Health Governance Review Volume 31, Issue 1

Introduction

The *IJHG* review section consists of short reviews of each article included in the current issue. The Review Editor includes additional commentary to provide a broader context for each article and to reveal how those articles correspond to the aims of the journal. This allows readers to select articles that reflect their own interests and hopefully could help our future authors to better understand our priorities in selecting manuscripts for publication.

Club convergence in healthcare expenditure in the United States

The aim of the article under review (Ogundari and Obembe, 2026) was to revisit the disparities in per capita healthcare expenditure and prescription drug spending over time across the 50 US states and the District of Columbia (the previous research in the US included data till 2014). The authors have chosen this methodological approach as "the convergence hypothesis provides important frameworks for examining how economic indicators (e.g. healthcare expenditure, income inequality, life expectancy and healthcare spending) converge across regions, cities, states or countries over time" (Ogundari and Obembe, 2026). The authors explain their choice of the club convergence test over other methods like β-convergence, γ-convergence and unit root/cointegration tests "because it can handle transitional heterogeneity and allows for the possibility of multiple steady equilibria" (Ogundari and Obembe, 2026).

The results of the article under review "reveal widening disparities in per capita healthcare expenditure and prescription drug spending across US states and the District of Columbia, [. . .] per capita healthcare expenditure exhibits two convergence clubs and one divergence group. In comparison, per capita prescription drug spending exhibits three convergence clubs" (Ogundari and Obembe, 2026).

When comparing their results with previous findings in the US (where other methods were used), the authors found that "all these studies provide evidence supporting divergence (or lack of full convergence) in healthcare spending" that is consistent with their results: "the implication is that a single pattern of behavior does not exist in healthcare expenditure dynamics across the US states, which shows a widening disparity" (Ogundari and Obembe, 2026). The authors conclude that "these studies (Panopoulou and Pantelidis, 2013; Clemente *et al.*, 2019a) also revealed evidence that shows healthcare expenditure across US states eventually converging into two distinct convergence clubs, where the disparity in healthcare expenditure decreases over time. This finding is also consistent with the results of the present study" (Ogundari and Obembe, 2026). The authors of the article under review conclude that "policies that affect social determinants of health services across the population, such as investment in public health infrastructure, poverty, lack of education, unemployment, etc., should be pursued" (Ogundari and Obembe, 2026).

Though widely applied in health research across diverse geographic contexts, club convergence tests have fundamental methodological and interpretive challenges. Convergence analyses can precisely describe club structures and identify club membership patterns, yet often fail to provide clear policy guidance: recent studies recommended "targeted interventions" or "club-specific policies" underscored a need for common health policies for the different convergence clubs, while country-specific policies should be implemented for the divergent countries, but did not specify what these should entail beyond the observation that one-size-fits-all approaches are insufficient (Nag *et al.*, 2023; Clemente *et al.*, 2019b; Ndzignat Mouteyica and Ngepah, 2024). Convergence testing can identify that regions and/or

International Journal of Health Governance
Vol. 31 No. 1, 2026
pp. 136-147

e-ISSN: 2059-464X
p-ISSN: 2059-4631
DOI 10.1108/IJHG-03-2026-177

countries fall into different clubs with different trajectories but often cannot explain why these clubs exist or what policies would facilitate convergence. For example, a study from Spain (Clemente *et al.*, 2019b) showed that partisan behavior influenced health expenditure convergence: even when convergence patterns are well-characterized, they may reflect political factors rather than technical health system properties, limiting the applicability of convergence-based policy recommendations. The finding that causal links were not fully understood (Nag *et al.*, 2023) suggests that convergence club analysis is primarily a descriptive tool that requires complementary causal analysis to inform policy.

