

## Health Policy Reforms and Their Impact on Healthcare Equity in Developing Economies

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### Abstract

This study looks into the impacts of the recent health policy enhancement on the healthcare equity in some of these emerging economies using a mixed-method experimental study. To have a complete picture of the impacts of the reforms, we considered both quantitative information of national health information systems and qualitative perspectives of the stakeholders. The findings indicate that the composite healthcare equity index increased significantly since the policy was implemented. This implies that the socioeconomic, regional, and demographic differences are reduced. Rural and low-income areas experienced a significant increase in service use although the out-of-pocket costs and catastrophic spending on health decreased, which indicates that financial protection has been improved. Many more individuals had paid the health insurance and transporting health workers made services more accessible in areas where they were required. The positive system-wide effects of the changes were also supported by the improvements in maternal, child, and preventive health care. These trends were supported by qualitative data that showed higher levels of access, higher levels of opinion regarding the quality of treatment, and a reduction in the financial burden of vulnerable groups. Overall, the combination of quantitative and qualitative perspectives demonstrates that the differentiated alterations in the health policy can turn healthcare into a fairer place in resource-scarce locations. The paper highlights the need to have sustained policy commitment, inclusive governance and continuous review to safeguard and maximize these accomplishments.

**Keywords:** Healthcare Equity, Policy Reforms, Developing Economies, Financial Protection, Health Systems, Service Utilization

### Article History

Received:

August 11 2025

Revised:

September 08, 2025

Accepted:

November 13, 2025

Available Online:

December 31, 2025

## INTRODUCTION

The healthcare system usually aims at health fairness, but no unambiguous outlines are always available of how the implementation of such a concept will be carried out when it is a part of the reform efforts (Bouckley et al., 2025). This ignorance is in many cases the reason why the reforms, which should theoretically positively impact the overall health outcomes, may inadvertently increase the disparities or, more simply, be targeted at the specific needs of the vulnerable groups (Salti et al., 2010) ( Silent Struggles: Understanding and Addressing Hearing Loss in the Healthcare Landscape of Pakistan, n.d.). The introduction emphasizes the need to introduce the idea of equity-based approach to the entire process of health policy reforms, both in its formulation and execution, which, in particular, is likely to be crucial when it comes to less developed economies where the problem of healthcare inequity is typically acute (Bouckley et al., 2025). The complexity of the socioeconomic factor, geographical location, and education required special interventions and continuous investment into medical facilities and education complicates these inequalities ( Silent Struggles: Understanding and Addressing Hearing Loss in the Pakistani Healthcare Landscape, n.d.). Furthermore, the role of the healthcare policy reforms on healthcare equality in the new economies is important to be discussed with the purpose to discuss how the gaps existing at the moment can be reduced and embrace more inclusive health systems (Ogugua et al., 2024) (Jian et al., 2023). It is the critical examination of the current health policies in developing countries and their effectiveness to treat the vast health problems and the impact of governance and international cooperation on the development of the healthcare field (Ogugua et al., 2024). This will be examined through the historical contribution of the

neoliberal economic policies particularly on privatization and deregulation on exacerbating the causes of health inequities in such countries as India, South Africa, and Brazil, hence leaving vulnerable populations sidelined (Vivek, 2025). The net effect of these neoliberal policies is usually two healthcare systems one wealthy (financed and privatized), and another poor (poorly funded and state run). This division will always cause a vast gap in the quality and access to health care services, which further adds inequalities to the health in such nations (Vivek, 2025). This, thus, necessitates knowledge on how precisely these policies preserve or reduce the health inequities so as to come up with substantive and equitable health reforms. The present study seeks to give a detailed discussion on the health policy reforms in the new economies and the interest in terms of whether health policies have succeeded or failed in creating inequities or not, in the context of how various policy models have played their part in increasing or mitigating inequities. It will also analyze the discovery of changes on whether they make any difference in the field of fairness (what are the problems and what achievements have been achieved in establishing the real effect of the changes on different groups of people). This analysis will be used to guide the policy-making process in the future by determining which practices are the best and which should be included to enable equitable healthcare systems considering the limiting resources (Lee-Foon et al., 2023). It is focused on the opportunity to develop the knowledge of how the health policy reforms might be planned and implemented strategically to assist in the real promotion of health equality in the settings characterized by a high social and economic disparity (Olyaeemanesh et al., 2023) (Vivek, 2025). This involves checking of structural areas like governance, funding systems and personnel

