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Introduction

The *IJHG* review section consists of short reviews of each article included in the current issue. Each mini-review starts with the phrase "this review is based on …" followed by the author(s) and title of the article in question. This allows readers to select subject matter that reflects their own interests or areas of expertise. The review editor includes additional commentary based on external sources as appropriate.

This month's selection could be described as a "mixed bag" as we look at a variety of topics, from global health advocacy in the Gulf States to governance determinants of health (GDH), health politics, professionalisation of an emergency service, food safety, hospital quality assurance, and self-healthcare in a changing society. As always, I would encourage readers not to skip articles that might not seem immediately relevant to their own professional agenda. We all have so much to learn from each other that it is difficult to predict where a lightbulb moment might occur, illuminating some aspect of practice that may have remained elusive had been one rigidly focussed on a narrow range of issues. The function of the review section is to enable readers to gain a quick overview of each issue's contents in order to prioritise relevant material. However, once key issues have been identified, take the time to go back and read the articles that were not part of your first round of choices.

Finally, the editorial staff of *IJHG* encourage readers to submit their own papers to us, as health governance is a broad church, encompassing many aspects of healthcare quality and improvement. If you are unsure whether your proposed paper is suitable for publication in *IJHG*, please do not hesitate to contact the editorial team for advice.

1. Can an oil rich nation forge a new identity as a climate change mitigator and global health advocate?

This review is based on Alkhaldi *et al.*'s (2023) article titled "Analysis of the United Arab Emirates' (UAE) contribution to sustainable development goals with a focus on global health and climate change".

The UAE consists of seven Gulf States, each of which is an absolute monarchy. Together, the states or Emirates, form one nation, with their monarchs acting together in the governing council to elect national officials. The UAE's primary resources are oil and gas, and the country is amongst the top ten world producers of both of these. The UAE has little arable land and no natural fresh water reserves. However, the UAE's fossil fuel wealth has enabled this desert nation to become a technologically advanced society with the vision to imagine a future as a leader in global health and green energy.

Alkhaldi *et al.* (2023) reviewed and analysed peer-reviewed and non-peer-reviewed academic papers as well as UAE Government documents to identify the extent of the UAE's contribution towards meeting sustainable development goals and mitigating climate change. In 2010, the UAE set out an ambitious vision to be the best country in the world in 50 years'

Further background information for Review 1 was taken from the following sources:
https://www.cia.gov/the-world-factbook/countries/united-arab-emirates/ (information on UAE)
https://en.wikipedia.org/wiki/United_Arab_Emirates

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time. Six national priorities were identified; one of these was healthcare. By 2022, the WHO reported that the UAE was amongst the top four countries in a number of key health indicators, including the lowest maternal mortality rates in Arab countries, the 4th lowest number of neonatal deaths and the lowest incidence of tuberculosis. In recent years, the UAE has increased its focus on preventative medicine. This has included free breast screening for women, vaccination campaigns and the development of apps to teach children about healthy living habits.

Other standards which have been adopted in order to achieve sustainable development goals include ensuring access to clean energy, affordable and adequate food and good quality education for all. Sustainable economic growth and making efficient use of resources are at the heart of achieving these goals.

However, questions remain about how the UAE's clean energy vision will be realised. Much of their focus is on the export of clean energy, whilst domestic consumption remains heavily dependent on fossil fuels (Shehabi, 2023). However, the country has exhibited a clear shift from climate change scepticism pre-COP 26 (United Nations, 2021) to emerge as a dedicated climate solution player. Together with other Gulf States, this includes a commitment to tree planting and development of clean blue hydrogen as an export fuel. Whether the UAE's green energy commitment can expand to include the domestic market and can effect a replacement of hydrocarbon exports are questions that only time can answer.

2. Power dynamics and the governance determinants of health

This review is based on Teig *et al.*'s (2023) study titled "Governance determinants of health: exploring the structural impact of politicalisation, bureaucratisation and medical standardisation on health inequity".

In this interesting article, Teig *et al.* (2023) coin the term "governance determinants of health" (GDH). These refer to government and hospital policies, laws and professional decisions that can have an impact on people's health. While these are often employed to combat inequities in healthcare access and uptake, some governance strategies may lead to the opposite outcome, thereby increasing rather than decreasing health inequalities.