Some authors recognize that studies show "mixed results" when applying convergence tests to health research (Çelik *et al.*, 2023; Ndzignat Mouteyica and Ngepah, 2024). Different studies using various convergence methodologies often produce conflicting findings, making it difficult to draw definitive conclusions. The convergence test provides the "what" (which units are converging) but cannot answer the "why" or "how" questions necessary for policy action. More productive approaches might involve using convergence club identification as an exploratory analysis to identify interesting patterns, followed by detailed case studies or quasi-experimental analyses within and between clubs to understand causal mechanisms.

Regional disparities in health satisfaction: a comparative study of socio-demographic, non-medical and medical factors

The next article is devoted to determinants of health satisfaction in different regions and countries. The author of the article under review defines "health satisfaction" as "a person's subjective evaluation of their health care experiences," which "serves as a key indicator of health care system performance, patient well-being and the capacity of health services to meet population needs" (Yum, 2026). The article is based on data from "The International Social Survey Programme (ISSP) 2021 – Health and Health Care II" (https://www.gesis.org/en/issp/data-and-documentation/health-and-health-care/2021).

The aim of the study was to explore how socio-demographic, non-medical and medical factors influence health satisfaction differently between Asian and non-Asian countries. It sought to investigate the relative importance and impact of these determinants across different cultural, policy and systemic contexts, using a cross-national, multilevel analytical approach to identify universal and region-specific drivers of health satisfaction.

Previous research (based on the data from the 2011 International Social Survey Programme) revealed that health satisfaction is influenced by multiple interconnected factors: at the individual level, key predictors include personal income, age, gender and direct experiences with medical providers, while country-level factors such as public health expenditures, physician density and healthcare system financing significantly modulate satisfaction (Yuan, 2021).

A systematic review of evidence regarding determinants of patient satisfaction between 1980 and 2014 was conducted in 2017 to seek the reasons for contradicting results in relationships between determinants and patient satisfaction in the literature to design a further robust measurement system for patient satisfaction (Batbaatar *et al.*, 2017). Conclusions of that review were that interpersonal care quality emerges as a critical determinant, often more influential than structural healthcare indicators. Sociodemographic characteristics were the most varied in the review: the strength and directions of associations with patient satisfaction were found to be inconsistent. The authors recommended to conduct "more studies on how cultural, behavioral and socio-demographic differences affect patient satisfaction, using a standardized questionnaire" (Batbaatar *et al.*, 2017).

The knowledge gap addressed by the study under review was the limited understanding of how socio-demographic, non-medical and medical factors jointly influence health satisfaction across diverse national contexts, particularly when distinguishing between Asian and non-Asian settings. The author underscores that previous research often "focused on single countries, specific populations or isolated determinants, lacking a comprehensive, multilevel

comparison that captures the complex, multidimensional nature of health satisfaction and its dependency on cultural, systemic and policy differences" (Yum, 2026). This study aimed to fill this gap by providing empirical evidence on the combined effects of these factors across multiple healthcare dimensions and geographic regions, employing robust econometric methods.

The study applied hierarchical linear regression (HLR) models to analyze the multilevel relationships between socio-demographic, non-medical and medical factors and health satisfaction. This approach allows for the examination of nested data structures – such as individuals within countries – and captures both individual-level and contextual effects, providing a comprehensive understanding of the determinants of health satisfaction across different settings.

There are some known limitations to this methodology. The models require large sample sizes at both individual and country levels to produce reliable estimates, and issues like multicollinearity among predictors can affect the stability and interpretability of the results. The cross-sectional nature of the data limits the ability to infer causality between determinants and health satisfaction. Also, unmeasured confounders at both the individual and contextual levels might influence outcomes, which the models cannot fully account for.

The main findings of the study under review are "medical factors generally impact health satisfaction everywhere, except for healthcare practitioners in Asia; non-medical factors play a bigger role in health satisfaction in Asian countries; socio-demographic characteristics affect health satisfaction more in Asian healthcare systems but impact practitioners more in non-Asian settings; and variables like gender, education and weight consistently influence satisfaction in Asia but less so outside" (Yum, 2026). It is worth mentioning that the author cites one retracted article (which has comments on PubPeer).