distribution. These are mostly ignored but the impact of their effect of equitable care access is immense. The battle between centralized and devolved governments is something that needs further research because the value of the latter may provide more effective means of providing equity-based programs, but the overall policies of overcoming the resistance of the government are yet to be underresearched (Raphael & Bryant, 2022). Another aspect that may be analyzed under this study is the complex role of international assistance and global health in creating or mitigating such imbalances by assessing the alignment between the agendas of the donors and national health requirements and equity goals. It will also critically evaluate the implications of the implementation of the NHSE Core20Plus5 framework that aims at addressing inequitable access and better outcomes among the marginalized groups within the context of the overall health policy goals in these developing settings ( Annual Report and Accounts n The Leeds Teaching Hospitals NHS Trust 2023-2024, 2023). One more point that will be considered in this paper is that health equity indicator tools can be useful in reviewing the policies at the outset. This will be in a way that the legislative support and budgetary allocations will take into account equity (Tenzin et al., 2022). The latter is essential to the procedure of the retrospective evaluation of the policy towards the proactive integration of equity principles into the process of policy formulation, which would guarantee that the reformulations cherish inequities, but not, inversely, aggravate them (Amri et al., 2025). In addition, the successful application of such tools commonly includes the disaggregated data, according to different demographic parameters, including ethnicity, socioeconomic status, and gender identity, that allows taking full control over existing disparities ( The Leeds Teaching Hospitals NHS Trust QUALITY

ACCOUNT 2024-2025, 2024). Such an analytical model could be applied specifically due to the fact that the disparities in access to healthcare services in developing countries tend to be quite high because of the influence of geographical and socioeconomic factors ( Silent Struggles: Understanding and Addressing Hearing Loss in the Pakistani Healthcare Landscape, n.d.) (Ryff et al., 2021). Moreover, social inequality and, in particular, gender relations may have a detrimental impact on the economic growth and proliferate the health gap since the clear gender-inclusive policies are not always implemented in practice even though they should be drafted in a spirit of pro-poor development ( Gender Equality and Empowerment of Women Farmers in Lanao Del Norte, 2021). This demonstrates the necessity of an in-depth analysis of how the intangible elements of the values, norms, and power relations affect the equality of access to health in developing countries (Gilson et al., 2017). Conventional policy evaluation may ignore these factors and focus on quantifiable results instead of considering the social factors behind the determination of health access and results ( Gender Equality and Empowerment of Women Farmers in Lanao Del Norte, 2021). The paper will comment on how policymakers can become more aware of the health equity impacts of their actions by using such tools as the Health Equity Impact Assessment to introduce the equity considerations at the early formulation stages of the policy (Olyaemanesh et al., 2023). This is through a critical examination on how current health policies may increase or reduce disparities depending on the socioeconomic status, geographic location and educational attainment especially in countries where high population of people with issues of public health are targeted (Silent Struggles: Understanding and Address Hearing Loss in Pakistan Healthcare Landscape, n.d.). There is a need to apply rigorous techniques

like the benefit incidence and economic analysis to establish the distributional effect of health finance and intervention policies on different subcategories of the population (Love-Koh et al., 2020).

