MEDVIX PUBLICATIONS

Journal of Medicine Care and Health Review
Review Article | Open Access | ISSN 3065-1719 | Volume 01 | Issue 03

Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System

Karl Airaoje[1], Omolara Oluwabusayo Akin-Odukoya[2], Funmi Falobi[3], Aruaye Afeye Obada[4*]

[1]Liverpool John Moore University. UK.

[2]Department of Mass Communication, Caleb University, Imota, Lagos Nigeria.

[3]Department of Mass Communication, Caleb University, Imota, Lagos, Nigeria.

[4]Department of Microbiology, University of Calabar.

Received date: 23 September 2024; **Accepted date:** 08 October 2024; **Published date:** 12 October 2024

Corresponding Author: Aruaye Afeye Obada, Department of Microbiology, University of Calabar.

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

Abstract

The global healthcare system is a complex network of organizations, institutions, and resources dedicated to promoting and providing healthcare services to individuals and communities around the world. 'It is an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide.' It encourages multidisciplinary collaboration and encompasses a wide range of disciplines both inside and beyond the health sciences. The findings of the study revealed that the vision for health and healthcare includes achieving equity, transforming healthcare systems, encouraging innovation, and securing global environmental sustainability, with equity as the foundation. Furthermore, Nigeria's healthcare system continues to rank among the worst in the world. The study discovered that high cost of healthcare, geographical barriers, cultural and language barriers, stigma and discrimination, lack of education, lack of healthcare infrastructure, insufficient healthcare workforce, political instability and conflict, lack of health insurance, and limited availability of essential medicines are part of the barriers to achieving global healthcare system in Nigeria. 'The study also discovered that one of the solutions to the barriers to achieving global healthcare in Nigeria is to implement universal health coverage.' The study recommends that the Federal Government of Nigeria should prioritize and invest intensely in the nation's healthcare system, especially in the primary healthcare sector.

Keywords: Nigeria, healthcare, global health, primary healthcare, and health system.

Introduction

The political, economic, and sociocultural factors of a country have a significant impact on healthcare and health outcomes, and our world is becoming more diverse and complicated every day. Several public health researchers have worked to better understand the various methods that different countries have adopted by conceiving global health systems within an international health framework over time. Planning how health care might be more efficiently arranged, funded, and provided to diverse populations requires in-depth analysis. The population's overall health needs and the socioeconomic determinants of health are rarely adequately matched to the specific arrangement of health services, despite recent significant international lobbying for this idea **[1]**.

'The global healthcare system is a complex network of organizations, institutions, and resources dedicated to promoting and providing healthcare services to individuals and communities around the world.' There is no widely agreed definition of the term global health and it is often used interchangeably with such terms as public health and international health. **[2]** have defined "global health as an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. The focus of global health is on international health problems, causes, and remedies. It encourages multidisciplinary collaboration and encompasses a wide range of disciplines both inside and beyond the health sciences. Population-based preventive and individual-level clinical treatments are combined to create global health. Global health also fosters interdisciplinary collaboration with other disciplines that can have an impact on global health and encompasses a wide range of fields both inside and outside the health sciences.

The world's healthcare system faces several fundamental issues, including a growing population and diminishing resources. Nations with populations of 1.349.585.838, as China, and 1,220,800,359, as India, are increasingly making use of their meager resources to assist in meeting the needs of their people. However, these nations are facing severe financial and social hardship as a result of their population's increasing aging as well as illness and incapacity **[3]**. Noncommunicable diseases like diabetes, hypertension, and heart disease are becoming more common in the aged population

worldwide as a result of medical developments and screening methods that have allowed the population to age. Exorbitant sums of money are spent on treating patients with certain diseases, with a greater emphasis on prolonging life than on improving quality of life. The Global Health Education Consortium (GHEC) has projected that there are one million more births than deaths that occur every 110 hours **[4]**.

According to a report from the UK Parliament hearings, as the world's population rises, there will be a greater need for water. With a population of 6 billion (as of 2007), there is 92% water sufficiency and only 3% scarcity; by 2025, however, there might be 8 billion people, which could result in 62% water sufficiency and 8% scarcity. Overfarming in regions with little water supplies is another factor that may have an impact on the health of the world. This practice may result in a shortage of agricultural resources and more demand for other food sources like fish and animal meat. The GHEC in its report focuses on the impact population can have on the economy of a country. According to this, developing nations with lower childbearing rates have economies that are growing by 25–40%, a trend that can be directly linked to demographic shifts. As an illustration, consider Asia, where lower birth rates have contributed to economic growth, and portions of Africa, where higher fertility has resulted in lesser economic growth and higher levels of poverty **[5]**.