While socio-economic status is well recognised as a determinant of health, efforts to mitigate inequality by creating greater access to healthcare and healthcare facilities are not always a viable solution in practice. For instance, if an individual lacks education, they may be unable to recognise a potential threat to their health or that of a family member. If someone wishes to access a health practitioner but is unable to afford the transport necessary to reach a facility or is unable to afford alternate care for children or other vulnerable family members whilst they are away from home, then care that was designed to be more accessible fails in that aim because of the personal circumstances of the person wishing to access care. This may also be true of entire communities that are experiencing poverty or other forms of discrimination or social isolation. Some of these issues were previously discussed as "health determinants" by Irving (2021), who called for cross-sector collaboration to develop initiatives to tackle the stall in life expectancy and increasing health inequalities in the UK. Her key point was that a focus on behaviour change is inadequate when many factors affecting health are outside of individuals' control.

The authors of the current article suggest three components of GDH that can have an impact on health inequalities within a society: politicalisation, bureaucratisation and medical standardisation. Politicalisation refers to political decisions affecting healthcare. This might be around the allocation of resources in healthcare budgets, or it may concern the wider realm of political philosophy, where arguments occur about whether healthcare should be privately or publicly funded.

Bureaucratisation refers to the use of hierarchical power to achieve standardised outcomes using predetermined algorithms or policies. While these have usually been

developed to achieve the expected outcome using the most efficient method, over-dependence on rigid structures may stifle creative thinking or the development of alternative solutions. Additionally, resources allocated to the bureaucratic structures of healthcare may mean reduced funding for the medical personnel who are actually needed to provide the services.

Medical standardisation refers to dependence on research findings to solve medical problems rather than using a practitioner's experience or intuition. While overall it may be beneficial to standardise medical practice in this way, it is important to acknowledge that some research may be flawed, creating questions about its findings, and that experienced practitioners may have a wealth of experiential knowledge that cannot always be quantified.

The authors suggest that understanding these components provides a framework in which health inequalities can be understood and discussed, thereby moving towards an equity of health outcomes rather than health inputs.

3. Is health a major issue in Indonesian election campaigns?

This review is based on Ridlo's (2023) study titled "Frequency and specificity of health issues in local political campaign".

This article follows neatly after the previous one, as its focus is on one of the GDH elements discussed by Teig *et al.* (2023), the politicalisation of health. Ridlo (2023) seeks to discover whether health issues form a significant component of local political campaigns in Indonesia. This author argues that health cannot be viewed separately from politics, as health services represent a commodity that is inherently entwined with the political discourse on finance and power.

The fact that health is a topic that engages voters may encourage candidates to make promises they cannot or do not intend to keep regarding the provision of healthcare facilities and increases in health personnel. The author points out that this is particularly true on the part of populist candidates who have a reputation for waging aggressive campaigns.

Using the East Java gubernatorial campaign as a case study, campaign documents and public newspapers were reviewed to ascertain both the importance of heath to the campaign and the issues that attracted the most campaign rhetoric.

Overall, health contributed to only about 6% of the campaign discussions. The issues that attracted the most coverage were health financing and facilities, malnutrition and stunting, leprosy and maternal/child health, especially around pregnancy and lactation. Other health issues, such as smoking and tobacco use proved more controversial because of the conflicts between supporting tobacco farmers versus reducing mortality and morbidity due to tobacco consumption.

Despite the limited focus on health in local elections, population health is an issue that is highly political and of great importance to the voting public. The author suggests that the media should play a greater role in bringing health to the forefront of political campaigns. However, McBride and Rosenstock (2021) discuss how politics and the media can be used to manipulate data in order to achieve outcomes that are politically desirable to certain parties or controlling interests in a society. This is particularly true in communities with low scientific literacy, indicating that education is a key factor in improving the health of populations. Achieving this is a complex issue that affects us all in this era of "fake news" and multi-national media conglomerates. In LMIC, where poor education is associated with poverty and isolation, this is an even more troubling problem in terms of voters' ability to make choices based on evidence rather than rhetoric.

4. Self-management of health problems in the Philippines

This review is based on Loreche *et al.'s* (2023) study titled "Self-care practices for common acute conditions in the Philippines: a scoping review".