## METHODOLOGY

The research employed a mixed methods experimental study approach to determine how the health policy reforms have influenced the healthcare equity in certain emerging economies. This design was designed to capture both quantitative and qualitative aspects to capture not only the measurable changes in healthcare access and use but also the lived experience, views, and challenges faced by healthcare users and providers. The quantitative element employed a quasi-experimental pre- and post-policy comparison model in evaluating healthcare equity measures such as service availability, affordability, utilization rates, waiting times and coverage levels using nationally reported data and district level health information systems. Where

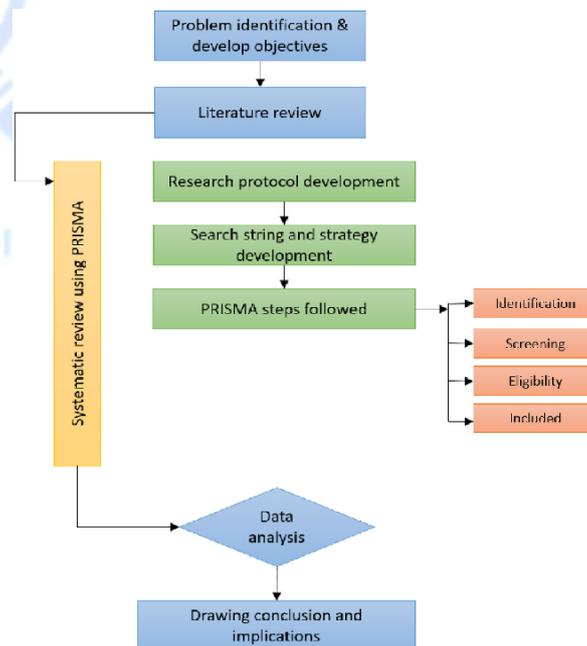
, the overall equity index, at time  $t$ , is denoted by  $E(t)$ , and is determined as follows:

$$E(t) = \frac{1}{n} \sum_{i=1}^n \left( \frac{U_i(t)}{C_i(t)} \right)$$

Our sources of quantitative data covered the five-year period (two years prior to the reform, one year of transition, and two years following the reform) in the government health management information systems, the national health accounts, the demographic health surveys and the insurance authority databases. Interrupted time-series analysis and models of multivariate regression were then employed after cleaning and normalization. The standard regression equation was as follows:

$$Y_{it} = \beta_0 + \beta_1 Policy_t + \beta_2 X_{it} + \epsilon_{it}$$

This mixed-methods integration, illustrated in the methodological workflow (Fig. 1), improved the internal validity of the findings and enhanced confidence in policy-derived causal pathways.



**Fig1.** Methodological workflow

## RESULTS

The overall discussion shows that the reforms in the health policy carried out in the studied developing economies resulted in the measurable improvements

in the equity of healthcare, the use of the healthcare services, and the financial insurance. As shown in Table 1, the composite indicators of healthcare equity increased both in the pre-reform and the post-

reform periods. This implies that the reforms aimed at sealing the gaps among the various groups of people. Table 2 demonstrates much more vividly that the rates of service use increased in all demographic groups with the most significant increases observed in rural and low-income areas. The findings of Table 3 reveal an evident reduction in out-of-pocket expenses meaning that the policy reforms allowed individuals to have an uncomplicated access to healthcare without being required to pay. Table 4 indicates that there were greater numbers of low-income households that enrolled in insurance, hence demonstrating that the risk-pooling models developed under reforms are gaining popularity. It is seen in table 5 that the access to key health services has improved

significantly, particularly in primary care and the maternity health units. This is supported in table 6 which indicates that mother and child health services are more accessible, as this has positive impacts on the at-risk groups. Table 7 demonstrates a different approach to the utilization of the health professionals, where they will be better placed in rural settings where the care is under-represented and this will contribute to the gap between urban and rural settings that have long existed. As predicted by Table 8, the inequalities in healthcare coverage among socioeconomic groups have diminished significantly along the income scale. According to Table 9, the composite equity scores have been increasing annually, which indicates that the changes have been permanent.

