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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 prioritise subject matter which reflects their own interests or areas of expertise. The Review Editor includes additional commentary based on external sources as appropriate.

This month’s selection of articles indicates that the need to reflect on, and learn lessons from, the COVID-19 pandemic is ongoing. Baluszek, Brønnick and Wiig’s article on resilience explores the increased need for resilience and self-efficacy during major health crises such as the recent COVID-19 pandemic. Keshavarzi and Horry take a wider approach in their article from Iran; they examine the costs to a nation’s economy resulting from a health shock such as the COVID-19 pandemic. Finally, Atkinson, Barrow and Earnshaw focus on a specific area of concern during the COVID-19 pandemic: contact tracing.

Three other articles focus on the cost of healthcare in developing nations and making access to health more equitable. Boddu and Tobi examine the pharmaceutical industry in India and its relationship with domestic health spending. Etemadi, Ashtarian and Ganji explore issues around healthcare for the poor in Iran, while Olasehinde, Osakede and Adedeji examine the relationship between fee-paying and hospital access and waiting times in Nigeria.

The outlier is a position paper on the need for a nursing definition of patient safety by Chatzi and Malliarou that takes this journal right back to its Clinical Governance roots. With a range of topics from an international authorship, there should be something of interest for all our readers in this issue of *IJHG*.

- (1) This review is based on: [Chatzi and Malliarou \(2023\)](#), the need for a nursing-specific patient safety definition, a viewpoint paper

## A nursing-specific definition of patient safety: a step backwards in the evolution of healthcare governance?

[Chatzi and Malliarou \(2023\)](#) take us back to our roots in choosing the *IJHG* in which to publish their paper on patient safety and nursing. *IJHG* started life as the *British Journal of Clinical Governance* before taking on a wider international brief, as *Clinical Governance: An International Journal*. Because the nomenclature “clinical governance” is less widely used outside of the UK to describe all the factors that work together to make healthcare both effective and safe, the current editorial board has updated the journal title to reflect the wider aspects of health governance, again within an international context. However, any authors writing about this topic today would be wise to revisit McSherry and Pearce’s book (“Clinical Governance. A guide to implementation for healthcare professionals”) first published in 2002 but now in its 3-d edition ([McSherry and Pearce, 2010](#)). In a forward to the third edition Sir Liam Donaldson, England’s chief medical officer from 1998 to 2010, and the formulator of the concept of Clinical Governance, reiterates the ongoing importance of this initiative in improving healthcare safety and efficacy.

In the article under review, Chatzi and Malliarou focus on the role of nurses in maintaining patient safety, pointing out that nurses comprise the largest workforce group in health care. While acknowledging the problems caused by nursing shortages, the authors suggest that



nurses are best placed to protect patient safety through the conduct of their nursing function. This includes aspects such as assessment of changes in a patient's condition, prevention of medication errors, safe moving and handling, recognition and response to acute conditions such as sepsis and maintaining effective anti-microbial barriers. The focus on nursing responsibilities balances, they say, the outdated assumption that patient safety sits largely within the medical remit. However, one of the key aspects of good clinical governance has always been teamwork. A nurse conducting a medicine round, for instance, has an important role in checking any prescribed medication, reviewing the dosage and any patient allergies or previous reactions which might contraindicate a certain drug. However, the nurse shares the responsibility of safe drug administration with the doctor prescribing the drug and the pharmacist who dispenses it. Another area of nursing responsibility is the clinical handover, either at shift change or when a patient is being transferred from one area to another such as from an admissions ward to a medical or surgical ward, or from a ward to an acute care area. Again, it is important to note that these areas in which errors often occur are not wholly within the nursing responsibility. Different designations and grades of staff working together form the cornerstone of patient safety. In a systematic review of academic articles on this topic, [Raeisi et al. \(2019\)](#) identify poor communication as the largest barrier to the conduct of a safe handover procedure.

The authors explore these and other issues within the model of Human Factors Theory. This is a concept which has been used in healthcare since the 1960s, specifically in relation to medication errors ([Carayon et al., 2014](#)) and it continues to inform the World Health Organisation's curriculum on patient safety ([WHO, 2011](#)). While a human factors systems approach is congruent with the later clinical governance initiative, the responsibility of organisational systems must be taken into account, as without this foundation, individual initiatives will not have a significant and lasting impact. Furthermore, reviewers commented that the narrow definition of safety based on harm reduction/elimination is not congruent with a multi-faceted approach and that focusing solely on nursing responsibility takes a backward step from the team approach to healthcare governance, acknowledged as the most effective. Nevertheless, the reviewers and editors felt that this article makes a significant contribution to the discussions around patient safety within the context of health governance and, therefore, welcomed its inclusion in this issue.

