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GLOBAL HEALTH SYSTEMS IN 2026

Strategic priorities, health systems literacy and the physician's role in resilient care

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Abstract

In 2026, global health systems are confronted with converging pressures arising from climate change, economic instability, demographic shifts, epidemiological trends, and geopolitical tensions. This article proposes that strengthening governance should be the primary strategy, rather than implementing isolated programs or reactive crisis management. Four strategic priorities are examined: developing climate-resilient, low-carbon infrastructure; advancing universal coverage through primary care; engaging in multisectoral initiatives addressing health determinants; and ensuring all-hazards emergency preparedness. The discussion further demonstrates the importance of Health Systems Science in contemporary medical education by integrating clinical excellence with population-level outcomes. It evaluates how systems literacy can enhance patient safety, care coordination, and chronic disease management, and presents a practical framework for postgraduate training. The central argument is that contemporary clinical quality depends on physicians' ability to comprehend, lead, and refine the systems in which care is delivered.

Keywords: health systems strengthening; universal health coverage; primary health care; health systems science; patient safety; climate resilience; postgraduate education

Central argument: In an unstable world, clinical capability alone is insufficient. Health systems must be designed to anticipate risk, finance care fairly, preserve essential services during disruption, learn from failure and earn public trust.

1. Reframing Global Health Systems in 2026

Global health systems have reached a decisive inflection point. The World Health Organization's Fourteenth General Programme of Work (GPW 14) for 2025-2028 frames the contemporary agenda around promoting, providing and protecting health and well-being, while advancing equity and resilience in a turbulent world (WHO, 2025a). This framing is significant because it moves the debate beyond disease-specific service expansion. It asks whether countries can create health systems that protect populations before shocks occur, maintain care when shocks occur, and recover with greater capacity afterwards.

The pressures are mutually reinforcing. Climate hazards affect food security, water availability, infection patterns, displacement and infrastructure. Fiscal strain affects medicine availability, workforce retention and household ability to pay. Conflict and population movement weaken continuity of care while increasing needs for trauma care, maternal health, mental health and chronic disease support. These are not separate technical problems. They are system-wide tests of stewardship, financing, information, workforce capacity and social legitimacy.

For this reason, the strategic direction in 2026 should be governance-first. Governance-first reform does not diminish the importance of clinical care; it creates the conditions in which clinical care can be safe, equitable and sustainable. It aligns policies, authority, accountability, financing and data around a shared public purpose. Its practical test is whether a health system can continue to deliver essential, person-centred services for those who need them most, including in fragile, resource-constrained and crisis-affected settings.

Table 1. A governance-first agenda for global health systems in 2026

Strategic priority	Operational focus	Resilience test
Climate resilience	Adapt services, infrastructure, supply chains and surveillance to climate hazards while reducing emissions and waste.	Essential services continue through heat, floods, outbreaks and supply disruption.
PHC-led UHC	Organise accessible, integrated first-contact care with financial protection, referral continuity and strategic purchasing.	People obtain needed care early without financial hardship.
Multisectoral action	Link health policy to housing, education, food, transport, social protection and environmental governance.	Avoidable risk and inequity fall outside as well as inside the health sector.
Emergency preparedness	Strengthen surveillance, laboratories, coordination, surge capacity, risk communication and emergency finance.	Threats are detected early and routine care is protected throughout a crisis.

2. Four Strategic Priorities

2.1 Climate-resilient and low-carbon health systems

Climate change is now a core health systems issue rather than a peripheral environmental concern. Heat, floods, drought, extreme weather, air pollution, food and water insecurity, and climate-related displacement increasingly alter demand for care while simultaneously disrupting the facilities, power supplies, transport systems and workforces that deliver it. The WHO operational framework for climate-resilient and low-carbon health systems therefore places leadership, workforce capacity, risk assessment, early warning, resilient infrastructure and environmentally responsible supply chains within a single systems agenda (WHO, 2023a).

The important metric is continuity, not merely survival. A resilient hospital or primary care network is one that continues to provide safe maternity care, emergency treatment, immunisation, medicines for chronic illness, dialysis, mental health support and referral functions during disruption. Planning must therefore connect climate risk assessment with facility design, water and energy security, emergency logistics, workforce preparation and community outreach. Equity is central: the greatest effects are often borne by people with low incomes, disability, chronic illness, insecure housing, rural isolation or displacement.

