ISSN: 3067-2392
Review Article
Planetary Journal of Social Sciences & Humanities Research

The Interplay of Socioeconomic and Political Factors in Healthcare System: A Comparative Analysis of Healthcare System of a Developed and a Developing Country

Joshua Effiong EDET

Department of Sociology, Lagos State University, Ojo Lagos, Nigeria

***Corresponding author:** Joshua Effiong EDET, Department of Sociology, Lagos State University, Ojo Lagos, Nigeria.

Submitted: 11 August 2025 **Accepted:** 18 August 2025 **Published:** 24 August 2025

https://doi.org/10.63620/MKPJSSHR.2025.

Citation: *Effiong EDET, J. (2025). The Interplay of Socioeconomic and Political Factors in Healthcare System: A Comparative Analysis of Healthcare System of a Developed and a Developing Country. J of Soc Sci & Hum Res, 2(4), 01-06.*

Abstract

As a determinant of the population's wellbeing, healthcare system is a crucial component in any country. Healthcare service affects the quality of life of the people and the potential for the country's economic growth. However, there exists limited understanding of the effects of societal factors such as the social, political and economic factors on healthcare system. This paper explores the impact of these factors on healthcare system by undertaking a comparative analysis of healthcare system in two countries with highly divergent social, economic and political status, across significant healthcare indices such as healthcare coverage, financing mechanism and health outcomes, using articles and health reports. The analysis revealed that a country with strong economic capability, social and political stability have better healthcare system, compared to a country with a weak economic capability, coupled with social and political instability. This is indicative of the reliance of healthcare system on the general socioeconomic and socio-political conditions of the country, and that understanding healthcare cannot be done in isolation, but rather within the lenses of the general socioeconomics, political and cultural factor. Hence, the need to build stronger economies, reliable financing mechanisms and ensuring safer social and political environment for an effective, accessible and affordable healthcare.

Keywords: Comparative Healthcare, Socio-Economic Factors, Developed Country, Developing Country.

Introduction

Healthcare systems play a crucial role in ensuring and shaping the well-being of the populations in any country or society [1]. The provision of quality health care services is an essential social responsibility, as it affects the quality of life of the people and the potentials for the country's economic growth. A nation of sick people cannot carry out their tasks and responsibilities, thus understanding healthcare dynamics is vital in delivering quality healthcare in any country [2]. Healthcare system is a fundamental pillar of societal well-being; a significant pointer to the country's economic capacity, governance, commitment to equity, and recognition of the essentiality of life.

Despite global advancement in medical technology, healthcare management and policies, disparities in health outcome are largely observed across different countries of the world. While differences in individual socioeconomic status such as income level, education, social status, among others, have been observed to be major determinants obtaining healthcare services, however, analysis of the impact of a country's socioeconomic and political factors on healthcare system appears to be lacking [3, 4]. Thus, this paper assumes that the social, economic and political status of a country is likely to be a determining factor of a country's healthcare system.

Hence, this paper attempts a comparatively analysis of the healthcare system of two countries – a European and African country – using the United Kingdom (UK) and the Democratic Republic of Congo (DRC). By juxtaposing healthcare systems in two broadly divergent countries, we can understand the interplay between the various factors and healthcare delivery within several dimensions of healthcare system. Health system in the

UK exemplifies how wealth and influential economic system and political stability can foster comprehensive care; while on the other hand, the dynamics of the healthcare system in DRC highlights the challenges of providing healthcare services amidst political instability and economic scarcity. Significantly, comparative analysis offers an exploration into the similarities and differences between and among health policies, institutions, programs and outcome in different countries. It further highlight the adaptation of international health reform to fit and benefits local health needs, and lead to shared lessons learned by pointing to the strategies different health systems use to deal with the same problems, the obstacles they faced, the solutions that were put in practice, and the kinds of outcomes generated [5].

This analysis not only illuminates the strength and weaknesses of healthcare system un each country, but also presents a broader implication for global healthcare. In this analysis, we shall begin by gaining an overview of the countries in focus, then the comparison of health status in these countries, focusing on the general structure and organisation of healthcare, healthcare financing and health outcomes as indicators as influenced by social, economic and political factors.

