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Comparison of Health Care Delivery System in Advantageous and Dis-Advantageous Areas of Lahore

FATIMA ISLAM
Department of Public Health
Institute of Social and Cultural Studies
University of the Punjab, Lahore, Pakistan

Abstract

Health care delivery system is an emerging public health concern especially in developing Nations and under developed Nations of the world. The Health care delivery system of Pakistan is facing many challenges including the lack of equitability, accessibility and patient satisfaction with the health care delivery system. The study proposed to analyze equitability, compare accessibility and patient satisfaction with the health care delivery system in the advantageous and dis-advantageous areas of Lahore. The study was the cross-sectional. There were challenges of equitable access to the Health care delivery system. The study also recommends some steps to improve equitable health care delivery system because of the disparity found in the equitable Health Care delivery in Dis- advantageous areas.

Keywords: health care delivery system, public health, Lahore, Pakistan

INTRODUCTION

Health is a fundamental human right. There are not only physical factors affecting the health of an individual, in fact health is affected by psychological and social factors. As defined by WHO, "it is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Focusing on this definition which was given by WHO, we can describe that health is dependent not only

physical factors but as well as Social and psychological factors has various roles in health status of any individual. Health has relation with overall quality of life. An individual who is healthy can spend his or her whole life with good quality of life. He or she can earn better livelihood in comparison to unhealthy individual. In this article, the focus is on health care delivery system. Health is defined as above definition. Now it is necessary to describe health care delivery system. According to WHO, "A health care delivery system is an organization of people, institutions, and resources to deliver health care services to meet the health needs of a target population" Pakistan has resources but these resources are not sufficient to deliver heath care services , it is also due to under utilization of resources. So it is required to utilize the resources in such ways to overcome the deficit.

The foundations of Health care delivery systems are primary health care, secondary health care and tertiary health care. Primarily the Public sector has Primary Health Care (PHC) facilities based on Basic Health Units (BHU) and Rural Health Centers (RHC). Tehsil Headquarters hospital handles population at sub district level and District Headquarters hospitals provide health services to the district population. The health system of Pakistan is mixed that primarily includes public, Para-state, private, civil society, humanitarian suppliers and donor organizations. In Pakistan the provision of health care services to public is regulated in four ways i.e. preventive, promotive, curative, and rehabilitative service. The public health delivery system plays its role through the three-stage approach i.e. primary, secondary, and tertiary. **(**Kumar &Banu, 2017)

In Pakistan the majority of the residents are living in the rural regions and slight ratio is living in the cities. (Imran et al., 2006). The inhabitants in the dis-advantageous regions are specially and the inhabitants in the advantageous regions to little degree are underprivileged of the basic rights. Particularly health care services as most of the public and private hospitals are situated in the larger cities (Irfan et al., 2011). Because increasing significance of facility quality particularly in the health sector of Pakistan, the research is based to assess the disparities between publicly and privately-run hospital's service quality in Pakistan. Though, extremely small work is apparent from the literature to determine the quality of facilities distribute to fulfill the needs of patients. (Comparison of Service

Quality between Private and Public Hospitals: Empirical Evidences from Pakistan). Out of many challenges one is that we could not persist consecutively to spend in more expensive health care services that would advantage a very few and with less than best outcomes, at the cost of not spending in lower cost interferences that have a higher health care concerned result by influencing on the bigger part of the population in the country. (Qidwai, 2015)

A very big issue mainly for the health care deliverers especially in the under-developed countries like Pakistan is access of health care services to everyone. Access to health care services means having "the timely use of personal health services to achieve the best health outcomes" (IOM, 1993). Though practically, accessibility to health care services is not generally functional **(**Huls). Distribution of health care services in more equitable and fair manner is another bigger issue... The patients who are satisfied with the health care system of their own country are much liable to report improved health. Patients who have the good satisfaction levels have a great deal of chances to get advantages from their health treatment. (Abid et al., 2019). Patient satisfaction is the essential estimator of qualities of healthcare because it provides information of the achievements of health care providers and fulfilling the most significant demands of the customers and it is the important determinant of patient's outlook behavioral intention (Xesfingi & Vozikis, 2015). How much Longer the patients have been with the doctors and the extent to which the doctors' interaction is patient-centeredness are important. (Ruth et al., 2017)

