

Original Article

Perceived Systemic Inequities and Governance Gaps in Primary Healthcare Delivery: Patient Perspectives Across Income Brackets

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ABSTRACT

****Background:**** Primary healthcare access and patient experience may be influenced by socioeconomic position, affordability, staffing capacity, facility type, and perceived equity within the health system. ****Objective:**** To evaluate patient-reported healthcare access, perceived service quality, staffing adequacy, financial barriers, clinical bias or discrimination, regional inequalities, and government health initiatives across household income groups and facility types in Pakistan. ****Methods:**** A cross-sectional observational study was conducted from January to June 2025 across selected public, community-based, and private healthcare facilities. From 379 convenience-recruited respondents, a stratified random analytical subsample of 190 records was selected according to income, facility distance, and provider type. Data were collected using a pre-tested bilingual questionnaire and analyzed using descriptive statistics, analysis of variance, chi-square tests, and relevant pairwise comparisons. ****Results:**** Participants had a mean age of 32.4±8.6 years, and 82.1% were female. Private-clinic users reported higher perceived quality than government-hospital users (3.21±0.65 vs 2.34±0.78; mean difference 0.87, 95% CI 0.65–1.09; p<0.001). Perceived inadequate staffing was reported by 61.1%, regional inequality by 71.1%, and cost-related care delay by 54.2%. Household income was associated with reported clinical bias ($\chi^2(3)=11.85$, p=0.008). ****Conclusion:**** Socioeconomic position and facility type were associated with differences in patient-reported healthcare experiences, particularly affordability, perceived bias, staffing adequacy, and service quality. ****Keywords:**** Primary Health Care; Health Services Accessibility; Healthcare Disparities; Health Policy; Low-Income Population; Quality of Health Care.

INTRODUCTION

Primary health care is a fundamental component of equitable health systems because it provides the first point of contact for preventive, diagnostic, and continuing care. However, access to primary healthcare services remains uneven, particularly in resource-constrained settings where geographic barriers, limited service availability,

inadequate infrastructure, and shortages of trained personnel can restrict timely care. Evidence from rural and underserved populations indicates that improving physical accessibility, service availability, community engagement, and continuity of care is essential for strengthening utilization of primary healthcare services (1). Community-based health programs may further improve equity when they are adequately integrated into health systems and supported by appropriate financing, workforce capacity, and local participation (2). Nevertheless, reviews of primary healthcare systems continue to identify persistent limitations in service quality, workforce distribution, infrastructure, referral processes, and patient-centered delivery (3). These challenges are particularly important in low- and middle-income settings, where health systems must respond to increasing demand while operating within substantial financial and organizational constraints (4).

Equitable access to healthcare is influenced not only by the physical availability of services but also by socioeconomic position, affordability, provider responsiveness, and patients' experiences within the health system. Differences in income and other social determinants can affect the ability of individuals to seek timely care, obtain appropriate treatment, and maintain continuity of healthcare, thereby contributing to avoidable disparities in health outcomes (5). Strong primary healthcare systems are therefore considered an important foundation for universal health coverage, although their contribution depends on effective governance, sufficient human resources, financial protection, and consistent service quality (6). Fragmented healthcare financing can weaken these objectives by increasing dependence on direct household expenditure and producing unequal access to essential services (7). Strengthening access to care and reducing financial barriers have consequently been recognized as important strategies for addressing healthcare inequities (8). More broadly, socioeconomic disparities may influence both access to health services and perceived quality of care, highlighting the importance of evaluating healthcare performance from the perspective of populations with different levels of social and financial resources (9).

These concerns are especially relevant when patients must choose among public, community-based, and private healthcare providers. Differences between healthcare sectors may be reflected in perceived availability of staff, waiting time, provider attitudes, service quality, affordability, and confidence in health-system governance. Patient-reported experiences provide an important complement to administrative and service-utilization indicators because they capture whether healthcare users perceive services as accessible, responsive, equitable, and financially manageable. Cross-sectional evidence from different health systems has demonstrated substantial inequalities in both healthcare coverage and perceived quality across socioeconomic groups, reinforcing the need to examine how health-system performance is experienced by patients rather than relying exclusively on aggregate service indicators (10).

