Good morning to everyone, and thanks to Professor Hanson for the introduction.

The objective of my presentation is to outline some attributes and strengths of what is emerging as a subfield of Health Systems Research, and can be termed: qualitative health systems science. I will also highlight some challenges, and ways to maximize the potential of the sub-field, while taking you through some of my own experiences as a qualitative researcher working in India and other low and middle-income country contexts.
I wanted to start with a brief mention of Mahatma Gandhi, a thinker whose relevance cuts across time and across all walks of life.

“Wealth without work, pleasure without conscience, commerce without morality”... some of these may seem more relevant in the context of recent global developments, but I am going to draw your attention to two of these blunders, which are specific to the themes that we are dealing with.

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Knowledge without Character, and Science without Humanity

I say this to highlight that Character and Humanity in Science are crucial elements that applications of the social sciences - specifically the humanities - can potentially highlight as the science of Health Systems Research develops and evolves.
My presentation is divided into four parts – in which I discuss respectively how we *envision* health systems from a qualitative science perspective, how we *research* health systems, and how we understand the *translation of research knowledge into policy and action*.

I will conclude with thoughts on challenges, and ways forward for qualitative researchers exploring health systems.
Before we enter into how we envision health systems, it’s useful to think about the history of the field as one that has evolved over several decades, and is not as new as we may imagine.

In a recent paper with some colleagues, published in PLoS Medicine, we traced how HSR as we now know it has developed through a mixing of influences - from public health specialists trying to resolve practical concerns of service delivery, and from social scientists trying to support change in health systems.

Health systems research has been deeply influenced by health economics, sociology, political science and anthropology...

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...but now other humanities disciplines such as philosophy, cultural studies, history and law are also increasingly finding application.
The multiple influences have been enriching, but have also led to markedly different ways in which we perceive health systems, and hence how we research them.

Probably the dominant approach currently is a functional perspective, which looks at systems primarily in terms of subcomponents and their utility in achieving specific outcomes; and tends to view policy decisions as emerging from focused, central locations – typically the centres of policymaking at global and national levels.
On the other hand, there also exists a qualitative science-driven lens on health systems – which is marked by an appreciation that health policy and systems are shaped by particular politics, culture and discourses, and that they are deeply complex. Other features of this perspective are that policy decisions are not seen to be unifocal, but rather, distributed throughout the system in the hands of various health systems actors. Also, crucially, this lens places human motivation and decisions at the heart of understanding how health systems operate, by focusing on the interface between the tangible hardware of health systems, and the intangible software – ideas and interests, relationships and power, and values and norms – that determine human action.
Although these qualitative or relativist perspectives may appear to be abstract or theoretical in their articulation of social construction of health systems, they can also be understood to be highly pragmatic.

Qualitative science operates on the principle that for policy and action, we need knowledge extending beyond ‘proof’ and ‘evidence’. We need to access multiple types of knowledge, drawing from the lived experiences of health systems actors and communities, including practical sense and accumulated understanding of field realities. When applied to policy and systems concerns, qualitative approaches awaken us to the full range of human action, and allow to explore all manners of phenomena and possibilities for change, through a reasoned and informed process.
I will now move on from how we envision health systems, to how we *research* health systems from a qualitative perspective...
There is of course a slew of different methodologies and approaches under the qualitative umbrella, and a majority of them are held together by some common attributes:

Obviously, they use mainly qualitative methods and analytical frameworks

They tend to focus on actors, and on understanding their varying perspectives, relationships and decisions

They are attentive to social and political context

They emphasize the ‘software’ of health systems, as already discussed, and its relationship with the hardware

They follow well-defined criteria for research quality, that are distinct from quantitative-focused health research

They operate with a nuanced understanding of the relationship between research and policy
Here is a list of some of the tools of the trade of the qualitative health systems researcher.

Most of you must be familiar with these terminologies, but I believe some of these approaches, analytical frameworks and methods should find greater currency in mainstream health publications and debates.

Let me elaborate on two of these approaches a bit more, in the following slides.
One approach that has deservedly but belatedly come into vogue in health research, is realist evaluation.

Realist evaluation is based on the understanding that in complex systems, interventions get enacted as varied mechanisms, and the relationship of these mechanisms with outcomes is mediated by conditions and contexts.

Further, particular combinations of mechanisms and contexts can lead to unexpected outcomes. This simple link between mechanisms, contexts and outcomes (M-C-O) is the seed of a potent research approach with diverse applications to understand complex systems change, both retrospectively and prospectively.
Another approach, and one that our research group in India has used extensively, is “Action-centred” implementation analysis. This is not a single approach but a group of methodologies, which focuses on analyzing implementation as a social and political process.

Action-centred analysis is a useful tool to investigate what is a paramount problem for LMIC planners – the problem that “we have policies, but they are not implemented”. Action-centred approaches apply in-depth research methods to understand, in an open-ended fashion, “what actually happens or gets done, how and why?”.

The analyst’s main focus is to draw out the experiences of the actors who make up the system – the health providers, administrators, planners, communities, and users of services.

I will illustrate this approach with a short case study from the Indian context.
The case study is based on research my group has conducted in 2 Indian states, trying to understand why health regulatory institutions don’t perform as they are expected to.
The research had broad objectives, but I am going to focus down on one particular aspect of the research: insight into how designated regulatory organizations – directorates, departments and professional councils - made decisions in the context of their work.