Despite many steps that have been taken for health care delivery system, Pakistan is still lagging behind many countries. Out of many problems, one problem Pakistan is facing is lack of equitability, accessibility and patient satisfaction with the health care delivery system. Taking in consideration this issue, the present study intends to analyze equitability, compare accessibility and patient satisfaction with the health care delivery system in the advantageous and dis-advantageous areas of Lahore. The present research aims to scrutinize that whether or not health care delivery system is accessible or equitable and to analyze that to which extent patients are satisfied with health services provided in advantageous and dis advantageous areas of Lahore. The main objectives of this study are:

I. To analyse that the health care delivery system in the advantageous and dis-advantageous areas of Lahore is equitable or not.
II. To make comparison to which extent the health care services are easily accessible in the Advantageous and dis-advantageous areas of Lahore
III. To study that to which extent patients are satisfied with health care delivery system in the Advantageous and dis-advantageous areas of Lahore

METHODOLOGY

This study adopted a cross sectional study. In the present study, it was analyzed that whether or not the health care delivery system in the advantageous and dis-advantageous areas of Lahore is equitable. It was also evaluate that to which extent the health care services are easily accessible in the Advantageous and dis-advantageous areas of Lahore as well as to study the extent to which patients are satisfied with the HCDS in the advantageous and dis-advantageous areas of Lahore. The research population is referred as "the well described gathering of the people who have identical features". All people or entities in the definite populations generally contain the familiar qualities or features. (Adam. at al). In the present study the patients from the hospitals in the Advantageous and Dis-advantageous areas of Lahore were taken as population. In the study, Areas of Lahore were categorized in the Advantageous and Dis- advantageous areas according to the two major factors: Crime rate and population density. Those areas which have lowest crime rate and lowest population density were grouped as Advantageous areas and those areas which have highest crime rate and highest population density were classified as Dis- advantageous areas.

In the present study, five towns of Lahore were selected to collect the data. These towns were: Aziz Bhatti town, Cantonment town, Gulberg town, Data Gunj Buksh town and Samanabad town. Aziz Bhatti town was considered as Advantageous area because it owned less population density and lowest crime rate. Cantonment town had the low population density and the low crime rate; it was taken as an advantageous area of Lahore. The population density of Gulberg town was high and its crime rate also touches the high range.

Due to these factors this town was considered as the dis-advantageous area of Lahore. Data Gunj Buksh town comprises of great population density as well as high crime rate, it was also considered as dis-advantageous area of Lahore. According to the statistics, Samanabad town contains high population density and crime rate so; this town was also categorized as the Dis- advantageous area of Lahore.

Questionnaires were distributed according to the population of the towns. As the population of Samanabad town was highest so large proportion of questionnaires were distributed in the Sheikh Zayed hospital and Samanabad hospital of this town. 105 questionnaires were given in this area. Both hospitals were public hospitals. Data Gunj Buksh town owned the population of 1,058,749, so keeping this in consideration, 100 questionnaires in total was given in Ganga ram and mayo hospital. The population of Gulberg town was 849,081 so according to the catchment population of town 70 questionnaires were distributed in the Jinnah hospital. Cantonment town had the population of 841,646, So 60 questionnaires were given in the Fauji foundation hospital and cantonment general hospital. Aziz Bhatti town had the lowest population of 615,621. 50 questionnaires were distributed in Shalamar and Society hospital. According to the (Henn, Weinstein & Foard, 2006) the sample is subset of the population, chosen so that their characteristics reveal those of the groups from which they are chosen. Hussey & Hussey, (1997) pointed that the sample size must be adequately huge and must have balance to complete the necessities of the research. The simple random sample of 385 patients was selected to analyze the equitability of health care delivery system in these advantageous and dis- advantageous areas of Lahore, to make comparison to which extent the health care services are easily accessible in the Advantageous and dis-advantageous areas of Lahore and to study that to which extent patients are satisfied with health care delivery system in the Advantageous and Dis-advantageous areas of Lahore.