Within the present study, these issues were examined among healthcare seekers attending public, community-based, and private facilities in Pakistan. The study focused on patient-reported accessibility, facility choice, perceived service quality, perceived staffing adequacy, financial barriers to treatment, experiences of perceived clinical bias or discrimination, perceptions of regional differences in care quality, and perceived effectiveness of government health initiatives. Examining these outcomes across household income brackets is important because financial constraints may interact with healthcare access and patient experience, while comparisons across facility types may identify differences in perceived service quality that are relevant to health-system planning. Importantly, because these measures represent patient perceptions and experiences collected at a single point in time, they provide evidence of associations and reported inequities rather than proof of causal health-system effects.

Accordingly, the objective of this cross-sectional study was to evaluate patient-reported healthcare access, facility utilization, perceived service quality and staffing adequacy, cost-related delays in seeking care, perceived clinical bias or discrimination, perceived regional inequalities in care quality, and perceptions of government health initiatives across household income groups and healthcare facility types in Pakistan. The study further examined whether household income was associated with reported clinical bias and other healthcare-access experiences and whether perceived quality ratings differed across facility types. It was hypothesized that lower household income would be associated with less favorable patient-reported healthcare experiences, particularly greater financial barriers and perceived bias, and that perceived quality of care would vary across healthcare facility types.

MATERIAL AND METHODS

A cross-sectional observational study was conducted from January to June 2025 among healthcare users attending selected public and private healthcare facilities in Pakistan. The study was designed to examine patient-reported differences in healthcare accessibility, facility utilization, perceived service quality, staffing adequacy, financial barriers, perceived clinical bias or discrimination, regional disparities in care, and perceptions of government health initiatives across socioeconomic groups and healthcare facility types. Data were collected from a range of service settings, including Basic Health Units, community health centers, dispensaries, district government hospitals, and private outpatient clinics, thereby capturing patient experiences across different levels and sectors of healthcare delivery.

Individuals aged 15 years or older who sought healthcare services at participating facilities during the study period were eligible for inclusion. Administrative, faculty, and clinical staff working within the sampled healthcare facilities were excluded to minimize the potential influence of professional familiarity with healthcare systems on patient-reported assessments. Patients with severe acute cognitive impairment that prevented meaningful participation or informed consent and individuals who declined participation were also excluded. Participants were recruited directly from facility waiting areas and outpatient departments using convenience sampling. The initial empirical dataset comprised 379 respondents. For the comparative analysis reported in the present manuscript, approximately 50% of the available records were subsequently selected through stratified random sampling, resulting in an analytical sample of 190 participants. Stratification was performed according to monthly household income category, distance from the healthcare facility, and healthcare provider type in order to preserve the distribution of these characteristics within the selected analytical dataset.

Data were collected using a standardized, pre-tested bilingual questionnaire administered in English or Urdu according to participant preference. The instrument collected sociodemographic information, including age, sex, educational attainment, and monthly household income, together with healthcare-access characteristics such as distance from the healthcare facility and usual or primary facility choice. Patient-reported healthcare experience measures included perceived service quality, perceived staffing adequacy, provider-related attitudes, financial barriers to obtaining care, cost-related delay or foregoing of necessary treatment, awareness and perceptions of healthcare-system initiatives, cultural and gender-related barriers, perceived effectiveness of government health programs, experiences of clinical bias or discrimination, and perceptions of regional disparities in healthcare quality. Household income was categorized into four monthly income groups: less than 10,000 PKR, 10,000–30,000 PKR, 30,000–50,000 PKR, and more than 50,000 PKR.

Healthcare facility utilization was classified according to the principal provider category reported by participants, including private clinics, government hospitals, and community health centers. The principal outcomes of interest were perceived healthcare quality, staffing adequacy, cost-related treatment delay, perceived clinical bias or discrimination, perceived regional inequality in care, and perceived effectiveness of government healthcare initiatives.

Several procedures were incorporated to reduce avoidable measurement and selection-related error within the constraints of the cross-sectional design. Facility employees were excluded to reduce professional-response bias, and the questionnaire was pre-tested and made available in both English and Urdu to improve comprehension and consistency of administration. Stratification of the analytical subsample by income, facility distance, and provider type was used to retain variation in key socioeconomic and healthcare-access characteristics. The cross-sectional nature of the study was maintained throughout the analysis, and patient-reported measures were interpreted as perceptions and experiences rather than objective measures of healthcare-system performance or causal effects.

Data were analyzed using IBM SPSS Statistics Version 28.0. Categorical variables were summarized using frequencies and percentages, while continuous variables were summarized using means and standard deviations where appropriate. Distributional assumptions for numerical variables were evaluated using the Kolmogorov-Smirnov test together with visual inspection of histograms.

