DOI: https://doi.org/10.20453/rmh.v35i1.5304

Tackling Challenges in Peru's Fragmented Healthcare System: Could Academia Become a True Agent of Change?

Afrontando los retos del fragmentado sistema de salud peruano: ¿Puede la academia realmente convertirse en un agente de cambio?

Luz M. Moyano[1,a; 3], *María J. Brunette*[2,b; 3], *Cristian Díaz-Vélez*[4]

[1] School of Medicine, Universidad Nacional de Tumbes; Tumbes, Perú.
[2] School of Health & Rehabilitation Sciences, College of Medicine, The Ohio State University; Ohio, USA.
[3] Mujeres en Salud Global Perú.
[4] General Director, Office of Strategic Interventions in Public Health, Ministerio de Salud, Lima, Perú.
[a] Assistant Professor
[b] Associate Professor

Citar como:
Moyano LM, Brunette MJ, Díaz-Vélez C. Tackling Challenges in Peru's Fragmented Healthcare System: Could Academia Become a True Agent of Change? Rev Méd Hered. 2024; 35(1):3-6. DOI: 10.20453/rmh.v35i1.5304

Correspondencia:
Luz M. Moyano
Email:
lmoyanov@untumbes.edu.pe

A Monday afternoon in the last days of January, three Peruvian scholars with similar social footprints but distinctive trajectories and perspectives —a health systems engineer passionate about social justice; a forensic medical researcher with experience in population-based studies; and a medical researcher, Ministry of Health officer— sat on a thought-provoking virtual coffee meeting to reflect on what could be done to strengthen and sustain the current bridge between academia and the national healthcare institutions. By posing few questions that might have cause some discomfort, they arrived at some consensus and embarked on ideas about how to best convey the key messages to the current and future generations of medical, health sciences, and public health researchers and practitioners. What should my work as a scientist be when facing urgent health demands that appear out of nowhere? How can we effectively translate evidence-based medicine into practice via meaningful health policies? How can we work in truly collaborative ways leaving our academic egos behind? How can we build trust among socially excluded communities and actively engage them in our research agendas?

Like many countries of the Global South, Perú grapples with the challenges of a seriously fragmented and resource-constrained healthcare system. As scientists with lived experiences of poverty, structural racism, and persistent social inequalities, we feel an urgent call to engage in a critical reflection about our role as agents of change to repair and strengthen our existing health system. This

editorial has a twofold aim. First, to discuss our role in co-designing both, biomedical and biosocial [1] research agendas grounded in evidence-based approaches that will later be adopted by our stakeholders including policy makers. Secondly, to offer an integrated perspective about the transformative role of scholars who occupying a privilege seat in academia, have the ability to contribute to strengthen the current health system aiming at equity and efficiency. At the end, our scholarly goals coincide with the commitment to being able to reduce the persistent health inequities in resource-constrained settings in Perú and beyond.

Understanding the root causes and the complex dynamics of fragmented health systems first requires that we begin to think systemically and push ourselves to learn to 'speak other languages'! -beyond the academic one! [2]. The health system in Perú as any other health system is structured in a logic way geared towards achieving societal well-being. Being able to speak the language of policy and decision makers working in each of the four pillars of the health system (resource generation, service delivery, financing, and governance) would prove beneficial to both academics and the local and national government agencies[3-6]. It is well known that the existing health system in Perú faces several challenges including geopolitical inequalities, uneven distribution of resources, and most importantly, lack of effective communication between key stakeholders [7]. Excessive administrative bureaucracy slows down the acquisition of medicines, equipment and the application of new treatments required by patients, significantly affecting the quality of care. What is written in the regulations and real life are two different scenarios [7,8]. The fragmentation hinders the fair provision of healthcare services at all levels, with a negative impact on our already socially excluded populations. It is crucial to acknowledge and tackle these underlying issues to construct a healthcare system that is *more integrated, equitable, and efficient* [9]

How do we know then when to wear the right hat? The following four suggested themes capture our opinion about the different roles that we, academics, have to contribute to health system strengthening efforts. Using the hat metaphor, we discussed that is critical to know when to wear a particular hat and most importantly, to demonstrate at all times a strong moral compass and a solid work ethic -besides the expected academic rigor of our scholarly outputs.