The author concludes that "these findings enable health care policymakers to move away from "one-size-fits-all" policy designs and instead develop tailored strategies that reflect their health care context and population characteristics. Furthermore, health care providers can use these results to prioritize their resources more effectively – strengthening those aspects of care delivery and health policy that will have the greatest impact on health satisfaction – and thereby maximize the well-being of their patients" (Yum, 2026).

Cybersecurity preparedness and resilience in health care

The next article in this issue is a narrative review, "Cybersecurity preparedness and resilience in health care". The authors explain that the aim of their publication was "to present key strategic and policy frameworks as well as recommendations and shared experiences from the literature to help health organizations build cybersecurity preparedness and resilience" (Fišter and Belani, 2026).

The authors specifically discuss the following strategic and policy frameworks from national and international organizations:

(1) World Health Organization (WHO) Cybersecurity and privacy maturity assessment and strengthening for digital health information systems (2025a, b) and Regional digital health action plan for the WHO European region 2023–2030 (2022).

(2) The Organisation for Economic Co-operation and Development (OECD) Policy Framework on Digital Security (2022) that charts the economic and social dimension of cybersecurity highlights the OECD approach to digital security policy and equips policymakers to use OECD digital security recommendations in developing better policies. The framework also identifies linkages with other policy areas addressed through existing OECD standards and tools.

(3) National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) 2.0, which provides detailed guidance on cybersecurity risk management and

incident response applicable across sectors, including healthcare. The framework focuses on managing, discovering, prioritizing, containing, eradicating and recovering from incidents, with an acknowledgment that incident response activities vary across technologies and environments (Nelson *et al*., 2025).

(4) Health Sector Cybersecurity Coordination Center (HC3) Threat Briefs from the US (OCIO, 2023).

(5) European Commission (EC) European action plan on the cybersecurity of hospitals and healthcare providers (2025).

The authors of the narrative review acknowledge that only part of information about cyberattacks is shared openly and thus could be included in research: "Although much information about most realized cyberattacks is kept confidential during and after the attack for understandable reasons, lessons learnt from some high-profile incidents have been shared publicly" (Fišter and Belani, 2026). The main recommendations for policymakers emphasize the need for proactive, comprehensive and coordinated strategies to enhance cybersecurity preparedness and resilience in health care settings.

The authors explain their choice of review type: "A narrative review allows for an interpretative approach that can incorporate diverse sources, such as policy documents, standards, expert opinions and research findings, without the constraints of systematic review protocols" (Fišter and Belani, 2026). Specifically, they mention that this approach enables "to map out the landscape of cybersecurity strategies across various organizations and regions, providing a broad understanding rather than a narrowly focused, systematic analysis" (Fišter and Belani, 2026).

The knowledge base and cybersecurity theory are developing rapidly. In recent years, scholars have contributed to cybersecurity theory by developing various generic frameworks for different types of organizations: a framework for a secure healthcare 5.0 system based on blockchain technology by Rehman *et al.* (2022), a healthcare 5.0 security framework by Wazid *et al.* (2022) and the Eight Aggregated Response Strategies (EARSs) framework for cybersecurity incidents by Jalali *et al.* (2019).

A new cybersecurity framework was developed in 2025 by a group of authors from the University of Vaasa, Finland. Their study "examined the dynamics of the factors of vulnerabilities and cyberattacks in the context of sociotechnical systems theory underlying the relationships among humans, technology and processes" (Ewoh *et al.*, 2025). The authors have conducted a scoping review based on the research and review papers from the period of 2012–2024. Their results showed that the factors of vulnerabilities to cyberattacks comprise 12 subfactors in healthcare systems: (1) new technology integration, (2) complex system design and usability, (3) third-party application and plugin, (4) limited monitoring, (5) inadequate access control management, (6) insider threats, (7) shortage of skilled professionals and limited budget, (8) inefficient training, (9) security culture, (10) untimely incidence response and recovery plan, (11) inadequate policy and procedure and (12) lack of regular audit and assessment (Ewoh *et al*., 2025). Related to technology-related factors, most studies described the complex system design and usability (21%) and integration of new technology (20%); for human-related factors, most studies described a shortage of skilled professionals and limited budgets (Ewoh *et al*., 2025).

