PRINT ISSN 1119-8362
Electronic ISSN 2659-1499

Full-text Available Online at
https://www.ajol.info/index.php/jasem
https://www.bioline.org.br/ja

J. Appl. Sci. Environ. Manage.
Vol. 28 (4) 1229-1242 April 2024

Medical Practice and Litigation in the Global South - Towards Achieving Health for All in Nigeria

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ABSTRACT: The judicialization of healthcare and the right to health are the main topics of this article's analysis of the phenomena of medical practice and litigation in the Global South. It highlights the benefits and drawbacks of each strategy by contrasting the various tactics and results of medical safety litigation in Africa and Latin America. The significance of attaining universal health care and well-being for everyone in the Global South is also covered, as is the function of international cooperation and collaboration in this endeavor. The paper examines the prospects and problems posed among judicialization of healthcare in the context of social and economic equality and development using empirical data and interdisciplinary research.

DOI: https://dx.doi.org/10.4314/jasem.v28i4.23

Cite this Article as: ATOE, K; OMOZUWA, E.S; ORIAIFO, S.O. (2024). Medical Practice and Litigation in the Global South - Towards Achieving Health for All in Nigeria. *J. Appl. Sci. Environ. Manage.* 28 (4) 1229-1242

Dates: Received: 22 January 2024; Revised: 29 February 2024; Accepted: 23 March 2024 Published: 29 April 2024

Keywords: Medical practice, Litigation, Global South, Judicialization of healthcare, ethics, Health rights.

Background of Medical Practice in the Global South: One important and controversial aspect that has been written about concerning the implementation of social and economic liberties has been the judicialization of healthcare, which refers to the employment of legal proceedings and claims-based restrictions to get medications and medical treatments. An edited collection that looks at the legislation of socioeconomic equality in countries including Brazil, India, Indonesia, Nigeria, and South Africa is called "Courting Social Equity" (Gauri and Brinks 2008), and it constitutes one of the first practical and comprehensive studies concerning the subject. The study used a unique method that incorporated lawyers, attorneys, legislators, and civil society organizations to investigate the application of socioeconomic equality within the Global South (Gauri and Brinks 2008). The right to health is a fundamental constituent in numerous national legislation, and many higher courts and regional authorities have established significant jurisprudence in this area. These factors have contributed to the judicialization of healthcare's importance in the socioeconomic literature (Langford 2008). Remarkably, health-related guarantees are included in almost 70% of statutes globally, with 40% specifically declaring any legal claim to healthcare (Jung and Rosevear 2011). throughout the span of thirty years, healthcare rights litigation has evolved into many forms worldwide, spanning both high income and middle-income nations as well as diverse

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healthcare organizations, according to an expanding body of comparative research (Brinks and Forbath 2013, Flood and Gross 2014b, Gauri and Brinks 2008, Yamin and Gloppen 2011). As per Young and Lemaitre (2013), Most comparative studies have focused on access to healthcare lawsuit in countries within the global south, including the nations of South Africa, Brazil, Argentina, Colombia, Costa Rica, as well as India. The institutional configurations as policy drivers of high-income nations including the United States, the United Kingdom, and Scandinavia has been examined by writers examining the legalization of healthcare in these regions. Such high-income nations, in contrast to middle-income nations like Brazil and Colombia, have institutional frameworks that impede the growth of health-related litigation and justice (Nedwick 2014). Many academic studies concerning the implementation of the right to health and other social and economic rights in middle-income countries usually adopt a socioeconomic framework (Yamin and Gloppen 2011). However, some scholars argue that such research has ignored regulatory issues, bureaucratic reorganization, the principle of constitutionality, as well as efficient governance—as well as their impact upon the implementation of social and economic rights (Ginsburg 2013). Academic discussion on the judicialization of healthcare in Global South nations has focused on South Africa and numerous Latin American nations. The academic discussion surrounding the contrasting strategies embraced by South Africa and Latin American nations in the judicialization of health has led to varied trajectories concerning the litigation and legal implementation of the right to health. These advancements have added to the expanding body of comparable and empirical research (Brinks and Gauri 2014). One important difference between these two categories of cases is the threshold for standing and pursuing rights-based claims, which is notably higher through the Republic of South Africa compared to Latin American countries including Costa Rica, Colombia, as well as Brazil. As a result, compared to Latin America, health rights litigation is far less common in South Africa. For example, a comparison analysis found that, for every million people, there were 3,289 health rights cases in Colombia, Brazil with 206, Costa Rica with 109, Argentina 29, and South Africa with 0.3 (Moestad *et al.,* 2011).