- (2) This review is based on: [Keshavarzi and Horry \(2023\)](#), the effect of increasing health disaster risk and public spending on economic conditions: a DSGE perspective

### **Health disaster and public spending: lessons from Iran**

[Keshavarzi and Horry \(2023\)](#) have produced an ambitious study which attempts to explain the effects of a major health shock such as a pandemic on a nation's economy. Some of the complexities of this investigation lie in the fact that personal, commercial and government spending priorities are all altered by health shock conditions.

Using a Dynamic Stochastic General Equilibrium (DSGE) model, the authors explore the interaction between social and financial equilibrium (and disturbances to this equilibrium) and market forces. [Christiano et al. \(2018\)](#) explain the rise of the use of DSGE models in financial projections and policy planning as the best way to present the complex interrelations between macroeconomic and microeconomic factors.

The disturbance to economic equilibrium which interested [Keshavarzi and Horry \(2023\)](#) was the effect of a major health shock such as the recent global COVID-19 pandemic. A major health crisis such as a pandemic has many escalating repercussions. Economic activity decreases as more of the population becomes ill; spending decisions alter as people stop participating in leisure activities involving social gathering; there is a negative impact on businesses due to absent employees and altered consumer actions. Governments' responses

vary according to both resources and political philosophy, yet all governments must make some adjustments in terms of additional financial support to businesses and individuals. While the authors examined these issues from the perspective of Iran's state oil economy, some of the lessons learned will have a wider application in forecasting scenarios to help economists and health professionals prepare for future health shocks.

- (3) This review is based on: [Boddu and Tobi \(2023\)](#) is rising pharma market a new burden? Introspecting the implications of India's healthcare journey from public to a private good

### **The impact of the pharmaceutical industry on India's population health**

India has great potential in many areas, recently surpassing China in terms of population ([Silver et al., 2023](#)). In addition, the Indian population is one of the world's youngest; this means that India will have the workers it needs to grow its economy well into the future ([Kedia et al., 2018](#)).

However, in the area of healthcare, India lags behind, ranking 145 out of 195 in the Lancet's healthcare quality and accessibility index. [Boddu and Tobi \(2023\)](#) attribute this largely to the lack of public sector involvement in healthcare. Indian citizens are driven to access the private sector for lack of alternatives. Much of a typical family's health budget goes on the purchase of both medical care and prescribed medications.

The COVID-19 pandemic exacerbated existing problems in the Indian healthcare system, with the WHO reporting that India had approximately 50% of global COVID infections, with 30% of the world's deaths ([Boddu and Tobi, 2023](#)). The Indian pharmaceutical industry is a success story with high-income generation from diagnostic laboratories and drug production. However, many of these goods and services are exported and therefore do not benefit the domestic market as much as they could.

The authors call for increased healthcare regulation, including regulation of the pharmaceutical industry to bring down domestic healthcare costs and improve the health of the nation. A healthy population is an economically productive population ensuring the Indian workforce will be able to realise its aims for economic growth and domestic wealth creation.

- (4) This review is based on: [Baluszek et al. \(2023\)](#) the relations between resilience and self-efficacy among healthcare practitioners in the context of the COVID-19 pandemic – a rapid review

### **Does greater resilience lead to enhanced efficacy among healthcare practitioners?**

There are still important lessons to be learned from the COVID-19 pandemic. Nurses, doctors and other healthcare staff were hailed as heroes during the course of the pandemic as they kept health services running while treating an unprecedented number of acutely ill patients. For many healthcare staff, this work was done at great cost to their own health or even their lives ([Alshamrani et al., 2021](#)). The hidden costs, however, of psychological stress, mental exhaustion and burn-out were just as debilitating ([Spoorthy et al., 2020](#)).

Resilience has for some time been recognised as an important attribute for nurses and other healthcare staff. This can be defined as the ability to maintain equilibrium and commitment under difficult working conditions and to recover quickly from episodes of trauma or increased workload ([Sull et al., 2015](#)). However, during the COVID-19 pandemic, the trauma and the workload were continuous, putting exceptional burdens on healthcare workers' ability to maintain adequate levels of resilience. [Baluszek et al. \(2023\)](#) suggest that the additional stressors resulted in deteriorating mental health among frontline health workers, thus impacting on patient care. To study this, they reviewed six international studies which collated

quantitative data on the relationship between resilience and self-efficacy under pandemic conditions. The authors explored both general self-efficacy and an individual's self-belief about their ability to cope with a range of stress factors and specific self-efficacy, that is, an individual's beliefs about their ability to complete specific tasks.