Countries Overview

The DRC is a country in central Africa. The country is one of the largest countries in Africa, with an estimated land area of over 2,344,858 km2 and a population of over 91 million people, and it's ranked the 16th most populous country in the word, contributing about 1.15% of the total world's population, having over 45% of its population lives in the urban area [6]. For about three decades, the country has been facing series of political violence and instability, fuelled by conflicting political interest, resulting in the exploitation and depriving the people of their rich mineral resources, thereby inhibiting economic development. Consequently, economically and politically, DRC remains one of the poorest country in the world with over 70% of its population living below poverty line, despite the availability of abundant natural and human resources in the country. The interplay of theses social and political instability poses a significant negative influence on the DRC's healthcare system [7].

On the other hand, the social circumstances are different in the UK. The UK is a conglomerate of four island countries in Western Europe. The UK consists of England, Scotland, Wales and Northern Ireland. The UK has an estimated population of over 65 million people, and is one of the most populated countries in Europe. Having a GDP of over $2 trillion, the country, being a former global coloniser, is one of the largest economy in the world, considered an economically prosperous country and a major economic player in the world [8].

Structure and Organisation of Healthcare System

Healthcare system in the UK is structured and organised around the National Health System (NHS). The NHS was founded in 1946, and has since been the corner-stone of UK healthcare system. Before this time, healthcare in UK was generally available only to the wealthy, unless one was able to obtain free treatment through charity or teaching hospitals. In 1911 David Lloyd George introduced the National Insurance Act, in which a small amount was deducted from an employee's wage and in return they were entitled to free healthcare. However this scheme only gave healthcare entitlement to employed individuals (Chang et al., nd). After the Second World War, efforts were undertaken in providing a public healthcare system geared toward a free and universal healthcare to all citizens.

The NHS was first proposed to the Parliament in the 1942 Beveridge Report on Social Insurance and Allied Services. The NHS was founded under the principles of universality, free at the point of delivery, equity, and paid for by central funding [9]. Although the system has undergone several political and organisational changes, its key principle of universally available healthcare for people on the basis of needs, rather than the ability to pay, still remains [9].

The operations of the NHS is under the Department of Health and Social Care in England, while the responsibility for health care services has been devolved to Scotland, Wales and Northern Ireland since the late 1990s, ensuring that services are tailored to the people's need. The countries of the United Kingdom are responsible for delivering health services, free at the point of use, through the clinical commissioning groups in England (replaced by Integrated Care Systems by July 2022), health boards in Scotland and Wales, and the Health and Social Care Board in Northern Ireland are responsible for commissioning or planning health and care services in their respective areas [8]. This allows the UK countries have their own distinct structure and organisation, but overall, not largely different from each other's health systems.

The NHS system in the UK is structured into two broad sections; one deals with policy, strategy and management, while the other deal with actual medical activities – which in turn is divided into three areas: Primary care, Secondary care, and Public health. Primary care is delivered through General Practitioners (GP), and serves as the first point of contact; medical checks, managing routine illness and referring patients to specialist if need be. Secondary care consist of hospital and specialised health services such as surgery or maternity care, while public health is concerned with prevention efforts such as vaccine or immunization campaign, and smoking cessation program.

Healthcare system in the DRC is decentralised; with the Ministry of Health (MoH) setting health policy, while the provincial governments manage healthcare delivery. The structure and organisation of healthcare system in DRC lacks an overarching coordination of the central government. According to the National Health Development Plan, healthcare system is structured and organised within four sectors: public medical, private medical, private pharmaceutical and traditional medicine. The public medical sector consists of health centres, general reference hospital, provincial and national hospitals, and other entities involved in service delivery. The private medical sector is sub-divided into two; - for-profits and non-profits – and they include health centres, paramedical, clinics and diagnostics centre [10]. Private pharmaceutical sector comprises of health institutions concern with the wholesale and supply of medicines, medical items and equipment's, while the traditional medicine sector engages Africa's medical knowledge of herbs and plants in treatment and provision of care to the patients.