To understand this, we interviewed members of these organizations, and applied this framework of policy decision-making to the data emerging from the interviews.

Geoffrey Vickers’ framework, from his book, ‘Art of Judgement’ suggests that policy decision-makers arrive at an APPRECIATION of a situation, which is a combination of their value judgments about a given situation, and judgements about the realities of that situation.
In the case of members of these regulatory organizations, this framework proved to be quite useful.

In the first place, we found that most of them did not really undertake many of the regulatory functions that they were expected to be doing – that is, inspecting clinics and prosecuting them if they did not comply with standards. Instead they focused on other activities such as setting up training programmes, launching public-private initiatives, and undertaking community health work.

So let's look at some of their value judgments, emerging from the interviews: being physicians themselves, they tended to empathize with the practitioners that they were expected to regulate, and they often made extensive arguments in defence of negligent or illegal practices of these practitioners. They favoured an entrepreneurial focus over regulatory concerns, and appeared disengaged with regulation as a public agenda.

Coming to judgments of reality, By the nature of their jobs, many of them were in some form of co-dependent relationships with the practitioners and clinics they were expected to regulate – either socially or professionally. They also lacked support from their senior authorities, and lacked adequate resources and capacity to do their jobs efficiently.

This led them to rationalize their non-implementation of regulations. Their actions tended to focus on entrepreneurial tasks, and they tended to negate the importance of their own fundamental roles of regulating clinics.

So this is an example of how a qualitative case study can throw up fine-grained findings. What we see is not simple lack of motivation or inefficiency, but a systematic set of reasons for how organizations malfunction.

Some solutions that emerge for this situation are: greater separation of regulatory and developmental roles in the health administration; and potentially, more autonomy and powers for regulators, coupled with stronger accountability measures.
Qualitative science also includes a range of nuanced perspectives on the relationship between research and policy. I will present my thoughts on this briefly before my concluding comments.
One of the commonest criticisms of qualitative research is that it is too particular to context. This is in part a logical fallacy – since it is not the methodology but the complex issues being studied that are specific to context. Particularity is actually a strength of qualitative science, since it provides deeper insights and explanations of those issues as they play out in varied contexts.

A form of generalization known as **analytic**, rather than direct **generalization** is also implicit in most qualitative approaches. Analytic generalization is based on the identification of causal mechanisms while, crucially, linking these mechanisms to the contexts in which they operate.

For instance in the case study previously cited, other Indian states, and even other countries with a comparable socio-political and bureaucratic environment are likely to witness a similar association between the role-perceptions of regulators and the non-performance of regulatory organizations.
Further, qualitative science also encourages the researcher to look beyond a conventional position of informing pre-determined policy choices, to a more transformative role.

Through their presence on various public and policy forums, researchers should and do engage in: generating new ideas for policy, reframing policy debates to make them more useful or more ethical, and ensuring that under-represented groups are heard.

Researchers can also crucially play a role in processes of policy learning...
This brings us back to Vickers’ model of how policy actors make decisions, which I presented earlier. Completing this cycle is a feedback loop, which highlights that policy decision-making is inherently a learning process. Actions have consequences in the real world, and this leads policymakers to learn, which in turn influences their judgments.

What is the place of the researcher in this process?

Researchers can try and engage with policymakers directly to support them to reflect on and rethink existing problems; or indirectly by stimulating public debate and opinion.

So here we have a different, nuanced perspective of how research and researchers interface with the world of policy and action.
I believe that qualitative approaches have immense potential in shaping health systems research, and contributing to more effective health systems globally. There are also significant challenges on the road ahead, and also some clear opportunities for strengthening the sub-field.
To start with the challenges...

**Biomedical science** perspectives dominate in all aspects of health research and HSR is no exception. This can sometimes “crowd out” qualitative forms of understanding and enquiry. Conversely, **social scientists are also frequently resistant** to engaging with the applied focus of health systems research. This is not helped by overall **low capacity for qualitative research** in LMIC, something that is often underscored by social mores favoring taking up the natural sciences, in those countries.

**Power** imbalances and inequities have often emerged as a finding from our research, and this makes the research extraordinarily difficult to write up. This is both due to political sensitivities, as well as to the limited strategic responses to power imbalances that can be found within the health system, since these often reflect broader social phenomena.

In my experience, I have not observed LMIC policymakers to be uniformly resistant to qualitative questions and approaches, although this is often assumed to be the case.
Finally, I would like to end with some notes for my colleagues and for students aiming to become qualitative researchers, on ways in which they can sharpen their practice and contributions. 

In terms of methodology, I would like to emphasize a focus on elaborating effective **mechanisms** from real-life experiences in health systems, and linking these mechanisms to broader **contexts**. I think this may be a crucial area for future research. 

Being **policy-minded** is crucial. I would encourage researchers not just to aim to inform policy, but to actively learn what policymakers need, to help in the policy learning process, and help reframe debates where necessary. 

Since health systems have a heterogeneous mix of actors, ensuring that different groups and constituencies find a **voice** and representation in research, is always going to be important. 

I can’t overestimate the importance of rigour and sheer exertion in arriving at credible research results. 

And finally I will encourage researchers to also try and be research developers, since health systems research is still in its infancy as a discipline.
I will close here with thanks and some acknowledgements

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