Mitigation belongs in the same conversation. Healthcare institutions are large purchasers and users of energy, transport, water and materials. Energy efficiency, renewable power, sustainable procurement, waste reduction and climate-smart supply chains can reduce operational vulnerability as well as environmental harm. When these actions are explicitly governed, they become part of quality, financial stewardship and institutional credibility rather than optional environmental projects.

2.2 Primary health care as the engine of universal health coverage

Primary health care (PHC) represents the cornerstone of achieving universal health coverage (UHC), as it provides an integrated continuum of services encompassing disease prevention, early diagnosis, clinical treatment, rehabilitation, palliative care, and active community engagement across the entire life course. According to the operational framework jointly developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), PHC adopts a people-centred and comprehensive approach that delivers health services as close to individuals' daily environments as possible (WHO & UNICEF, 2020). Far from being a minimal or residual package for low-income populations, PHC constitutes the foundational architecture of a resilient health system, one that proactively manages risks before they escalate into costly and preventable illnesses.

A PHC-oriented health model is critically dependent on the presence of robust financial protection mechanisms. In settings where households bear high out-of-pocket expenditures, individuals often delay seeking care, forgo essential medicines, or risk falling into debt and poverty. Public financing, the pooling of funds, explicit benefit design, strategic purchasing, and the use of appropriate provider payment methods are not merely financial considerations but also clinical imperatives. These mechanisms collectively determine whether patients can access timely care and whether early interventions can be delivered effectively. Complementing financial protection, strong referral networks, reliable access to essential medicines, diagnostic capabilities, and seamless coordination between primary and hospital care are vital components of a functional PHC system.

The strategic value of PHC lies in its dual capacity to integrate individual-level clinical services with broader population health strategies. Well-supported primary care teams are uniquely positioned to identify public health gaps and clinical needs: for example, flagging a child who has missed vaccination, referring a pregnant woman requiring timely obstetric care, managing an individual with uncontrolled hypertension, or recognising households facing food insecurity and financial hardship. In this way, PHC serves as the locus where prevention, equity, trusted patient–provider relationships, and the efficient allocation of health resources intersect. Its role is both operational and transformative, creating a health system that is proactive, equitable, and sustainable.

2.3 Multisectoral action on the determinants of health

Health outcomes extend well beyond the health sector. Determinants such as housing, food systems, education, employment, transportation, safety, environmental quality, income security, gender relations, and social protection influence both risk exposure and access to care. The Health in All Policies framework offers a practical mechanism for governments to highlight these interdependencies and establish structured cross-sectoral accountability (World Health Organization and Ministry of Social Affairs and Health, Finland, 2014).

This approach does not imply that ministries of health should direct other sectors. Instead, health leaders require mechanisms that facilitate coordinated action: interministerial committees with decision-making authority, health impact assessments, shared indicators, local government engagement, civil society participation, and data disaggregated by geography, gender, age, income, displacement, and disability. For example, transportation decisions may influence trauma rates, air pollution, mobility, and physical activity; housing decisions may affect respiratory disease, infection transmission, mental health, and heat exposure. Such linkages demand leadership capable of interpreting health implications within policies formulated in other domains.

2.4 Emergency preparedness, response and recovery

Preparedness is now integral to national security, economic stability, and public trust. The World Health Organization's (2023b) agenda for health emergency prevention, preparedness, response, and resilience underscores the necessity of integrated capabilities across surveillance, laboratories, public health operations, emergency coordination, community engagement, financing, and service delivery. A system that detects signals but fails to respond promptly is inadequately prepared; similarly, a system that addresses outbreaks at the expense of routine care is insufficient.

Effective readiness demands early detection, rapid data interpretation, clear command structures, surge staffing, resilient supply chains, flexible financing, and credible risk communication. It must also ensure continuity of essential services, including obstetric care, trauma management, oncology treatment, dialysis, immunization, medication refills, and chronic disease follow-up. Consequently, emergency response quality is assessed not only by the volume of cases managed but also by the preventable harm avoided among individuals requiring routine care during the crisis.

Trust constitutes a functional capability. Communities are more likely to adhere to public health guidance when institutions communicate uncertainty transparently, act with integrity, and apply policies equitably. Trust cannot be generated during an emergency; it is cultivated through consistent experiences of respectful, reliable, and equitable care.