1. ***Health Equity Research and CBPR as our modus operandi*** Academics have the capacity to interact with communities including social actors and local governments to be able to address and co-design solutions to their complex health challenges. The opportunities offered by Community-Based Participatory Research (CBPR) are highly relevant but have been overlooked. CBPR is a systems approach to research that engages patients, clinicians, hospital managers, government policymakers, and the impacted communities -all from the lens of power balance and shared decision making[2,10]. In addition, the significance of community engagement in integrated healthcare is underscored in the WHO's Framework on Integrated People-Centered Health Services[11]. By integrating community viewpoints into policy deliberations and research, scholars can guarantee that suggested remedies align with the practical realities of the populace. The local community health administration (CLAS) was one of the best initiatives to integrate the community into health decisions[12], but the excesses of both made this marriage end in divorce. Not integrating the community into health decisions would turn the system into anarchy. Researchers must be the voice for both (community/system) to be heard each-other again.

2. ***From Evidence-Based Research to Effective Policy Implementation*** Through interdisciplinary research, the complex reality of health fragmentation can be addressed[11,13]. To successfully adopt new working strategies and health policies, evidence-based medicine (EBM) is essential[14]. For example, EBM during COVID-19 times demonstrated the ineffective use of ivermectin and antimalaria drugs in the hospitalization of patients with moderate COVID-19; EBM demonstrated the use of standing, ankle, or sitting births as institutionalized humanized and culturally relevant birth processes in many areas of our Peruvian Sierra, involving community midwives. And EBM has demonstrated the effectiveness of the current dengue vaccine only for those who have previously been exposed to a prior dengue. Academics must produce evidence-based insights through rigorous studies to guide policy development and improvement[15].

3. ***Role of multi-stakeholder partnerships***: Interdisciplinary and multisectoral collaboration plays a pivotal role in tackling the complex issues associated with healthcare fragmentation.

Academics' diverse knowledge and skills integrate several subjects not only from medicine, health sciences and public health. We need truly interdisciplinary teams, -including engineers and social scientists. Academics can contribute to integrated solutions that address the underlying causes of fragmentation. In our modest opinion, the first step would then be to reflect and ask ourselves: How could we made this initial step? How do we begin the process of systems change? How can we best understand the health priorities of the communities we serve? Do we depend on national priorities, or do we work in our priorities? Who sets the agenda? Should we create a change process roadmap with an internal checklist?

4. ***Maintaining a Systems Perspective***: By considering the three distinctive characteristics of any system: elements, interconnectedness, and purpose! academics and practitioners can begin shifting their mindset and work style to truly collaborate and acknowledge the impact of their daily tasks in the ultimate goal of improving health and wellbeing for all Peruvians. In addition, while academic institutions can effect significant change, it is important to recognize our responsibilities to confront and disrupt rigid systems and obstacles such as resource-constrained environments, budget allocations, bureaucratic complexities, power imbalances, and resistance to change.

Final Reflections: Food for thought!

Finally, the ability of academics to drive change in Peru's fragmented healthcare system goes beyond theory and should drive concrete actions. Scientists can make significant contributions to creating transformative change by using their research skills, engaging in multidisciplinary collaboration, and empowering affected communities. The use of scientific evidence in decision-making permits objective assessment, the prediction of outcomes, the reduction of risks, and the maximization of long-term outcomes. The scientific evidence that supports well-informed decision-making encourages transparency and accountability to achieve clear and unified direction, successful policy implementation, and genuine community involvement. It is important to seek consensus that is achieved through effective communication and strategic research partnerships involving social actors, the civil society, and local governments. As the clock is ticking towards achieving the Sustainable Development Goals (SDG 2030), we firmly agree that Peruvian academics must now fulfill their duty as catalysts for change to promote health for all by working together with local and national stakeholders addressing the existing national health priorities. [5]