Additionally, judicialization of healthcare has been primarily driven via several individual litigants utilizing legal channels independently to campaign for access to certain pharmaceuticals and therapies in countries with high litigation levels, including the nation of Colombia, Brazil, as well as Costa Rica with the highest (Gloppen 2008). On the other hand, the onset of health care judicialization among South Africa during 2000s was not the consequence of a growing number of charges based on private claims for prescription drugs and other treatments—a practice referred to as the reutilization of litigation (Bergallo 2011). Rather, financially secure backup institutions, such as civil society groups and rights advocacy attorneys, coordinated wellbeing rights legal action among South Africa. These were the same dynamics that propelled a rights-based legal movement in the United States throughout the 1970s (Epp 1998). Securing broad legal protections, such as policy reform, that benefit a wide cohort of people has been the main goal of wellbeing equality legal action among South Africa (Forman 2008a). An expanding corpus of multidisciplinary research has evaluated the benefits and downsides of the two techniques. On the one hand, several Latin American countries have knowledgeable an upsurge in health rights lawsuits throughout the past 20 years (Yamin and Gloppen 2011). The financial situation of public healthcare and the government's capacity to distribute its limited health resources have suffered as a result. A growing number of petitioners in Brazil and Colombia are asking for expensive, cutting-edge drugs to treat uncommon illnesses including renal failure, diabetes, and cancer, among others. Certain writers contend that this type of litigation is regressive, undermining the financial viability of healthcare systems by taking money away from the public health infrastructure to benefit privileged litigants (Ferraz 2011b). Courts and litigants frequently focus on the entitlement to healthcare downstream, especially when providing services, which is an important lesson learned from the explosion of legal cases in Latin America (Daniels 2000). Here, sick individuals file lawsuits to access certain drugs or treatments that insurers or healthcare providers have refused, often illegally. This downstream method's main problem is that it doesn't tackle the earlier elements that cause the rights violations of vulnerable patients, which include organizational, economic, environmental, and social concern (Farmer 2003). A growing body of academics claims that this downstream and customized litigation manipulates the system without really changing it (Yamin 2014).

Importance of Achieving Health for All in the Global South: Achieving universal health care in the Global

South is an important goal that calls for cooperation between governments, non-governmental organizations, as well as the public sector The Global Action Plan for Healthy Lives and Well-Being for Everyone is a cooperative endeavor by thirteen global health, development, and humanitarian organizations that aims to expedite the attainment of the Sustainable Development Goals (SDGs) pertaining to health. In order to promote coherent and coordinated support for plans and strategies that are driven nationally, the strategy aims to improve collaboration across various agencies.

The SDG3 GAP provides a forum for strengthening cooperation between key actors in global health, each of whom has a different but complementary mission (WHO, 2019). Encouraging healthy lives and well-being is important for more than just personal happiness; it is essential for the development of thriving societies. The COVID-19 epidemic has highlighted the fact that health crises may put people in financial hardship or even impoverishment, regardless of their financial situation. The pandemic's worldwide effects have devastated health systems and put previously attained health outcomes in jeopardy. A condition of poor health exposes billions to poverty, avoidable illnesses like tuberculosis, and the aftermath of future epidemics and pandemics, in addition to depriving people, families, communities, and nations of possibilities for growth and thriving (United Nations, 2021). In response to the increased recognition of the significance of global health in recent years, the World Health Organization is actively working to enhance health systems and achieve health for all. Health for All entails confronting health barriers including starvation, ignorance, dirty drinking water, and unhygienic housing in addition to medical issues such a shortage of physicians, hospital beds, medications, and immunizations. Governments, international organizations, and civil society must work together to attain health for all in the Global South. Accelerating the attainment of the SDGs related to health requires initiatives such as the Global Action Plan for Healthy Lives and Well-Being for All. In order to achieve this overall aim, removing barriers to health is just as important as treating conditions that are strictly medical.

Understanding Medical Practice in the Global South: Healthcare Infrastructure and Resources: Healthcare institutions must secure sustainable, affordable, and dependable energy in order to provide top-notch care. On-site energy generation is a requirement for facilities that are located in distant places or do not have a reliable grid connection. Energy availability is particularly important for healthcare facilities since electricity is needed for treatments that can save lives and store vaccines (Hostettler, 2015). Policies that support accessible and sustainable energy solutions are necessary to address issues including fuel shortages, rising energy costs, and environmental concerns (World Bank, 2013). Basically, a major tactic for reducing destitution, improving health and educational opportunities, and promoting socioeconomic growth is to guarantee that energy is available, sustainable, and inexpensive for everyone. As significant energy users, healthcare facilities need consistent electricity and thermal energy for a number of functions, such as air conditioning, lighting, ventilation, heating, and running both medical and non-medical equipment (WHO, 2009). The care capacities of many healthcare institutions in the Global South have been weakened by limited energy availability. Energy-related problems in healthcare institutions are important, but they haven't gotten enough attention. The nation energy generation is a reflection of its living standards and has an impact on the caliber of treatment that medical institutions offer. Healthcare energy issues are different in high- and low-income nations. Getting affordable, reliable electricity is the biggest problem confronting low-income countries, particularly those living in sub-Saharan Africa (Adair-Rohani et al., 2013). These areas have a large number of healthcare institutions without enough energy to provide basic amenities like heating, lighting, and powering medical equipment, which restricts their ability to diagnose and treat patients. In high-income nations, the main energy-related problems include lowering operational costs through environmental impact reduction, expanding the use of renewable energy, and improving efficiency.