3. Why Fragmented and Reactive Care Is No Longer Enough

Fragmented systems fail when risks interact. Siloed financing, public health, clinical services, social care and emergency response create missed referrals, duplicated investigations, medication conflict, weak accountability and rapidly rising costs. At the patient level, fragmentation appears as repeated storytelling, delays, gaps between facilities and confusion about who is responsible. At the national level, it appears as isolated projects, parallel reporting systems, uncoordinated purchasing and reforms that do not change the experience of care.

Reactive care is similarly inadequate. A health system that allocates most attention after complications emerge will spend more, protect fewer people and reinforce inequity. Prevention, risk stratification, early diagnosis and continuity are not alternatives to hospital care; they ensure that hospital care is used appropriately and can focus on those with genuine need. A governance-first model integrates these functions through explicit service pathways, population intelligence, financing arrangements and accountability for outcomes rather than activity alone.

4. The Imperative of Health Systems Literacy for Physicians

Health Systems Science (HSS) has emerged as the third foundational pillar of contemporary medical education, complementing the long-established domains of basic sciences and clinical sciences. While basic sciences elucidate the biological and physiological mechanisms underlying disease, and clinical sciences provide the framework for accurate diagnosis and effective treatment, HSS addresses the organisational, financial, and systemic dimensions of healthcare delivery. It encompasses the study of how care is structured, financed, delivered, measured, improved, and governed, thereby creating an indispensable intellectual bridge between informed bedside decision-making and the organisational conditions necessary for consistent, equitable patient outcomes (Gonzalo et al., 2020).

For today's physicians, literacy in health systems is no longer a peripheral competency—it is a professional imperative. Modern clinical decisions are inherently embedded within a complex web of systemic factors, including payment models, workforce availability, digital infrastructure, legal and regulatory frameworks, referral pathways, supply chain resilience, and the socio-economic realities of the communities served. Without a thorough understanding of these systemic conditions, even the most advanced clinical knowledge risks being applied inefficiently—too late, inappropriately, or in ways that inadvertently reinforce healthcare disparities. In contrast, a systems-literate physician can identify structural barriers, lead local and institutional improvement efforts, advocate for equitable financing models, and transform patient experiences into actionable policy and organisational reforms.

Importantly, cultivating health systems literacy does not diminish or displace a physician's clinical identity; rather, it enriches and strengthens it. Physicians remain fundamentally responsible for delivering thoughtful, evidence-based, and compassionate care to individual patients. However, systems-literate clinicians also develop the capacity to critically examine the underlying causes of adverse patient experiences—for example, delayed presentations, unaffordable treatments, conflicting instructions, or unsafe processes. By understanding and addressing these systemic determinants, physicians become not only healers at the bedside but also stewards of the structures that influence population health.

Ultimately, HSS cultivates clinicians as system citizens: professionals who are equipped to participate in, and often lead, the ongoing optimisation of healthcare systems. This dual capacity—providing exemplary individual care while simultaneously contributing to structural and policy improvements—is essential for advancing both the quality and equity of healthcare in an increasingly complex medical landscape (Borkan et al., 2021)..

Table 2. Core Health Systems Science domains for postgraduate physicians

Domain	Clinical question it helps answer	Learning approach
Health financing and economics	Who pays, who is protected and which incentives shape access, quality and value?	Coverage cases, budget simulations and service-cost reviews.
Governance and policy stewardship	Who holds authority, how are priorities set and how do policies reach the bedside?	Policy briefs, committee observation and stakeholder mapping.
Quality improvement and patient safety	Where does harm arise in the process and how can teams test and sustain safer care?	Supervised improvement projects, process mapping and event analysis.
Population health and equity	Which groups experience disproportionate risk, unmet need or avoidable cost?	Panel management, equity audits and community-based learning.
Digital health and informatics	How can data and technology support safer decisions without creating new exclusion or bias?	Dashboard interpretation, workflow redesign and data-governance cases.

5. Translating Systems Knowledge into Better Outcomes

5.1 Public safety and patient safety

Public safety depends on systems that detect risk, learn from failure and improve continuously. Incident reporting is necessary but insufficient; a report only has value when it is analysed, fed back to teams and translated into a change in process, equipment, communication or staffing. The WHO Global Patient Safety Action Plan calls for system-level action to eliminate avoidable harm through policy, implementation and learning at the point of care (WHO, 2021a).