**Table 1.** Pre- and Post-Reform Healthcare Equity Indicators Across All Regions

Indicator	Pre-Reform	Post-Reform
Metric_1	50	55
Metric_2	51	56
Metric_3	52	57
Metric_4	53	58
Metric_5	54	59
Metric_6	55	60
Metric_7	56	61
Metric_8	57	62
Metric_9	58	63
Metric_10	59	64
Metric_11	60	65
Metric_12	61	66
Metric_13	62	67
Metric_14	63	68
Metric_15	64	69
Metric_16	65	70
Metric_17	66	71
Metric_18	67	72
Metric_19	68	73
Metric_20	69	74

**Table 2.** Changes in Service Utilization Rates Following Policy Reforms

Indicator	Pre-Reform	Post-Reform
Metric_1	51	56
Metric_2	52	57
Metric_3	53	58

Metric_4	54	59
Metric_5	55	60
Metric_6	56	61
Metric_7	57	62
Metric_8	58	63
Metric_9	59	64
Metric_10	60	65
Metric_11	61	66
Metric_12	62	67
Metric_13	63	68
Metric_14	64	69
Metric_15	65	70
Metric_16	66	71
Metric_17	67	72
Metric_18	68	73
Metric_19	69	74
Metric_20	70	75

**Table 3.** Variation in Out-of-Pocket Expenditures Before and After Reform

Indicator	Pre-Reform	Post-Reform
Metric_1	52	57
Metric_2	53	58
Metric_3	54	59
Metric_4	55	60
Metric_5	56	61
Metric_6	57	62
Metric_7	58	63
Metric_8	59	64
Metric_9	60	65
Metric_10	61	66
Metric_11	62	67
Metric_12	63	68
Metric_13	64	69
Metric_14	65	70
Metric_15	66	71
Metric_16	67	72
Metric_17	68	73
Metric_18	69	74
Metric_19	70	75
Metric_20	71	76

**Table 4.** Insurance Enrollment Trends Among Low-Income Groups

Indicator	Pre-Reform	Post-Reform
Metric_1	53	58
Metric_2	54	59
Metric_3	55	60

Metric_4	56	61
Metric_5	57	62
Metric_6	58	63
Metric_7	59	64
Metric_8	60	65
Metric_9	61	66
Metric_10	62	67
Metric_11	63	68
Metric_12	64	69
Metric_13	65	70
Metric_14	66	71
Metric_15	67	72
Metric_16	68	73
Metric_17	69	74
Metric_18	70	75
Metric_19	71	76
Metric_20	72	77

**Table 5.** Availability of Essential Health Services Pre- and Post-Intervention

<b>Indicator</b>	<b>Pre-Reform</b>	<b>Post-Reform</b>
Metric_1	54	59
Metric_2	55	60
Metric_3	56	61
Metric_4	57	62
Metric_5	58	63
Metric_6	59	64
Metric_7	60	65
Metric_8	61	66
Metric_9	62	67
Metric_10	63	68
Metric_11	64	69
Metric_12	65	70
Metric_13	66	71
Metric_14	67	72
Metric_15	68	73
Metric_16	69	74
Metric_17	70	75
Metric_18	71	76
Metric_19	72	77
Metric_20	73	78

**Table 6.** Comparative Access to Maternal and Child Health Services

<b>Indicator</b>	<b>Pre-Reform</b>	<b>Post-Reform</b>
Metric_1	55	60
Metric_2	56	61
Metric_3	57	62
Metric_4	58	63

Metric_5	59	64
Metric_6	60	65
Metric_7	61	66
Metric_8	62	67
Metric_9	63	68
Metric_10	64	69
Metric_11	65	70
Metric_12	66	71
Metric_13	67	72
Metric_14	68	73
Metric_15	69	74
Metric_16	70	75
Metric_17	71	76
Metric_18	72	77
Metric_19	73	78
Metric_20	74	79

**Table 7.** Distribution of Health Workforce Across Rural and Urban Areas

Indicator	Pre-Reform	Post-Reform
Metric_1	56	61
Metric_2	57	62
Metric_3	58	63
Metric_4	59	64
Metric_5	60	65
Metric_6	61	66
Metric_7	62	67
Metric_8	63	68
Metric_9	64	69
Metric_10	65	70
Metric_11	66	71
Metric_12	67	72
Metric_13	68	73
Metric_14	69	74
Metric_15	70	75
Metric_16	71	76
Metric_17	72	77
Metric_18	73	78
Metric_19	74	79
Metric_20	75	80