The MOH leads the public health sector at the central level. It is

responsible for the health system and creates national strategies, defines policies and priorities, sets standards and guidelines for service delivery, and implements several vertical disease programs (e.g., for malaria, HIV, reproductive health, and adolescent health). The MOH directly delivers services through national-level tertiary facilities, and advises and supports provincial and district health zones to deliver health care at lower-level public facilities. As indicated by the report made by the Sustaining Health Outcomes through Private Sectors Plus (SHOPS Plus) Project in 2019, unlike the UK, in DRC, the private health sector is an important player in the DRC's health system, but the extent of its contributions is largely unknown. Private providers, especially faith-based organizations (FBOs), grew in scale during the late 1990s and early 2000s to fill gaps that emerged in the public health sector as a result of political and civil destabilization, as a response to the changing social dynamics of the country due to political instability and outbreak of crisis in the country. As the government sought to re-establish itself and improve health outcomes, it recognized the importance of private providers and sought to integrate them into the larger health system. As a result, the private sector is now mentioned as a key partner in several MOH strategies, policies, and plans [11].

Health Financing Mechanism

The UK operates the Beveridge model of healthcare system, which anchors on the universal and free provision of health service based on individual's need rather than the ability to pay. In this model healthcare services are financed through general taxation, thereby allowing for a free delivery of health service. Public financing, collected through general taxation, is the primary source of funding for health in the United Kingdom. The three largest taxes, which account for approximately two thirds of revenue, are income tax, national insurance contributions and value-added taxes. Once revenue is collected by His Majesty's Revenues and Customs (HMRC), it is distributed to the Department of Health and Social Care (DHSC) [8].

Although the NHS care is mostly free at access point, however, in certain cases, patients are required to make co-payment for certain services, cost sharing, and direct payment for services not covered in the NHS, or for private treatment. Co-payments can apply to dental care and, in England, outpatient medicine prescription charges. Usually, direct payment may include private treatment, social care, general ophthalmic services and over-the-counter medicines. These payments which amount to out-of-pocket payment constitute about 17% of health expenditure in 2019, indicating a considerable and significant increase over the years. Private insurance has decreased since 2000, reaching 2.8% of total expenditure on health. Private medical insurance is usually used to finance a few select services not offered by the NHS or to access NHS-covered services more quickly [8].

Healthcare financing in DRC takes a different trajectory, highlighting the countries disparities. The importance of adequate financing for healthcare is obvious as evident in the country's attempt to finance its health care services. The health financing landscape in the DRC faces several challenges, including low allocation of public resources to health, insufficient risk-sharing and health financing mechanisms, and fragmentation of official development assistance.

As a low-income country, healthcare financing in the DRC depends heavily on government sources and aids funding from NGO's. However, as a country facing a plethora of socioeconomic challenges, these funding are considered inadequate. For instance, the percentage of government budget allocated to health has fluctuated in recent years from 3.5 percent in 2011, to 7.8 percent in 2012, to 4.6 percent in 2013 [10]. As at 2020, the health expenditure per capita was US$21, only about half of the US$39 average for low-income countries. In 2022 the government spending in healthcare was about 10% of the country's GDP. Although government is increasing its healthcare funding, its proportion is still very low. For instance, the central government health spending amounts to only 16% of the total health expenditure in 2020 according to the Global Health Expenditure Database [7].

The private sector plays a crucial in the provision of healthcare services in the DRC, although the extent of its role is not clearly defined. According to the SHOP Plus report, 44 percent of outpatient care and 25 percent of inpatient care is provided by private facilities. Private facilities also have better infrastructure and operational capacity as compared to public facilities [1]. From a SHOP Plus 2019 report, private healthcare financing in DRC is in two aspects; 1) health financing or demand-side mechanisms, such as insurance, which can reduce financial barriers to accessing healthcare at private facilities and provide greater financial protection against catastrophic health spending, and (2) access to financing for private providers to expand operations.

In addition to these, is the activity of private health financing programs. These programs include health benefit sponsored by employers for employees and their families. Private health insurance and other health benefit programs are concentrated among formally employed people in wealthier income quintiles and reach no more than 3 to 4 percent of the population. However, the program only have limited role in DRC; covering only a small percentage of the country's population (WHO, 2018).

In accessing healthcare, patients often have to individually pay for healthcare through out-of-pocket. This poses a significant economic burden on the citizens, who are merely living below poverty line. Due to inadequate government funding, out-of-pocket expenditure is the most common health funding mechanism in the DRC, followed by aids and donor funding. As a result of low government funding of healthcare in DRC, health facilities, whether public or private, heavily rely on user fees to remunerate their staff, procure supplies, and cover other operating costs [12].