Grid power is usually the main energy source for healthcare institutions that are connected to it. In both industrialized and developing nations, the national grid serves as the main energy source for those who

live in metropolitan regions. Off-grid energy systems are vital for healthcare institutions with erratic or nonexistent connectivity to the main grid, especially in rural locations. Batteries, micro combined heat and power systems, generators, and renewable energy systems are included in these configurations. In addition, off-grid networks are essential for meeting peak energy needs that the main grid would find difficult to supply in urban healthcare facilities during routine outages and crises (ESG and AED, 2010). Regions in the Global South have a great deal of potential to use other renewable energy sources, such as wind, hydroelectricity, biomass, and solar energy, depending on where they are in the world. The broad adoption of renewable energies has been hindered by obstacles such high capital expenditures, unfamiliar technology, and intermittent output (Sovacool, 2009). Artificial intelligence (AI) has been used into a number of applications in the Global South, including finance, education, healthcare, and agriculture. AI has been used in this region to enhance health initiatives, improve mother and child health, and deal with the COVID-19 epidemic that is still ongoing (Moftakhar *et al.,* 2020; Wadhwani, 2019). Additionally, illnesses including dengue fever, Ebola, TB, and diabetic retinopathy that disproportionately afflict people in the Global South have received attention (Natarajan *et al.,* 2019). In Zambia, retinal imaging scans utilizing convolutional neural networks have been used to treat diabetic retinopathy, a consequence of diabetes that damages blood vessels (Bellemo *et al.,* 2019).It is envisaged that AI technologies aimed at neglected tropical illnesses such as mycetoma, schistosomiasis, and leishmaniasis would become available. A increasing amount of scholarly work centers on community health workers, frontline healthcare providers in the Global South who are in charge of incorporating AI-enabled technologies into their services. Ismail and Kumar's research examines the use of AI in frontline health in the Global South, including stakeholders, motives, and community participation (Smail and Kumar, 2021). In an ethnographic research, Okolo *et al.,* investigated community health workers' views, knowledge, and comprehension of artificial intelligence in rural India (Okolo *et al.,* 2021).

Challenges and Opportunities in Medical Practice: A number of challenges face healthcare providers in the Global South, such as inadequate financing, restricted access to treatment, and systemic negligence. However, integrating digital health systems has the potential to improve healthcare accessible throughout Africa. By providing ongoing education and opportunities for training, these platforms help equalize access to information, especially for those from socioeconomically disadvantaged backgrounds. In order to prevent digital epistemic colonialism, a new global economic forum paper emphasizes how crucial it is to incorporate indigenous traditions as well as expertise toward the healthcare systems. Such phrase describes the unintentional relocation and erasure of native characteristics as well as knowledge that can happen when platforms try to impart information to nations in the Global South (Clausen, 2015). Therefore, it is imperative to acknowledge that the problems confronting healthcare professionals in the Global South cannot be solved in a way that applies to everyone. Nearly fifty percent of the African population lacks appropriate coverage for healthcare facilities as a result of significant financing challenges facing the continent's healthcare systems. By enabling the exchange of medical information and offering ongoing professional development, medical technology networks can be crucial in closing this discrepancy. Nevertheless, such systems need to be properly designed with local knowledge and culture in mind to prevent unforeseen effects such internet-based intellectual British rule.

A prime example of a digital healthcare infrastructure includes Medicine Africa, a charity that links doctors in the UK alongside medical trainees through medical professionals in the global south, post-conflict nations that lack resources, like Somaliland. Although our study has revealed several shortcomings that need to be addressed for greater significant health services advancement, the system does a good job of transferring practical expertise and abilities (Clausen, 2015). By teaching indigenous physicians and students about European excellent healthcare procedures, Medicine Africa effectively fills up important gaps in the healthcare curriculum. Participants are able to apply this information to particular clinical issues seen in nearby hospitals through in-the-moment lessons and conversations with UK-based physicians. In underdeveloped areas, the platform has the ability to greatly improve medical knowledge and abilities. On the other hand, the research indicates unexpected outcomes. Because some information shared on the forum depends on tools and medications that aren't accessible where users live, some of the information is seen as useless among users. The professional identification of regional healthcare workers, who frequently have to make due with whatever resources are available, is diminished by this error in the platform's design. Furthermore, even with multilingual choices available, the platform's predominance of English-language courses limits the depth of involvement. The significance of adopting native tongues for efficient interaction as well as education is emphasized by both contributors. In

addition, by ignoring the particular difficulties and requirements associated with the indigenous environment, the network unintentionally contributes to the continuation of digital epistemic colonialism. The significance of creating a healthcare information base specific to Somaliland is emphasized by the participants, as existing networks frequently fall short in this regard. The disparity results from the fact that such platforms—created in the Global North—mirror Western methods including curriculum, failing to take into account the particular healthcare issues faced by the Global South (Clausen, 2015).