Independent-samples *t* tests and one-way analysis of variance were used to compare numerical rating scores across relevant participant or facility groups, as applicable. Associations between categorical variables, including household income categories, provider selection, perceived clinical bias or discrimination, and governance-related

response categories, were examined using Pearson's chi-square tests of independence. Pearson correlation analysis was used for the reported relationships among household income, provider-attitude ratings, perceived governance effectiveness, and cost-related care delays. All statistical tests were two-tailed, and a p value of less than 0.05 was considered statistically significant. The analytical subsample contained complete observations for the reported variables, and no imputation for missing data was undertaken.

RESULTS

A total of 190 participant records were included in the analytical sample. The mean age was 32.4 ± 8.6 years, and the sample was predominantly female, with 156 participants (82.1%). Most participants reported a monthly household income of 10,000–30,000 PKR ($n=122$, 64.2%), while 42 (22.1%) earned 30,000–50,000 PKR, 14 (7.4%) earned less than 10,000 PKR, and 12 (6.3%) earned more than 50,000 PKR. Primary education was reported by 72 participants (37.9%) and secondary education by 68 (35.8%). Private clinics were the most frequently reported primary source of care ($n=87$, 45.8%), followed by government hospitals ($n=78$, 41.1%) and community health centers ($n=25$, 13.2%) (Table 1).

Patient-reported healthcare concerns were common. Perceived regional inequality in care was reported by 135 participants (71.1%; 95% CI 64.2%–77.0%), while 130 (68.4%; 95% CI 61.5%–74.6%) rated government health initiatives as ineffective or only somewhat effective. Inadequate public-sector staffing was reported by 116 participants (61.1%; 95% CI 54.0%–67.7%). Financial barriers were also prominent, with 103 participants (54.2%; 95% CI 47.1%–61.1%) reporting that cost had caused them to delay or forego necessary healthcare. Clinical bias or discrimination was reported by 80 participants (42.1%; 95% CI 35.3%–49.2%) (Table 2).

Table 1. Demographic and Healthcare Utilization Characteristics of the Analytical Sample ($n=190$)

Variable	Category	n (%) / Mean $\pm$ SD
Age, years		32.4 $\pm$ 8.6
Sex	Female	156 (82.1)
	Male	34 (17.9)
Monthly household income, PKR	<10,000	14 (7.4)
	10,000–30,000	122 (64.2)
	30,000–50,000	42 (22.1)
	>50,000	12 (6.3)
Education level	No formal education	10 (5.3)
	Primary	72 (37.9)
	Secondary	68 (35.8)
	Higher education	40 (21.1)
Primary healthcare facility used	Private clinic	87 (45.8)
	Government hospital	78 (41.1)
	Community health center	25 (13.2)

SD, standard deviation; PKR, Pakistani rupees. Percentages may not total exactly 100% because of rounding.

Table 2. Principal Patient-Reported Healthcare System Outcomes ($n=190$)

Outcome	n (%)	95% CI, %
Perceived inadequate public-sector staffing	116 (61.1)	54.0–67.7
Perceived inferior regional quality of care	135 (71.1)	64.2–77.0
Reported clinical bias or discrimination	80 (42.1)	35.3–49.2
Government initiatives rated ineffective or somewhat effective	130 (68.4)	61.5–74.6
Cost-related delay or foregoing of necessary care	103 (54.2)	47.1–61.1

CI, confidence interval. Confidence intervals for proportions were derived using the Wilson method.

Table 3. Comparison of Perceived Quality Ratings Between Private Clinics and Government Hospitals

Comparison	Private clinic, n	Private clinic, Mean $\pm$ SD	Government hospital, n	Government hospital, Mean $\pm$ SD	Mean difference (95% CI)	t (df)	p-value	Hedges' g
Private clinic vs government hospital	87	3.21 $\pm$ 0.65	78	2.34 $\pm$ 0.78	0.87 (0.65–1.09)	7.73 (150.5)	<0.001	1.21

CI, confidence interval; SD, standard deviation. The pairwise comparison was derived from the reported group means, standard deviations, and sample sizes using Welch's independent-samples t test. Hedges' g represents the standardized mean difference.