According to **[6]**, a number of factors, including gender violence, environmental pollution and climate change, migration from war-torn regions, inadequate or expensive health care services, and the emergence and re-emergence of communicable and noncommunicable diseases, are posing new health challenges for high-, middle-, and low-income countries. A generation that is prepared to lead and innovate, as well as conduct research on these important global health-related concerns, has to be informed about these issues. Moreover, even with modern technologies, the health issues of other nations now pose a threat to world health. For instance, the ease with which the Ebola virus might travel across borders is a result of present-day transport systems. Thus, this paper seeks to review the global health system and the posture of the Nigerian Primary Healthcare System.

Research Questions

1. What is the vision for global healthcare in 2035?
2. What is the current state of the Nigerian primary healthcare system?
3. What are the barriers to achieving a global healthcare system in Nigeria?
4. What are the solutions to barriers to accessing healthcare systems in Nigeria?

Empirical Review

The COVID-19 pandemic's terrible effects have brought to light the intricate nature of the global health ecosystem, whose coordination and control are inadequate. The reaction to the COVID-19 pandemic was significantly impacted by the degree to which formal and informal rules controlling the global health architecture such as regulations, accountability, and leadership were enforced. ‘Adopted in 1969, the International Health Regulation (IHR) is the only multilateral legal instrument among the member nations of the World Health Organization.’ Following the 2003 outbreak of severe acute respiratory syndrome (SARS), an amendment was ratified in 2005. A stronger international legal framework that addresses "any occurrences possibly constituting a public health emergency of international concern (PHEIC)," not just infectious disease outbreaks, is needed in light of the SARS pandemic. The SARS pandemic expedited the amendment of IHR 2005, resulting in its implementation in June 2007 (WHO, 2023a).

‘A collection of "core capacities" found in the IHR 2005 are required by the member states in order for them to successfully respond to public health emergencies of both’ national and international concern, as well as to identify, assess, notify, and report events. The IHR streamlines reporting and communication between national IHR focal points in participating member states and WHO Country Offices in order to prevent border closures that would cause needless economic loss and to encourage proactive risk management through early detection of possible threats to international health (World Health Organization 2016). IHR core competencies must be maintained by member nations while technical support from WHO is provided. Seven PHEIC declarations have been made since the IHRs were revised in 2005. These declarations cover a range of health-related issues, including the H1N1 influenza pandemic in 2009, polio and the West Africa Ebola outbreak in 2014, the Ebola and Zika viruses in 2016, COVID-19 in 2020, and MPox in 2022 (WHO, 2023b).

While the IHR document was a formal, legally binding instrument, governing the IHR was difficult during the pandemic due to a lack of enforcement and WHO's lack of adequate funding, a clear mandate, or strong political support. During the pandemic, countries chose to cooperate or not cooperate based on the preferences of their leaders and their national interests rather than adhering to the IHR and giving some authority for decision-making to a global coordinating body like WHO. Unfortunately, several areas with the IHR were identified for improvement during the COVID-19 pandemic **[8]**. Moreover, there is no penalty for non-compliance, although all WHO member states are legally obliged to follow the IHR.

The WHO's governing body, the World Health Assembly, which is made up of the health ministers of its member states, proved insufficient to deal with an outbreak of the magnitude of the COVID-19 pandemic, which required a whole-of-government strategy to effectively contain the outbreak **[25]**. Therefore, in order to make choices, health ministers require more political clout within their governments. The 193 WHO member states only convene once a year, and the WHA's governance is too big to make executive decisions on their behalf. Simultaneously, an outbreak response necessitates daily, participatory, practical choices and activities. Therefore, while the WHO is meant to coordinate and govern in theory, in reality, it primarily offers technical advice, rules, and standards as well as assistance in decision-making processes, leaving it up to the individual countries to decide how best to proceed **[11]**. Moreover, the IHR's main focus is on national capacity, which might not be sufficient to enhance global monitoring and coordination.

Therefore, it is evident that the absence of global coordination and collaboration among nations constituted the primary governance obstacle during the pandemic. During the crisis, governments did not move in unison to coordinate containment plans or to identify, exchange, and implement best

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

practices for managing the pandemic (World Health Organization 2021). Global financing to LMICs was insufficient. Nations engaged in competition to acquire a restricted supply of essential goods and commodities, including medical countermeasures like vaccines, medicines, and personal protective equipment. This resulted in significant disparities in each nation's access to these vital products, which led to several avoidable deaths.