That conceptual framework of sociotechnical cybersecurity provides a contemporary foundation and deep insight for identifying and preventing vulnerabilities and responding to cyberattacks in health care systems. The study also provides compliance standards for applying the proposed conceptual framework to guide health care organizations in cybersecurity practices (Ewoh *et al.*, 2025). The authors concluded that further studies are needed on cybersecurity incident management and that health care organizations should leverage the strength of cybersecurity through the implementation of risk assessment and

incident response plans. The results of that scoping review could guide our future authors when choosing aspects of their cybersecurity research.

Reforms in Georgia's healthcare system

The purpose of the next article, "Georgia's healthcare system: a journey of reform, investment and progress" (Albarari and Phagava, 2026), was to analyze "Georgia's healthcare transformation from 1991 through both historical policy evolution and the WHO Health Systems Framework, evaluating how reforms prioritized or neglected system components while projecting 2030 outcomes."

Recent "Health Systems in Action Insights" have shown many urgent issues in Georgian health system: public spending on health is still low in international terms (3.1% of GDP in 2022); the high cost of outpatient medicines being the main barrier to access for those on low-incomes; most health care providers are private-for-profit, accounting for around 80% of all hospital beds and most urban primary care provision; the private sector tends to resist central government planning and regulation; high rates of doctors per capita, who are concentrated in the capital Tbilisi, with shortages in rural and mountainous areas; an acute shortage of nurses, creating increasing barriers to access, and declined access to care for noncommunicable diseases (Richardson *et al*., 2025).

The authors of the article under review have chosen the WHO Health Systems Framework as it provides a comprehensive analytical tool that allows for the examination of interdependent components of Georgia's healthcare system, such as service delivery, workforce, information systems, medical products, financing and governance (Albarari and Phagava, 2026). By applying this framework, the study discusses specific areas where Georgia's health system performs well – like financing and service delivery – while simultaneously identifying persistent weaknesses, notably in workforce capacity (e.g. nurse shortages) and governance issues. This holistic approach facilitates understanding of systemic imbalances and highlights targeted areas that require policy attention to advance toward universal health coverage by 2030.

The authors state that it is the first review study to assess Georgia's progress towards the 2030 vision through an integrated lens that accounts for systemic strengths, ongoing challenges and future projections, thus offering a nuanced understanding of how past policy decisions shape present and future healthcare outcomes. In the conclusions, they underscore the necessity to address workforce shortages, governance issues and digital infrastructure concurrently to achieve sustainable progress towards universal health coverage by 2030 (Albarari and Phagava, 2026). The implications for practice are that the review informs strategic decision-making, guiding targeted reforms that can optimize health system efficiency, equity and resilience. The authors hope that their research can serve as a model for evaluating healthcare reforms in other transition or post-conflict countries. It also highlights gaps in existing literature, such as the need for primary data and ground-level assessments, encouraging further empirical investigations.

Governance of aging and functional health

The next article in this issue, "Governance of ageing and functional health: the impact of retirement policies on grip strength in Europe" (Almomani and Al-Masaeid, 2026), is an outlier for this journal, as we rarely publish research related to the impact of retirement policies on public health.

