Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir

Supervised by: Dr. Waqas Ali Kausar

Submitted by: Iqra Manzoor Kiani

Department of Governance and Public Policy

NUML

Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir

By

IQRA MANZOOR KIANI

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF
MASTER OF PHILOSOPHY IN GOVERNANCE AND PUBLIC POLICY
TO
DEPARTMENT OF GOVERNANCE AND PUBLIC POLICY
FACULTY OF SOCIAL SCIENCES

NATIONAL UNIVERSITY OF MODERN LANGUAGES, ISLAMABAD

FEBRUARY 2021

NATIONAL UNIVERSITY OF MODERN LANGUAGES
FACULTY OF SOCIAL SCIENCES

THESIS/DISSERTATION AND DEFENCE APPROVAL FORM

The undersigned certifies that he has read the following thesis, examined the defense, is satisfied with the overall exam performance, and recommends the thesis to the Faculty of Social Sciences for acceptance:

Thesis/ Dissertation Title:
Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir

Submitted By**:** **Iqra Manzzor Kiani** Registration No: **1560 MPhil/GPP/S18**

Masters of Philosophy
Degree name in full

Governance and Public Policy
Name of Discipline

Dr, Waqas Ali Kausar
Name of research supervisor Signature

Prof Dr. Mustafeez Ahmad Alvi
Name of Dean (FSS) Signature

Prof Dr. Muhammad Safeer Awan
Name of Pro-Rector (Academics) Signature

Date: _____

NATIONAL UNIVERSITY OF MODERN LANGUAGES
FACULTY OF SOCIAL SCIENCES

CANDIDATE DECLARATION FORM

I,
Daughter of: **MANZOOR AHMED KIANI**
Registration No: **1560 MPhil/GPP/S18**
Discipline of **Governance and Public Policy**

Candidate of **Master of Philosophy** at the National University of Modern Languages, do hereby declare that the thesis "**Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir**." submitted by me in partial fulfillment of M.Phil degree, is my original work, and has not been submitted or published earlier. I also solemnly declare that it shall not, in future, be submitted by me for obtaining any other degree from this or any other university or institution.

I also understand that if evidence of plagiarism is found in my dissertation at any stage, even after the award of a degree, the work may be cancelled and the degree revoked.

Name of Candidate: Iqra Manzoor Kiani

Signature of Candidate: _____

Date: _____

NATIONAL UNIVERSITY OF MODERN LANGUAGES
FACULTY OF SOCIAL SCIENCES

THESIS SUBMISSION APPROVAL FORM

(Supervisor)

A Thesis" Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir".

Submitted By: **Iqra Manzoor Kiani**
Registration No. **1560 MPhil/GPP/S18**
Discipline of **Governance and Public Policy**

Candidate of **Master of Philosophy** at **National University of Modern Languages**

This thesis has been read by me and has been found to be satisfactory regarding content, English usage, format, citations, bibliography style ,consistency, thus the fulfill of qualitative requirement of the study. It is ready for submission to the department of Governance and Public Policy, Faculty of Management sciences for internal and external evaluation.

Dr. Waqas Ali Kausar

Name of Research Supervisor Signature

Date: _____

NATIONAL UNIVERSITY OF MODERN LANGUAGES
FACULTY OF MANAGEMENT SCIENCES

CERTIFICATE

It is certified that the research work contained in this thesis titled: "**Comparative Analysis of Public and Private Health System Governance at Secondary Level: A Case Study of Azad Jammu & Kashmir**", has been carried out and completed by **Iqra Manzoor Kiani** under my supervision during this Mphil in Governance and Public Policy at the department of Governance and Public Policy, Faculty of Management Sciences National University of Modern Languages Islamabad.

Dr. Waqas Ali kausar

Name of Research Supervisor Signature

Date: _____

TABLE OF CONTENTS

ACKNOWLEDGEMENT

I would like to express my gratitude to Allah who has given me strength to fulfill this research. I am deeply grateful to my parents who have continuously supported me and enable me to fulfill this dream.

I am extremely grateful to my supervisor Dr. Waqas Ali Kausar for his invaluable advice, continuous support, and patience during my study. I would like to thank esteemed Madam Kehkshan Rizwan who inspired and developed my interest in research.

I would extend my gratitude to all my teachers who have made my study and life at NUML a wonderful time.

Finally, I would like to offer special thanks to my sister Memoona Manzoor and all my friends for their tremendous understanding and encouragement in the past few years.

Thank you all for your contribution and continuous support without which this study could not have been possible.

Iqra Manzoor Kiani

DEDICATION

To my beloved parents

“MANZOOR AHMED KIANI & **HASFA KHATOON”**

For their advice, patience, and faith because they always understood.

ABSTRACT

Health system governance refers to the actions and measures adopted by any public or private sector health providers to elevate the standard of the health support facilities of its inhabitants. The health system governance is complex and dynamic, and it experiences problems peculiar to its unique characteristics. Such problems include internal pressures arising from increased demands for transparency, responsiveness and accountability. Moreover, effective leadership and socio-economic factors have been recognized as essential in shaping organizational culture and driving the implementation of reforms in health system governance. In Pakistan health system governance has been challenged with problems of transparency, inadequate accountability and responsiveness especially in AJ&K. So, the objective of this study is to compare the health governance delivered by the public and private hospitals in AJ&K. For this purpose, effective health governance is measured by three dimensions namely accountability, transparency and responsiveness. The independent variables are leadership which is measured by knowledge, skills and ability and socio-economic factors and instrument used to measure are social connectedness, income inequality and collective efficacy. Due to the nature of this study only those respondents were included in the study having perceptions about both the hospitals. Therefore, 450 questionnaires were selected for this study. Results showed that private hospitals are showing better health governance as compared to public hospitals.

CHAPTER 1

INTRODUCTION

1.1 Background of the Study

Health is regulated by numerous factors which influence all aspects of life, including leadership, culture, accountability and transparency. Developments in overall health status of people and quality of living are linked to each other. To attain better health and quality of living, the principles of health system governance are adopted by countries all over the world rapidly. The other aspect of health that needed more attention was health responsiveness and regulation. Laws and regulations of responsiveness by health authorities also addressed equity of health services for the general public and also addressed how economic factors affect the health of people (WHO, 2007).

Health system governance refers to the actions and measures adopted by any public or private sector health providers to elevate the standard of the health support facilities of its inhabitants. It also comprises the institutions, the formal and informal procedures that shape actions of relevant actors those who work within these procedures to perform the key affairs of a health system (Siddiqi, et al. 2009). The health system governance is dynamic and very complex and faces numerous challenges (Counte and Newman, 2000; Garman and Scribner, 2011; Liang and Howard, 2010). Such challenges are related to internal mechanisms of transparency, responsiveness, accountability and intensifying impact of different investors and stakeholders involved in this process (Stefl, 2008; Wallick and Stager, 2002).

Besides internal forces, external factors also affect the health system governance, such

as altering population record, globalization, economic factors, administrative strategies, leadership, expansion in medical and information technologies and socio-economic factors. All these dimensions wield profound effects on the health area (Leggat, 2007; Guo and Anderson, 2005). Thus, the health system governance experiences constant changes emerging from the cooperation of variables both inside as well as beyond the ability of health system to do things. Efficient leadership and socio-economic factors have been acknowledged as essential variables in modeling organizational culture and urging the implementation of latest transformations in health system governance Liang & Howard, (2010).

1.2 Pakistani Context

In Pakistan, health system governance has been confronted with complications of transparency, insufficient accountability and responsiveness (Sheikh, n.d). According to Brookings institution of United States, Pakistan's health segment is extremely unhealthy amongst the eighteen developing economies. Pakistan recorded inadequate performance in leadership and socio-economic aspects and health procedures (Darrell et al., 2017). Essentially, all those matters through which practical actions of good governance are getting affected eventually impacts healthcare and health system components (transparency, responsibility, responsiveness) and such matters either on the government or personal level are still weakly understood. As per the WHO (2007), the idea of leadership and good governance "contains safeguarding strategic policy frameworks which are combined with effective oversight, coalition building, guideline, attention to structural design and accountability for the better health system governance." (Travis et al., 2001; WHO, 2007).

Health system governance is made effective by the more extensive governance structure in the country which in Pakistan case, it lacks; anyway, there are signs that good

governance itself is a strong autonomous component. Health system governance has viability and capacity to accomplish its objectives through these extensive good governance components (transparency, accountability & responsiveness) (Siddiqi et al., 2009). Notwithstanding while perceiving the meaning of good governance within health system governance, there is a generous absence of clarity with regards to other central components ('building blocks') of the health system governance, regardless of whether good governance is one of the significant 'building blocks' or a main factor of better health system governance while holding back all other remaining health system governance dimensions (Travis et al., 2001).

One of the building blocks of health system governance is the concept and role of leadership in taking care of health care units and setting up different actors involved in drafting health strategy and policies and its application and implementation. Different definitions have described the duties of leadership as the methods through which general public puts together itself to achieve strengthening of better health for general population (Joshi & Moore, 2004; Dodgson, 2002). Under viably administered health system governance, the strategy focuses on the continuous arrangements and actions that carry better opportunities for general public to access to the health services. Health system governance techniques are probably going to be strategically arranged; and the authorities are successfully ready to design, achieve, manage strategies and plans and then execute them (Brinkerhoff, et al. 2009)

Health system governance is experiencing rapid modification and the necessities for following the challenges of these modifications have enforced a widespread analysis of health system governance and their functioning. As the countries inspect their health system governance in more depth to modify to new demands, the number of problems and

complexities of problems identified, this need of inspection is required more in developing countries WHO (2007). Leadership and governance require managing and controlling the whole health system including all sectors, not just the public sector. To guard the public interest, the entire health system governance needs to be modified according to the public demand more than just enlightening health status (Siddiqi, et al. 2009).

1.3 Context of Azad Jammu & Kashmir

Current study basically focuses on health system governance and its shortcomings in Azad Jammu & Kashmir. There are 7 DHQ's (District headquarter hospitals) and 9 THQ's (Tehsil headquarter hospitals) forty-seven RHCs (Rural Health Centers) and 229 BHUs (Basic Health Units) established across Azad Jammu & Kashmir. There are around 3752 hospital beds accessible. On average about one bed per 1078 people. (DOH, 2014-2018).

There are various insufficiencies in health system governance like transparency, accountability and responsiveness (WHO 2004). Considering the existing state of health system governance of Azad Jammu & Kashmir, the primary health facilities are somehow meeting the needs of people, but real issue of health system governance is at secondary and tertiary level as stated by Health Population & Nutrition Unit (1998). So, there is an essential need to regard attention to this noteworthy feature of human welfare.

