view that the NPAPH had never truly built a partnership between the levels of government.

When asked about the degree of national coordination of chronic disease prevention activities, most informants were of the view that during the time of the NPAPH there was a greater degree of coordination. Informants particularly valued the ability to share information and ideas through the prevention managers' forum, facilitated at the time by the Australian National Preventive Health Agency (ANPHA). This was put forward as providing a real practical benefit. Following are some indicative quotes illustrating the value placed on this national coordination and its loss following abolishment of the NPAPH:

The main thing we lost was the ability to interact directly with the Commonwealth. We have to be talking to one another. (Practitioner/policy maker)

The national structure and the sharing that occurred under the NPAPH is a big loss. (Practitioner/policy maker)

Discussion

With Australia a signatory to the World Health Organization's global action plan for the prevention and control of non-communicable diseases with a global target of achieving 25% reduction in the burden of chronic disease by 2025,¹⁷ it is timely, and indeed imperative, that Australia takes substantive action.

Through semistructured, qualitative interviews with practitioners, policy makers, advocates, researchers and thought leaders from a diverse cross-section across Australia, including input from all state and territory health departments across Australia, the present study demonstrated consistent support for the Australian Government taking a leadership role in driving the preventive health agenda across Australia. However, comments reflected quite marked differences in views to the 2005 NCDS and the 2008 NPAPH, both national approaches with the same overarching aim of controlling chronic diseases.

In summary, although there was some cynicism as to the value of the 2005 NCDS and possible future incarnations of it, overall national strategies of this nature were viewed by respondents as necessary and useful for national coordination, setting a common agenda and serving as an anchor to align jurisdictional priorities and action. However, without funding

or other infrastructure commitments or implementation plans, any expectations as to what could be meaningfully achieved were limited.

Conversely, with the NPAPH there was near universal agreement among respondents that this approach was achieving or on the way to achieving its overarching desired outputs, including programs to build foundations for healthy behaviours, enabling infrastructure for evidence-based policy and partnerships for sustainable national action, across and between levels of government as well as with other sectors. Supported by available evidence for achieving large-scale, health system change, with the NPAPH there was national leadership,¹⁸ a focus on partnerships¹⁹ and significant funding commitment with reward payments to incentivise jurisdictions.²⁰ However, there was little national direction and although jurisdictions appeared to welcome the opportunity to tailor strategy to their unique needs and populations, there were commonly calls for some level of guidance and evidence base at the national level to inform decisions.

Both the 2005 NCDS and the 2008 NPAPH are consistent with the growing literature on the value of considering country health systems in their totality rather than emphasising disease-focused programming.²¹ In essence, health system strengthening approaches differ from disease-focused programming in that the focus is on the underlying infrastructure needed to effect change.²⁰ However, standing alone, the NCDS lacked any mechanism for implementation and the NPAPH itself had little strategy to drive action. The combination of these two approaches perhaps was what was needed to meaningfully effect system-wide, sustainable chronic disease prevention.

Consistent with this notion of whole-of-system strengthening espoused in the literature, and taking into account the views elicited through this study, it is the opinion of the authors that within the limits of the current legislative and policy environments any forthcoming national approaches to the prevention of chronic diseases should:

- acknowledge and build on previous work in the space, with a recognition of the current political, financial and technical environment and what realistically can be aimed for
- take a long-term view that extends more than one electoral cycle
- provide funding and other infrastructure commitments
- address the complex and interdependent root causes of chronic disease and accommodate geographical and cultural contexts to avoid 'one-size-fits-all' approaches
- use, link and sequence evidence-based interventions over a person's life course
- identify and articulate the interests and roles that can be played by all actors in the system, including individuals, health professionals, governments, researchers, NGOs and private sector organisations, with a view to aligning interests and 'buy-in'
- create mechanisms for cross-sectoral engagement and coordination, especially where there are opportunities to make use of the expertise or capabilities from different sectors (e.g. the marketing expertise within the private sector)
- identify how interventions can affect the system, not just individuals, with a focus on changing social norms rather than just individual behaviour

- rather than rely on health outcomes alone, establish indicators to reflect broader system change, like change in policy direction, volume of prevention activity and social norms.

Conclusions

The views of policy makers and thought leaders on the Australian Government's two national policy approaches to the control of chronic disease indicate that both approaches were useful, practical and set in motion potential gains for the health system. Future national approaches to control chronic diseases in Australia should draw on the experience of these approaches. The NCDS was seen as an important agenda-setting document, but it lacked transformative power due to the absence of funding or concrete implementation plans. Similarly, in many jurisdictions the NPAPH did not transform the chronic disease prevention field or offer any particular cohesive strategy for how best to control chronic diseases, but it did enable an expansion of existing efforts and a coalition among governments across Australia that was important for building policy momentum. Combined, the NPAPH and the NCDS provided a step forward in prioritising chronic disease prevention in Australia in terms of both strategic direction and programs on the ground. Our research suggests that future approaches should focus on generating more sustainable, system-wide change. That is, change across the people, processes, activities, settings and structures (and the dynamic relationships between them) that facilitate or hinder chronic condition prevention efforts. With a new chronic disease strategy on the horizon (see <http://www.health.gov.au/internet/main/publishing.nsf/Content/nsfcc>, accessed 5 January 2016), these results indicate that this new strategy will be important for helping to reset the direction for preventative health, but that it should be accompanied by an implementation mechanism to ensure that change happens.

Competing interests

No authors have any conflicts of interest to declare.

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