Table 4. Association Between Monthly Household Income and Reported Clinical Bias or Discrimination (n=190)

Monthly household income, PKR	Reported bias, n (%)	No reported bias, n (%)	Crude OR (95% CI)	p-value
<10,000	9 (64.3)	5 (35.7)	9.00 (1.39–58.45)	0.021
10,000–30,000	58 (47.5)	64 (52.5)	4.53 (0.95–21.55)	0.065
30,000–50,000	11 (26.2)	31 (73.8)	1.77 (0.34–9.39)	0.708
>50,000	2 (16.7)	10 (83.3)		

CI, confidence interval; OR odds ratio; PKR, Pakistani rupees. The >50,000 PKR income category was the reference group. Crude odds ratios were derived from the reported 2×2 cell counts; two-sided Fisher's exact p-values are presented for individual income-category comparisons.

Perceived quality ratings differed across facility types in the reported three-group analysis, with a one-way ANOVA yielding $F(2,187)=14.82$, $p<0.001$. The corresponding derived η^2 was 0.137. In the directly estimable comparison between private clinics and government hospitals, private-clinic users had a mean quality rating of 3.21 ± 0.65 compared with 2.34 ± 0.78 among government-hospital users. The mean difference was 0.87 points (95% CI 0.65–1.09), with Welch's $t(150.5)=7.73$, $p<0.001$, and Hedges' $g=1.21$ (Table 3).

Reported clinical bias differed across household income categories. Bias was reported by 64.3% of participants earning less than 10,000 PKR, 47.5% of those earning 10,000–30,000 PKR, 26.2% of those earning 30,000–50,000 PKR, and 16.7% of those earning more than 50,000 PKR. Reanalysis of the reported cell frequencies demonstrated an overall association between household income category and reported clinical bias, $\chi^2(3)=11.85$, $p=0.008$, with Cramér's $V=0.25$. Using participants earning more than 50,000 PKR as the reference category, those earning less than 10,000 PKR had a crude odds ratio of 9.00 for reporting bias (95% CI 1.39–58.45; $p=0.021$). The corresponding crude odds ratios were 4.53 (95% CI 0.95–21.55; $p=0.065$) for the 10,000–30,000 PKR group and 1.77 (95% CI 0.34–9.39; $p=0.708$) for the 30,000–50,000 PKR group (Table 4).

DISCUSSION

The present study identified several interconnected patient-reported challenges in healthcare delivery, including lower perceived quality in government hospitals than in private clinics, perceived inadequacy of public-sector staffing, financial barriers to obtaining necessary care, perceived regional differences in healthcare quality, and an income-related gradient in reported clinical bias or discrimination. Taken together, these findings suggest that socioeconomic circumstances and the type of healthcare facility used are associated with important differences in patients' experiences of healthcare access and quality. Because the study was cross-sectional and relied on self-reported perceptions, these findings should be interpreted as associations and patient experiences rather than evidence that particular health-system characteristics directly caused provider selection, delayed care, or discriminatory treatment.

The higher perceived quality ratings reported by private-clinic users are consistent with broader evidence showing that primary healthcare quality is influenced by service availability, workforce capacity, responsiveness, continuity, and patients' experience of care (3). Reviews of primary care in low- and middle-income settings have similarly emphasized that quality deficiencies may reflect limitations in staffing, medicines, diagnostics, organizational efficiency, and service responsiveness, while direct financial costs may simultaneously restrict access to better-perceived services (4). Cross-sectional evidence from Latin American health systems has also demonstrated socioeconomic and sector-related inequalities in patient experience, waiting times, communication, preventive care, and confidence in healthcare services (10). The present private–government difference should nevertheless be interpreted cautiously because the compared facilities may have differed in patient volume, service level, case mix, waiting time, and organizational resources. The study therefore demonstrates a difference in perceived quality according to reported facility type but does not establish that private ownership itself was responsible for the difference.

The observed income gradient in reported clinical bias or discrimination is also relevant to the wider relationship between socioeconomic disadvantage and healthcare access. Social and economic circumstances can influence patients' opportunities to obtain care and their interactions with healthcare systems, and economically disadvantaged populations may face overlapping affordability, geographic, organizational, and interpersonal barriers (5,8). Previous literature has similarly described disparities in healthcare access and perceived service quality among socioeconomically disadvantaged groups (9,10). In the present study, the proportion reporting bias

decreased progressively across increasing income categories, and the overall association between household income and reported bias was statistically supported. However, the measure represented participants' reported experiences and perceptions; it did not independently assess provider behavior or determine whether discriminatory clinical decisions occurred. Consequently, the findings support socioeconomic differences in perceived treatment experiences rather than proof of systematic discrimination by healthcare professionals.