1.4 Problem Statement

Health systems are developing and have to regularly respond to the evolving demographic status of populations; increasing expectations of highly educated clients; rapidly developing private health sector; fast growing changes in public health sector; growth in influence of globalization on health sector; and the wish to rapidly develop health services and gain

universal health exposure. Usually, governments are not able to adjust rapidly to the changes in the health systems and the new responsibilities attached to it. Health system governance should be strong enough to be able to measure the demands of health systems under accessible circumstances by the general public (Siddiqi et al., 2009). Such lacking can also be seen in the health system of AJ&K. Health sector in AJK is marred with challenges which have bearing its effectiveness. This study is basically the comparative analysis of public and private health system governance of Azad Jammu & Kashmir. The study contains the population of private and public sector hospitals of Azad Jammu & Kashmir. The study will show the overall effectiveness of health governance in both public and private sector. Furthermore, it explains how leadership and socio-economic factors impact on health system governance in the context of AJ&K.

1.5 Research Objectives

1. To analyze impact of leadership on effectiveness of health system governance in public and private hospitals of Azad Jammu & Kashmir.
2. To measure effect of socio-economic factors as income inequalities, social connectedness and collective efficacy on effectiveness of health system governance in public and private hospitals of Azad Jammu & Kashmir.
3. To compare public and private health system governance of Azad Jammu & Kashmir through skills knowledge and abilities of the health leaders.

1.5 Research Questions

1. How leadership through accountability, transparency and responsiveness effects on health system governance in public and private hospitals of Azad Jammu & Kashmir?

2. How do socio-economic factors as income inequalities, social connectedness and collective efficacy affect health system governance in public and private hospitals of Azad Jammu & Kashmir?

3. How public and private health system governance of Azad Jammu & Kashmir can be compared through skills, knowledge and abilities of the health leaders?

1.7 Scope of the Study

This section provides insight into the research scope. This study ought to present the comparative analysis of public and private health system governance through hospitals in different divisions at only secondary level in AJK. It is beyond the capability as well as time limitations do not permit to enlarge the research to further levels hence, the scope is restricted to the secondary level.

1.8 Significance of Study

The international organizations and the advanced world emphasize on the health system governance at all ranks, but the dynamics of underdeveloped countries are different. The true characteristics have not been determined; however, the association has been studied among the indicators of health system governance. This study will help to understand the factors which prevail within private and public to achieve effective health system governance at secondary level in Azad Jammu & Kashmir as well as also it will aid in creating the over review that how public and private hospitals differ in many ways. This study also presents the principles and indicators through which health system governance could be made better and better performance could be achieved.

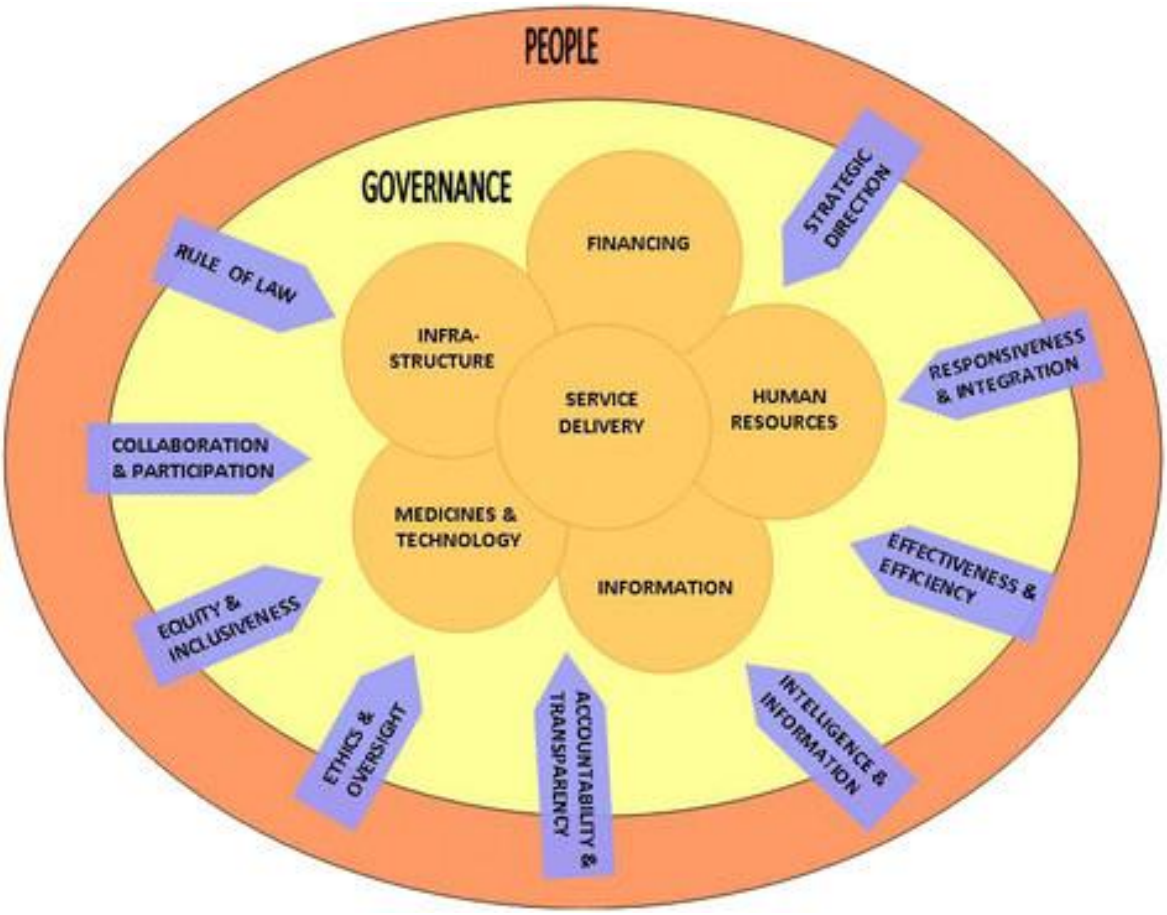
There will be applied significance of the study in addition to findings and suggestions can

be used by hospitals of Azad Jammu & Kashmir to expand the effectiveness of health system governance with understandings on how hospitals can overcome the obstacles of effective health system governance at secondary level. This research can assist in training the hospital functionaries on how to pursue and attain effective health system governance and how they can increase their effectiveness by their contribution. The study is unique in targeted area. The researcher has found no noteworthy study of this precise problem especially in context of Azad Jammu & Kashmir. Furthermore, this study will aid in policy making and will be a help for policy makers in decision to improve the health system governance of Azad Jammu & Kashmir.

1.9 Organization of Study

This thesis is divided into six chapters. In chapter 1, the background of the study is discussed where I explained how the need of the changes is health system and its governance is mandatory for overall health of public followed by the context of Pakistan and Azad Jammu & Kashmir. I then explained the problem statement, stated the research objectives and research questions followed by the significance and scope of the study. In chapter 2, Literature Review is conducted, and I explained the concept of health system governance, leadership and socio-economic factors followed by health system in Azad Jammu &Kashmir In chapter 3, conceptual framework and research design is discussed. Chapter 4, the quantitative data is analyzed in detail. In chapter 5, the findings of the study are discussed followed by chapter 6, which is about conclusion and recommendations based on the findings of the study.

1.10 Diagrammatic Representation of Health System Governance



CHAPTER 2

LITERATURE REVIEW

2.1 Effective Health Governance

Literature on health governance proposes that effective health system governance has been a key for achieving healthcare reforms, accomplishing significant advancements in health system and access to healthcare compared with other countries with no health system governance reforms (Balabanova, et al. 2013). The suggested health system governance valuation framework in this study comprises the following three principles- transparency, responsiveness and accountability (Siddiqi et al. 2009). These principles are illustrated below:

Transparency: In public sector of AJK takes longer time frame and loads of obstacles to make and break any approach as numerous actors engage all the while. Due to the involvement of these actors' procedures gets complicated. Adequacy of healthcare relies upon the fast reaction to any need that emerges. Processes are not as smooth as they look like not as transparent as they are supposed to be, both for public and private sector in health system it means a procedure that provides adaptable, reliable, valuable and latest info to all concerned stakeholders so they can get meaningful understanding of the eminence, patient experience, finance, governance, and distinct health data related with the health system, and make choice on its fairness (Britnell et al. 2017). The necessity for transparency in the private sector is, henceforth, in no way less important than in the public sector. Transparency is perceived as an approach to expand trust in government (Grimmelikhuijsen, 2012; Porumbescu, 2015), state

authenticity (De Fine Licht, 2011), citizen inclusion (Porumbescu, 2015b), and to lessening corruption (Bauhr and Grimes, 2014). Two cultural advancements have added to the solid allure of transparency now. Firstly, to start with, the advancement of the internet and data advances has essentially intensified the size of government data accessible to the general population (Meijer, 2009). And secondly the data innovation evaluation as in advancement in information technology and the tremendous expansion in the proportion of data accumulated by government have likewise improved the meaning of transparency. If additional data could be institutionalized, there is greater chance of exposure and enhanced transparency. This concept to some degree overlaps with a second progression: The ascension of New Public Management (NPM) as technique for building up governments and its better administration (Hood, 1991).

Public sector changes unified by NPM encourage an improved level of transparency of government organizations and their exercises, with the possibility that improved impression of how these offices work will improve their performance. Likewise, it is also agreed that a specific level of transparency is vital for democratic responsibility. Lacking information about political or managerial dynamic makes it difficult to hold administrators accountable (Florini, 2007; Roberts, 2006). These advancements have given a government transparency a reinforced pertinence; and with its better-quality innovative and convincing decisions, transparency has been seen by numerous individuals as a panacea for improved governance. Yet at the same time the inquiry is what transparency is? The term is consistently utilized in different ways by various individuals (Meijer, 2009).

Transparency is characterized all around as 'how much a public association lets outside actors to control and gauge at its center works and presentations (Grimmelikhuijsen and

Meijer, 2014). Researchers debate that in spite of the fact that transparency introduces to a major measure of available data, this doesn't bring about improved degrees of trust. In reality, O'Neill (2002) claims that transparency may even wear out trust. She clarifies that the internet makes it simple to spread the word about a lot of information, which not just offers demeanors to a course of information yet in addition to a huge amount of untruth about the government actions. Furthermore, public overseers could 'extract' or 'alter' the data. Furthermore, transparency fidget's pressures that better-quality transparency could direct to improved and imbalanced condemning of government (for example Commendable, 2010). A third and furthermore the 'obscure side' of transparency may be that when individuals can see things in the background of government, they may make feeling of disappointed with it. Administering is routinely an untidy and indistinct action and illuminating this may destroy resident trust and authenticity of government tasks.