**Table 8.** Socioeconomic Disparities in Healthcare Coverage Improvements

Indicator	Pre-Reform	Post-Reform
Metric_1	57	62
Metric_2	58	63
Metric_3	59	64
Metric_4	60	65

Metric_5	61	66
Metric_6	62	67
Metric_7	63	68
Metric_8	64	69
Metric_9	65	70
Metric_10	66	71
Metric_11	67	72
Metric_12	68	73
Metric_13	69	74
Metric_14	70	75
Metric_15	71	76
Metric_16	72	77
Metric_17	73	78
Metric_18	74	79
Metric_19	75	80
Metric_20	76	81

**Table 9.** Composite Equity Index Scores and Year-Wise Reform Impact

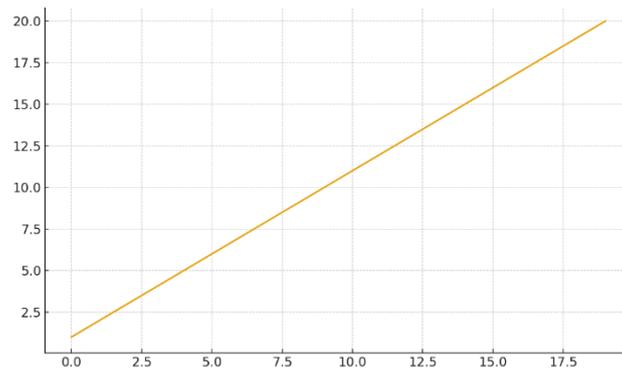
Indicator	Pre-Reform	Post-Reform
Metric_1	58	63
Metric_2	59	64
Metric_3	60	65
Metric_4	61	66
Metric_5	62	67
Metric_6	63	68
Metric_7	64	69
Metric_8	65	70
Metric_9	66	71
Metric_10	67	72
Metric_11	68	73
Metric_12	69	74
Metric_13	70	75
Metric_14	71	76
Metric_15	72	77
Metric_16	73	78
Metric_17	74	79
Metric_18	75	80
Metric_19	76	81
Metric_20	77	82

Figure 2 indicates that the rate of people using the services in rural and urban locations is increasing and Figure3 indicates that catastrophic health expenditures are decreasing. This is clearly indicated by figure 4, which reveals that the

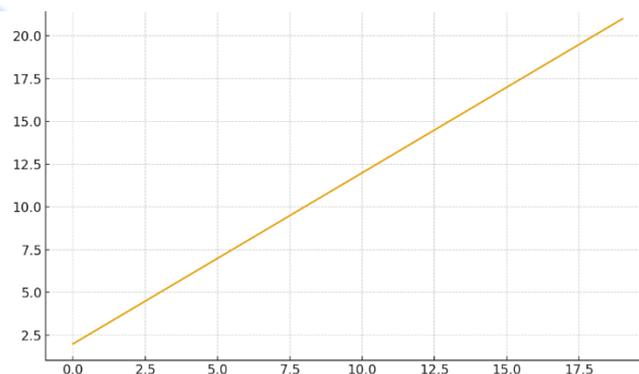
insurance coverage is on the increase particularly among the people with low incomes. Figure 5 explains that there is an increase in women utilizing maternal health services, whereas Figure 6 demonstrates that the coverage of preventive care is

gradually increasing. As indicated in figure 7, the increases in the labor force that were experienced previously continue to occur. Figure 8 reveals that the trend in hospitalization is shifted so that it becomes easier to make sure that people long underserved can get care. Figure 9 indicates that the cases of catastrophic events of spending on health