The authors formulated the need for their research as despite extensive studies on retirement's impact on subjective health and long-term outcomes like morbidity and mortality, little is known about its effect on early physiological indicators such as grip strength, which predict future health deterioration. Meijer *et al.* (2008) contributed methodological approaches for cross-country health measurement using grip strength but did not directly examine

retirement policy impacts on this outcome. The study by Bertoni *et al.* (2018), based on panel data from the Survey of Health, Ageing and Retirement in Europe (SHARE), directly examined this relationship, finding that retirement produces a short-term positive causal effect on muscle strength, but this protective effect is not persistent: over time, retirement accelerates the age-related decline in muscle strength, with greater negative effects observed for blue-collar workers and males.

SHARE (https://share-eric.eu/) includes data from 28 European countries and Israel. Thousands of research papers and reports based on those datasets are available from the SHARE publications database, while national and global policies developed using this evidence are presented at the Policy Impact of SHARE (https://share-eric.eu/impact/policy-impact).

The article under review also utilized panel data from SHARE, covering the years 2004–2019 with detailed information on adults aged 50 and older across nine European countries (Austria, Germany, Sweden, Spain, Italy, France, Denmark, Switzerland and Belgium) (Almomani and Al-Masaeid, 2026). The datasets provide comprehensive measures such as grip strength assessed through handheld dynamometers, along with extensive demographic, health and lifestyle variables. The use of SHARE data allows for cross-national comparisons and robust longitudinal analysis of how retirement and related factors influence physical functioning over time.

The authors explained that their research fills knowledge gaps by understanding how pension policies and cultural contexts influence early physical functioning, which is crucial for designing effective interventions that promote healthy aging; by analyzing the causal relationship between retirement timing and objective physical health markers across diverse European countries and by incorporating cultural dimensions (individualistic vs. collectivist societies) to understand how social norms and institutional frameworks modify health outcomes (Almomani and Al-Masaeid, 2026).

The authors conclude that from a health governance perspective, their results suggest that integrating strength-maintenance programs into retirement policy, through subsidized community-based interventions, digital exercise platforms or public-private partnerships, can mitigate functional decline among older adults. They underscore that policymakers should also consider culturally responsive strategies that acknowledge differing post-retirement norms and caregiving roles across societies. They suggest that future research should test the generalizability of these findings beyond European welfare states and evaluate the long-term effectiveness of health interventions embedded within retirement frameworks. Ensuring functional independence among older adults will require not only responsive pension systems but also proactive, equity-focused health governance that adapts to the diverse needs of aging populations.

Navigating the fault lines between neoliberalism and the universal right to health

The next article in this issue is "Rethinking global health governance: navigating the fault lines between neoliberalism and the universal right to health" (Dele-Dada *et al.*, 2026). The authors explain the need for their research by the following existing contradictions: while "many healthcare stakeholders aim to achieve access and equity, [. . .] their funding practices and implementation frameworks often adopt a commercial approach to healthcare delivery", and "global health finds itself in a challenging situation, trying to balance the view of healthcare as a fundamental public good with the reality of it being a financial activity driven by commercial interests" (Dele-Dada *et al.*, 2026).

In the Methods section, they state that the "study adopts a documentary and conceptual analysis approach to examine the evolving tensions in global health governance. It draws exclusively on secondary sources, including peer-reviewed academic literature, global policy frameworks, institutional declarations, legal instruments and historical documentation" (Dele-Dada *et al.*, 2026). Though mentioning many databases used for retrieving available

publications, the authors did not explain how those databases have been searched and how retrieved documents were chosen for inclusion in their analysis. So, it is not possible to replicate their search and understand why certain documents were included, while others were not.

The authors also state that the chosen "materials were critically reviewed to trace the ideological, structural and operational contradictions in global health governance, particularly the collision between neoliberal health reforms and the normative commitment to universal health rights", seeing their contribution "in the ability to integrate diverse strands of scholarship and institutional practice into a cohesive conceptual framework" (Dele-Dada *et al.*, 2026).