$$\mathbf{N=Z^2\ p\ (1\text{-}p)/d^2}$$

Where, Z= Alpha =95%=1.96
P=Prevalence Rate
d= margin of error =0.05
$N= (1.96)^2(0.50)\ (1\text{-}0.50)/\ (0.05)^2$
N=385

Polit, Beck &Hungler, (2001) described sampling as the procedure of selecting the fraction of the population to give the representation of the whole population. The Simple random sampling was used as the sampling technique which is a type of probability sampling. Pre-testing was done on 10% of sample size to check the reliability of the modified questionnaire by using Cronbach's alpha. The value of Cronbach's alpha was 0.70 which is acceptable. The Simple random sampling was used as the sampling technique. Primary data was collected from the patients. In the present study structured closed-ended questionnaire was the primary source of data. Survey was used as the tool for data collection. Survey was used as the research technique. According to the (Check &Schutt, 2012, p. 160) survey research can be described as "the compilation of information from the sample of individuals through their answers to the questions". Total of 385 questionnaires were distributed among the patients. Questionnaires just took 5-10 minutes. The data was collected within 2 months.

Ethical approval and informed consent was taken. The data collected was then analyzed and assessed to estimate effectiveness and consistency. The data collected from the survey was analyzed, present and interpret by using IBM SPSS Version 21. The data was analyzed by both descriptive and inferential analysis. In descriptive analysis, frequencies and percentages were calculated. Whereas, in inferential analysis Independent sample T test was used to compare HCDS in advantageous and dis-advantageous areas of Lahore.

RESULTS

Socio-demographic characteristics by Advantageous and Dis-advantageous areas

Descriptive Results

Variables	Advantageous Areas		Dis-advantageous areas	
	Frequency	Percent	Frequency	Percent
Age group				
18-23	10	9.09%	48	17.45%
24-29	18	16.36%	51	18.54%
30 and above	82	74.54%	176	64%
Total	**110**	**100%**	**275**	**100%**
Gender				
Male	36	32.7%	113	41.1%
Female	74	67.3%	162	58.9%
Total	**110**	**100%**	**275**	**100%**
Educational status				
Till Matric	41	37.27%	113	41.09%
Intermediate	37	33.6%	81	29.5%
Graduation and above	32	29.09%	81	29.5%
Total	**110**	**100%**	**275**	**100%**
Marital status				
Never Married	11	10.0%	52	18.9%
Ever married	99	90%	223	81.09%
Total	**110**	**100%**	**275**	**100%**
No. of children				
One	56	50.9%	51	18.5%
Two	21	19.1%	36	13.1%
Above	28	25.45%	127	46.18%
Total	**105**	**95.4%**	**214**	**77.7%**
System missing	5	4.5%	61	22.2%
Total	**110**	**100%**	**275**	**100%**
Monthly income				
<Rs 50,000	59	53.6%	237	86.2%
50,000 to 100,000	30	27.3%	38	13.8%
>100,000	21	19.09%	0	0%
Total	**110**	**100%**	**275**	**100%**
Disease pattern				
Acute	45	40.9%	40	14.5%
Chronic	26	23.6%	50	18.2%
Others	39	35.45%	185	67.27%
Total	**110**	**100%**	**275**	**100%**
Distance				
1 km	11	10.0%	1	0.36%
2 km	24	21.8%	40	14.5%
Above	75	68.18%	234	85.09%
Total	**110**	**100%**	**275**	**100%**
No. of visits				
1visit	26	23.6%	36	13.1%
2 visits	25	22.7%	49	17.8%
Above	59	53.6%	190	69.09%
Total	**110**	**100%**	**275**	**100%**