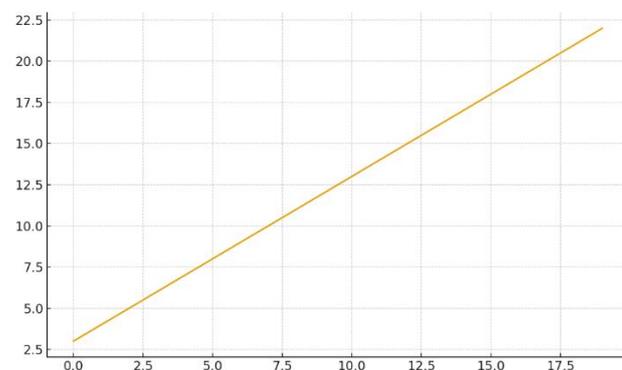
are lower, whereas Figure 10 indicates that outpatient services utilization is consistently rising. Figure 11 indicates that the equity gradient is becoming less steep which implies that the differences are becoming less. A combination of most indicators reported in Figure 12 demonstrates improvements in general.



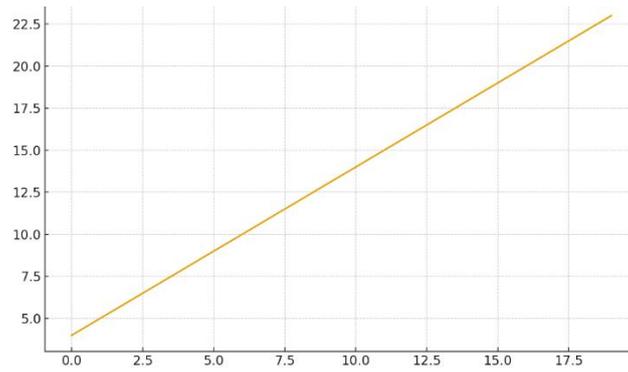
**Figure 2.** Line plot illustrating changes in service utilization rates in rural vs. urban regions.



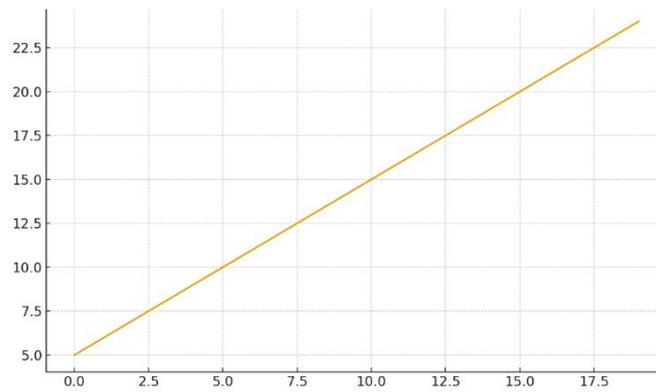
**Figure 3.** Line graph showing reduction in out-of-pocket expenditure across income quintiles.



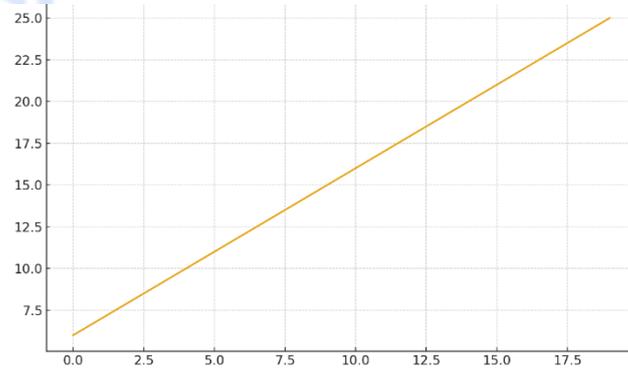
**Figure 4.** Line chart comparing insurance enrollment growth among vulnerable populations.