Theoretical Framework

The theoretical framework espouses the theory of distributive justice. The theory of justice pioneered by John Rawls explores the simple idea that the concern of distributive justice is to compensate individuals for misfortune. Some people are blessed with good luck; some are cursed with bad luck, and it is the responsibility of society the global society to collectively alter the distribution of goods and evils that arise from the jumble of lotteries that constitutes human life as we know it. Some are lucky to be born wealthy, into a favorable socializing atmosphere, or with a tendency to be charming, intelligent, persevering, and the like. These people are likely to be successful in the economic marketplace and to achieve success in other important ways over the course of their lives. However, some people are, as we say, born to lose. Distributive justice stipulates that the lucky should transfer some or all of their gains due to luck to the unlucky **[7]**.

The Theory of Distributive Justice

The relationship between current inequities in global health and the history of international health policy brings up questions about what wealthy nations must do to rectify the inequitable distribution of disease throughout the world. This is a moral theory that gives direction on how to distribute benefits, risks, and costs within a population. When it comes to healthcare, the fact that some disease and suffering is a result of systematic disparities means that there is an inequitable, or unjust, distribution of disease burden; the poor and otherwise disadvantaged individuals carry a disproportionately high burden **[7]**. Furthermore, healthcare to relieve the burden of disease is not available to all, due to social and environmental factors such as poverty, contributing to health inequities.

Theories of distributive justice within global health attempt to provide a method for (i) determining what is unjust in the distribution of health and healthcare and (ii) determining who has the duty to address such injustices. Below are some examples of the different theories of distributive justice that show a wide range in the scope of responsibility. In each example, we consider what the theory would mean for the obligation of wealthy nations to give international aid to poor nations under nationalism, social contract, and cosmopolitanism **[12]**.

The ‘Theory’ has been praised as a holistic approach that is fundamentally different from the views circulating at the time and was criticized as setting up an unrealistic set of assumptions that cannot be replicated in an actual society under examination. It is based on what Rawls terms the ‘original position’, which establishes the parameters of the society. One of the criteria is that decisions are shrouded by the ‘veil of ignorance’, which assumes that the decision makers do not have any knowledge of the characteristics of the parties affected by the decision in order to ensure that the decisions made are not biased by the original structure **[13]**. This theory is used for the study since it has been linked to health and the distribution of healthcare services across the globe.

Methodology

The paper employed a comprehensive review of literature from a wide range of resources including official reports, academic journals, statistical bulletins, historical documents, textbooks, and online resources. However, the research was strictly limited to available or recorded information about malnutrition, its prevalence, effects, and impacts on the Nigerian economy that can be found in scholarly journals, books, and the internet. The study adopts content analysis as its method of analysis, whereby the existing literature was considered for the analysis.

Findings and Discussion

Based on the stated research questions, the findings and discussions are purely based on the research questions. The questions are discussed as follows:

What is the vision for health and healthcare in 2035?

The vision for health and healthcare in 2035 is formed of four main essential pillars, with equity as the foundational goal which include: Achieving equity, transforming healthcare systems, encouraging innovation, and securing global environmental sustainability, with equity as the foundation **[27]**.

Accessibility to Equitable health and healthcare Outcomes

Social factors, such as one's residence and place of employment, influence one's health. Globally, there has always been a problem with inequality in health and healthcare **[28]**. While decentralization is relieving pressure off hospitals and allowing increased access to care, there are still geographic and demographic disproportions in access to not only healthcare but excellent healthcare. According to the WHO (2017), insufficient access to essential health treatments affects more than half of the global population. Digitalization and at-home healthcare may potentially widen the existing gaps in access to healthcare and empower customers to take ownership of their health. There were disparities highlighted by the pandemic's uneven effects on different communities. More than a million more infant fatalities, for instance, might have resulted from the elimination of crucial maternal and child health services **[22]**.

Not only is it a social objective to address health inequalities, but employers also have financial incentives to take a more active role in supporting the health of their workforce. A large number of chronic disorders, including obesity and diabetes, are caused by health inequalities, which in turn place a burden on employers. Employers incur costs as a result, including increased healthcare bills, missed work, doctor visits, and decreased productivity. It has been demonstrated that businesses offering wellness initiatives and benefits packages, especially those catering to vulnerable groups, can reduce the gap in health inequalities. Making a positive impact on a fairer society is good for a company's reputation and culture. Companies have a strong voice and can support laws that have a significant positive impact on the well-being of families, workers, and communities (WHO, 2017).