Responsiveness: the public sector there is more responsive behavior as the government is obliged to respond to the public opinion because it works in the favor of public and responsible for the overall betterment of health rather than the profit maximization. Public pressure is one major factor that is being exerted on the government whereas this could never be done in the private sector as there is no direct pressure of general public on private sector in terms of making their policies and strategic planning. In the private sector the people will never get a chance to intervene in the managerial process and get the insight of the internal proceedings. In health system governance, administration develops a genuine communication of individuals' correspondence with their medical and health care services framework. This experience of correspondence of people with their health systems is formed by both the people and their opinions on the basic side of the medical and healthcare services frameworks feedback of the health system on the other side (Mirzoev and Kane, 2017). Responsiveness is obvious as

viewpoints associated with the procedure where individuals are dealt with and the circumstance or environment in which they are dealt with (Fillipo, 2003). It also emphasizes on ‘actual’ involvements with less dependence than the satisfaction capacities on needs and expectations (Busse, et al., 2003). Eight dimensions were recognized by WHO that most expansively captured responsiveness (Fillipo, 2003; World Health Organization, 2005): quick attention, dignity, communication, independence, privacy, and choice, quality of facilities, and right to use social support. In literature, the WHO responsiveness notion has been used to compare health care systems (Grol, et al., 2000; Robone, Rice and Smith, 2011; Saltman, 2018) either usage has donated valuable information representing the suitability of the responsiveness areas in measuring patient involvement with healthcare systems.

Accountability: Private sector health care workers raise the funds by themselves and few shareholders needs to be keen about the profit. By doing so private sector workers are held more accountable because a few mistakes could lead to the effecting of organizational value in the market. Private sector healthcare workers strongly rely on the public opinion by directly telling them what the procedures are being followed. The public sector of AJK clinics utilized well conscious and coordinated approaches and plans, endorsed through the approved cycles that are utilized to make individuals accountable to the government not the public Accountability is meant for the allocated choices and the courses of action to promise that designated assets for health care are utilized appropriately by government authorities. At the specialist or service provider level, the accountability connection is among patient and supplier, Secondly the health care accountability highlights on the quality of health care administration, proficient assets usage, just not the expense utilized by health care services (Emmanuel and Emmanuel, 1996; Fuchs, 1996). Thirdly, the institutional capacity loopholes mean whether the institutions are accountable for the loopholes in resource allocation. This

helps to build accountability for the entirety of all three purposes.

The lack of healthcare units to follow up the services and report on spending plans, rates of services, drug acquisitions and supply inventories, vehicles and all the healthcare equipment, etc, effects the processes for accountability for guideline and confirmation purposes. It results in misuse of resources in the health care services and can deliver ground for violation of policies. Moreover, weak ability to see the errors made by doctors and specialist hinders the accountability actions and also it impacts the unjustified up gradation of doctors.

The lack of accountability has increased the trouble in analyzing the actions of various healthcare system actors in achieving performance objectives, as if the health care actors meet the set standard of operations or not. Many developing/progressing nations that have moved away from public sector of healthcare toward private sector. This has shown that such nations have delicate administrative limits to execute accountability, making it difficult to utilize quality health care operations (Standing and Bloom, 2003). The gap between the approvals set by any organization that exists 'on paper' and how they executed are very much like genuine accountability issues.

Health care facilities that come up with lack of info about current health care needs for accountability are more likely to fall apart. Information like who works there, where they work and are, they working on given time and what they are doing. Any organization can't move toward without considering staff accountable for execution of their performances. Insurance finances that can't build up an evidence information base on expenses of healthcare that can guide dealings with private suppliers can't utilize agreements as a viable approval for either monetary or performance accountability. (Siddiqi, et al. 2009). Accountability includes the

responsibility of persons or organizations to provide info about or may have explanation of their activities to other stakeholders (Brinkerhoff, 2003). Decision- makers in administration, the private sector and civil-societies actors in healthcare are accountable to the general public, as well as to authorized stakeholders. This accountability varies which depends on the organization and whether the valuation is inside or outside to an organization as well as actor forum relationship (Siddiqi, et al. 2009). The health system governance reforms are important for the improvement of abilities of the policy makers to safeguard the distribution of effective, operational, and outstanding healthcare care services. (Gertner, et al. 2010). This study inspects the concept of leadership and socio-economic factors in relation to the health system governance in detail.

2.2 Leadership and the Health System Governance

Leadership is an essential and key element to attain the ideal purposes of the global health system governance. Admitting it as the most multifarious challenge in health systems, former Centers for Disease Control (CDC) director, William Foege addressed that the “absence of management skills seems to be the single most significant barrier to advancing health all through the world” (Foege, et al. 2005). There is general consensus that more consideration should be paid to leadership, including from an analysis of current methods to public health, in which the authors note "all too often, we emphasis on falling disease specific morbidity and mortality rather than the substantial leadership and management skills required to achieve the results we desire most” (Fraser, et al. 2017). However, in spite of all other skills there is philosophical skill for health care reforms which defines that a good leadership is a key factor in making up health systems and refining health outcomes.

There is no mutual agreement on what definite behaviors make up good leadership, nor how variations in individual behavior leads to variations in teams or administrations, and

ultimately to stronger health systems and better health outcomes (Frieden, 2014). There is an expanding body of research work that seeks to describe the influence of leadership on health systems and health outcomes (Adam, et al. 2012.

Present focus in health system governance and leadership are, still, directed towards acknowledgement and control of vital capabilities (that is knowledge, skills, and abilities) needed and used by healthcare pioneers for candid performance in their jobs. Identification of such abilities is indispensable to create healthcare framework administration or health system governance (Calhoun, et al. 2008). Leadership revolves around inspiration, planning, ways, and inspiration; it forms direction and inspires others to achieve organizational goals (Hintea, et al. 2009). These capacities are considered as important factor for a leader in execution of better leadership for associations; such capacities are recognized as 'center abilities', an idea initially supported by Prahalad (1990). For a leader many competencies are required as knowledge, skills and abilities. These capacities are required by healthcare leaders or managers for successful execution of their duties and with these capacities can help in getting better at preparing and developing of plans and strategies for success of the organization (Shewchuk, O'Connor and Fine, 2005).

- **Knowledge** The public sector healthcare workers have précised knowledge about their specific fields, and they are more effective at problem solving as there exists more help by upper hierarchal doctors/specialist**.** Whereas in the private sector doctors or other healthcare professionals face a little hurdle in problem solving as the clinics or other healthcare units are established by single owners and all the pressure reside at the owner. Whenever any problem arises both the sector address to them immediately. Knowledge is so far is labeled as a rally of the know-how or understanding of the philosophies,

concepts, strategies, or values essential to perform a task effectively (Harris and Bleakley, 1991). In writing about learning and preparing, information preforms a key job and is qualified a comprehensive variety of properties and characteristics. Among the models met are nonexclusive and district explicit knowledge, genuine and scholarly knowledge, perceived and easygoing knowledge, explanatory and specialized knowledge, hypothetical and methodological knowledge, extended and aggregated knowledge, free and (exceptionally) arranged knowledge, understood or aloof knowledge, determined knowledge, acquirement knowledge, sited knowledge, and meta-knowledge. It has been exemplified, in an article by Reif and Allen (1992) in these articles at any rate eight distinctive knowledge terms has been utilized, which are known as: principal investigation knowledge, they utilized the word general knowledge, and furthermore definitional knowledge, subordinate knowledge, extra knowledge, determined knowledge over the case, involved knowledge, and ultimately thought knowledge. Comparative subject articles additionally show that (understanding logical ideas), Reif (1987) likewise indicated the phrasing definitive knowledge, viable knowledge, formal knowledge, rational knowledge, assembled knowledge, unique knowledge, general knowledge, procedural translation knowledge. Apparently, scientists need various and tweaked terms for portraying the knowledge condition of people. Various examinations have signaled this blast of ideas and terms and have begun to structure the field, moving toward the various parts of knowledge from an overall solicitation for reissues ought to be coordinated to Ton de Jong, Quality of Educational Science and Technology, University of Twente had thought that it was efficient to present two measurements that depict knowledge: first is sort of knowledge and the other is nature of knowledge.

- **Skill**, after the knowledge abilities, skill on the opposite side, indicates to the responsibility

for capacity to viably execute physical or scholarly undertakings to accomplish an explicit result In the public sector specialists and doctors are more effective to the detailed aspects of their work as there is proper channel through which all the doctors and other staff get promotions and seek the upper positions. Whereas in the private sector effectiveness in terms of detailed work are questionable because of the less interactions and discussions with the other staff as there is always less number of doctors compared to the public sector also there is one aspect that in public sector the practices of medical staff and doctors is always high in number as the number of patients are more than private. (Marrelli, Tondora and Hoge, 2005).

•**Ability**; Ability talks about going to a sensibly suffering group of convictions, mental state, and conduct tendencies towards socially significant objects, gatherings, events or descriptions. In the private sector the health care workers have an ability to actively control patients and people to act in a desired way whereas the public sector health workers lack such ability as the management of the patients in the public sector is difficult because of huge number of coming patients(Prahalad and Hamel, 1990).In an appropriate health system governance the required knowledge, abilities and capacities that empower the person in question to accomplish or lead viably (Hintea, et al. 2009). A considerable amount of studies have been coordinated on health system governance and initiative (Lockhart and Backman, 2009; MacKinnon, et al. 2004). The greater part of these is focused on Identification and additionally valuation of crucial capabilities needed by healthcare actors for viable execution of influential positions. The accentuation on abilities has been educated by the imperative to develop further and competent initiative labor forces, given the significant jobs of pioneers in driving varieties and driving advancement in health system governance (MacKinnon, et al. 2004). This much has additionally been

recognized by the World Health Organization (2007), which has urged the need to reinforce the board and authority capacities at all levels of the health system.

This study proposes the following hypothesis.