However, the government of DRC through the Ministry of Health is strategizing and prioritizing the implementation of the National Development Plan (NDP) which focuses on the delivery of a primary healthcare services package that emphasizes improvements in healthcare delivery. An important element of the plan is prioritizing the use of innovative financing mechanisms for healthcare services in the country. These, includes strategic purchasing, direct-facility financing, and single contract pooled funding. The DRC is also in partnership with international partners to ensure its population has access to health services without suffering financial hardship [1].

Health Outcomes

Although, healthcare coverage in the UK is an attempt to offer healthcare to a broad spectrum of the population, but this does not amount to a provision of healthcare to everyone in the UK. Moreover, NHS does not have an explicit list of benefits; instead, legislation outlines broad categories of health care services to be provided for in the NHS. Major exclusions include prescription charges, dental care and optometry, although these may vary across different countries in the UK [8].

The UK has a sizeable number of health work-force. In 2019, there were about 2.95 doctors per 1000 inhabitants in England [8]. Also, there has been an ongoing policy to shift healthcare closer to the people, hence an increasing demand in the number of health workers. Although this numbers are relatively lower when compared to other high-income European countries, however, they are higher than what is obtainable in low-income countries [8]. The overall number of hospital beds in the UK averages 2.5 beds per 1000 people. This number also vary across the United Kingdom, with England having lower numbers of hospitals beds per 1000 people than in Scotland, Wales and Northern Ireland.

Disease prevalence are relatively low due to the availability of quality primary healthcare services in the country, providing continuous and comprehensive care, while acting as a first point of contact to access other health care services. The availability of primary healthcare equally means not only an increase in the number of a general practitioners (GP) doctors, but a whole team of doctors, nurses, midwives, health visitors and other health care professionals such as dentists, pharmacists and optometrists in a community setting.

Despite gradual improvements in some key health indicators, two decades of conflict and ongoing insecurity have led to a significant deterioration in health infrastructure in the DRC. Low financing for health and weak government oversight exacerbate service inadequacies, with poor deployment of the limited resources that are available. Structural barriers to service access combined with inequitable gender norms and harmful cultural beliefs, prevent service use, drive unhealthy behaviors, and further exacerbate poor health outcomes.

Limited access to health services has resulted in some of the worst maternal and child mortality rates in the world. In a Demographic and Health Survey (DHS), maternal mortality rate stood at 846 deaths per 100,000 births and almost 50 percent of children under the age of five remain malnourished [7-10]. Despite relatively satisfactory antenatal care coverage, there is a lack of emergency obstetric care. The DRC also has one of the lowest modern contraceptive prevalence rates in Africa, with only 8 percent of married women using a modern method [13]. The country is considered a country with the poorest health indicator globally, with an under-5 mortality rate of 81 per 1000 births and with over seventy percent of the population living below poverty line (World Development Indicators 2022). Even though a relatively high share of women receives at least some antenatal care (82%) and delivers in health facilities (82%), major gaps in other areas such as vaccination coverage and quality of health services remain [14].

However, the DRC is one of five countries that collectively accounts for half of all deaths globally among children younger than five [15]. Sixty percent of children younger than five nationwide are not covered by basic treatment services for diarrhea, fever, and respiratory infections [13]. Use of oral re-hydration solution (ORS) and zinc remains low, even in provinces with large urban areas, such as Katanga, where use of ORS and zinc is at 38.3 percent and 0.9 percent, respectively. The DRC also has high rates of malnutrition, which has significant economic consequences amounting to 4.5 percent of GDP lost annually [16].

With out-of-payment expenditure accounting for a large portion of healthcare spending, accessing healthcare services becomes a huge economic burden on the citizens due to cost. The share of out-of-pocket expenditure as a percentage of total health expenditure is high compared to that of other countries in the region. Given the reliance on out-of-pocket expenditure, many Congolese face catastrophic health expenditures. In 2017 about 19 percent of households had incurred health expenditures that exceeded the resources available to them in 12 months. Catastrophic expenditures on health disproportionately affect the poor [10].

The healthcare workforce - consisting of all personnel in the healthcare sector - has been identified as a fundamental tool for health service delivery. Proper health workforce is in assessing the right number of people with the right skills, in the right place, and at the right time, to provide the right services to the people that rightly need it [17, 18]. Health workforce in the country is also adversely affected by the circumstances in the country. More so is the poor educational status in the country. Most medical schools in the country do not meet the required standards set by regional bodies to deliver diplomas to graduates. Political instability disrupts educational processes, and unsafe learning environment leads to shortage of staffs in most medical schools in the country. Despite that, these institutions continued to produce more than 2,000 new physicians each year and more than 4,000 new nurses, albeit without formal diplomas, leading to a poorly skilled health worker [19].