Defining characteristics of accessibility

Variables	Advantageous Areas		Dis-advantageous areas	
	Frequency	Percent	Frequency	Percent
Hospitalization In the past year				
Yes	62	56.4%	128	46.5%
No	48	43.6%	147	53.5%
Total	**110**	**100%**	**275**	**100%**
Transportation availability				
Yes	85	77.3%	263	95.6%
No	25	22.7%	12	4.4%
Total	**110**	**100%**	**275**	**100%**
Affordability Of transportation costs				
Yes	72	65.5%	210	76.4%
No	38	34.5%	65	23.6%
Total	**110**	**100%**	**275**	**100%**
Availability of infrastructure				
Yes	93	84.5%	196	71.3%
No	17	15.5%	79	28.72%
Total	**110**	**100%**	**275**	**100%**
Traveling to the hospitals Irrespective of the inadequate Weather conditions				
Yes	63	57.3%	102	37.1%
No	47	42.7%	173	62.9%
Total	**110**	**100%**	**275**	**100%**
Understanding of the language				
Yes	73	66.4%	234	85.1%
No	37	33.6%	41	14.9%
Total	**110**	**100%**	**275**	**100%**
Availability of telephones				
Yes	94	85.5%	209	76.0%
No	16	14.5%	66	24.0%
Total	**110**	**100%**	**275**	**100%**
Health education				
Yes	82	74.5%	203	73.8%
No	28	25.5%	72	26.2%
Total	**110**	**100%**	**275**	**100%**
Health insurance coverage				
Yes	45	40.9%	72	26.2%
No	65	59.1%	203	73.8%
Total	**110**	**100%**	**275**	**100%**
			N=385	

Equitability in HCDS

Variables	Advantageous Areas		Dis-advantageous areas	
	Frequency	Percent	Frequency	Percent
Experience of similar health care irrespective of the ethnic group				
Yes	61	55.5%	246	89.5%
No	49	44.5%	29	] 10.5%
Total	**110**	**100%**	**275**	**100%**
Receiving of adequate health care services irrespective of the age				
Yes	85	77.3%	258	93.8%
No	25	22.7%	17	6.2%
Total	**110**	**100%**	**275**	**100%**
Experiences of good health care irrespective of the income				
Yes	51	46.4%	209	76.0%
No	59	53.6%	66	24.0%
Total	**110**	**100%**	**275**	**100%**
Experience of adequate health care irrespective of the gender				
Yes	65	59.1%	264	96.0%
No	45	40.9%	11	4.0%
Total	**110**	**100%**	**275**	**100%**
Experience of adequate health care irrespective of psychological problems				
Yes	68	61.8%	228	82.9%
No	42	38.2%	47	17.1%
Total	**110**	**100%**	**275**	**100%**
Experience of health service's receiving irrespective of the level of education				
Yes	87	79.1%	183	66.5%
No	23	20.90%	92	33.5%
Total	**110**	**100%**	**275**	**100%**
Receiving of good health services irrespective of disability				
Yes	88	80.0%	260	94.5%
No	22	20.0%	15	5.5%
Total	**110**	**100%**	**275**	**100%**
			N=385	