2.3 Socio-Economic Influences on Health System Governance

Alluding to the report by World Health Organization (2012), the social determinants of health framework governance are the conditions where persons are born, grow, live, work, and develop. These situations are framed by the money circulation, authority, and resources at worldwide, public, and local levels. Social determinants of health assume the principle part in deciding the general's healthcare status (Berkman, et al. 2000). General healthcare can be coordinated by the arrangements and practices set up in homes, universities, working environments, and other social orders. A significant number of these determinants are hard to get, if not studied together they are hard, to control, like monetary or financial standing, traditions, behaviors, standards, and perspectives of the local area in which we are raised up (Umberson, 1992). There is a lot exploration and work done on the social determinants of health. Limit of it coordinates to three extensive elements:

- **Income inequality**. In many developing countries deaths are caused not because of irresistible ailments such as tuberculosis, loose bowels, cholera, jungle fever, influenza, pneumonia, and so forth, yet ongoing ailments (coronary illness, diabetes, disease) and the monetary and social inequality in the provision of health facilities to general public is a greater determinant of death rates. Income inequality has greatly amplified since the early 1970s such that it started growing slowly initially but ultimately leading up to the Great Depression

- Components causing to income inequality contain technological advances, hampered development in learning accomplishment, globalization, less progressed tax assessment, and the weakening of worker's organizations. Income inequality harms healthcare by increasing the presence and elevation of poverty. Income inequality also has an impact on delayed decision making in healthcare as there is a pressure by the rich segment of society. Income inequality also impacts on the weakening of organizations and associations that protect healthcare system. The damaging impacts of income inequality on health care needs focused activity concerning the government, academic circles, managers, private organizations, and the media to diminish inequality conducted through taxes and transfers. This could also be done through rising employment and pays while cleansing working conditions. Rising access to education starting from early childhood education through higher education, also dedicating people in societal programs that defend the valuable and enlightening impact of poverty elevation on the public and also defining the means through which inflation could be controlled. (Chokshi, 2018) Within the community the people with the high income will prefer to seek the private sector health care service to avoid long queues and paperwork. While the public sector is for the people with low net income. Free or minimal charges for the basic checkup allow the poor segment of society to have access to the medical care. Income inequality or pay disparity harms healthcare system transparency and causing constant pressure on account of social examination. Also, it damages health circuitously by eroding societal trust and decline communities. As income inequality increases, lower income workers see their income deteriorate or even decline, a relationship described as the "concavity effect Lower incomes dispose individuals to worse health straight through exposure to damaging environments, decreased opportunities for educational and occupational advancement, and a reduced ability to stop and cope with disability and

illness. Income is positively correlated with life expectancy, and advances in life expectancy have been more concentrated among top earners as inequality has deteriorated.

- **Social connectedness**. While clarifying this idea numerous studies determine that "belonging" either to a majorly big family and or distant family, a set-up of companions, a common or aiding association, or a devoted community is connected to productive life and improved health, and also to the community participation (Stafford, et al. 2018). People with poor social connectedness seem to experience the greater risk not being able to access healthcare services than people with good social connectedness. Social connections and networks are even now suggested for the conservation of better mental health. The prevailing study suggests that social connectedness in private sector hospitals of AJK increase contribution in an extensive range of health services, and therefore improves usage of the health-care system and people health.

It is a reality that social relationships have significant implications on physical health and well-being of a person. Summarizing the literature published between 1970 and 1998, Seeman (2000) concluded that highly socially integrated individuals (as reflected in a greater number of ties with a spouse, close friends and relatives, affiliation with religious and other groups) live significantly longer than the less integrated counterparts, and that socially isolated individuals are at greater risk for broad based illness such as any incidence of disease and poor recovery from diseases. The harmful effects of societal isolation are same in magnitude to the impacts of recognized health risk elements such as smoking and laziness and are generally independent of behavior and biological risk elements in forecasting broad-based health effects. Social relationships operate to influence health and well-being. A useful inroad into this complexity has been to move beyond the presence and number of social ties to consider how social relationships are perceived and experienced. Perceptions and receipt of social support, for instance, have been shown to contribute to health outcomes. The part of social support in

healthcare is just one feature of a more intensely seated part for societal connections in human health and flourishing, however.

- **Sense of personal and self-efficacy**

This alludes to individuals' feeling of authority over their lives. Individuals with a higher civic sense or more grounded history of acceptability of their lives tend to live more compared to the others with no sense to live. This sense of efficacy keep up better healthcare or wellbeing, and help to take part more overwhelmingly in civic life (Tasa, et al. 2007). Verifiably the studies on long-term condition management of an individual have highlighted the important role played by person’s information or knowledge, abilities, inspiration and ability to self-manage. There is developing acknowledgment that self-management is certifiably not an individual cycle, yet one that relies upon the help given by individuals from one's interactive organization (Rebecca, et al. 2016).

The interest of organization and individuals in sickness management makes it possible for the overall organization to interact with other people effortlessly hence making a change on aggregate health as opposed to personal self-efficacy. New discoveries and features define how friendly the behavior of individuals is with different types of individuals, their exercises and gatherings. Collective efficacy gives support to social and mental freedoms and assets which give rise to self-management support (SMS) for physical and mental well-being of individuals (Koetsenruijter et al., 2015; Reeves et al., 2014). This support has later on highlighted the impact of a need for all the individuals that how they deal with social capital and assets in a way that is worthy and significant to them. Collective efficacy also impacts individuals from their related organizations when overseeing and living with a long-term health condition (Ohlert, 2016).

Here, the considered networks are those which are as close to home networks that spread past understanding of health care systems (like companions and partners) that are effectively or approximately connected with each other referred to as one unit (Vassilev et al., 2011)]. The dynamic of an individual working inside this sort of organizations who are connected to each other and help in getting better civic sense, may incorporate settling on choices about when and who to contact, perceiving and using assets that were some time ago under used, picking a few people over others, and giving an establishment that helps continue to exist connections content (Kennedy et al., 2015). Collective efficacy focuses to the need to discover the connection between social connectedness and social support through providing more noteworthy thought regarding the strategy of commitment between individuals. Inside interactive organizations and the changing degrees of collective efficacy of various organizations, self-efficacy impacts their individual to interact with each other and also impacts collective limit of interacting with respect to such commitment (Vassilev, et al., 2014).

Collective efficacy was first proposed by Bandura (1986) who characterized it as 'a group's normal faith in its conjoint skills to set up and play out the strategies important to produce given degrees of achievements'. Referring to social psychological hypothesis, collective efficacy incorporates coordinated, teaming up and shared effort, beliefs, impact, constancy and goals chasing on behavioral outcomes (Bandura and Kazdin, 2000). Collective efficacy (CE) is a 'new property' of the group, instead of the amount of the self-efficacy levels of individual group members and is 'the result of the working together and co-coordinative elements of its individuals' (Bandura, 1998). In Bandura's unique work CE is conceptualized as a gathering interaction that can work on the micro, meso and full-scale levels as macro, where it is of importance for understanding the basic problems of families, social communities, associations and public networks (Bandura, 1997). Collective efficacy has most consistently

been analyzed on the meso level to contemplate various networks of having a place (family, ethnic, social, confidence) and spot (neighborhoods), and foundations the limits of which are generally well-defined (local area care settings, schools, organizations) (Bazant and Boulay, 2007; Goddard, Burns, and Catty, 2004; Lawrence and Schiegelone, 2002; Sampson, Raudenbush and Earls, 1997).

When applied to neighborhood healthcare and wellbeing for instance collective efficacy is intended to work concerning bunch support, inspiration, responsibility, and the ability to accomplish shared objectives and readiness to meddle for the 'benefit of all' (Sampson et al., 1997). Social cohesion and union and casual social control are perceived as two significant components of CE in neighborhoods the previous partners fortitude and common trust, while casual social control is expected to accomplish the gathering assumption to have the option to make a move together. The thought of CE has been set up little past such applications on the meso level however the thought re-appeared inside investigations of LTCM (Long-Term Capital Management), where it has various degrees (Sampson et al., 1997).

In spite of the fact that not very many global laws are being acknowledged exactly to help human healthcare and wellbeing, and a lot more worldwide laws have conceivable compulsory impacts on medical services as they may influence the social determinants of health (that possibly, the external conditions where people live that may upset their healthcare systems). Models may be of social determinants of healthcare include outfitted clash, work, approval, circumstance, cash, common liberties, deficiency, cleanliness, social arrangements, business, and water supply (Weil, 2005).

2.4 Health Governance System in Pakistan

Ongoing change in Pakistani health system governance emphasize on decentralization, autonomy at local level self-sufficiency, the management of assets at local level, at last prompting expanding funding of medical and healthcare services consumption to people in general (WHO, 2007). Transparency in the administration and accountability at all levels is unavoidable through the advancement of such framework. This is maybe the ideal time for the public authority to understand the requirement for backing such changes through an appropriate health care system governance (Pyone, et al. 2017 A few studies have shown the meaning of health care transparency in giving financial know-how of medical care administrations, understanding and dealing with real necessities of the patients, improving consumer loyalty at all levels. In this manner of improving the nature of medical and health care services administrations, transparent health care policies are being shown to the general public (Abri and Balushi, 2014). Consumer loyalty at all levels and in this manner improving the nature of medical and health care services administrations being given to the general public (Abri and Balushi, 2014). Eventually such a framework makes ready to some type of accreditation framework through government or non-government organizations to validate the nature of health system governance being given (WHO, 2017).

Maybe the significant problem of Pakistani health system governance is that a particularly huge and mixed up governance system is being controlled by weak and incompetent governors, both at the public and private (office) levels (Hassan et al. 2017). Health care system management as a organized order has never been given its due consideration in Pakistan. At the public level the principle obligation of framework of health system governance and strategy detailing lies with our civil servants who are neither qualified

nor upheld by qualified and experienced executives' counsels of health care systems (Wajid, et al. 2002).

2.5 Health System Governance in AJK

A government report by health care office AJK (2018) portrays that medical care frameworks at secondary level contain emergency clinics generally arranged in a region or district level or tehsil level serving the number of inhabitants in that area. The current health system at any levels of governance either secondary or primary, it is expected at giving determined and reasonable administrations to analyze various diseases and their therapies This group of medical and health care frameworks forms in Tehsil Head Quarter (THQ) clinics/centers and District head quarter (DHQ) emergency clinics.

Multiyear plan report AJK (2014-2018) shows that the governance structure of health department AJK is separated into three tiers first is provincial, second district and third sub-district level. At the rural level, in the leadership of the Health Minister, department of health is governed by the Secretary Health. The Director General Health Services (DGHS) is responsible for supervision and the application of health care system services in entire AJK. At the district level, a District Health Officer (DHO) is liable for the supervision of health care services through an extensive network of primary and also the secondary health amenities. And also s/he also oversees the execution of vertical health plans. On the sub-district level, generally at union council level, the health services administrators are responsible for delivery of health services within their allocated zones.

Policy building, planning and regulating and management are comparatively weak links at provincial level of AJK. As there is no exercise of making annual health plans. By not setting area-specific targets for health services, it is not possible for the district or tehsil

hospitals to review all performance accurately.

Quite a few steps have been taken by AJK government hospitals during COVID-19 outbreak. Infected patients, for example, are isolated from other patients to reduce the spread of diseases. The isolation hospitals were divided region by region. In Islamabad, there exists only one isolation center with ten beds. Baluchistan got 11 regions and 14 healthcare centers with a total of 534 beds, while KPK has 33 regions and 110 healthcare centers with a total of 856 beds. Punjab is divided into 34 divisions, and 50 healthcare centers with a total of 955 beds which are operational. Sindh is divided into four regions, and four healthcare centers with a total of 151 beds are operational. Gilgit-Baltistan (GB) gotten districts and twenty-one diagnostic centers with a total of 126 beds, though Azad Jammu and Kashmir has gotten nine districts and fifteen health centres with a total of 310 beds. Most customers and beds available are determined by the number of active COVID-19 cases.