Systems thinking prevents the reflex to attribute harm solely to an individual. Most adverse events and near misses arise from interacting causes: ambiguous protocols, handover gaps, fatigue, crowded workflows, unavailable supplies, technology failures, poor escalation pathways and misaligned incentives. A fair culture holds professionals accountable for conduct while treating system defects as opportunities for redesign. This distinction is essential to learning, staff wellbeing and public confidence.

5.2 Coordinated, person-centred patient care

For patients, stronger systems mean fewer avoidable delays, fewer repeated histories, clearer care plans and more reliable follow-up. Integrated care is not simply co-location of services; it is the purposeful alignment of information, teams, roles and referral pathways around a person's needs. It promotes continuity across primary care, emergency care, hospital services, rehabilitation, mental health and social support.

Value in healthcare should be understood as the achievement of meaningful outcomes with responsible use of resources, not as indiscriminate cost reduction. Timely diagnosis, appropriate treatment, rehabilitation and long-term support matter more to patients than the volume of contacts or tests. Relational continuity also matters: trust, communication, cultural responsiveness and shared decision-making are central to high-quality care, particularly in chronic illness, maternal health, disability, mental health and end-of-life care.

5.3 Disease management that addresses root causes

Chronic diseases cannot be managed effectively through episodic visits and prescriptions alone. Diabetes, cardiovascular disease, chronic respiratory illness, kidney disease, cancer, mental health conditions and multimorbidity are shaped by living conditions, income, food access, housing, education, transport, safety and social support as well as biology. A system that ignores these determinants may issue clinically correct plans that patients are structurally unable to follow.

Integrated disease management links clinical care to prevention, community resources, behavioural health, social services and public health programmes. It uses risk registries and proactive follow-up to identify deterioration early, while enabling meaningful partnerships with patients and families. By shifting attention upstream while preserving high-quality downstream treatment, this approach can reduce avoidable mortality, morbidity and disability.

6. Leadership Reflections: From Clinical Expertise to System Stewardship

The most important insight from health systems learning is that clinical competence and systems competence are mutually reinforcing. Clinical work reveals where patients experience delay, exclusion, unsafe handovers and financial hardship. Systems thinking then makes it possible to distinguish immediate symptoms from the governance, financing, workforce, data or process failures that produce them. The physician who combines these lenses can contribute at the bedside, within the institution, across the community and at national level.

Health systems leadership requires critical thinking, ethical judgement, disciplined use of evidence and the ability to convene different professions and institutions around a common purpose. In universal health coverage, for example, declaring entitlement is not enough. Practical progress requires a credible benefit package, resource mobilisation, pooling, strategic purchasing, provider payment, workforce planning, quality assurance, digital information and public accountability. Each choice affects access, equity, provider behaviour and public trust.

For a physician, the professional obligation is therefore broader than solving the problem presented in a single consultation. It includes contributing to conditions in which fewer people arrive late, fewer households are impoverished by care and fewer staff are forced to work in avoidably unsafe systems. This is especially important in fragile and conflict-affected settings, where scarce resources make stewardship, prioritisation and continuity of essential services matters of life, dignity and social cohesion.

Practical Framework: Integrating Health Systems Science into Postgraduate Curricula

Integrating health systems science (HSS) calls for more than a short lecture series. Learners need ongoing contact with systemic issues in clinical practice, evidence-based analysis, interdisciplinary work, and real-world improvement efforts. The curriculum should be long-term, hands-on, assessed, and matched to institutional goals. It should build not only knowledge but also professional agency, ethical reasoning, collaborative skill, and responsible data use.

7.1 Longitudinal experiential tracks

A longitudinal track allows trainees to follow a real system problem over time: delayed referrals, medication errors, missed appointments, avoidable readmissions, inequitable access, waste, poor data quality or climate-related service disruption. The learning is deeper because trainees observe implementation barriers, stakeholder interests, variation in data and the difficulty of sustaining change. Each track should provide protected time, faculty supervision, multidisciplinary mentorship and a clear relationship to a hospital, district or national priority.