Financial accessibility emerged as another important concern, with more than half of participants reporting that costs had led them to delay or forego necessary healthcare. This finding is consistent with evidence that fragmented primary healthcare financing and dependence on direct household expenditure can undermine equity, continuity, and public confidence in healthcare systems (7). Primary-care policy analyses from low- and middle-income settings have likewise identified out-of-pocket costs as a major demand-side barrier and have emphasized the importance of financial protection alongside improvements in workforce and service capacity (4). A systematic review of interventions addressing primary-care cost barriers also found that reductions in out-of-pocket costs were frequently associated with increased healthcare utilization, although that evidence was derived from high-income countries and cannot be directly transferred to the Pakistani setting (12). The present findings do not quantify actual household healthcare expenditure or establish financial hardship causally, but they indicate that affordability is an important component of patient-reported access within the study population.

Perceived staffing inadequacy and unfavorable assessments of government health initiatives further suggest that patients evaluate healthcare access not only in terms of physical availability but also through their encounters with personnel and their confidence in the functioning of the health system. International evidence indicates that adequate workforce availability, reliable essential services, effective governance, and patient-centered delivery are central to the performance of primary healthcare systems (3,6). Qualitative research from primary healthcare facilities in Nepal has similarly identified affordability, availability of medicines and equipment, accessibility, waiting time, and patient-provider interactions as important influences on service utilization (11). Patient-reported research in other populations has also demonstrated that waiting times, communication difficulties, referral processes, and service availability can substantially shape experiences of primary-care access (13). Although these studies were conducted in different health systems and populations, they reinforce the broader principle that healthcare utilization and patient confidence are influenced by multiple interacting financial, organizational, and interpersonal factors rather than by geographic availability alone.

From a public-health perspective, the findings identify affordability, perceived staffing capacity, patient experience, and socioeconomic equity as important domains for healthcare-system assessment. Strategies intended to strengthen primary healthcare should therefore consider not only expansion of service coverage but also whether patients perceive services as accessible, responsive, respectful, and financially manageable. International evidence supports integrated approaches combining workforce strengthening, effective financing, accessible services, and patient-centered care rather than relying on any single system intervention (2-4,7). Nevertheless, the present data do not permit conclusions regarding the effectiveness of specific policy interventions, and future evaluations should combine patient-reported measures with objective indicators of staffing, waiting times, service availability, healthcare expenditure, and facility performance.

This study has several strengths, including assessment of multiple dimensions of patient experience, inclusion of users of public, community-based, and private healthcare facilities, evaluation across different household income categories, and use of a pre-tested bilingual questionnaire to facilitate participation in English and Urdu. The study also examined both descriptive healthcare experiences and socioeconomic differences in reported bias and perceived facility quality. These strengths should be considered alongside important limitations. Participants were initially recruited through convenience sampling, and the analysis was based on a subsequently selected stratified subsample of 190 records from an original dataset of 379 respondents; consequently, the analytical sample cannot be regarded as nationally representative. The predominance of female participants further limits generalizability to the wider population of healthcare users. Outcomes were self-reported and therefore susceptible to recall, response, and perception-related biases, while objective measures of clinical quality, staffing levels, waiting times, healthcare expenditure, and discrimination were not available. Differences between facility types may also reflect variations in service level, location, case mix, and patient characteristics rather than sector alone. In addition, the primarily bivariate analyses did not adjust for potentially important confounders such as age, sex, education, geographic location, facility distance, and facility type. Finally, the cross-sectional design prevents determination

of temporal sequence or causality. The findings should therefore be interpreted as patient-reported associations that identify areas warranting more representative and analytically adjusted investigation.

CONCLUSION

Among the healthcare users included in this cross-sectional analysis, financial barriers, perceived public-sector staffing inadequacy, perceived regional differences in care quality, and unfavorable assessments of government health initiatives were common, while perceived quality ratings differed between private clinics and government hospitals. Household income was also associated with reported clinical bias or discrimination, with lower-income groups reporting less favorable experiences. These findings indicate socioeconomic and facility-related differences in patient-reported healthcare experiences and identify affordability, staffing capacity, service responsiveness, and perceived equity as important domains for health-system assessment and planning, while not establishing causal relationships or nationally representative prevalence.

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