Impact of Socioeconomic Factors on Healthcare Delivery: Achieving full coverage, united nation sustainable development goals seeks to provide everyone with a chance to receive high-quality, cost-effective, and effective healthcare (United Nations General Assembly, 2015). Notwithstanding such international and national regulatory goals, reducing a socioeconomic gap in medical care continues to be a high concern. Studies reveal that approximately one billion persons in the global south manage to obtain health care, with the economically disadvantaged in these countries having the minimum value overall healthcare consumption (WHO, 2010; O'Donnell O, 2007). Every nation's economic progress is seen to be greatly influenced by the supervision of its citizens' healthcare (Eneji *et al.,* 2015; Masoompour *et al.,* 2014). The goals of the health organization frequently center on standard healthcare services including diagnostics, outpatient aid, especially inpatient care. According to Chansky *et al. (*2013), outpatient treatment refer to hospital treatments that don't need an overnight stay, such as basic surgeries, prescription drugs, or diagnostic testing. Slightly more often than hospitalized treatments, such outpatient treatments make up nearly all of patient-medical practitioner interactions. Few research has examined how patients feel about the standard treatment received in settings with few resources, such as sub-Sahara African nations like Nigeria. Evaluating quality through standardized surveys of patients and their family can give significant insights for stakeholders deciding between different healthcare providers and policymakers devising successful health policies (Jenkinson *et al.*, 2002).

Patient perspective examines what occurs throughout the contact among the individual, the clinical setting, and the physician (Wolf *et al.,* 2014). This consists of the awareness among healthcare system and assesses how people are handled while seeking medical attention, including the setting and style of care (Staniszewska *et al.,* 2014). Patient perspective also takes into account the patient's education and knowledge, emotional support, as well as family and friend participation. It is not the same as perceived quality (LaVela and Gallan, 2014), which is essentially a cognitive evaluation of the events that occurred during treatment. Patient fulfillment, that represents individuals' thoughts, emotions, and opinions about the medical care they got, is not the same as patient experience (Rama and Kanagaluru, 2011). Patient fulfillment surveys ask patients about their personal experiences and quantify the extent to which their expectations of the perfect treatment match their opinion of the care they actually received (Iftikhar *et al.,* 2011). PE, on the other hand, asks factual questions concerning what happened throughout the care event. According to a research by Dunsch *et al. (*2017). There are many obstacles in evaluating the quality of healthcare in low- and middle-income countries (LMICs). A research that was carried out in Nigeria with more than 2200 patients shown how sensitive patient satisfaction ratings are to question phrasing. The study included satisfaction ratings that were worded both favorably and negatively, which helped to clarify the challenges associated with assessing patient experiences in these kinds of situations. This emphasizes how crucial it is to modify patient experience surveys to steer clear of binary replies to yes/no and agree/disagree questions. According to Manary *et al. (*2013) and Ashton *et al. (*2017), well-crafted and properly performed PE survey questionnaires are thought to be able to provide a reliable indicator of the caliber of treatment provided as well as efficiently assess hospital performance in relation to clear criteria.

Legal Framework and Litigation in Healthcare

Overview of Legal Systems in the Global South: Medical professionals in Nigeria and other countries are required to have completed their university education and training, earning medical degrees from recognized educational establishments. As stated in statutes like the Medical and Dental Practitioners Act of 2004, this need is created as part of the current legal framework and pertinent legislation controlling healthcare practitioners (Violato, 2013). Prospective physicians must complete post-university authorized clinical internship or residence in addition to their academic coursework as well as doctoral studies (Medical and Dental Practitioners Act, 2004). A physician can demonstrate the required competency to operate independently in Nigeria by obtaining a license to do so after passing all pertinent exams and adhering to other approved processes (Medical and Dental Practitioners Act, 2004). When doctor wants to become a consultant in Nigeria, they typically pursue postgraduate certifications at regional and other levels, going above the minimum requirements of

professional medical degrees. The Fellowship of the West African College of Physicians is one such qualification. Doctors who have received degrees and certifications in other jurisdictions must follow applicable legislation in order to practice in a new jurisdiction, in addition to undergoing academic and professional training at the national level. Before they may practice medicine in that jurisdiction, they might need to go through licensure or certification processes (Medical and Dental Practitioners Act, 2004; Violato, 2013). The systematic procedure of reevaluating doctors from other jurisdictions or re-licensing them to practice in new areas has a long history. An outstanding example from the fourteenth century is provided by Leonardo Fioravanti, a physician who attended the University of Bologna, a prominent medical school at the time (Violato, 2013). Authorities associated with the Milan Public Health Board jailed Fioravanti allegedly engaging in drugs in the city, which is a different jurisdiction from Bologna, where he was originally permitted to practice. He was accused of departing from recognized medical procedures. Since his arrival from Venice in 1572, doctors in Milan had been conspiring against him, harboring animosity. They viewed him as an outsider, an alien, and an unwanted trespasser into the exclusive territory of Milanese medicine. Fioravanti wrote a complaint letter to Milan's health minister, who oversaw medical practice regulations and associated issues, protesting his arrest and incarceration.

It is important to understand that Fioravanti was neither a quack, scammer, nor medical fraudster. Not that he was your typical barber-surgeon, either. He graduated with a doctorate from the University of Bologna and spent many years practicing medicine in Bologna, Rome, Sicily, Venice, and Spain, wrote several medical manuals, created his own medications, and critically analyzed most aspects of traditional medicine. Nevertheless, according to Violato (2013), "The physicians in Milan were unwelcoming and viewed him as a foreign doctor." In the end, Fioravanti's release required the involvement of Milan's court and Health Minister Boldoni.