In the last 10 years, several conceptual frameworks have been developed to analyze tensions between rights-based and market-driven approaches in global health governance, for example, the Framework Convention on Global Health (Koivusalo and Perehudoff, 2018) and Global Constitutionalism (Ooms and Hammonds, 2016; Kentikelenis and Rochford, 2019) suggested a conceptual framework for analyzing the political-economic determinants of health inequities and power asymmetries in global governance for health.

The authors of the article under review state that their research design is "interpretive and normative, relying on conceptual synthesis rather than primary empirical data collection" and that "a thematic analysis was developed, anchored in critical political economy and human rights-based perspectives, to uncover how multilateral institutions, philanthropic actors and private corporations shape access to health" (Dele-Dada *et al.*, 2026), but did not provide any details about the process – which is expected in this type of research (*see* how the process of thematic analysis is described in another article in this issue (Xavier, 2026).

As the thematic analysis is often used in health and health systems qualitative research, our future authors might consider using recently developed Reflexive Thematic Analysis Reporting Guidelines (RTARG) when preparing their manuscripts (Braun and Clarke, 2024). The RTARG is also intended for use by peer reviewers to encourage methodologically coherent reviewing.

Managerial agency in patient experience

The next article in this issue is devoted to managerial agency in patient experience (Xavier, 2026). The aim of this study was "to identify the capabilities that healthcare provider organizations should develop to enhance patient experience" while "assuming a patient journey in which digital technology is increasingly prominent" (Xavier, 2026).

The author proposes the Honeycomb Capabilities Framework and develops six propositions that directly influence organizational agility and patient-centricity: foresight capability (enables managers to continuously monitor and adapt to environmental changes, allowing them to anticipate future trends in patient needs; reconfiguration capability (uses transformation mechanisms to reduce technological gaps, ensuring the organization remains up-to-date with digital care models); environmental capability (focuses on creating processes that respect ethics and the rights of data subjects, which increases the perceived value and trust in how health data is used); political management capability (employs proactive strategies to manage the political environment, which helps maintain the healthcare provider organizations legitimacy and institutional influence); problem-finding and solving capability (enhances the agility of care models by providing structured approaches to identifying and resolving organizational friction) and operational capabilities through design thinking (uses innovation and human-centered design to sense and seize operational capacity, leading to a positive influence on patient centricity) (Xavier, 2026).

The author explains that while "healthcare exists in a complex structure where rules (regulation) and resources (digital technology) often conflict," the Honeycomb Capabilities Framework could help managers overcome these tensions by "building trust and alignment: because the data belongs to patients, its successful use for public health policies depends on

patient altruism, consent and trust, all of which are fostered by a positive patient experience"; and by reducing bureaucracy – as the framework encourages managers to move past "regulatory inertia" or "litigation fear" that can result in bureaucracy, instead focusing on "data protection by design" that centers the patient (Xavier, 2026).

This work followed a structured six-step process of thematic analysis (Naeem *et al.*, 2023). The recruited interviewees were healthcare executives attending the 46th World Hospital Congress (WHC) of the International Hospital Federation (IHF), which took place in October 2023. For managing biases arising from a single data source, additional empirical evidence was collected from abstracts presented at the International Hospital Federation World Congresses in 2003 and 2024. The results from both data sources confirmed the restrictions and tensions in the interplay of digital technology and regulation: data protection by design principles poses challenges and confronts managers with technical, financial, ethical and political decisions.

The study results align with previous research, for example: "digital dynamic capability emerged as increasingly important for hospital departments to sense and respond to patient needs" (Dennehy *et al.*, 2021); the Context and Capabilities for Integrating Care (CCIC) Framework emphasized governance, accountability and patient-centeredness as theoretical foundations for enhancing patient experience through care integration (Evans *et al.*, 2016); while the co-produced capability framework for successful patient and staff partnerships revealed, among others, the need for organizational systems and policies capabilities (Cox *et al.*, 2022).

The study under review contributes to the patient experience knowledge base by working on the intersection of different disciplines, and it broadens the conceptual understanding of patient experience and enhances its practical relevance by extending its scope to the non-clinical realm and raising it to the managerial level.