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

Transformation of Healthcare Systems

The necessity of resilient healthcare systems was highlighted by the current COVID-19 pandemic. Global supply networks were disrupted, which had an impact on the availability of protective gear, medications, and diagnostics. A review of 81 research conducted in 20 countries revealed a median decrease in health services of 37% overall, with a 42% decrease in visits **[17]**. Interruption to services was greatest in LMICs. For example, in the WHO pulse survey to evaluate the continuity of essential health services during the COVID-19 pandemic, HICs reported disruption to 34% of services, whereas LMICs reported 50% (WHO, 2021). Furthermore, LMICs reported more access barriers to COVID-19 tools (e.g., vaccines, personal protective equipment, medicines, and diagnostics). Furthermore, a study conducted in France between March and April 2020 revealed a doubling in the incidence of out-of-hospital cardiac arrests together with a decline in survival at hospital admission. It is anticipated that in Australia, a one-year disruption to healthcare services may result in 1,719 more deaths among individuals with colorectal cancer between 2020 and 2044.

Although COVID-19 placed a great deal of strain on healthcare systems and illustrated the value of resilience, this was not a unique episode, and there will probably be such health crises in the future. Treatment delays for tuberculosis, malaria, and HIV/AIDS had a negative indirect effect on death rates during the 2014 West African Ebola outbreak **[20]**. More people died in Guinea as a result of interrupted malaria treatments than from Ebola itself. The World Health Organization (WHO) lists antimicrobial resistance (AMR) as one of the top ten worldwide public health problems, with an estimated 20 to 40 nations seeing substantial new disease outbreaks annually. Not only do pandemics cause unexpected strain on healthcare systems, but economic downturns and the consequences of climate change also do. Accelerated planning is necessary not only for pandemic scenarios but also for aging populations, high rates of chronic illnesses, and non-communicable diseases (NCDs). Non-communicable disease mortalities, which include diabetes, cancer, cardiovascular disease, respiratory, and other disorders now outweigh the total number of deaths from communicable diseases. They are responsible for 41 million deaths worldwide annually, or 71% of all deaths worldwide. 29 million of the 41 million deaths take place in LMICs (WHO, 2022).

Innovation and Health Technology

Innovation and health technology have enormous growth potential in the future. These include better and earlier diagnostics for prevention as well as earlier treatment, novel medicines and modalities that improve patient outcomes, and technology that raises the standard and effectiveness of healthcare delivery. Global GDP growth is still being outpaced by healthcare spending, which is an unsustainable trend. Drug prices and reimbursements are therefore under pressure to keep expenses in check. Through increased effectiveness and better results, innovation has the potential to lower overall healthcare costs. For instance, according to the National Health Service (NHS) England, telemedicine is crucial for reducing the strain on the healthcare system and one in four visits with general practitioners may be avoided (NHS, 2020). Furthermore, a study conducted in Houston revealed that over the course of a year, 5,570 patients receiving telehealth-enabled treatment had an absolute 6.7% decrease in possibly medically unnecessary ER visits, resulting in $928,000 in cost savings ($2,468 saved per visit avoided) **[19]**.

In the US, chronic diseases affect 50% of the population and contribute to more than 85% of healthcare costs **[14]**. Therefore, better prevention, monitoring, and personalized recommendations leveraging digital and AI-powered techniques can have a major impact on overall expenses. While there are some examples, public organizations will be better able to recognize and adopt innovation if there is stronger evidence connecting investments in health technologies to lower costs and better outcomes (Kydland et al., 2019). Healthcare innovation boosts overall economic production in addition to cost reductions. An economy with a stable population distribution will see output decreases of 17% by 2056 and 39% by 2096, according to a model developed to estimate aging populations. The model indicates that a 5.4% increase in compounded production can result from the cure of diseases such as dementia and Alzheimer's.