According to figures, AJK has an average of 364 medical facilities per million residents. In each of the 7 districts, the very same average is used (Neelum was still not carved out of the district of Muzaffarabad in 2005 when the data was being collected). According to the numbers, districts Mirpur and Bagh have better accessibility to healthcare facilities, districts Muzaffarabad, Sudhnoti, and Bhinder are about average, and districts Ponch and Kotli are well below average. For the Mirpur district, the provision of health system institutions is determined by the urban-to-rural population ratio. Contrary to popular opinion, it tends to adopt the opposite ratio, i.e. The rural-to-urban population ratio. This means that greater availability of hospitals in remote areas is linked to improved access to health-care services. It tries to justify the designation of Bagh district as having excellent connectivity and Bhinder, Sudhnoti, and Muzaffarabad as completely decent links to Basic Health Units, Rural Health

Centres, and related facilities at the grass roots level. As a result, it appears that the coverage in districts Kotli and Poonch, although getting a greater portion of establishments, is not proportional with their significant rural population, which has concentrated in difficult-to-access areas. Recent report by Health Department AJK shows that about 4.1 million external patients were treated on an annual basis at AJK Healthcare Service units, whereas 75,000 people were admitted to district hospitals per year, 32,000 of them for any kind of emergencies.

There are records of almost 4,000 people who died in hospitals each year which now has increased due to COVID-19 with a much larger number resulting from certain sort of injury as a result of the inadequate capacity of hospital emergency departments. Besides that, of the 500 severely burned cases recorded each year, more than half die due to a shortage of life-saving equipment. Numerous lives may have been preserved and can be saved, as well as injuries avoided, if hospital emergency services are rehabilitated, medical transport infrastructure are upgraded with proper ambulance crews, a sufficient number of physicians and paramedics are hired and equipped, and critical life-saving equipment is accessible and operational. To that end, AJK has given priority to the reconstruction of accident and emergency services, as well as the repair of some obsolete and inoperable facilities in all district headquarter (DHQ) hospitals, as well as the reconstruction of four severely damaged tehsil hospitals, for immediate equity funds. To entice doctors to come and work in remote THQ hospitals, AJKG has given a PRs25,000 monthly compensation package and removed limits on non-AJK doctors working in these areas. The Department of Health (DOH) plans to deputise a sufficient number of doctors in THQ hospitals in addition to having lodging facilities as part of the Program.

The private sector is relevant for new health care knowledge and can make a substantial contribution to an overall market commitment to achieving contraceptive services. Knowledge on existing sources of contemporary contraception strategies is important for program preparation and execution. In AJK, however, there is no detailed, spatially explicit database of public and private health facilities that offer extensive database on effective health system governance services. It's the first project to plan out public and private sector services to improve district level teamwork, reduce redundancy, and be a part of the wider reference structure.

The report's results suggest that there is a need to increase the availability of skilled staff through all the private sector, especially pharmacies and private hospitals. Accomplishing better health governance system targets is increasingly dependent on increased collaboration with the private sector, as well as improvements in spending decisions in countries with large communities and high levels of unmet needs. Divisions are urged to use the preliminary search to improve health services in order to address people's immediate improved health needs. The results show that there is a large potential for private sector participation in improving health care system to supplement public sector initiatives.

Recent report by WHO states that during the pandemic of COVID-19, remarkable steps have been taken by the government of Azad Jammu and Kashmir. To reduce the spread of the virus, many isolation centers were made in hospitals or near to hospitals to isolate the person that was infected from the disease of coronavirus. The government has made many isolation centers in all over the country. There was one isolation center made in Islamabad by the government having the facility of isolation of the people infected from coronavirus and government has made 14 healthcare units all over country having the facility of 534 beds for

the people infected from coronavirus. In KPK, there are 33 regions and government has made 110 healthcare centers having the facility of 856 beds. Punjab was divided into 34 divisions and 50 health care centers were made by the government having the facility of 955 beds. In Sind, there are four regions and four health care centers were made by the government having the facility of 151 beds. In Gilgit-Baltistan, there are ten districts and government has made 20 health care centers having the facility of 126 beds. Azad Jammu and Kashmir got nine districts and government has made 15 health care centers having the facility of 310 beds. Ventilators were available at public sector hospitals for the serious patients of coronavirus. All the facilities related to coronavirus patients were available at the public sector hospitals in Azad Jammu and Kashmir. The hospitals were being provided with the latest instruments and machinery for the diagnosis of coronavirus by the government. So, comparatively in the situation of pandemic the public sector hospitals were providing better health facilities to the general public than the private sector hospitals, there was no facility of isolation for the patients affected from coronavirus in private hospitals. There was not enough space to accommodate the patients affected from coronavirus.

Moreover, private sector hospitals were not provided with the latest technology and equipment for the diagnosis of coronavirus. Due to lack of basic facilities to treat the patients of coronavirus, Private sector hospitals were unable to provide their services during the pandemic of coronavirus. Public sector hospitals were at far distance from small areas and private sector hospitals were not providing proper facilities to treat the patients of corona virus. So, it was a challenge for the people living. In remote areas of Azad Jammu and Kashmir to get the proper treatment or facility of isolation or even diagnosis of the disease. The number of beds and health care centers were decided according to the number of corona cases in that area. Most of the people were getting lab, isolation and treatment, facilities from public sector

hospitals. So, Government sector was working in an efficient way to facilitate the people during the span of COVID-19. But during this pandemic of coronavirus, Private sector hospitals were unable to provide their services in the form of laboratories, isolation centers and treatment of corona virus. Private sector has no contribution in the battle with the corona virus due to lack of latest equipment and space for isolation in Azad Jammu and Kashmir.

According to an estimate, there has an average 364 medical centers along with medical facilities for the 1 million people in Azad Jammu and Kashmir. Same distribution is being done in 7 districts of the region. According to a WHO survey, the public sector hospitals of district Mirpur and Bagh are providing with high quality health care facility to the patients, the public sector hospitals of district Muzaffarabad and Sudhnoti are providing with average health care facilities to the patient and the public sector hospitals in district Ponch and Kotli are providing with below the average health care facilities. The quality of health care system depends on urban to rural ratio of population. But according to survey, the quality of health care system must depend on the rural to urban ratio of population. It is necessary to improve the health care facilities in the remote areas because it is hard for the people living in remote areas to reach the hospitals that is far away from them. There are many health care centers in Bagh district as it is linked with Bhinder, Sudhnoti and Muzaffarabad. There must be health care centers in remote areas to facilitate the people of remote areas.

The government of Azad Jammu and Kashmir is working hard to provide the better health care facilities to the people of remote areas because it is necessary to facilitate the people living in remote areas. Because according to an estimate, lots of people lost their lives due to having no health care facilities near them. In case of emergency, private hospitals do not have emergency center or facilities. Moreover, private hospitals do not have latest diagnosis

equipment or machinery and even X-RAY machines. So, the people have to move towards a distant area for finding a public sector hospital to get the emergency services in case of any emergency. According to an estimate, 75000 people are admitted in district hospitals on annually basis and around 32000 patients get admitted for emergency services. According to an estimate, around 4000 people got died due to unavailability of emergency services in nearby hospitals. It is estimated that along with that 500 burned cases also recorded on annually basis and more than half of the patients got died due to lack of life saving facilities and equipment. It is possible to save thousands of lives by starting some emergency services, rehabilitation centers, modern medical technology, ambulance services and high qualified doctors and paramedical staff.

The government has given priority to reconstruct the emergency centers in remote areas of Azad Jammu and Kashmir to reduce the number of deaths due to lack of medical services. The hospitals of Azad Jammu and Kashmir are being provided with the monthly funds and to have qualified doctors, the doctors who are outside from Azad Jammu and Kashmir are allowed to work in this area. The private sector hospitals are playing their part mainly in family planning sector. An important role is being played by the private sector hospitals by providing knowledge about family planning to the people of remote areas. On implementation of this program that having public sector hospitals along with emergency services, modern equipment and updated machinery for the diagnosis of diseases and qualified doctors, nurses and paramedical staff, the standard of living of the people living in remote areas will improve and they will be able to get better health facilities on time.

The private sector can play a significant role in contraceptive services in the overall market. For the execution of the program related to family planning, it is necessary to have

knowledge about existing ways of contraception. Private sector hospitals can spread knowledge about contraceptives by educating people about family planning. There was no project about family planning before and it was for the first time that public and private sectors working together to improve the team work at district level to reduce the issues related to health and family planning. It will develop a strong structure for the provision of better health care facilities at remote areas. It is suggested to increase the quantity of contraceptive at private sector hospitals. It is necessary to make collaboration with private as well public health care centers to spread the knowledge about family planning. This is a project to improve the health care facilities and family planning awareness in Azad Jammu and Kashmir. Private health care units can play a momentous role in the generative health care. It has been analyzed through different studies that the private health care centers are successful in achieving their goals and objectives about family planning.

Hence it is analyzed from the WHO survey that in Azad Jammu and Kashmir, Public sector hospitals are well reputed health care centers for emergency services and burnt cases also. The public health care centers are well equipped and have better health care facilities. So, these are playing important role in the health services being provided by the government. The government has to start public sector hospitals in remote areas so people can get emergency services near to them. It is necessary because so many people got died due to unavailability of health care and emergency facilities near them. Public sector can support private sector by providing them with latest equipment, machinery and space because private sector can fill the gap that is not being filled by public health care centers. And private health care units can play a significant role by spreading knowledge and awareness about the hormonal contraceptives and their role in family planning. Private medical services units can cause individuals to acknowledge about the benefits and significance of family arranging that how family arranging

can assume a significant part in the better improvement and development of the youngsters. Both the private health care centers and public health care centers are playing their role for the betterment of the society.