This scoping review examines the extent to which the population of the Philippines depends on self-care to manage acute medical conditions. The authors discovered that self-care is very prevalent and consists of traditional medicine and the appropriate or inappropriate use of Western medical treatments. Appropriate self-care may include the use of over-the-counter remedies or lifestyle changes such as a healthy diet, the cessation of smoking or adopting an exercise regime. Inappropriate self-treatment might be the overuse of antibiotics, using out-of-date drugs or taking medication that has been prescribed to another person. Traditional medicine covers a wide range of treatments, which may or may not be effective. Ironically, the efficacy of traditional medicine may be reduced by the growing reliance on modern medicine. The authors report that indigenous people traditionally used up to 125 different varieties of herbs and medicinal plants to treat pain and illness. However, as culture transfers from rural traditional life to urban life, much of this knowledge is being lost. However, one ethnic group, the Agusan Manobo, who live in the Highlands of the Philippines, has preserved their oral tradition of up to 90 plant species that have ethnomedicinal importance. Their knowledge has recently been the subject of a research project to document and further study this plant-based medicine (Dapar *et al.*, 2020).

Self-care can be beneficial when it reduces the use of scarce health resources, but it can have the opposite effect if inappropriate treatment leads to more severe health problems, which ultimately will require medical attention.

The authors suggest that increasing health literacy whilst formally incorporating traditional medicines and health practices into the country's health care system may be ways to improve the safety and efficacy of self-care.

5. Assessment of quality improvement in Norwegian and USA healthcare

This review is based on Øyri *et al.*'s (2023) study titled "Comparison of external evaluation policies and regulations for quality improvement and safety of health services in Norway and the United States".

Quality control and external regulation are important factors in healthcare governance in both the USA and Norway. However, the philosophy informing this governance is quite different. In Norway, medical errors or other problems potentially leading to patient harm are seen as faults of the system or process rather than of an individual practitioner. In contrast, in the USA a blame culture exists that seeks to identify individual errors. This may be due to the structure of care in the USA, which is governed by insurance companies and remains highly litigious as a result. The contrast in healthcare systems goes beyond the response to medical error. Norway has been identified as having the most successful healthcare system in the world, with the USA ranking last amongst developed nations. However, this contrast may be multi-factorial. The USA is a much more divided society racially, culturally and socio-economically. Poor health in the USA is associated with poor quality housing, a lack of education and economic opportunity, and poor nutrition based on high-fat, high-sugar-content foods. Added to the lack of access to healthcare for many people due to the fact that America does not have a universal healthcare system, the contrast in the health of the populations of these two countries is perhaps unsurprising. However, even when comparing the health outcomes of white Americans living in the most affluent counties in the USA with the health outcomes of average residents in other developed countries such as Norway, even the most privileged Americans have worse health outcomes in terms of maternal and infant mortality, childhood leukaemia, colon cancer and myocardial infarction (Emanuel *et al.*, 2021).

Despite differences in regulatory and governance philosophies, both the USA and Norway aim to improve the quality and safety of their healthcare provision through the use of external evaluation. In Norway, however, external inspectors may delegate areas of their inspection to

the healthcare facility, for instance, by requiring a series of audits to be carried out. The USA regulatory system depends on accreditation by accreditation bodies, which may make unannounced spot checks at any time. Hospitals must be reaccredited on a three-year cycle.

Despite these efforts, adverse incidents remain a significant problem in both countries. In Norway, the authors report that patient harm occurs in 12% of all hospital admissions, whilst in the USA, almost a quarter of all admissions are associated with an adverse incident (23.6%). In addition, it is estimated that in the USA, 10% of all deaths in hospitals are due to medical errors. While comparing and contrasting how quality control evaluations are carried out in Norway and the USA provides some interesting insights, it is clear that differences in safety standards may be due to very different health care systems as much as to differences in quality control philosophies and procedures.

6. Has regulation of the paramedic service improved professional identity in Australia?

This review is based on Reed *et al.*'s (2023) study titled "An exploration of perceptions and experiences of Australian paramedics following the introduction of professional registration".

Paramedicine has evolved considerably since its inception as a way of transporting accident victims or people experiencing acute illness to medical facilities. Ambulance crews were trained in basic life support techniques in order to give those being transported the best chance of reaching a hospital alive. Today, paramedics are increasingly taking on the role of front-line medical workers with the knowledge and skills to perform sophisticated diagnostics and procedures. The education and regulation of paramedics reflect this shifting role, with the majority of paramedics now being trained through university degree courses. However, it was only in 2018 that Australia accepted paramedicine into the National Registration and Accreditation Scheme (NRAS) for health professions, thereby fully recognising paramedicine as a health profession in its own right. This reflects the experience in other countries where paramedicine is now a rapidly expanding profession found within a range of medical and academic settings (Eaton, 2023).