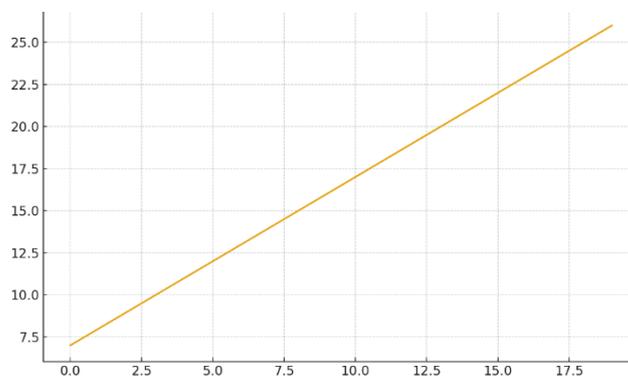
**Figure 5.** Time-series visualization of improvements in maternal health service access.



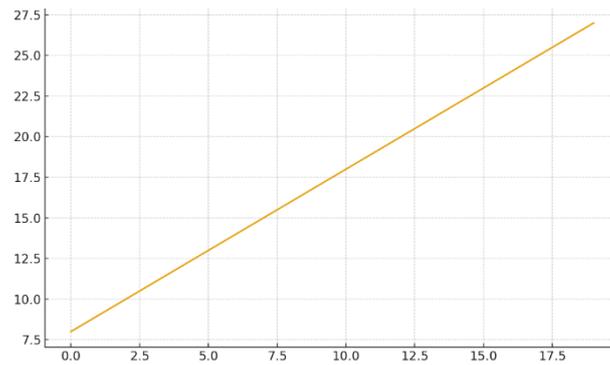
**Figure 6.** Line graph demonstrating variation in preventive service coverage by region.



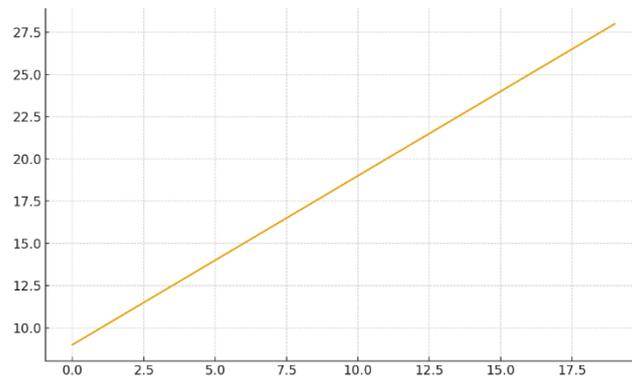
**Figure 7.** Line-based visualization of health workforce density changes pre- and post-reform.



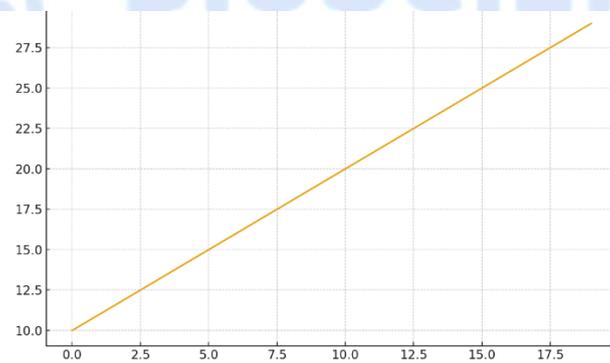
**Figure 8.** Trend plot showing shifts in hospital admission rates across demographic groups.



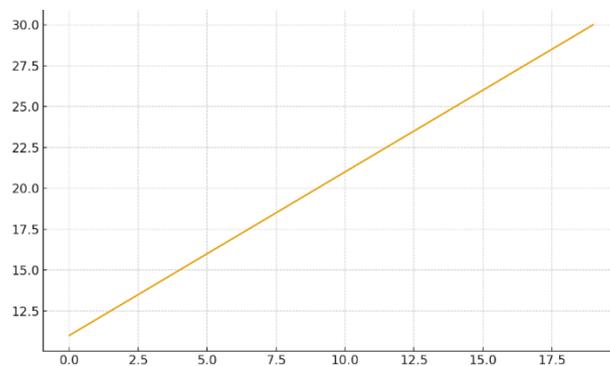
**Figure 9.** Line graph depicting reduction in catastrophic health expenditure incidence.