2.6 Theoretical Narrative of the Study

(a) Institutional Theory

Institutional theory follows to clarify why countries are given to logical establishments and furthermore what rehearses these takes. The fundamental subject is that hierarchical designs perceived in industrialized nations are viewed by strategy creators, donors, and different states as signs of improvement towards present-day institutional turn of events and thus benevolent of monetary consideration. Notwithstanding the positive or negative implications of their exercises, the presentation and security of specific structures in tertiary schooling and government assists with associating this commitment. Institutional theory and his hypothesis propose a record of the development and construction of the scholastic and state research segments, as prosperous associations in mechanical countries work as models a long way from their unique settings (Shurm, 2001). Institutional theory also highlights on the parts of societal, political and commercial systems in which the companies function and increase their lawfulness. As clarified by Scott, organizations suggest for the rules of the game and describe the available ways to function by discouraging, convincing or boosting given behavioral patterns. They affect the dynamic interaction in giving recommendations of what might be reasonable or not, and in relating the discrete socialization of standards and behaviors in a given society. Scott stated the three pillars on them the societies are constructed: firstly the regulation, secondly the norms and the lastly the cognition. The first regulative pillar is official and legitimately codified, while the other normative one covers non-codified approaches

present in societies. When normative capabilities and attitudes are commonly spread in society, they are slowly embraced by individuals and become acknowledged as the norms to which everyone is cheered to conform. Institutions give reliability and confidence to social behavior. Pressures and opportunities can be exerted by influential constituents, such as the state, businesses, interest groups, the public opinion and family. The important logic of the regulative pillar is traditionalism to the principles and laws, while that of the normative pillar relays to what is dignified appropriate. But reactions to institutional stresses and prospects may range from passive conformism to active confrontation, dependent on the nature and perception of the pressures. In general expressions, it has been thought that Asian cultural characters and standard values, counting in the designated countries, are not encouraging to the growth of entrepreneurial spirit. Up until lately, for a combination of religious, logical and ethical reasons, this solid sense of social grading infusing human relationships prepared entrepreneurial endeavors a comparatively unappealing expert choice, especially for newer members of the institution in the entire East and South-East Asian area.

(b) Leadership Theory

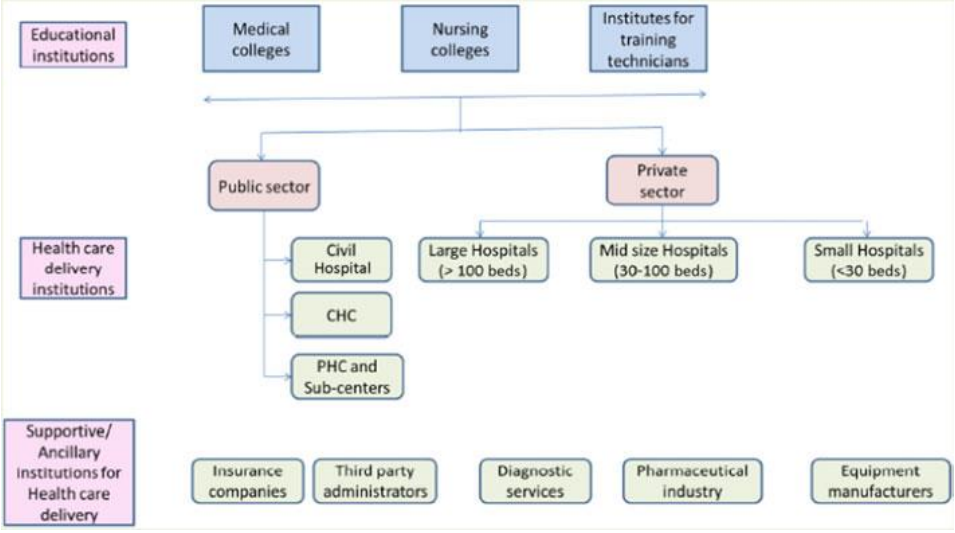
A defined leader is the one who accepts the charge of being concerned for something on bestead of another person or group of person. Leadership theory is a structure which claims that individuals are essentially interested to work for other people or for peoples' organizations to complete all the responsibilities and all duties with which they are delegated. It claims that individuals are collective minded and pro-organizational instead of individualistic and subsequently work to the achievement of administration, group, or communal goals since doing so offers them an advanced level of gratification.

Leadership theory consequently provides one structure for illustrating the efforts of managerial behavior in many kinds of organizations (Menyah, 2013).

(c) Theorizing

This is evident from the literature that for the effective health system governance, institutions need to be restructured and regulated. These institutions include hospitals and all other health care related organizations for delivery and regulation for health system. According to the institutional theory the policy makers and donors can impose rule of law and structural reforms in the institutions. According to leadership theory institutions and people need to work in collaboration for the achievement of the better effective governance directed by a leader. And such type of collaboration will cover the aspect of responsiveness. More the people will get involved in the health care process more the process will be responsive. Leadership theory also forms the basis of the transparency as when there is coordination among people in order to gain institutional gain; processes will get more transparent as per involvement within the procedures.

2.7 REPRESENTATION OF SERVICE DELIVERY OF HEALTH SYSTEM

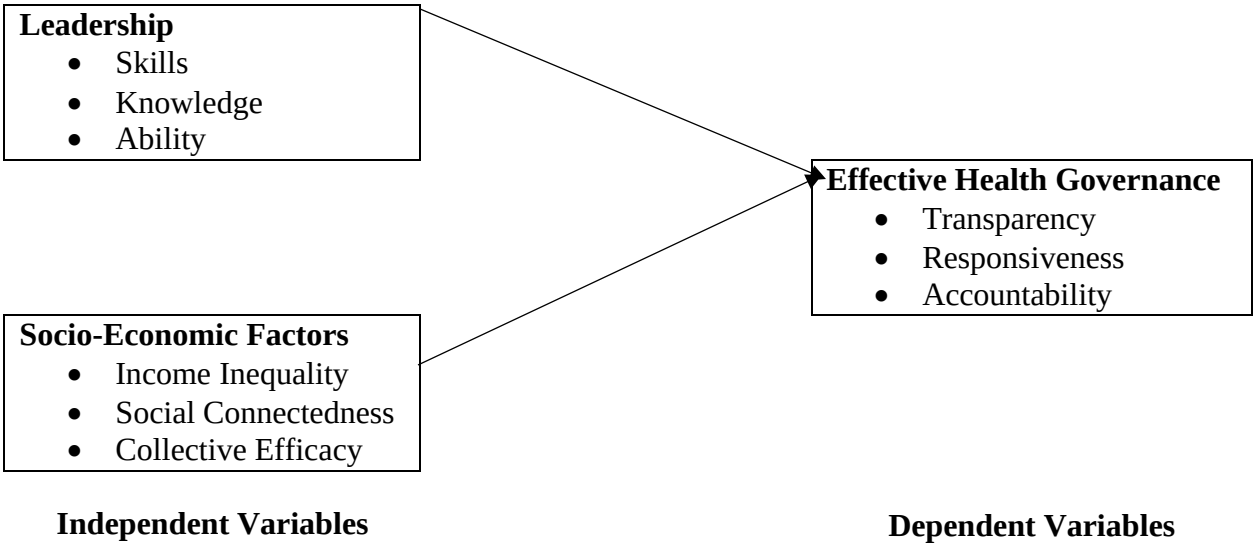


CHAPTER 3

CONCEPTUAL FRAMEWORK AND METHODOLOGY

3.1 Theoretical Framework

The theoretical framework in this research is founded on the identification of diverse variables and the correlation among them.



3.2 Variables

This study considered two main players of the health system governance: leadership and socio-economic factors. This study opted a series of characters, which will place as independent variables to evaluate the health governance system of hospitals (dependent variables). In this regard, this study measured various features, which are being examined before, such as transparency, responsiveness, accountability, knowledge etc. as shown in Table 1.

Table 1: Dependent and Independent Variables

Independent Variable	**Leadership**	Teodorescu (2006); Ayeleke, et al. (2018)
	Knowledge	Harris and Bleakley (1991)
	Skill	Marrelli, Tondora and Hoge (2005)
	Ability	Prahalad and Hamel (1990)
	Income Inequality	Chokshi (2018)
	Social Connectedness	Stafford, et al. (2018)
	Personal Efficacy	Tasa et al. (2007)
Dependent Variable	**Health System Governance**	Siddiqi et al. (2009)
	Transparency	Britnell et al. (2017)
	Responsiveness	Mirzoev and Kane (2017)
	Accountability	Brinkerhoff (2003)

Hypothesis

H1: The constructs of leadership (knowledge, skills, ability) will enhance the effectiveness of health governance in the private hospitals of AJK.

H2: The socio-economic factors (income inequality, social connectedness, self-efficacy will enhance the effectiveness of health governance in the private hospitals of AJK.

3.3 Research Methodology

Since this study investigated the impact of leadership and socio-economic factors on effective health governance, therefore a case study design was adopted incorporating the triangulation method. Triangulation is often used to describe research where two or more methods are used, known as mixed methods. Research conducted in a single study involving the collection, analysis and integrating the quantitative and qualitative data is driven by this methodology (Creswell, 2014; Creswell & Clark, 2011; Denscombe, 2008). Guion (2002)

argued that it is the significant method to enhance the reliability and validity of research design by combing the quantitative and qualitative techniques in triangulation at the stages of sampling, analysis and the research instrument used. It is focused on collecting the quantitative and qualitative data at the same time and ask for integration of both qualitative and quantitative data at the same time for better understanding of the problem. This study has adopted this method as the loopholes of adopting only method were covered by the other method i-e through both qualitative and quantitative approach. Furthermore, the viewpoint of multiple stakeholders has been incorporated in the study and wider aspects are explored to answer the research questions.

3.4 Quantitative Approach

In the quantitative approach, the survey method used provided the numerical explanation of the attitudes through sample selection from the target population. The survey research can use questionnaire or structured interviews to gather data from the participants (Creswell, 2014). This study used quantitative approach to address the impact of leadership and social economic factors on effectiveness of health system governance and the difference in public and private health sectors of AJ&K. This nature of study and the research question, supported by various studies, considered to use the survey method more appropriate (Fowler & Floyed, 2008; Hall, 2008; Kalof, Dan, & Dietz, 2008)

3.4 (a) Qualitative Approach

The first objective of the study intended to seek the impact of leadership and socio-economic factors on effectiveness of health system governance. Moreover, the study also explored the comparison between public and private health system governance through the dimensions

like knowledge, skills and abilities of leaders. Also, the objective was to see which sector is more effective. To get the detailed understanding of these objectives, qualitative approach was used which is significant approach to investigate critical problems of socio-economic factors.

By focusing on the research objectives of this paper, the survey technique through structured questionnaire and in-depth interviews was keenly chosen to collect the statistics. The data has been collected by the usage of planned questionnaire and interview guide. The present study comprises of thirty-four items, which are gathered according to the distinct variables (Accountability-03, Tranparency-04, Responsiveness-03, Knowledge-06, Skills-06, Ability-04, Social connectedness-02, Income inequalities-03, Self-efficacy-03). The responses have been distinguished in five-point scale from 1 for “strongly disagree” to 5 for “strongly agree”. The study has taken Azad Jammu & Kashmir as a case study and adopts mix method approach for this research.

3.5 Population, Sampling Technique and Size of Sample

The targeted population for the present study comprises of all the public and private hospitals of Azad Jammu & Kashmir as shown in Table 2. In terms of sampling technique, the quantitative part of the study has adopted **nonprobability purposive sampling technique.** While talking about the qualitative part of the study, it has used the **convenience sampling.**

3.5 (a) Purposive Sampling Technique (Quantitative)

In the purposive sampling technique, researchers choose the samples based entirely on the researcher’s knowledge, information and understanding. This can also be described in a way that; researchers select only those participants who they think are best to participate in the

survey. The reason why the purposive sampling is chosen for this study is because, this is the most cost-effective and time-efficient sampling technique. This sampling technique might be the sole suitable method available if there are limited numbers of data sources available who are able to take part in the study. Sample size collected is 350 which is selected through purposive sampling.