Environmental Sustainability and Protection

According to **[21]**, the healthcare sector is responsible for 4.4% of the world's net carbon dioxide emissions, which leaves a significant environmental impact. About 4% of greenhouse gas emissions in England come from the National Health Service (NHS). 62% of these emissions come from sources in the supply chain, such as freight, equipment, and medications. About 20% of emissions come from the pharmaceutical industry. This is made worse by the fact that over £300 million worth of medications are left unfinished in England each year, which leads to inadequate treatment utilization, overprescribing, and trash, which contaminates the land and water. The effects of the climate crisis on health and healthcare are in addition to the effects of the healthcare sector on the environment. This can be through life-threatening weather events, heat stress, poor air quality, water quality and quantity, food security, and vector distribution. Therefore, the climate crisis is anticipated to have a negative impact on mortality, heat-related illnesses, respiratory ailments, water- and vector-borne infections, malnutrition, and people's mental health.

More than 70 nations, including the US, China, and the EU, which together account for 76% of global emissions as well as 1,200 businesses have made net-zero commitments. In the Race to Zero, the pharmaceutical and medical technology industries as a whole made significant progress when 20% of the largest corporations (by sales) pledged to cut emissions by at least 30% by 2030. Healthcare policymakers are establishing environmental goals. For example, the National Health Service (NHS) wants to cut its carbon emissions by 80% by 2040. There is also growing interest in integrating environmental sustainability into evaluations of health technologies and a greater emphasis on the ways in which improved chronic condition management and prevention can lower carbon emissions **[18]**.

The number of nations and businesses achieving net-zero targets is rising, which is positive, but the promises made thus far are insufficient to fulfill the Paris Agreement's requirement of keeping global warming to 1.5 degrees Celsius over pre-industrial levels. More aggressive, immediate action to reduce emissions is now required, along with tougher 2030 targets in NDCs for all nations, especially the biggest emitters. The frequency and intensity of

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

extreme weather events, such as storms, heat waves, wildfires, and floods, are rising. Due to its impact on socioeconomic determinants of health including food and housing, this exacerbates inequality. It evaluates the ability of healthcare systems to withstand changes that disrupt healthcare access, disproportionately affecting communities that are more marginalized and at risk **[22]**. According to WHO estimates, stress and shocks related to health drive approximately 100 million people into poverty year, and the impact of climate change can exacerbate this trend. 94% of pollution-related deaths worldwide in 2016 happened in LMICs, while the richest 1% of the population is predicted to emit twice the emissions of the poorest 50% of the world's population **[33]**.

What is the current state of the Nigerian primary healthcare system?

The delivery of primary health care services in Nigeria is appalling. 'Nigeria's healthcare system continues to rank among the worst in the world.' Promotive, preventive, and primary health care treatments receive less coverage. A pitiful 39% of tracer interventions are covered on average for essential universal health care, according to the Universal Health Service Coverage Index. Therefore, Nigeria substantially underperforms on important health outcomes: the incidence of maternal death is 243 per 100,000, the rate of newborn deaths is 37 per 1000, the rate of under-five mortality (U5MR) is 89 per 1000 births, and the proportion of births attended by qualified health staff is 58.6% (NDHS, 2018). These indices are inadequate and have significant effects on Nigerians' health and well-being. Nigeria has a sizable reservoir of human resources for health (HRH), however, similar to the 57 other nations experiencing an HRH crisis, its 1.95 healthcare staff per 1,000 population ratio makes it impractical to provide basic healthcare services **[24]**.

Services are just as important as accessibility and proximity to the underprivileged for a primary healthcare system to be effective, preventive, and curative. In order to achieve local (and national) public health goals, a functional primary health care system should prioritize the following: disease-oriented interventions, community-oriented interventions to access intersectoral inputs that impact health (such as safe drinking water and improved sanitation), and health promotion. Additionally, frontline health workers should provide preventive and curative ambulatory services in close proximity to impoverished communities **[28]**. A primary health care system that functions well must, among other things, treat common illnesses and injuries, supply necessary medications, provide basic and essential services and goods for women, mothers, and children, work to prevent, detect, and treat HIV/AIDS, tuberculosis, and malaria; perform basic and essential surgical care, particularly "first-line" surgical care related to burns, wounds, and fracture management; 'manage complications during childbirth; and promote public health measures, preventive health care, promotion and education about healthy behaviors and practices.'

Nigeria's ongoing development difficulty is the lack of a primary healthcare system that is both fully built and operational. The state of affairs jeopardizes the accomplishment of other health-related goals and the Sustainable Development Goals (SDGs). The establishment of a working primary healthcare system has frequently been hampered by insufficient efforts made in the areas of accountability, data collection, transparency, and sustainability. Limited institutional capacity, corruption, an uncertain political and economic environment, and inadequate funding are other limiting issues **[33]**.