Interestingly, this represents a return to the origins of the profession, with the prefix "para" indicating one who works along with medical practitioners rather than as an assistant to doctors. The origin of the paramedic service can be traced back to the 11th century, during the Crusades, when members of the Knights Hospitaller were trained to provide emergency care both for soldiers injured in battle and for pilgrims experiencing illness or accidents (Eaton, 2023).

Although NRAS registration is largely viewed as beneficial in advancing the profession of paramedicine, Reed *et al.* (2023) were aware of dissenting voices amongst rank-and-file paramedics. Therefore, they designed this study using a before and after survey design to capture the thoughts and feelings of paramedics concerning the recent changes in their professional identity. Although the time gap between the pre- and post-registration surveys was quite short (31 months), a clear shift in perspective was observed. In the pre-registration survey, a significant minority of paramedics expressed concern about their changing status, claiming that they did not perceive it as beneficial or worrying that it might adversely affect patient safety. In the second survey, many of those fears seem to have been resolved. There were also differences in how paramedics experienced the process of registration. University-educated paramedics found the process easy and straight-forward. Older paramedics who had to achieve registration through the "grandfather" route, i.e. by providing evidence of their skills and experience, reported registration as being a more difficult procedure.

The authors suggest that paramedic education should include a greater focus on the utility of registration and how it intersects with the professionalisation of the paramedic service.

7. Achieving WHO standards for healthy eating in a bid to reduce non-communicable disease (NCD) in India

This review is based on Kaladharan *et al.*'s (2023) study titled "Transforming food systems: A case of Eat Right India".

Eat Right India (ERI) is a government initiative designed to improve the safety, sustainability and nutritional value of food in order to raise standards of health, particularly in terms of reducing non-communicable disease (NCD). The rise in NCD threatens the achievement of the WHO's sustainable development goal of cutting the incidence of the most common NCDs by 1/3 by 2030.

In addition to reducing the fat and sugar content of popular foods and encouraging healthy eating, Eat Right India aims to increase the safety of street food to ensure food for sale is fresh and prepared in a hygienic manner.

In this article, Kaladharan *et al.* evaluate the Eat Right India programme using the nourishing framework developed by the World Cancer Research Fund International to promote healthy eating. This framework contains three domains: food environments, food systems and behaviour change. The food environment refers to any place where food is prepared and consumed. This can be further broken down into internal or domestic environments such as the home and external environments such as schools, restaurants and street vendors. Food systems cover the whole farm-to-consumer journey and include food production and sales. Behaviour change refers to the food-related behaviour of individuals and groups. For instance, rising incomes have facilitated a move towards convenience, which means that more food produced outside the home is being consumed. Commercially produced foods often contain higher levels of sugar and saturated fat. Education about nutrition is an important aspect of helping people make good choices about the foods they consume; this is especially important for school-age children and teenagers.

To ensure the safety of street food, several certification initiatives have been implemented. These include clean street food hubs, clean and fresh fruit and vegetable markets and even blissful hygienic offerings to god (BHOG), which is a certification for vendors offering food outside religious establishments.

Behaviour change is supported by a variety of information and training materials produced by ERI and made available for use by nutrition counsellors and social workers. However, the authors suggest advertising for the promotion of healthy eating should be increased as part of an integrated healthy behaviour campaign. This would aim to encourage people to increase exercise, reduce unhealthy behaviours such as smoking or excessive alcohol consumption and select nutritional and sustainable foods.

A previously published international scoping exercise into the topic of food environments (Turner *et al.*, 2020) in LMIC highlighted many of the same problems, although they pointed out that there is a lack of clear health outcomes related to food environment indicators. One worrying finding from Turner *et al.* (2020) was that across LMIC, school environs are becoming swamped with fast food vendors. Snack items that contain high-sugar and high-fat are appealing to children and adolescents, but early introduction and easy access to these foods may set the scene for life-long health problems such as obesity and diabetes.

Conclusion

The *IJHG* is unique in its clear focus on healthcare governance and all that this entails. Starting life as the *British Journal of Clinical Governance*, the journal has evolved to encompass an international perspective, inviting authors from around the world for contributions and thus attracting international authorship and readership.

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