Table 2: Population and Sample Size

Participants	
Admin	100
Doctors	100
Medical Staff	150
Total	350

3.5 (b) Convenience Sampling (Qualitative)

Convenience sampling (also known as availability sampling) is a specific type of non-probability sampling method that relies on data collection from population members who are conveniently available to participate in study. Convenience sampling is a type of sampling where the first available primary data source will be used for the research without additional requirements. In other words, this sampling method involves getting participants wherever you can find them and typically wherever is convenient. In convenience sampling no inclusion criteria identified prior to the selection of subjects. All subjects are invited to participate.

3.5 (c) Rationale for Selecting Sample Size for Quantitative

This sampling is also called judgement sampling for this kind of sampling there is no set formula for selecting sample size. The researcher decides which particular groups to survey. Non-probability sampling does not involve random selection, so the results can be used to characterize the selected population. Its value lies in selecting information-rich cases to gain a deeper understanding of the situation when random sampling is not possible. The researcher selects what she/he regards as representative sampling units.

3.6 Categories of Investigation

In this paper of the relative examination the connection between various factors are being considered. The sort of examination that observed will be, in this way, co-relational.

3.7 Degree of Investigator Interference

Since the overall examination is a co-relational investigation, the level of scientist obstruction would be ostensible.

3.8 Setting of the Research

The focused study has been directed as a field study and is non-manipulative.

3.9 Unit of Analysis

The basic unit of analysis would be distinct persons.

3.10 Horizon of Time

The facts have been gathered once in this study. This study hence is cross-sectional.

3.11 Data Analysis

Data analysis is carried out in statistical software called SPSS. The hence the reliability of questionnaire has been checked via Cronbach Alpha. Additional the construct validity is being tested via Factor Analysis. While this questionnaire is validated, through the hypothesis also has been verified through Correlation and Independent T- Test. The measurement scale used is Interval Scale having equal intervals between 1-5. The rating scale used is Likert Scale having values from 1-5. And for qualitative study the data was collected through in-depth face to face interviews. Interviews are the best form of data collection in reducing the non-response and elevating the data quality (Lavrakas, 2008). The interviews schedule contained open-ended questions for gathering information and data.

CHAPTER 4

DATA COLLECTION AND ANALYSIS

4.1 The Instrument Validity and Reliability

Prior to beginning the measurable investigation, it is truly imperative to look at the consistency (reliability) and unbiasedness (validity) of the instrument (survey) from which the data is aggregated. Reliability and dependability or validity checks are utilized to gauge the consistency and precision of instrument.

4.1.1 Reliability of the Tool

Reliability legitimizes steadiness of ascertaining instrument and the solidness of components to check whether they figure what they are probably going to compute. Reliability indicates that it should produce the same outcomes on nonstop measures. The aftereffect of Reliability demonstrated whether consistency gets by in the measurements of the respondents or might not. Unwavering quality is analyzed through Cronbach's Alpha. The characterized scope of Reliability exists somewhere in the range of 0 and 1. On the off chance that the finish of the result is close to 1 it expresses that the assessing instrument is supposed to be Reliable. What's more, if the worth of the Cronbach's alpha is 0.7 or the worth goes above it distinguishes that survey is Reliable. Unwavering quality in this investigation as tried through Cronbach's Alpha in statiscal programming SPSS has been indicated as 0.803. The worth of Cronbach's Alpha is more than 0.7 which show that the instrument is solid.

This moreover confirms that consistency occur in the information conveyed by respondents. Checking for Reliability is significant as it portrays to the consistency from the pieces of an assessing instrument (Huck, 2007). Any scale is considered to have extraordinary

inward consistency unwavering quality if the objects of a scale "hang together" and amount a similar develop (Huck, 2007; Robinson, 2009). The most more than once utilized internal consistency measure is the Cronbach Alpha coefficient. It is viewed as the most appropriate proportion of unwavering quality subsequent to utilizing Likert scales (Whitley, 2002; Robinson, 2009). No intensive standards happen for inward textures, yet most choose a least inner consistency coefficient of .70 (Whitley, 2002; Robinson, 2009).

For an analyzing or pilot study, it is expected that unwavering quality should be journalist to or above 0.60 (Straub et al., 2004). Hinton et al. (2004) have suggested four removed subjects for Reliability, which covers astounding unwavering quality (0.90 or more), high unwavering quality (0.70-0.90), moderate unwavering quality (0.50-0.70) and low Reliability (0.50 and below) (Hinton et al., 2004). In spite of the fact that unwavering quality is significant for any investigation, it isn't sufficient except if joint with legitimacy. In different contentions, for an assessment to be Reliable, it should likewise be substantial (Wilson, 2010). The review is decisively substantial if the test unequivocally predicts what it is expected to anticipate. It might likewise allude to when numbers from the translator measure are involved first and afterward the standard information is gathered later. As such, the capacity of one evaluation device to anticipate future execution either in some movement or on another task of a similar builds. The best method to properly make prescient legitimacy is to carry out a drawn out legitimacy.

Table 1: Research Instrument Reliability

Variables	**No of Items**	**Reliability Cronbach's alpha**	**Comments**
Effective health governance	10	0.786	Accepted
Transparency	4	0.755	Accepted
Accountability	3	0.922	Accepted
Responsiveness	3	0.76	Accepted
Leadership	16	0.800	Accepted
Knowledge	6	0.824	Accepted
Skill	6	0.798	Accepted
Ability	4	0.866	Accepted
Socio-economic factors	8	0.791	Accepted
Social Connectedness	2	0.721	Accepted
Income inequalities	3	0.956	Accepted
Collective efficacy	3	0.725	Accepted

4.1.2 Validity

Validity of the registering instrument shows the level or degree to which instrument measures what it should gauge. Validity can be guaranteed by two unique ways. The first is identified with the substance of the investigation and called as substance or content Validity and the other one identified with the design and the design is construct Validity. So the content Validity could be determined through the face and measure related Validity. Though the construct Validity is inspected by convergent Validity and discriminant legitimacy.

4.1.2 (a) Content Validity

Content validity recognizes legitimate extent of the subject of the theme to be analyzed and this is too better when it checks the case of uncommon and universe assessment of the thought. Content validity confirms that the substance and language utilized in the instrument is reasonable and it measures the said factors by its measurements. It can ensure the validity through two phases. First is outlining the estimation of subject which is distinctive of past sending in winning setting and second by accomplishment of acknowledgment by the trained professionals. Developing on their analysis, the instrument is changed, reconsidered reshaped and other focal changes made.

When all is said in done, content validity involves assessment of another overview instrument to guarantee that it incorporates every one of the things that are fundamental and eliminates bothersome things to a specific develop area (Lewis et al., 1995, Boudreau et al., 2001). The critical way to deal with start content validity legitimacy incorporates writing surveys and afterward subsequent meet-ups with the assessment by master judges or sheets. The method of critical methodology of content validity needs scientists to be available with specialists to help approval. Anyway it isn't in every case prone to have numerous experts of a

specific examination subject at one spot. This places an impediment to lead validity on a study instrument when specialists are situated in various topographical territories (Choudrie and Dwivedi, 2005). Contrastingly, a quantitative methodology may let analysts to send content validity polls to experts working at better places, whereby distance isn't a restriction. To apply content validity following advances are followed:

1. An exhaustive writing surveys to separate the connected things.

2. A substance legitimacy study is created (everything is estimated utilizing three-point (excessive, helpful but rather not fundamental and fundamental).

3. The overview ought to ship off the experts in a similar field of the examination.

4. The substance legitimacy proportion (CVR) is then planned for everything by utilizing Lawshe (1975's) strategy.

5. Items that are not huge at the basic level are wiped out.

Face Validity: To protect the face validity, specialists ensure that the study is figuring what is wanted to be register. The face validity, of the estimating poll could be mediated by driving a pilot sign and exhibiting it to various respondents to ensure that it assesses the appropriate reasons in like manner sense and generally speaking agreement. A study is appeared and perceived by all accomplices to assess on the off chance that it registers the followed thought or not. Face validity, in this space of examination was ensured through administering the survey to a more modest piece segment of populace and it was perceived that the language utilized and the substance was sensible by the respondents. A test has face validity, if its substance just looks identified with the individual stepping through the examination. It evaluates the presence of the poll regarding possibility, meaningfulness, consistency of style and masterminding, and the transparency of the language utilized.

As such, face validity, means to scientists' abstract evaluations of the appearance and importance of the estimating instrument with regards to whether the things in the instrument

seem, by all accounts, to be significant, reasonable, and express and clear (Oluwatayo, 2012). To inspect the face validity, the dichotomous scale can be utilized with absolute choice of "Yes" and "No" which distinguish a good and negative thing correspondingly. Where great thing implies that the thing is precisely organized and can be decidedly classified under the topical classification. At that point the created information is investigated utilizing Cohen's Kappa Index (CKI) in characterizing the face validity, of the instrument. DM. et al. (1975) recommended an insignificantly worthy Kappa of 0.60 for between rater understanding. Tragically, face validity, is questionably the most fragile type of validity, and many would recommend that it's anything but a type of validity, in the firmest feeling of the word.

4.1.2 (b) Construct Validity

The construct validity is measured by two validities:

- Convergent validity
- Discriminant validity.

1. Convergent Validity

Convergent validity can likewise be inspected by the scholar. To do the motivation behind the apparatus, initially factor examination is estimated by the scientist and it is sure through Exploratory Factor Analysis (EFA). Like Sekaran (2003) announced that factor examination could be characterized as multivariate procedure which may have affirm the components of the thoughts that had been operationally thought of, and also show which of the articles are generally suitable for every estimation. Skerlavaj, Stemberger and Dimovski (2007) has set up the calculate examination their own space of exploration work. Executing the methodology of these creators and in assessment of the plans of Sekaran (2003) the specialist played out the factor examination. While doing the factor examination the Principle

Components Analysis with Varimax factor pivot is executed. In the factor investigation the Eigen Value should be more noteworthy than 1, the change should be higher than half. The construct validity is shown in Table 3.