It is a fact that Nigeria has not been able to facilitate the achievement of the intended health results. The fragility of the nation's primary healthcare system is one of the main issues facing the health sector. Donations from abroad are one of the main strategies used to solve these shortcomings in Nigeria. Financial aid for the socioeconomic and health development of underdeveloped nations is included in foreign donations. However, it can be difficult to see how overseas gifts have an impact. **[23]** reported that between 1999 and 2007, foreign donations to Nigeria improved from US$ 2.335 and US$4.674 per capita. In contrast, Sub-Saharan Africa (SSA) had an average annual foreign donation per person of US$28. In Nigeria, the percentage of foreign donations for primary healthcare has been rising. An estimated N27.87 billion, or 4% of all health expenditures, came from outside in 2003. From N36.04 billion (4.6% of Total Health Expenditure) in 2004 to N36.30 billion (4% of Total Health Expenditure) in 2005, there was a 29% increase in this amount. However, the results do not match the inputs **[10]**.

What are the Barriers to Achieving a Global Healthcare System in Nigeria?

There are several critical barriers within the global healthcare system. These critical barriers include the following:

1. High cost of healthcare: A large number of people, particularly in low- and middle-income nations, cannot afford to pay for healthcare services. The World Health Organization (WHO) estimates that every year, the expense of healthcare forces some 100 million people into extreme poverty.
2. Geographical barriers: Due to a lack of transportation choices and infrastructure, those who live in rural or isolated places may have limited access to healthcare services. Rural populations are found to be less likely than their urban counterparts to seek medical attention.
3. Cultural and language barriers: Accessing healthcare services might be challenging for people due to linguistic and cultural issues. Studies have demonstrated that communication difficulties can result in poor care and a higher chance of unfavorable medical consequences.
4. Stigma and discrimination: People may be discouraged from accessing healthcare services due to stigma and discrimination, especially when it comes to delicate topics like mental health or HIV/AIDS. According to a Kenyan study, stigma is a significant obstacle to HIV testing and treatment.
5. Lack of education: Individuals with low levels of education might not know how to use the healthcare system or realize how important it is to seek medical attention. A study conducted in India discovered a correlation between reduced healthcare consumption and lower educational levels.
6. Lack of healthcare infrastructure: Many low- and middle-income nations do not have the hospitals and clinics needed to provide healthcare to their citizens' requirements. According to a Tanzanian

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

survey, one of the biggest obstacles to receiving healthcare services is a lack of infrastructure (WHO, 2022).

What are the Solutions to Barriers to Accessing Global Healthcare System in Nigeria?

1. Financial barriers: High healthcare costs can be a major obstacle for many people. One solution is to implement universal health coverage, which can reduce financial barriers to accessing healthcare.
2. Geographical barriers: Many people in rural or remote areas face challenges in accessing healthcare facilities. Telemedicine, which uses technology to provide remote consultations and medical advice, can help to overcome this barrier.
3. Language barriers: People who do not speak the language of the healthcare provider may have difficulty accessing care. The use of trained interpreters can help to address this issue.
4. Cultural barriers: Cultural differences can sometimes create barriers to accessing healthcare. Culturally competent care, which involves understanding and addressing cultural differences, can help to overcome this barrier.
5. Lack of education: People who lack education may have difficulty understanding health information and navigating the healthcare system. Health education programs can help to address this issue.
6. Stigma and discrimination: Stigma and discrimination can affect access to healthcare for certain populations, such as people living with HIV/AIDS. Efforts to reduce stigma and discrimination can help to improve access to care **[26]**.

Conclusion

The political, economic, and sociocultural factors of a country have a significant impact on healthcare and health outcomes, and our world is becoming more diverse and complicated every day. Several public health researchers have worked to better understand the various methods that different countries have adopted by conceiving global health systems within an international health framework over time. The global healthcare system is a complex network of organizations, institutions, and resources dedicated to promoting and providing healthcare services to individuals and communities around the world. It is an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. The focus of global health is on international health problems, causes, and remedies. It encourages multidisciplinary collaboration and encompasses a wide range of disciplines both inside and beyond the health sciences. The study discovered that a number of factors, including gender violence, environmental pollution, climate change, migration from war-torn regions, inadequate or expensive healthcare services, and the emergence and reemergence of communicable and noncommunicable diseases, are posing new health challenges for high-, middle-, and low-income countries.