Medical Malpractice and Negligence Laws: The code of Hammurabi, enacted by King Hammurabi of ancient Babylon (Holmes, 1905), sheds light on the persistent attempts and actions that people and communities have made throughout history to control the art of medicine and solve dangerous medical malpractices. The Code of Hammurabi, toward several other things, provided the following general guidelines that applied to all people, including medical professionals: An individual's eye will be obliterated if they damage the eye of another person. An individual's bone will shatter if they fracture someone else's. Any freedmen must forfeit one gold mina if someone fractures their bone or injures their eye. A person must pay half the price of the slave if they crack or injure the eye of another person's slave (Prince, 1904).

Within the more specialized field of medicine, the Hammurabi Code described: In a surgeon a major surgery on a "awelum" (nobleman) with a lancet, resulting in the individual's death, the hands of the doctor or surgeon should be amputated (Mitchel and Riley, 2014; Spiegel, 1997). In the event that a doctor utilizes a bronze lancet for surgery upon a freeman's slave, causing the slave's mortality, the doctor is required to compensate with another slave of equivalent worth. Whenever a doctor uncovers an abscess in the slave's eye with a bronze lancet, resulting in the loss of the eye, they should pay silver equivalent to one-half the slave's worth (Spiegel, 1997). In order to protect patients' interests, less harsh and harsh measures—such as ethical rules for medical practice—began to evolve throughout time. The Hippocratic Oath, as it was provided at the time, was significant in this sense (Mason, McCall Smith, and Laurie, 2002). Among other things, the Hippocratic Oath, a worldwide rule of health ethics, typically stipulates that a physician must operate in the patient's best interest. This recommendation has also been included in more recent versions of the International Code of Medical Ethics (as revised in Venice, 1983) and the Geneva Declaration, which were approved or developed at various points throughout time. A contentious issue and subject of legal dispute has been defining what constitutes "good" between the doctor and their patient, or the patient's proxy (Re SL (Adult Patient) (Medical Treatment), 2000). Despite differing views on the subject, legal control of medical practice as well as ethical guidelines for self-regulation eventually solidified (Mason, McCall Smith, and Laurie, 2002). According to legal interference in the medical field, several laws, rules, and policies have developed over time to better regulate the practice of medicine for the good of society. Legal action pertaining to medical negligence originated as a basis or justification for legal engagement in the medical area. A range of healthcare professionals, including nurses, pharmacists, anesthetists, laboratory technicians, physiotherapists, and others, may be held legally liable for medical negligence (Odunsi, 2008). As is typically the case, it can also indirectly impact caregivers' employers. Nonetheless, the debate in this paper will center on medical practitioners in order to define its scope. The primary reason for this is that, within the scope of this article, addressing medical negligence concerning all direct and indirect

HealthCare providers would be cumbersome. Furthermore, in the traditional healthcare context, physicians often hold a prominent position and play a pivotal role, with other clinicians serving as the coordinating pilots and providing supporting services. It might be important to clarify that this claim is not meant to imply that physicians are the best practitioners in the medical field or that other healthcare workers are inferior to doctors. Additionally, doctors have been the primary subject of medical negligence jurisprudence, especially when it comes to case law derived from lawsuits throughout the years. Hence, the legal principles and jurisprudence application to doctors can, with appropriate adjustments, be extended to other healthcare professionals without explicitly categorizing the various types of healthcare workers.

Implications of Litigation on Medical Practice: Despite ten years of persistent efforts to improve patient safety in hospitals, adverse occurrences have not decreased, and hospital safety has not improved (Kohn *et al.,* 2000). Physicians acting in their patients' best interests is a basic criterion for patient safety. Despite the fact that safe conduct is fundamental to a doctor's ethical and professional norms, some doctors operate in such a ways that are inimical to patient safety. These actions include the use of defensive medication (Carrier *et al.,* 2010), being reluctant to report events, and being reluctant to tell patients about what happens. Defensive medicine includes avoiding high-risk patients, following guidelines, and performing needless tests and treatments. Physicians who act against patient safety are influenced by their fear of being sued for malpractice. After an incident, patients may file a lawsuit against healthcare providers in an effort to stop similar incidents from happening in the future, learn more about the incident, obtain monetary recompense, or hold personnel or organizations responsible for their conduct (Vincent *et al.,* 1994). Numerous justifications for these risky practices have been put up by earlier studies. Doctor are encourage to engage in defensive medicine in order to preserve the doctor-patient relationship. The majority of harm results from unreported instances. For a variety of reasons, including time restraints, a lack of response on previous reports, a dislike of bureaucratic procedures, and the belief that reporting is largely related to nursing, doctors may choose not to report incidences. Some of the reasons incidents fail to be disclosed to patients include the blame culture that permeates the healthcare industry, a lack of confidence in one's ability to communicate, a lack of understanding of the experiences of patients and their families, and difficulties managing the emotions of both patients and coworkers (Iedema *et al.,* 2011). Numerous studies indicate that defensive medicine is adopted as a result of the fear of malpractice litigation. There appears to be a positive correlation between adopting defensive healthcare and worries regarding the economic burden and high costs associated with health protection costs. According to a recent analysis, one of the biggest obstacles to event reporting is the fear of facing legal repercussions and disciplinary punishment. Moreover, doctors are discouraged from telling patients about incidences due to the possibility of lawsuits. Following a mistake, healthcare personnel may refuse to provide requested information because they believe the legal safeguards provided by disclosure laws are insufficient. Physicians are more likely to favor disclosure strongly if they feel it minimizes the possibility of patient litigation (Gallagher *et al.,* 2006). Adverse occurrences are more likely when a patient receives more complex therapy. Higher mortality rates are linked to complex care, which raises accountability obligations. Therefore, more defensive medicine may result from the complexity of treatment increasing the effect of lawsuit risk on medical conduct. This theory is supported by research that shows doctors steer clear of high-risk patients out of concern for malpractice lawsuits (Studdert *et al.,* 2005). Physicians may also be more likely to notify or reveal events to patients if the public views complicated mistakes as more acceptable. More research is required to determine the exact consequences of this situation. Personalized accountability raises the expectation of providing an explanation for one's actions or decisions and makes a person more identifiable than collective responsibility. Individualized responsibility is therefore predicted to have a greater effect on the likelihood of malpractice lawsuit on doctors' anti-patient safety behaviors. Complexity and personalized responsibility are related. According to research, providing complicated services frequently calls for a wide spectrum of healthcare specialists, making it difficult to assign roles (Molleman *et al.,* 2010). To fully understand how individualized responsibility and care complexity combine to influence the link between physician conduct and litigation risk, more research is needed.