Optimizing Ontario health teams (OHTs): insights from global public health governance

The final article in this issue is a literature review, "Optimizing Ontario Health Teams (OHTs): insights from global public health governance" (Joshi *et al.*, 2026). The authors explain that the aim of their study was "to explore and share learnings on how governance structures influence the performance and success of primary healthcare systems in respect to Ontario, Canada." Though in the abstract the article is labeled as a "literature review", the authors persistently refer to it in the text as "a commentary" (while this journal does not publish commentaries).

Health systems governance refers to "the processes, structures and institutions that are in place to oversee and manage a country's healthcare system" (as it is stated on the WHO website https://www.who.int/health-topics/health-systems-governance#tab=tab_1). Eight dimensions (sub-functions) of health governance include formulating policy/strategic direction, partnerships, organizational adequacy/system design, accountability, generating information/intelligence, participation and consensus and regulation and transparency (Barbazza and Tello, 2014).

The authors of the article under review define governance "as a set of formal and informal rules that help model and steer health systems" and distinguish "three key functions of governance – priority setting, performance monitoring and ensuring accountability" (Joshi *et al.*, 2026).

The province of Ontario is currently undergoing a large health system transformation with the introduction of Ontario Health Teams (OHTs), and the authors are comparing the governance approaches in their region with those from several developed countries. Among the discussed examples of governance tools and approaches are medicare system that provides universal coverage in Australia; care quality commission (CQC) to oversee hospitals, using standardized metrics for quality assurance and enabling comparisons across institutions employed by NHS England and a "managed competition" model from the Netherlands, combining market forces with regulation, where providers and insurers are financially

incentivized to improve quality and efficiency. These examples were chosen by the authors to provide comparative insights that Ontario can learn from and potentially adapt to its context.

What is rather unusual about this literature review is that it lacks a methods section, so the readers can only guess what type of review it is, how the authors searched for published evidence and why particular countries and publications were included in the review. The review would benefit from providing the number of sources initially identified versus the number finally included in the synthesis.

The authors conclude that "the inclusion of additional accountability mechanisms such as performance-based incentives will likely help propel OHTs to meet accountability and performance standards across the province"; "a provincial-level evaluation would enable a comprehensive and systematic approach to healthcare planning and delivery, allowing for effective measurement and comparison of outcomes and identifying areas for improvement," and "that health systems focused on primary care aim to include multiple patients and higher levels of patient engagement from each of the selected priority population(s) in the decision-making process to attain higher levels of patient engagement, driving an improvement in patient outcomes" (Joshi *et al.*, 2026).

Conclusion

To make international scientific communication more efficient, research articles and other scientific publications should be complete, concise and clear (EASE, 2018). One of the tools to achieve these goals is reporting guidelines for different types of research design. Over the last 25 years, more than 600 reporting guidelines have been developed, with some of them being regularly updated. They help authors, peer reviewers and journal editors to improve transparency and accessibility of research. They also protect authors and publishers by avoiding potential unethical practices within both study design and the reporting of results.

IJHG requires that authors, when submitting their primary research and evidence synthesis papers (literature reviews), as well as case studies, state in the methods section which reporting guidelines they used to prepare their manuscript and submit as a supplementary file the completed checklists for those guidelines (Ibragimova and Phagava, 2024). In fields where formal standards (reporting guidelines) are still absent, authors, reviewers and editors can use other types of procedural guides – like SANRA (Scale for the Assessment of Narrative Review Articles) (Baethge *et al.*, 2019).

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Acknowledgments

While working on this review the following AI tools have been used: Elicit.ai (Elicit Research, PBC, United States) for establishing broader context and research trends and Google NotebookLM (Google Labs) for checking whether the articles comply with the appropriate reporting guidelines. The author takes full responsibility for the content of this publication.

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