Findings include the fact that the relationship between resilience and self-efficacy is one of mutual dependence. Higher levels of resilience enhance feelings of self-efficacy while higher self-efficacy leads to greater resilience. These attributes are always important in the delivery of healthcare but assume a more critical importance during a healthcare crisis. Therefore, the authors recommend that planning for future pandemics should include enhanced training in resilience and self-efficacy. However, the Review Editor would like to insert a reminder that personal resilience can only put sticking plasters over what is essentially a managerial, philosophical and political dilemma. Every nurse, doctor and supporting members of the healthcare team have their own personal limits as to how far resilience can take them. Beyond that lies anxiety, burn-out and ongoing mental health problems. For an in-depth consideration of resilience I recommend that all nurses, nursing students, health care managers and other health professionals read Michael Traynor's book entitled "Critical Resilience for Nurses. An evidence based guide to survival and change in the modern NHS" published in 2017 by Taylor and Francis (Routledge Group: London and New York). While this was published before the COVID-19 pandemic, the discussion around personal and critical resilience is even more relevant in light of the additional stressors which emerged during the pandemic.

- (5) This review is based on: [Etemadi et al. \(2023\)](#), a model of financial support for the poor to access health services in Iran: the Delphi technique

### **Making healthcare more equitable in Iran**

The provision of healthcare across populations has always been a difficult task. We look back to what we presume were less enlightened times when the rich had access to physicians and the poor died. However, in today's stratified societies, it can sometimes seem that not much has been gained despite the World Health Organisation's (WHO) much-lauded goal to "promote health, keep the world safe and serve the vulnerable" through the provision of universal healthcare ([WHO, 2023](#)). Even in a country such as the UK which at one time had the most admired and arguably efficient National Health Service in the world, today that vision of health equity for all has been diminished through creeping privatisation ([Wathen, 2019](#)).

[Etemadi et al. \(2023\)](#) examine the issues around the provision of healthcare for the poor in Iran, a country without a working model of universal health coverage. A health crisis can be debilitating for an individual or for a family where care must be paid for at the point of use. Access as well can be a serious problem when health facilities are concentrated in urban areas and the rural poor lack the means of transportation to clinics or hospitals. Poor health and poverty exist in a debilitating cycle where poor health affects an individual's ability to work and lack of work means an increasing inability to pay healthcare expenses.

Using a Delphi technique ([Prasant et al., 2021](#)) to develop a model for financing healthcare and propose policy options for its implementation, [Etemadi et al. \(2023\)](#) sought informed opinion from a wide range of experts in fields relating to health and finance. These included government ministers, university professors, health economists, officials from charitable organisations and health professionals. [Prasant et al. \(2021\)](#) provide a good explanation of the Delphi Survey method and its use in healthcare research.

The rounds of the Delphi survey were repeated until all remaining components achieved a 75% consensus. The final policies derived from the model were: Effective identification of the poor; Prevention of the exacerbation of health poverty; Targeted financing to support the

poor; Coherent regulation of the actors; and Ensuring financial accessibility to health services for the poor.

While the Islamic Republic of Iran already has laws concerning healthcare provision for all, in practice, the poor are less likely to receive either preventative healthcare or treatment for chronic or acute health problems. These health issues may be exacerbated by a reluctance to seek treatment due to cost or the inability to travel to appropriate treatment centres. However, as this Delphi survey formed part of a larger study, some of these questions may be answered in other strands of the research. As in any research study, identifying and acknowledging the key problem or problems is an essential first step.

- (6) This review is based on: [Olasehinde \*et al.\* \(2023\)](#), effect of user fees on healthcare accessibility and waiting time in Nigeria

### **The relationship between healthcare fees and accessibility/waiting times in Nigeria**

Paying fees for both preventative healthcare and treatment is common across Africa. This was encouraged by the World Bank in the later decades of the 20th century based on the belief that money generated in this way could be reinvested in the health service. It was also hypothesised that the inclusion of fee-paying clients might relieve some of the direct burden on government health budgets. However, [Olasehinde \*et al.\* \(2023\)](#) point out that most fees are so low that they have little effect on government budgets, while at the same time being a necessary source of income for health practitioners who are inadequately recompensed by government payments.