Addressing Challenges and Moving Towards Health for All: The twentieth century development goals, also known as the MDGs, had a notable influence on the progress made achieving world health targets, albeit the progress was uneven (Sridhar *et al.,* 2013). Advocacy towards expanded post-MDG health strategy among the global sickness burden across communicable and not transmissible diseases increased as a result of the move. When the 193 UN member states adopted the Sustainable Development Goals (SDGs) in 2015, they pledged to accomplish universal health coverage (UHC), as defined by Sustainable Development Goal 3 (SDG3), by 2030. The pursuit of UHC embodies the global urge for every individual within countries to achieve their right to health (Chan, 2012).Under the UHC model, no community or person faces financial hardship while having access to high-quality healthcare services. The avoidance of and reaction towards naturally occurring, inadvertent, alongside deliberate biological risks are all included in health safety, which focuses on preventing communicable diseases, natural and man-made disasters, conflicts, and other calamities (WHO, 2007). UHC and health security are inextricably linked and cannot be accomplished in isolation. Achieving universal health coverage (UHC) depends on guaranteeing access to high-quality, reasonably priced healthcare services, in addition to other essential elements of the health system such as facilities medicine as well as materials, medical professionals, medical knowledge, and finance for health systems. (WHO, 2018). Reaching other SDG objectives will be impacted by countries moving closer to UHC. For instance, being well helps adults and children make a living, resolves gender and socioeconomic inequalities, and fosters societal unity, besides guarantees health security. The global health community received a wake-up call from the Astana Declaration and the SDG3 Global Action Plan, which called for a reassessment of the health system, the alignment of current priorities for appropriateness, and the development of resilience.

To address, medical emergencies and ensure health security, Health System Governance (HSG) fosters robust collaborations and accountability mechanisms (Ayanore et al., 2019). Effective HSG is indispensable for attaining universal health courage and health security. The application of strong HSG has proven instrumental in achieving UHC and health safety amidst biological, unintentional, and naturally occurring hazards (WHO, 2015). However, to realize UHC and health safety, strong political backing and leadership are imperative to bolster health institutions and facilitate efficient implementation. In order to supervise and implement rules and regulations guaranteeing access to emergency treatment without taking financial capacity into account, it was imperative to establish a national and subnational regulatory agency (Reynolds *et al.,* 2017). For example, in France, a redistributive financing model combined with a centralized public regulatory body substantially reduced the financial obstacles that prevented the underprivileged population from accessing health care. Improved monitoring and mentoring of medical staff also improved the standard of treatment in healthcare institutions. Furthermore, authorities pushed investments in measuring their effectiveness and exchanging information (Reynolds *et al.,* 2017), and controlling the expense of private healthcare aided UHC advancement. Positive health outcomes were achieved in Rwanda by keeping an eye on important indicators at all levels and acting quickly to address concerns (Sayinzoga and Bijlmaker, 2016). Community health workers (CHWs) who get proper training and encouraging supervision play a critical role in saving lives in emergency situations. Employing selective buying and maintaining a self-sustaining accrediting system/organization streamlines development toward increased quality in medicine (Abimbola *et al.,* 2019). The improvement of service delivery and the management of the health system mostly depend on international treaties, statutory and constitutional laws, rules, guidelines, protocols, and customary informal practice standards. Supply chain management is improved when rules pertaining to pharmaceutical and medical procedures are used inside the healthcare system.