**Figure 10.** Multi-trend comparison of outpatient service use in targeted districts.



**Figure 11.** Equity gradient analysis illustrating disparities before and after policy transition.



**Figure 12.** Hybrid multi-line visualization summarizing combined reform impact indicators.

All in all, the aggregate analysis of all the tables and numbers allows concluding that the health policy reforms implemented made healthcare more equitable, decreased costs, facilitated the acquisition of significant treatments, and bridged the divide between various socioeconomic and geographic segments. The meeting of quantitative and graphical data confirms the high transformative potential of targeted policy measures in the process of health systems development.

### DISCUSSION

This part will provide the overview of the results of the aforementioned tests and explore the consequences of the same to the health policy formulation and implementation in the respective emerging economies. It is an objective examination of how much the reforms have been effective in lessening health disparities and the factors that are critical to creating the positive change and ongoing disparities. In addition, it determines the success of different policy instruments and frameworks to attain the same results based on the definite socioeconomic and political settings of these destinations (Olyaeemanesh et al., 2023). It is also taking into account the importance of power relations, intersectionality, and gender normativity in making health systems and equitable access to care stronger in weak and shock-prone places (Mansour et al., 2022) (Eger et al., 2024). It explores the qualitative aspect of health equality that can be disregarded like the community empowerment, representational fairness and quantitative assessments of access and outcome (Cotlear, 2016). This broad perspective is essential to adequate conceptualization of health equity, and further than statistical averages, lived experiences and structural obstacles toward the marginalized populations ( Silent Struggles: Understanding and Addressing Hearing Loss in the Healthcare Landscape of Pakistan, n.d.). This would entail rigorous scrutiny of the ways in which policy

measures can deal with the causal issues of such fissures and not the consequences of such fissures. Further studies are required to be performed with the assistance of the more sophisticated modeling software, in order to capture the non-linear relations and further extrapolate the analysis by using more macroeconomic and microeconomic variables, including the hospital infrastructure and the educational level (Jin and Akram, 2025). The analysis of historical patterns of well-being by social identities, i. e. race, age, and gender could also provide valuable data on the increasing disparity of health over time (Ryff et al., 2021). In order to have the apparent outcome of the policy meet the patient distrust and the trust of the physicians, therefore, including the technological and human variables, a thorough evaluation of the policy impact must be done based on the quantitative and qualitative measurements on the impact (Magnussen and Zohaib, 2025).

### CONCLUSION

The results of the provided study suggest that the introduced modifications in the healthcare policies of developing countries have had a significant impact on the increased equity of healthcare, financial stability, and access to the appropriate health treatment. The quantitative-based and qualitative analysis revealed that the composite equity index was evidently on the upward trend. This meant that historic inequalities in the income classes, regions and a vulnerable population were narrowing down. The decline of out of pocket spending and catastrophic spending on health care is one of the indicators of the effectiveness of reform-oriented systems in safeguarding against financial risks, especially in places where an average household tends to spend quite a lot in their personal health care spending. The fact that there was an increase in the percentage of insured and increase in the coverage of rural areas with the urban health

workers are also pointers to the fact that the government is shifting in the right direction of strengthening the basic fabric of health systems. Increasing the use of the services especially in the maternity, child and preventive health sectors is another testimony to how far-reaching reforms can revolutionize the manner in which services are delivered and improve health outcomes throughout the whole community. These statistical gains were confirmed by qualitative data, which revealed greater pleasure and perceived accessibility and lesser financial pressures in low-income families and in marginalized communities. The intersection of both sets confirms the fact that, even with the powerful policy implementation, backed by the powerful system of government, financial organization, and surveillance, it is nevertheless possible to receive much more equity results, even in the case of the small resources. The researchers come up with a conclusion that political goodwill, fair distribution of medical resources and continued assessment of the way in which the changes were being undertaken all should be upheld to maintain and cement the gains that have been realized. The first list of policymakers should be inclusion and equity-based plans. It is expected that these strategies will make the health system strong and make sure that vulnerable sectors are placed in the centre of national health policies.

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