Patient satisfaction with HCDS

Variables	Advantageous Areas		Dis-advantageous areas	
	Frequency	Percent	Frequency	Percent
Admission to the hospital				
Strongly agree	42	38.2%	93	33.8%
Agree	49	44.5%	124	45.1%
Uncertain	16	14.5%	18	6.5%
Disagree	2	1.8%	16	5.8%
Strongly disagree	1	0.9%	24	8.7%
Total	**110**	**100%**	**275**	**100%**
Doctors need to be more thorough in treatment and examination				
Strongly agree	27	24.5%	82	29.8%
Agree	36	32.7%	103	37.5%
Uncertain	14	12.7%	18	6.5%
Disagree	31	28.2%	46	16.7%
Strongly disagree	2	1.8%	26	9.5%
Total	**110**	**100%**	**275**	**100%**
Satisfaction with the health care they receive				
Strongly agree	37	33.6%	120	43.6%
Agree	49	44.5%	96	34.9%
Uncertain	15	13.6%	30	10.9%
Disagree	76	63%	21	7.6%
Strongly disagree	2	1.818%	8	2 .9%
Total	110	100%	275	100%
It is easy to get health care in an emergency				
Strongly agree	25	22.7%	72	26.2%
Agree	41	37.3%	103	37.5%
Uncertain	33	30.0%	46	16.7%
Disagree	9	8.2%	44	16.0%
Strongly disagree	2	1.8%	10	3.6%
Total	**110**	**100%**	**275**	**100%**
Doctors are good about explaining the reason for medical tests				
Strongly agree	31	28.2%	84	30.5%
Agree	38	34.5%	86	31.3%
Uncertain	24	21.8%	46	16.7%
Disagree	15	13.6%	35	12.7%
Strongly disagree	2	1.8%	24	8.7%
Total	**110**	**100%**	**275**	**100%**
Long waiting times				
Strongly agree	21	19.1%	90	32.7%
Agree	35	31.8%	114	41.5%
Uncertain	19	17.3%	10	3.6%
Disagree	23	20.9%	34	12.4%
Strongly disagree	12	10.9%	27	9.8%
Total	**110**	**100%**	**275**	**100%**
During visits to the hospitals, I was always allowed to say everything i think was important				
Strongly agree	60	54.5%	11	40.0%
Agree	30	27.3%	101	36.7%
Uncertain	12	10.9%	40	14.5%
Disagree	5	4.5%	19	6.9%
Strongly disagree	3	2.7%	5	1.8%
Total	**110**	**100%**	**275**	**100%**
Sometimes doctors use medical terms without explaining what they mean				
Strongly agree	16	14.5%	58	21.1%
Agree	4	3.6%	46	16.7%
Uncertain	14	12.7%	25	9.1%
Disagree	51	46.4%	73	26.5%
Strongly disagree	25	22.7%	73	26.5%
Total	**110**	**100%**	**275**	**100%**
Sometimes i go without the health care services I need because it is too expensive				
Strongly agree	21	19.1%	62	22.5%
Agree	14	12.7%	50	18.2%
Uncertain	8	7.3%	37	13.5%
Disagree	29	26.4%	79	28.7%
Strongly disagree	38	34.5%	47	17.1%
Total	**110**	**100%**	**275**	**100%**
Doctors usually spend plenty of time with me				
Strongly agree	72	65.5%	121	44.0%
Agree	20	18.2%	98	35.6%
Uncertain	9	8.2%	17	6.2%
Disagree	4	3.6%	27	9.8%
Strongly disagree	5	4.5%	12	4.4%
Total	**110**	**100%**	**275**	**100%**
			N=385	

The results of the analysis show that ratio of female participants (patients) was more than male participants (patients) in both groups (advantageous and dis advantageous areas of Lahore).Most of the respondents fall in the age group of 30 and above than 30 years in both areas. The results indicated that in the advantageous and dis-advantageous areas majority of patients had education till Matric. Most of the patients were ever married in both groups (advantageous and dis advantageous areas). Majority of the participants in the advantageous areas had only one child. Comparatively to it, most of the respondents had children more than two in the dis-advantageous areas. The results represented that majority of patients earned less than 50,000 in both areas. The results revealed that majority of participants in the advantageous areas had acute diseases. However, majority of respondents in dis-advantageous had diseases other than acute or chronic. The participants said that they had to travel more to reach the hospital. This showed that more respondents belonged to far flung areas.

In the advantageous and dis -advantageous areas majority of patients had more than 2 visits to the hospital in the past. Most respondents hospitalized from the advantageous areas relative to dis-advantageous areas. The results indicated that majority of respondents had availability of transport in both areas. This showed that there was accessibility to HCDS in terms of transportation. It would conclude that no transportation barriers were there to reach the hospital. Most of the participants could afford the transport. This also impacts positively HCDS in terms of accessibility. The results revealed that available infrastructure in both areas helped patients to have accessibility to HCDS. The results revealed that in the advantageous areas, more patients could travel to hospital even in the fog or rain. Whereas in dis- advantageous areas majority said they could not travel. The results indicated us that there was no language barrier. The patients could easily understand the language of doctors. Majority had availability of telephones in both groups. This shows that there was accessibility to HCDS in terms of telephones. Mostly patients had basic or primary health education in both groups. There was limited access to Health insurance in both areas which would affect HCDS in negative way. The results indicated that majority of the patients received similar health care irrespective of the ethnic group, age, gender, psychological factors, education, disability.