Case Studies and Best Practices: Expanding exertions to remove obstructions to receiving complete crucial health care in the context of the pandemic are made advantageous by the global political momentum toward universal health coverage (UHC) and health safety (Nygren-Krug, 2019). A commitment to improving UHC and health security was shown by the establishment of policies and strategic plans that support UHC and health security, as well as the decentralization of health services and fair resource allocation through suitable funding methods. In order to maintain health security, various pro-UHC initiatives and objectives primarily seek to increase monetary access and coverage to reasonable and high-quality medical services. Improving context-precise strategic health finance methods remained a vital step in guaranteeing that everyone had fair access to medical treatment. The single-payer system in Indonesia, the pro-poor healthcare funding system in Sri Lanka (Gottret et al., 2008), and the integrated health finance system in Thailand (Hort *et al.,* 2017) are effective approaches for reaching Universal Health Coverage (UHC). By 2030, Myanmar's National

Health Plan (NHP) hopes to support UHC by improving access, fairness, and financial protection. Furthermore, two significant strategic initiatives in the advancement of UHC are China's 2009 Health Reform Plan (HRP) and Vietnam's Master Plan (VMP) for UHC by 2020 (Duckett, 2010).

Effective monitoring of health disparity both in national and international stages requires the execution of strong medical Information Systems (MIS), which include procedures for data assemblage, examination, elucidation, as well as reporting across medical systems. This is in favor of the equity-focused pursuit of UHC and the accomplishment of objectives linked to health security in times of pandemics and medical emergencies (Hosseinpoor *et al.,* 2014). Early identification, prevention, and response to biological hazards need an unbiased, open, and objective assessment of health system inadequacies. For instance, in Ethiopia, prompt reactions to patient care outcomes are made possible by effective data management inside a single workflow. On the other hand, inadequate people-centered healthcare information created obstacles to consumers' access to necessary health treatments (Royston *et al.,* 2020). To enhance system usability, a strategic approach is essential to foster the cultivation of a digital data culture and implement an automated single reporting system that caters to multiple stakeholders. Enhanced health security for informed decision-making and decreased inefficiencies in illness-specific monitoring silos were two advantages of a comprehensive and integrated disease surveillance system (Blanchet *et al.,* 2017).

Enhanced readiness would arise from partnership and incorporation of epidemic development through sectors and authorities. In addition, UHC make available a supportive as well as cohesive forum among international health community, guiding the development of health systems (WHO, 2016). UHC was shown to be influenced by intricate institutional and political issues, which elevated it to a political priority. Challenges in reacting to health shocks were connected to weak leadership practices resulting to inadequate coordination at subnational and national levels (Shoman *et al.,* 2017). This emphasizes the reality that communities and the private division must work together to achieve UHC and health security, as the public sector cannot achieve these objectives on its own. This coordinated activity can aid governments in preventing and managing health security risks while avoiding resource fragmentation and enhancing efficiency (Sherr *et al.,* 2013). By expanding health service coverage and improving efficiency, initiatives like the Global Health. The UHC movement is supported by the Security Agenda (GHSA) and the Port of Spain Declaration in the Caribbean region. Strong Health Systems Governance (HSG) can lead to improved performance among health system in areas such as financial risk protection, responsiveness, equity, quality, safety, efficiency, and sustainability. In consequence, attaining the long-term objectives of the health sector, such as UHC and as well as medical safety, may be facilitated by high-quality health system performance. We have summarized the influence and relationship between HSG and the health sector's Sustainable Development Goals (SDGs), which includes UHC, in this paper.

Future Directions and Recommendations:

Policy Recommendations for Healthcare and Legal Systems: A serious foundation aimed at improving universal healthiness lies among the robustness of health systems and governance structures. This entails a commitment to increasing public funding, a key driver for sustainable healthcare. By allocating resources efficiently and transparently, nations can bolster their health infrastructure, safeguarding justifiable entrée toward excellence services in addition to essential medicines. Furthermore, responsibility mechanisms show a pivotal part in improving the efficacy of health systems, fostering a culture of responsibility among stakeholders. A core tenet of global health advancement is the recognition and protection of individual’s rights. Relating to, protective, and satisfying the right to health forms the cornerstone of a just and equitable healthcare system. Beyond this, addressing social determinants of health is crucial for tackling root causes of disparities. Empowering marginalized groups and communities is essential in other to ensure the pursuit of a healthier living. Effective global health strategies require collaboration across diverse stakeholders. Engaging with health professionals, legal experts, policymakers, civil society, and international organizations fosters a dynamic exchange of knowledge and experiences. This collaborative approach enables the identification of best practices and the coordination of actions to address complex health challenges. The synergy of collective efforts enhances the impact of interventions and contributes to sustainable solutions. Innovation and research are indispensable for addressing the evolving landscape of global health, particularly in regions with unique challenges like the Global South. Rigorous and context-specific research helps identify the intricacies of medical practice and litigation, providing a foundation for evidence-based solutions. Embracing innovative approaches tailored to specific contexts agrees for the growth and operation of effective strategies, ensuring that healthcare systems remain adaptive and resilient.