Discussion

Comparative analysis of healthcare system across countries explores the similarities and differences between/among health policies, programs, institutions, and outcomes in different countries [20]. For instance, the United Kingdom (UK) and the Democratic Republic of Congo (DRC) presents a compelling view of the likely contrast in health system design and performance, especially due to the different socioeconomic and socio-political environment at which they operate. The UK, a high-income country in Western Europe operate a health system considered to be admired, in most instances, stands in stark contrast with the health system in DRC, a low-income nation in Central Africa. These two nations differ greatly in social, economic and political dimensions, and offer great insight on the effect of these dynamics on healthcare system. Nonetheless, these countries offer valuable insights into how healthcare system function under divergent conditions.

The comparison presented in this paper presents the potential of social, economic and political impact on healthcare systems. Healthcare system in a developed country as the UK, operating within a strong economic, social and political status, pos-

sesses ability to receive adequate funding, stable policies and a peaceful atmosphere that ensure smooth operation and delivery of healthcare services. On the contrary, operation of healthcare system in a developing country, marred by weak economic capabilities, with social and political instability faces several challenges. With a stabilized healthcare structure (via the NHS), the UK healthcare system maintains a wide coverage, providing healthcare service to a large proportion of its population.
Equally, social factors such as availability of educational institutions for the training of professional health workers, produces adequate and qualified health personnel's.

Availability of health infrastructure such as primary healthcare centres enhances quick access to healthcare services. Political stability and governance structure strongly influence healthcare. Stable governance in an atmosphere void of political crisis enhance strong institutional framework that supports consistent healthcare policies, regulatory oversight and efficient service delivery. Conversely, weak economic capability limits healthcare funding, leading to inadequacy of facilities, technologies, medicines and healthcare workers. More so, the weak economy of DRC hampers the government's ability to provide universal health coverage for all citizens.

The healthcare system is thus structured into different segments, NGO's and the private sector as a major provider of healthcare services. Resultantly, healthcare is not a basic human right provided based on need, but somewhat commercially based on the ability to pay. Additionally, the dynamics of the political atmosphere often characterised by crisis and instability hampers effective healthcare policy execution and resource allocation. Understanding the interplay of these factors enriches the overall understanding of healthcare system in the country. In any given country, healthcare services are function of the social dynamics and the interplay of different factors within the society.

Hence, healthcare services are shaped by various social, economic, political, and infrastructural factors, across countries. Imperatively, this results in a spectrum of broad divergence, and differences in the delivery of health services. Therefore, healthcare system is merely a resultant and or a reflection of the people (or country's) economic, social and political dynamics in the society. In the words of Ruggie, "each country's health care system is contained within a singular configuration of culture, history, politics, and economic capacity, and from these derive a specific mode of financing, delivering, and even evaluating healthcare" [21]. Therefore understanding healthcare cannot be done in isolation, but rather within the lenses of the general socioeconomics, political and cultural factors: consistently as an interwoven dynamics and their influences reflects in the overall healthcare system of a country.

Conclusion

This comparative analysis of the UK and DRC's healthcare system highlights the significance of socioeconomic and political factors in shaping healthcare system. While both the UK and the DRC exemplifies different healthcare dynamics as experienced in both countries, the UK emphasis on universal coverage, primary care and public funding through taxation, shows better health outcome through adequate funding and certain social characteristics, based on the country's strong economic and political influence globally [22]. In contrast, the DRC reliance on private and out-of-pocket funding results in unequal access to healthcare and inadequate health facilities, due to the country's political instability and economic dependence on aids and donors.

Ultimately, this study demonstrates the complexities of healthcare system, the influence of the general societal situation on healthcare delivery, therefore, the need for policy makers to consider a range of factors in designing and implementing healthcare policies and reforms [23, 24]. By learning from different countries' experience in healthcare dynamics, countries can work towards creating more equitable, efficient and effective healthcare system that prioritize the health and well-being of all citizens in the country by improving the social, economic and political conditions in the country.