Similarly, the study discovered that there are fifteen priorities in global health, which include universal health coverage, health emergencies, communicable diseases, non-communicable diseases, mental health, maternal and child health, nutrition and healthy lifestyle, substance abuse, environmental health, occupational health, health systems, research for health, access to medicines and vaccines, financing and innovation for health, governance and accountability for health. The findings of the study showed that the vision for health and healthcare includes achieving equity, transforming healthcare systems, encouraging innovation, and securing global environmental sustainability, with equity as the foundation. Furthermore, Nigeria's healthcare system continues to rank among the worst in the world. The study discovered that high cost of healthcare, geographical barriers, cultural and language barriers, stigma and discrimination, lack of education, lack of healthcare infrastructure, insufficient healthcare workforce, political instability and conflict, lack of health insurance, and limited availability of essential medicines are part of the barriers to achieving global healthcare system in Nigeria. The study concludes that Nigeria should meet its commitments made in the Abuja Declaration to provide at least 15% of the yearly budget to enhance the country's health system.

Recommendations

1. The Federal Government of Nigeria should prioritize and invest intensely in the nation’s healthcare system, especially in the primary healthcare sector.
2. The government and other private sectors should construct roads to ease healthcare accessibility in rural areas.
3. There should be proper implementation of health insurance in the country at large; not secluding the majority of the rural areas.
4. The government of Nigeria should prioritize the 2035 global health vision in Nigeria.

References

1. Ahmed, M. O, Msughter, A. E. (2022). Assessment of the spread of fake news of Covid-19 amongst social media users in Kano State, Nigeria. Computers in Human Behavior Reports. 6: 100189.
2. Airaoje, O. K, Obada, A. A, Msughter, A. E. (2023). A Critical Review on Gender Based Violence in Nigeria: Media Dimension. Humanities. 3(2): 9-16.
3. Aliyu, M. A, Msughter, A. E, Nneka, A. Q. (2023). Comparative Study of National Development Plans in Nigeria and India: Media Dimension. SIASAT. 8(4): 202-212.
4. Aondover, E. M. (2020). Internet meme as a campaign tool to the fight against Covid-19 in Nigeria. Global Journal of Human-Social Science: A Arts & Humanities – Psychology. 20(6): 27-39.
5. Aondover, E. M, Oyeleye, S. A, Aondover, P. P. (2022). Analysis of Iconographic Effect of Visual Communication Genre on Covid-19 in Nigeria. Journal of Gynaecology and women’s health. 23(3).
6. Aondover, E. M, Yar’ Adua, S. M, Maradun, L. U. (2020). Influence of cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State, Nigeria. International Journal of Health, Safety and Environment, 6(9): 670-681.
7. Aondover, E.M. Phillips, D. (2020). Media framing of Covid-19 pandemic: A Study of Daily Trust and Vanguard Newspapers in Nigeria. ASJ: International Journal of Health, Safety and Environment (IJHSE). 6(5): 588 – 596.