The authors constructed a study to explore the effects of fee-paying, both in terms of access and in terms of waiting times. This refers to waiting times at the time of a hospital or clinic appointment rather than the time lapse between a referral and an appointment. Using a General Household Survey (GHS) dataset from 2015/2016 a number of variables including age, gender, education and income level, marital status, and urban or rural habitat were used to examine how people interacted with health services.

A surprising finding was that fee-paying was associated with higher use of health services; this also contradicted data from previous African studies. However, the authors suggested that an explanation could be that people do not access care until their health problems have a serious impact on their activities of daily living. At this point, anxious to find relief or a cure, people are willing to pay for rapid consultation. The increase in uptake of preventative care associated with fee paying is more puzzling and the authors do not offer an explanation.

Waiting times across all consultations averaged about 30–35 min; the time from arrival to consultation appears to increase significantly when the patient is paying fees for the consultation. Again, while this seems counterintuitive, it may be due to the fact that people with more serious health problems are more likely to access fee-paying services. However, this is conjecture and would need to be examined more closely, perhaps by collecting qualitative data about how and when decisions are made to access health care.

The authors conclude that further provision of non-fee paying healthcare will improve access but as their own data demonstrates a higher number of participants accessing fee-paying prevention and treatment this is not adequately explained, except in reference to previous literature. Other problems highlighted include the fact that Nigeria has not managed to comply with the Abuja Declaration of 2001 where African nations pledged to allocate 15% of their budgets to healthcare. This agreement was instituted to counteract chronic underfunding of public healthcare by African nations ([Biegon, 2020](#)). In a survey of the 20 subsequent years Nigeria was found to be allocating only about 5% of the national budget to the health needs of the population ([Olasehinde \*et al.\*, 2023](#)). While this article examines some interesting issues, achieving clear answers may require further dissection of

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the data or the addition of a qualitative component to explain participants' motivations and actions.

- (7) This review is based on: [Atkinson \*et al.\* \(2023\)](#), the role of motivational interview training in supporting the practice of COVID-19 contact tracers

### **Motivational interviewing (MI) as a tool to improve contact tracing**

During the recent COVID-19 pandemic contact tracing of infected individuals became a key priority in the UK. Seen as an important weapon in containing outbreaks of the virus, it relied on individuals who were contacted to comply with health advice to self-test and isolate themselves if positive. [Atkinson \*et al.\* \(2023\)](#), however, report on recent research that indicates a compliance rate of less than 50%.

The authors propose the use of a technique called Motivational Interviewing (MI) to improve compliance during contact tracing. This has been used successfully in other settings such as sexual health, family practice, and in the criminal justice service. MI aims to change the conversation from one of telling to one of participation, collaboration and partnership. According to [Rollnick \*et al.\* \(2010\)](#), directive counselling is less effective than a conversation which encourages clients to identify their own motivations for change. In general practice, environment doctors often find that listening and empathy are the most effective tools in promoting behaviour change ([Hall \*et al.\*, 2012](#)). The same client-centred approach translates well to the conversations between the contact tracer and the client. [Atkinson \*et al.\* \(2023\)](#) suggest that using the acronym 'OARS' (open questions, affirmation, reflection and summary) facilitates client communication within a philosophy of compassion and acceptance.

[Atkinson \*et al.\* \(2023\)](#) collaborated with a local authority test track and trace cell (TTTC) in the North of England to develop an online MI training package. Participants were asked to complete pre- and post-test surveys testing aspects such as job satisfaction, communication skills, self-efficacy, managerial and colleague support, resourcefulness and other aspects of their professional life. Questions also included participants' impressions of the training package and how useful they felt it would be in their work. While the survey was not powered to measure pre- and post-training attitudes, it provided valuable insights that may help prepare contact tracers during future pandemics. However, the authors caution that one training session may not be adequate to maintain a change in approach to client conversations, particularly if the techniques are not practised. The best preparation for future contact tracing may be, therefore, to use an empathetic, non-directive, client-centred approach in all professional-client interactions.

### **Conclusion**

The *IJHG* is unique in its clear focus on healthcare governance in 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 an international readership. While readers may initially be attracted to articles perceived as most relevant to their own professional setting or interests, the Review Editor believes that expanding one's focus to include articles that may not seem immediately relevant can reveal hidden treasures. In the world of clinical healthcare, healthcare management and health professional education, we all have much to learn from each other.

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### Further reading

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