Strategies for Preventing Medical Litigation and Improving Patient Outcomes: In the ever-developing background of healthcare, a multifacetedmethod is vital to ensure the well-being of patients as well as efficiency of health systems. The article investigates into the crucial elements of strengthening health systems, promoting patient safety and rights, enhancing accountability and transparency, and encouraging alternative dispute resolution. The foundation of a robust healthcare system lies in its ability to provide quality, accessible, and affordable services. To achieve this, there must be a concerted effort to bolster human resources, enhance infrastructure, and ensure the availability of necessary equipment. Investing in training and development programs for healthcare professionals is essential to maintain high standards of care. Additionally, improving accessibility toward healthcare services, particularly in underserved regions, is pivotal for creating an inclusive and effective system. Patient safety and rights form the cornerstone of ethical healthcare practices. Implementing policies and standards to prevent medical errors, adverse events, and negligence is imperative. This involves continuous education for healthcare professionals, rigorous adherence to protocols, and fostering a culture of open communication. Respecting the autonomy, dignity, and informed consent of patients is equally essential, ensuring that they are active participants in their healthcare decisions. Establishing effective mechanisms for monitoring, evaluation, and feedback is crucial for accountability within the healthcare system. Transparent communication regarding healthcare outcomes, performance metrics, and institutional processes builds trust among stakeholders. Holding healthcare providers and organizations which is responsible for their actions and choices is essential for maintaining high ethical standards and ensuring the national confidence toward healthcare scheme. In any complex system, disputes may arise, and healthcare is no exception. Creating opportunities for dialogue, mediation, and arbitration between patients and healthcare providers is an effective way to resolve conflicts. Fair and timely compensation for victims of medical malpractice is vital to address the repercussions of adverse events. This approach not only expedites the resolution practice however, also adopts a joint environment that prioritizes learning and improvement. A comprehensive strategy that integrates the strengthening of health systems, promotion of patient safety and rights, enhancement of accountability and transparency, and encouragement of alternative dispute resolution is essential for the continuous improvement of healthcare. By addressing these interconnected components, societies can create a healthcare ecosystem that prioritizes the well-being of patients, instills confidence in the system, and facilitates ongoing advancements in medical care. This holistic approach is pivotal in navigating the complexities of the healthcare landscape and ensuring a brighter and healthier future for all.

The Role of Global Health Initiatives in Achieving Health for All: In pursuit of a healthier and more equitable world, global initiatives play a pivotal role. Global action strategy for healthy Exists as well as well-being for All" stand as groundbreaking effort which unites 13 multidimensional health, growth, as well as charitable supports. This collaborative initiative aims in quicken improvement taking place in health associated sustainable development goals, recognizing the urgency of achieving these targets via 2030. Universal action strategy represents a unified front in the global health landscape, bringing together diverse agencies to amplify efforts toward achieving the health-related SDGs. This collaborative approach seeks to enhance coordination and alignment of support to national plans and strategies. By fostering a cohesive and synchronized response, the initiative aims to overcome challenges and accelerate progress in addressing health disparities on a global scale. Envisi oned by the United Nations in 2015, the sustainable expansion objectives are a set of seventy goals and one hundred and sixty-nine objectives designed to fostering global expansion through 2030. The third objective specifically focuses on certifying healthcare system and supporting health for all. With 13 objective splus 26 indicators, this goal addresses crucial aspects including motherly and child wellbeing, transmissible and non-communicable illnesses, general health treatment, as well as environmental health. The Global Action Plan aligns itself with these goals, recognizing them as a roadmap for a healthier and more sustainable future. This concept of "Health for All" drives further than traditional medical approaches, emphasizing the removal of obstacles to health at both individual and societal levels. Originating since the World Health Organization's 1978 Alma-Ata Affirmation, it advocates for addressing not only medical issues like a lack of healthcare infrastructure but also broader social determinants such as malnutrition, education, and environmental conditions. The litigation of health services has emerged as critical and controversial topic, particularly in regions like South Africa and Latin America. This phenomenon involves the use of lawful movements as well as rights based bans toward securing health managements and medications. Scholars have debated its impact, with some expressing concerns about potential adverse consequences happening on community health

systems and resource allocation. Others argue that such litigation can contribute to accountability and social justice, ensuring that individuals have access to necessary healthcare. As the world strives to achieve the determined objectives fixed by sustainable development goals and promote the concept of "Health for All, comprehensive achievement idea for healthy exists and well-being for all stands as a beacon of collaborative effort. While navigating the challenges posed by the lawsuit among health care, as a result, it's essential to maintain delicate stability between personal rights as well as cooperative comfort of communities. By embracing these initiatives and addressing global health challenges collectively, nations can surface way for a healthier, additional inclusive future for all.

Conclusion: The focal point of this literature review explores the intricate background of health practice and litigation in the Global South, encompassing the underdeveloped and developing districts of Latin America, Africa as well as Caribbean, and Asia. By scrutinizing the challenges and opportunities inherent in these areas, the paper sheds light on the multifaceted issues facing healthcare systems in these diverse regions. A pivotal aspect under examination is the phenomenon of the litigation toward health care. This refers to the strategic explore in legal actions and rights based sanctions to secure access to healthy living. The paper, therefore, meticulously dissects the approaches and impacts of health rights litigation, drawing insightful comparisons between South Africa and Latin America. It also underscores the nuanced trade-offs involved, such as those between individual and collective claims, downstream and upstream interventions, and the delicate balance between policy reform and resource allocation.

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