However, there were some disparities in Health care services provision in advantageous areas due to income factor. The results revealed that there were inequities in health care provision due to income status in advantageous areas only. The results revealed that there was no statistically significant difference in the level of patient satisfaction in both areas.

Comparing health care delivery system in two groups (advantageous and dis-advantageous areas using independent sample T test

Variable		M	SD	t	p
Accessibility to HCDS	Advantageous areas	11.92	1.714	-1.254	0.211
	Dis-advantageous areas	12.13	1.373		
Equitability of HCDS	Advantageous areas	10.20	1.904	8.614	0.000
	Dis-advantageous areas	8.91	1.000		
Patient satisfaction	Advantageous areas	22.51	4.265	1.634	0.103
	Dis-advantageous areas	21.70	4.409		

An independent sample T test was carried to compare the HCDS in two groups. These groups were advantageous and dis advantageous areas of Lahore. The health care delivery system was measured from the level or intensity of accessibility, equitability and patient satisfaction. The above table shows that levels of accessibility in both groups: advantageous areas (M=11.92, S. D=1.714) and dis-advantageous areas (M=12.13, S. D=1.373, t (383) = -1.254, p=0.211 were not statistically significantly different. Whilst, the levels of equitability in the advantageous (M=10.20, S. D=1.904 and dis-advantageous areas (M= 8.91, S. D=1.000, t (383) = 8.614, p=0.000 were statistically significantly different. Thus, the levels of patient satisfaction in the advantageous areas (M=22.51, S. D=4.265) and dis-advantageous areas (M= 21.70, S. D=4.409, t (383) =1.634, p=0.103 were not statistically significantly different.

DISCUSSION

In one of the past researches done in Botosani county, Romania, entitled "The relationship between health care needs and accessibility to health care services in Botosani county- Romania", it was indicated that the age of the population is important determinant which is identified to enlarge the needs and consequently the demands for healthcare facilities. From the view point of demographical characteristics, the groups of age within the 2013 specify the

previously aging population, with the 26.12 percent of inhabitants above than 65 of the entire population, relative to the age category of youth, ranging from (0-5 years) of 5.15 percent. Comparatively to this, in the present research, the population based on most of the inhabitants (patients) ranging from the age group of 30 and above.

The number of visits for each person also demonstrated the wants of healthcare services and it's differs on the basis of area or location of the patients. In countryside regions the number of visits in the year of 2013 was 2.9 visits for each inhabitant, however in the city areas there were 1.3 visits for each person explained by the fact that the elderly population in rural areas goes to the general practitioners' offices more regularly as compared to the people from cities. However, in the present research, number of visits in the past by respondents in advantageous and dis-advantageous areas was asked.59 and 190 respondents had more than 2 visits to the hospital in the advantageous areas and the dis-advantageous areas. This showed that more visits were made by patients in the both groups.

The common diseases of the population had the growing tendency over the preceding ten years. The progression of morbidity categories and new cases of diseases illustrate that from 2000 to 2009 there was a boost in the figure of new cases of diseases including circulatory, musculoskeletal, nervous system and the sensory organs, as well as endocrine and nutrition disorders. Also, upsetting are the cases of chronic morbidities which generate reliance on the medical facilities including the diabetes, cardiovascular diseases, cancer, obesity, pulmonary diseases. However, in the present research, it was asked from the patients regarding the kind of morbidity. The results of the analysis indicated that in the advantageous areas, most of the patients had acute diseases, whereas the patients from dis-advantageous areas suffered from the diseases other than acute or chronic.

According to one study done by N'doh., et al., (2019) the more exposure rates of health insurance are for the disadvantaged residents, resultantly the higher people would accessibility to it, showing the equitability in health care as well as the social fairness. It was indicated that in Madagascar, without any cost maternal health care services has amplified the usage of health services, together with more accessibility to this service for the dis advantaged and thus for all society. Similarly, in the country of Rwanda, social

fairness occurs to the degree at which deprived inhabitants as well as people existing in the greater scarcity had accessibility to the basic health care services rendering to World Health Organizations ideals. Like, wisely in the Ghana health insurance coverage had meaningfully expanded accessibility to pre-natal health care services, as well as the distributions in health care services for the utmost under-privileged inhabitants. Though, insurance coverage of health expand the accessibility to HCDS of each class of society to the prime health care by meaningfully falling the fiscal involvement of all users, the superiority of all facilities consecutively creates the challenges in the most cases. Conversely to this in the present study, it was indicated that majority of participants did not receive health insurance coverage which in turn effects the accessibility negatively in terms health insurance coverage. If there would be access to Health insurance coverage there would be more chances to health accessibility expansions.