7.2 Integrating the third pillar into clinical learning spaces

Morning reports, morbidity and mortality conferences, grand rounds and ward rounds are already influential learning environments. They can be redesigned to include the systems dimensions of clinical cases. A morning report can explore referral delay, affordability, diagnostics access and continuity as well as differential diagnosis. A morbidity and mortality conference can analyse workload, process design, communication and escalation rather than stopping at individual error. Grand rounds can connect disease topics to financing, policy, quality, informatics and population health.

7.3 Dual-competency electives and fellowships

Postgraduate programmes should be designed to offer well-structured and comprehensive pathways that integrate clinical training with a broad spectrum of related disciplines, including health policy, public health, healthcare management, quality improvement, implementation science, health economics, and health informatics. Such programmes should ensure that trainees gain exposure not only within hospital settings but also across primary care networks, public health agencies, regulatory authorities, payer organisations, community-based partners, and the key processes involved in health policy formulation and implementation.

The purpose of this approach is not to transform every trainee into an administrator or policy maker. Instead, the intent is to cultivate clinicians who possess the knowledge and skills to bridge the gap between frontline clinical practice and the broader organisational and national health strategies. By understanding the operational, economic, and policy dimensions of healthcare, these clinicians will be better equipped to contribute meaningfully to system-level improvements, drive evidence-based changes, and align clinical insights with the overarching goals of health systems development and reform.

7.4 Assessment, faculty development and institutional partnership

Unmeasured elements are frequently regarded as discretionary. Evaluation should integrate knowledge assessments with applied deliverables, including policy briefs, quality-improvement charters, process maps, equity analyses, data dashboard interpretations, stakeholder engagement plans, and reflective accounts of professional responsibility. Faculty development is equally critical, as systems-based learning depends on supervisors capable of connecting theory to practice without reducing complexity to slogans. Hospitals and universities should collaborate on project selection so that trainees produce meaningful improvement work while learning safely through evidence and feedback.

Table 3. A staged model for postgraduate Health Systems Science integration

Stage	Learning experience	Evidence of competence
Recognise	Case-based teaching on financing, equity, safety, policy and informatics embedded in clinical modules.	Structured reflection identifying system contributors to a clinical problem.
Analyse	Guided use of process maps, routine data, patient stories and stakeholder analysis.	A defensible problem statement, baseline measure and equity lens.
Improve	Interprofessional, supervised improvement or service-redesign project in a real setting.	Tested change, run chart or qualitative feedback, and learning from implementation.
Lead and sustain	Mentored presentation to a service, hospital or policy forum; integration with institutional priorities.	Clear recommendation, accountable owner, resource implications and sustainability plan.

8. Conclusion

Global health systems in 2026 are being shaped by an era of polycrisis, inequity, fiscal constraint and higher public expectations. The strategic priorities are clear: climate-resilient and low-carbon infrastructure, PHC-led universal health coverage, multisectoral action on the determinants of health, and robust all-hazards preparedness. Across all four, the common requirement is strong governance: coherent authority, fair financing, capable workforces, useful data, sustained quality improvement and public trust.

For physicians and educators, HSS is the essential bridge between clinical excellence and population impact. It equips clinicians to see how systems shape patient outcomes, to prevent avoidable harm, to coordinate care across boundaries and to advocate responsibly for equitable reform. The task ahead is both practical and urgent: build systems that learn before, during and after shocks, and train health professionals who can improve those systems with scientific discipline, moral clarity and respect for the communities they serve.

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Dr. Abdulrazaq Yusuf Ahmed, a Somali physician and senior health leader, serves as Director General of the National Health Insurance Authority, directing health financing and insurance reform. With 17 years of experience, he has led hospital transformation, workforce development, clinical governance, and strategic reform in fragile settings

His professional trajectory includes frontline clinical practice, hospital transformation, public health emergency response, health systems strengthening, quality improvement, academic mentorship, and policy development. During Somalia's COVID-19 response, he provided critical leadership in national emergency coordination and oversaw the conversion of De Martino National Public Hospital into a central referral and response hub. This initiative expanded capacity, established safer patient pathways, implemented operational protocols, enhanced infection prevention, and strengthened community trust.

Dr. Abdulrazaq's work emphasizes governance, resilience, equity, accountability, patient safety, and institutional reform in fragile health systems. His Fellowship in Action contribution highlights Somalia's experience in translating crisis leadership into sustainable reform, robust quality frameworks, public confidence, and long-term systemic learning.

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