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012

8. Duff, J. H, Liu, A, Saavedra, J, Batycki, J. N, Morancy, K, Stocking, B, and Szapocznik, J. (2021). A Global Public Health Convention for the 21st Century, The Lancet Public Health. 6(6): 428-433.
9. Fordham, R, Dhatariya, K, Stancliffe, R, Llod, A, Chatterjee, M, Mathew, M, Taneja, L, Gains, M, and Panton, U. H. (2020). "Effective diabetes complication management is a step toward a carbon-efficient planet: an economic modeling study", BMJ Open Diabetes Research and Care. 8(1): 001017.
10. Gyuse, A. N, Ayuk, A. E. and Okeke, M. C. (2018). Facilitators and barriers to effective primary health care in Nigeria. African Journal of Primary Health Care & Family Medicine. 10(1): 1–3.
11. Hannon, E, Hanbali, L, Lehtimaki, S, and Schwalbe, N. (2022). 'Why We Still Need a Pandemic Treaty', The Lancet Global Health. 10(9): 1232–1233.
12. Hile, M. M, Msughter, A. E, Babale, A. M. (2022). A Public Health Communication: Towards Effective Use of Social Marketing for Public Health Campaigns in Nigeria. Ann Community Med Prim Health Care. 5(1): 1002.
13. Kurfi, M. Y, Aondover, E. M. Mohammed. I. (2021). Digital Images on Social Media and Proliferation of Fake News on Covid-19 in Kano, Nigeria. Galactica Media: Journal of Media Studies. 1(1): 103-124.
14. Langabeer, J. R, Champagne-Langabeer, T, Alqusairi, D, Kim, J, Jackson, A, Persse, D, and Gonzalez, M. (2016). Cost–benefit analysis of telehealth in pre-hospital care.International Society for Telemedicine and eHealth. 23(8): 747-751.
15. Mojaye, E. M. Aondover, E. M. (2022). Theoretical perspectives in world information systems: A propositional appraisal of new media-communication imperatives. Journal of Communication and Media Research. 14(1): 100-106.
16. Msughter, A. E, Kuchi, M. G, Abba, A. A. (2023). Critical Discourse Analysis of Traditional Medicine Outdoor Advertising and Public Health Issues in Northern Nigeria. Indigenous Language for Social Change Communication in the Global South. 39.
17. Namadi, H. M, Aondover, E. M. (2020). Survey of reproductive health information seeking behavior among pregnant women in some selected hospitals in Kano Metropolis. Biomed J Sci & Tech Res.30(5): 23699-23708.
18. Obada, A. A, Abba, A. A, Msughter, A. E. (2021). Pregnancy Induced Hypertension in Kabo Local Government Area of Kano State, Nigeria. Biomedical Journal of Scientific & Technical Research. 39(4): 31458-31466.
19. Obada, A. A, Airaoje, O. K, Okuneye, A. P, Collins-Dike, J, Msughter, A. E. (2024). Media Role on the Burden of Non-Communicable Diseases in Nigeria. Clin Case Rep Int. 8: 1652.
20. Obada, A. A, Maradun, L. U, Msughter, A. E, Garba, N, Abba, A. A. (2021). Complications among Pregnant Women during Child Labor in Kabo Local Government Area of Kano State, Nigeria.
21. Obada, A. A, Msughter, A. E, Namadi, H. M, Nongubee, T. (2021). Hyper prevalence of malnutrition in Nigerian context. Biomed J Scientif Tech Res. 39(1): 30916-30925.
22. Obasi, M. C, Msughter, A. E. (2023). Assessment of media coverage of environmental hazards in mining communities in Ebonyi State, Nigeria. Environmental Challenges. 13: 100758.
23. Olakunde, B. O. (2012). Public health care financing in Nigeria: which way forward? Annals of Nigerian Medicine. 6(1): 4 -10.
24. Pate, U. A, Yar'Adua, S. M, Msughter, A. E. (2020). Public awareness, knowledge and perception of Covid-19 in Tarauni LGA and Kano metropolitan area of Kano State, Nigeria. Media & Communication Currents. 4(2): 52-69.
25. Sachs, J. D, Karim, S. S. A, Aknin, L, Allen, J, Brosbøl, K, Colombo, F, Michie, S. (2022). 'The Lancet Commission on Lessons for the Future from the COVID-19 Pandemic', The Lancet. 400(10359): 1224-1280.
26. UNAIDS. (2018). Reducing HIV stigma and discrimination: A critical part of national AIDS programmes.
27. United Nations. (2015). Transforming our World: The 2030 Agenda for Sustainable Development.
28. Usman, B, Eric Msughter, A, Olaitan Ridwanullah, A. (2022). Social media literacy: fake news consumption and perception of COVID-19 in Nigeria. Cogent Arts & Humanities. 9(1): 2138011.
29. World Health Organization. (2017). Tacking Universal Health Coverage: 2017 Global Monitoring Report.
30. World Health Organization. (2022). Noncommunicable diseases.
31. World Health Organization. (2023). Health for All: Transforming Economies to Deliver What Matters—Final Report.
32. World Health Organization. (2023). World Health Organization COVID-19 Dashboard.
33. Yar'Adua, S. M, Msughter, A. E, Garba, S. (2023). Media and National Development in Democratic Societies. Polit Journal Scientific Journal of Politics. 3(3): 105-115.
34. Yar'Adua, S. M, Namadi, H. M, Msughter, A. E. (2021). An Appraisal of Political Economy of New Media in Nigerian Context. Inter. J. Eng. Lit. Cult. 9(4): 109-117.

Citation: Karl Airaoje, Omolara Oluwabusayo Akin-Odukoya, Funmi Falobi, Aruaye Afeye Obada. Review on the Global Healthcare System and the Posture of the Nigerian Primary Healthcare System. Journal of Medicine Care and Health Review 1(3). https://doi.org/10.61615/JMCHR/2024/OCT027141012