REFERENCES

1. Farmer P, Basilico M, Kerry V, Ballard M, Becker A, Bukhman G, et al. Global Health Priorities for the Early Twenty-First Century. En: Reimagining Global Health [Internet]. 1.a ed. University of California Press; 2013 [citado 6 de marzo de 2024]. p. 302-39. (An Introduction). Disponible en: http://www.jstor.org/stable/10.1525/j.ctt46n4b2.15
2. Brunette MJ. Moving the needle on global health equity: a look back from 2030. Arch Environ Occup Health. 3 de abril de 2021;76(3):121-2. DOI: 10.1080/19338244.2021.1892922
3. Zimmermann J, McKee C, Karanikolos M, Cylus J, members of the OECD Health Division. Strengthening Health Systems: A Practical Handbook for Resilience Testing. Copenhagen: WHO Regional Office for Europe, OECD Publishing. Paris; 2024.
4. Papanicolas I, Rajan D, Karanikolos M, Soucat A, Figueras J. editores. Health system performance assessment: a framework for policy analysis [Internet]. Geneva: World Health Organization; 2022 (Health Policy Series, No. 57). 2022. Disponible en: https://eurohealthobservatory.who.int/publications/i/health-system-performance-assessment-a-framework-for-policy-analysis
5. Ministerio de Salud Perú. Prioridades Nacionales en Salud 2024-2030. RM No. 184-2024. Marzo 13, 2024. Diario Oficial El Peruano. Disponible en: https://busquedas.elperuano.pe/dispositivo/NL/2270511-1
6. Organización Panamericana de la Salud. Evaluación del desempeño de los sistemas de salud: Un marco para el análisis de políticas. 2023; Disponible en: https://iris.paho.org/handle/10665.2/57392
7. Ballard Brief [Internet]. [citado 28 de febrero de 2024]. Lack of Access to Quality Healthcare in Peru. Disponible en: https://ballardbrief.byu.edu/issue-briefs/lack-of-access-to-quality-healthcare-in-peru
8. Healthcare in Peru: From coverage on paper to real coverage [Internet]. 2023 [citado 28 de febrero de 2024]. Disponible en: https://blogs.worldbank.org/latinamerica/healthcare-coverage-peru
9. Yip W, Hafez R. Improving health system efficiency. Reforms for improving the efficiency

of health systems: lessons from 10 country cases. Geneva: World Health Organization. 2015.
10. Wallerstein NB, Duran B. Using community-based participatory research to address health disparities. Health Promot Pract. julio de 2006;7(3):312-23.
11. World Health Organization. WHO global strategy on people-centred and integrated health services: interim report. Geneva: World Health Organization. 2015.
12. Los Comités Locales de Administración de Salud (CLAS): Organización y modelo de gestión - El programa de salud local [Internet]. [citado 28 de febrero de 2024]. Disponible en: https://www.gob.pe/institucion/minsa/informes-publicaciones/320952-los-comites-locales-de-administracion-de-salud-clas-organizacion-y-modelo-de-gestion-el-programa-de-salud-local
13. Ostlin P, Braveman P, Dachs N, WHO Task Force on Research Priorities for Equity in Health, WHO Equity Team. Priorities for research to take forward the health equity policy agenda. Bull World Health Organ. diciembre de 2005;83(12):948-53.
14. Bullock HL, Lavis JN, Wilson MG, Mulvale G, Miatello A. Understanding the implementation of evidence-informed policies and practices from a policy perspective: a critical interpretive synthesis. Implement Sci. 15 de febrero de 2021;16(1):18.
15. Kotur PF, Kotur P. Challenges for the practice of evidence-based medicine during COVID-19 pandemic (practice of evidence-based medicine in the new normal). Indian J Anaesth. abril de 2022;66(4):290-3.