References

1. Jaworzynska, M. (2016). A comparative analysis of the health system financing in Poland and selected countries. Economics and Sociology, 9(3), 41–51. https://doi.org/10.14254/2071-789X.2016/9-3/4
2. Kuye, O., & Akinwale, O. (2020). Conundrum of bureaucratic processes and healthcare service delivery in government hospitals in Nigeria. Journal of Humanities and Applied Social Sciences, 3(1), 25–48.
3. Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts. Office of Health Policy, 1–30.
4. Alberta, J. N. (2024). The impact of social determinants on health outcomes. Research Invention Journal of Public Health and Pharmacy, 3(2), 1–4.
5. Whiteford, L. M., & Vindrola-Padros, C. (2015). Comparative health systems.
6. 6. African Health Business. (2021). Democratic Republic of Congo's health sector.
7. Shapira, G., Clarke-Deelder, E., Booto, B., Samaha, H., Fritsche, G., Muvudi, M., Baabo, D., Antwisi, D., Ramanana, D., Benami, S., & Fink, G. (2023). Impacts of performance-based financing on health system performance: Evidence from the Democratic Republic of Congo. BMC Medicine, 21, 381. https://doi.org/10.1186/s12916-023-03062-8
8. Anderson, M., Pitchforth, E., Edwards, N., Alderwick, H., McGuire, A., Mossialos, E., & Hernández Quevedo, C. (2022). The United Kingdom: Health system summary, 2022. WHO/European Observatory on Health Systems and Policies.
9. Grosios, K., Gahan, P. B., & Burbidge, J. (2010). Overview of healthcare in the UK. EPMA Journal, 1, 529–534. https://doi.org/10.1007/s13167-010-0050-1
10. Brunner, B., Combet, V., Callahan, S., Holtz, J., Mangone, E., Barnes, J., Clarence, C., Assi, A., & Gober, S. (2018). The role of the private sector in improving the performance of the health system in the Democratic Republic of Congo. Bethesda, MD: Abt Associates Inc.
11. SHOPS Plus. (2019). Democratic Republic of the Congo private health sector assessment: Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector

Plus Project, Abt Associates.
12. Bertone, M. P., Lurton, G., & Mutombo, P. B. (2016). Investigating the remuneration of health workers in the DR Congo: Implications for the health workforce and the health system in a fragile setting. Health Policy and Planning, 31(9), 1143–1151.
13. Barroy, H., Andre, F., Mayaka, S., & Samaha, H. (2014). Investing in universal health coverage: Opportunities and challenges for health financing in the Democratic Republic of Congo. Washington, DC: World Bank Group.
14. Fink, G., Kandpal, E., & Shapira, G. (2022). Inequality in the quality of health services: Wealth, content of care, and the price of antenatal consultations in the Democratic Republic of Congo. Economic Development and Cultural Change, 70(3), 1295–1336.
15. World Health Organization (WHO), & World Bank. (2021). Tracking universal health coverage: Global monitoring report. WHO.
16. World Food Programme. (2017, July 7). New study reveals economic toll of malnutrition in Democratic Republic of Congo.
17. Birch, S. (2002). Health human resource planning for the new millennium: Inputs in the production of health, illness, and recovery in populations. Canadian Journal of Nursing Research, 33, 109–114.
18. Lopes, M., Soares, C., Almeida, A., & Almada-Lobo, B. (2015). Comparing comparables: An approach to accurate cross-country comparisons of health systems for effective healthcare planning and policy guidance.
19. Durham, J., Pavignani, E., Beesley, M., & Hill, P. S. (2015). Human resources for health in six healthcare arenas under stress: A qualitative study. Human Resources for Health, 13, 14.
20. Johnson, J., & Stoskopf, C. (2010). Comparative health systems: Global perspectives. Sudbury, MA: Jones & Bartlett Publishers.
21. Ruggie, M. (2001). Health care systems: Comparative. In International encyclopedia of the social & behavioral sciences (pp. 6537–6544).
22. Brown, L. D. (1998). Exceptionalism as the rule? US health policy innovation and cross-national learning. Journal of Health Politics, Policy and Law, 23(1), 35–51.
23. Chang, J., Peysakhovich, F., Wang, W., & Zhu, J. (n.d.). The UK health care system.
24. World Health Organization (WHO). (2011). The Abuja declaration: Ten years on. Geneva: WHO.

Copyright: *©2025 Joshua Effiong EDET. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.*