Similarly, one research done by Babar, (2018), it was indicated that Health education and answerability of health care suppliers are important steps to dismiss disparities in the health care. In the present research, health education of respondents was taken as the important measure to gauging health accessibility. It was analyzed that from both advantageous and dis advantageous areas, majority of respondents were health educated. In the study the analysis showed that 157 respondents that makes 40.8 % marked themselves as strongly agreed with the satisfaction of health care they received.

The analysis revealed that according to them they were fully satisfied with the health care they received. Comparatively to it, one research done in the past by Otani, (2009) his analysis revealed that evenly when patients rated as excellent on all characteristics, they do not at all times marked “excellent” on the whole satisfaction from the health care they received. According to the author, from the total 14,432 patients that were incorporated in the study, 1,077 patients had mark excellent on every characteristic. Amongst them, 998 patients (92.66 percent) used to give excellent scores on the general satisfaction and 79 patients (7.34 percent) did not give excellent rating. However, these 79 patients were completely satisfied with all attributes, but still their overall satisfaction was not excellent.

CONCLUSION

Health care delivery system is very vital from the public health view. The foundations of Health care delivery systems are primary health care, secondary health care and tertiary health care. Public and private sector has role in the health care delivery system. The present research aims to scrutinize that whether or not health care delivery system is accessible and equitable and to analyze that to which extent patients are satisfied with health services provided in advantageous and dis advantageous areas of Lahore. For this purpose, survey questionnaire was used to collect data. It is interpreted that there were no statistically significantly differences in the levels of accessibility and patient satisfaction in both groups but the levels of equitability had statistically significantly differenced in both groups.

Recommendations

1. The findings of the study revealed that in the advantageous areas most respondents did not experienced good health care respective of the income. Whereas, in the dis–advantageous areas most of the participants received good health care irrespective of the income. So, keeping in view this disparity due to income factor, the study recommends that income aspect should be addressed; there should be creation of more employment so that everyone would be able to get health services. More the income of the people, more they would be able to have access to HCDS.
2. The findings of the study revealed that there was significant statistically difference in the level of equitability in both areas, to eliminate this disparity with respect to equity the research suggests that such policies should be created as well as implemented that would be helpful in promoting equitable access to Health Services in both advantageous and dis-advantageous groups.

REFERENCES

1. (Abid et al., 2019).
2. Adam, Hassan.,Indian Ocean University, Business Administration, Department Member, Somalia
3. Huls, N., Access to health. Review digest: Human Rights &Health
4. Qidwai, W., (2015), Promoting Access and Equity in Healthcare: Issues, Challenges and Way Forward in Pakistan. J Liaquat Unit Med Health Sci. 14(02):56-7
5. Henn., Weinstein., Foard., (2006)
6. Hussey., Hussey., (1997)
7. WHO (World Health Organization)
8. Scott, (2005)
9. N'doh., et al., (2019)
10. Otani, K., (2009). Journal of Healthcare Management (54:2)
11. (Imran et al., 2006).
12. (Irfan et al., 2011)
13. (Comparison of Service Quality between Private and Public Hospitals: Empirical Evidences from Pakistan).
14. Kumar, S., Bano, S., **(**2017), Comparison and Analysis of Health Care Delivery Systems, Pakistan versus Bangladesh. Journal, Aga Khan University School of Nursing and Midwifery, Karachi, Pakistan, 3:1
15. Babar, (2018)
16. Check &Schutt. 2012, p. 160 Canadian institute for health information
17. Polit., Beck &Hungler., (2001)
18. Xesfingi &Vozikis (2015)
19. Ruth et al., 2017
20. (IOM, 1993)