Table 3: Construct Validity

Factor Analysis (Extraction Method: Principal Component Analysis)										
Sr. No.	Items	Knowledge	Skill	Ability	Accountability	Transparency	Responsiveness	Social Connectedness	Income Inequality	Collective Efficacy
1	Question_1	0.841								
2	Question_2	0.821								
3	Question_3	0.620								
4	Question_4	0.706								
5	Question_5	0.789								
6	Question_6	0.656								
7	Question_7		0.765							
8	Question_8		0.719							
9	Question_9		0.564							
10	Question_10		0.620							
11	Question_11		0.676							
12	Question_12		0.671							
13	Question_13			0.704						

14	Question_14	0.778						
15	Question_15	0.506						
16	Question_16	0.696						
17	Question_17		0.713					
18	Question_18		0.728					
19	Question_19		0.680					
20	Question_20			0.684				
21	Question_21			0.641				
22	Question_22			0.586				
23	Question_23			0.694				
24	Question_24				0.774			
25	Question_25				0.858			
26	Question_26				0.643			
27	Question_27					0.729		
28	Question_28					0.720		
29	Question_29						0.657	
30	Question_30						0.740	

31	Question_31								0.815	
32	Question_32									0.730
33	Question_33									0.700
34	Question_34									0.540
Initial Eigen Values		3.480	2.320	2.127	1.944	1.698	1.419	1.398	1.129	1.035
% of Variance		14.501	9.666	8.862	8.100	7.077	5.914	5.826	4.706	4.314
Cumulative %		14.501	24.166	33.028	41.128	48.205	54.119	59.946	64.651	68.965

Eigen regard places of the level of variety portrayed by a factor. Eigen esteems further perceptible than 1 is considered as huge and the qualities those are under 1 are considered as being inconsequential. The result demonstrates that every one of the components can be held for additional investigation.

Discriminant Validity: The Discriminant validity shows the contrast between each hypothetical thought. It is required for the investigation that the subject of each component of the audit should be one of fundamental sorts and not exactly the comparable under as the other kind. It confirmations the uniqueness of the each component and variable from changed estimations in the instrument (Escring-Tena and Bou-Llusar, 2005). Cadotte (1987) battled about discriminant validity that its each surface self-governing upgrades towards the thought and is honorable through pair astute connection. In this current examination, discriminant validity is analyzed through pair insightful relationship in the software of SPSS. To check the discriminant validity, the cutoff esteem utilized for relationship proposed by scientists is under 0.85 (Harrington, 2009). The results are shown in Table 4.

65

Table 4: Correlations

	Knowledge	Skill	Ability	Accountability	Transparency	Responsiveness	Social Connectedness	Income Inequality	Collective Efficacy
Knowledge	1								
Skill	.850**	1							
Ability	.582**	.747**	1						
Accountability	.978**	.829**	.539**	1					
Transparency	.966**	.753**	.932**	.411**	1				
Responsiveness	.919**	.739**	.391**	.869**	.887**	1			
Social Connectedness	.802**	.961**	.633**	.788**	.734**	.695**	1		
Income Inequality	.861**	.960**	.657**	.841**	.785**	.773**	.842**	1	
Collective Efficacy	.706**	.875**	.628**	.671**	.630**	.634**	.758**	.864**	1

** Correlation is significant at the 0.01 level (2-tailed).

The above table shows the correlation among all the dimensions of independent and dependent variables ** shows highly significance among the dimensions of variables.

The above table explains the values of Pearson correlations between all considered variables. ** shows exceedingly significance amongst the dimensions of variables.

4.2 Descriptive Analysis

To comprehend the distinction between the health system governance conveyed by private and public clinics in AJ&K, enlightening insights addressing the mean, standard deviation and mean square error for every one of the health care governance develop was utilized to build understanding in regard to the distinction in health care system governance conveyed to patients by private and public emergency clinics against every one of the health care administration measurement. Also, autonomous example t-test was performed to ascertain the upsides of Levene's test for uniformity of fluctuations, t-test, df and p-value to test the importance level of the private and general health care system develops.

Table 5, 6 shows the computation of mean and the standard deviation of the factors and ideas utilized in this investigation. These outcomes determine that comprehensive mean upsides of health system governance ideas connoting private emergency clinics are ideal than the public emergency clinics. This shows that greater part of the respondent benefiting medical care public offices from private clinics see that private clinics are conveying better medical services framework to their patients when contrasted with the public medical clinics of AJK. Figure shows graphical illustration of mean values provides a vibrant understanding about the health system governance provided by the public sector and private sector hospitals in AJ&K.

Table: 5

Variables and Constructs	Public		Private	
	Mean	**SD**	**Mean**	**SD**
Knowledge				
I am effective at problem solving.	4.12	.322	4.07	.347
When problems arise, I immediately address them.	4.09	.359	4.09	.314
Seeing the big picture comes easily for me.	4.32	.623	4.23	.505
Making strategic plans for my company appeals to me.	4.35	.597	4.50	.557
I enjoy discussing organizational values and philosophy.	4.56	.540	4.58	.585
I am flexible about making changes in our organization.	4.64	.524	4.66	.552
Skills				
I am effective with the detailed aspects of my work.	4.19	.490	4.10	.390
Filling out forms and working with details comes easily for me.	4.21	.503	4.18	.455
Managing people and resources is one of my strengths.	4.37	.637	4.39	.546
In my work, I enjoy responding to people's requests and concerns.	4.35	.649	4.43	.618
Obtaining and allocating resources is a challenging aspect of my job.	4.29	.756	4.44	.733
I am effective at obtaining resources to support our programs.	4.64	.634	4.60	.582
Ability				
Actively attempts to sway others through direct commands to act in a desired way.	4.06	.522	4.08	.409

Open to other ideas and listens actively to others before directing them to act in a desired way.	4.15	.505	4.16	.483
Coaches others in desired ways to act.	4.34	.612	4.41	.631
Influences others by acting in desired way themselves and delegates work in an organized manner which allows others to act in a desired way.	4.56	.520	4.55	.604
Accountability				
Is able to establish commitment through directly telling people what to do.	3.81	.734	3.97	.672
Listens to others ideas and then directs members to be accountable.	4.00	.772	4.08	.631
Use well organized action plans and delegates tasks through collaboration and situational management to make people accountable.	4.26	.853	4.30	.678
Transparency				
Health service providers formulate policies, plans, regulations, procedures and standards on the basis of evidence about the effectiveness of health interventions and allocation of resources.	3.81	.719	3.75	.690
Health service providers make decisions about resource allocation for health services on the basis of evidence regarding needs and effectiveness of services and in conformity with policies.	3.91	.716	3.90	.759
Service providers regularly review and update the mix of services they deliver on the basis of evidence about the effectiveness of health services, client needs and health problems.	4.00	.812	3.84	.904

Protocols, standards, and codes of conduct, including certification procedures for training institutions, health service facilities, and health providers, have been developed for all actors involved in health services delivery and have been widely disseminated.	3.62	.702	3.66	.677
Responsiveness				
Structures and procedures exist to allow/encourage the public, technical experts and local communities to review and comment upon health priorities, resource allocation decisions and service quality during government strategic planning processes.	2.59	.905	2.60	.967
Government and health provider organizations regularly organize forums to solicit input/views/ideas from the public and concerned stakeholders about priorities, services and resources.	2.37	.851	2.35	.961
The public or concerned stakeholders have regular opportunities to meet with management of health service organizations to raise issues about service efficiency or quality.	2.61	.914	2.58	1.090
Social Connectedness				
Is social connectedness and social support associated with the health of individuals?	3.94	.665	3.90	.706
Do these constructs differ in their associations with health depending on individuals' experiences and perceptions?	4.09	.620	4.13	.538
Income Inequality				

Minimizing inequalities/disparities in responsiveness (the health system is equally responsive to all people, no matter their wealth, social status, sex, age or religious or other beliefs).	4.06	.598	4.10	.581
Residents have equal access to resources, services and opportunities within the community.	4.05	.625	3.99	.803
Procedures/systems exist to reduce/eliminate/control bias and inequity in accessing health services.	4.32	.688	4.30	.867
Collective Efficacy				
People in your community could work together to improve health services in this community.	4.04	.617	4.00	.604
People in your community could work together to improve how patients are treated at the health facility.	4.09	.670	4.30	.622
People in your community could work together to obtain government services and entitlements.	4.58	.557	4.60	.598

Table 6: Descriptive Statistics

	Factor	N	Mean	S.D	Std. Error Mean
Knowledge	Public	100	26.07	1.933	.189
	Private	100	26.11	1.665	.171
Skill	Public	100	26.14	2.021	.197
	Private	100	26.05	2.180	.224
Ability	Public	100	17.1790	1.47674	.14412
	Private	100	17.2000	1.59436	.16358
Accountability	Public	100	12.3429	1.65151	.16117
	Private	100	12.0737	2.07437	.21283
Transparency	Public	100	15.1048	2.09360	.20431
	Private	100	15.3368	1.99793	.20498
Responsiveness	Public	100	7.5333	2.47319	.24136
	Private	100	7.5684	2.09179	.21461
Social Connectedness	Public	100	8.0286	1.06027	.10347
	Private	100	8.0316	1.14346	.11732
Income Inequality	Public	100	12.3905	1.59624	.15578
	Private	100	12.4316	1.39644	.14327
Collective Efficacy	Public	100	12.9048	1.26737	.12368
	Private	100	12.7158	1.30191	.13357

4.3 Independent T-Test

Table 7 displays independent sample t-test for calculating the values of Levene's test for equivalence of variances, t-value, df and p-value to investigation the significance level of the private and public health system governance concepts.

Table 7: Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Knowledge	Equal variances assumed	.316	.575	.154	197	.000	.040	.258	.468	.548
	Equal variances not assumed			.156	196.788	.000	.040	.256	.464	.544
Skill	Equal variances assumed	.001	.981	.372	197	.000	.111	.298	.477	.699
	Equal variances not Assumed			.371	190.317	.000	.111	.299	.479	.701
Ability	Equal variances assumed	.425	.515	.478	197	.000	.10426	.21814	.32593	.53444
	Equal variances not Assumed			.476	190.071	.000	.10426	.21911	.32795	.53646
Accountability	Equal variances assumed	.266	.606	1.052	197	.000	.27903	.26522	.24400	.80205
	Equal variances not Assumed			1.039	176.987	.000	.27903	.26860	.25104	.80910
Transparency	Equal variances assumed	.673	.413	.772	197	.000	.22503	.29157	.80002	.34997

	Equal variances not assumed			.774	196.060	.000	.22503	.29089	.79869	.34864
Responsiveness	Equal variances assumed	4.036	.046	.037	197	.000	.01206	.32430	.62749	.65160
	Equal variances not Assumed			.038	195.896	.000	.01206	.32099	.62098	.64509
Social Connectedness	Equal variances assumed	.121	.729	.021	197	.000	.00334	.15667	.31230	.30562
	Equal variances not Assumed			.021	190.030	.000	.00334	.15737	.31376	.30707
Income Inequality	Equal variances assumed	.389	.533	.114	197	.000	.02442	.21360	.44566	.39683
	Equal variances not Assumed			.115	196.888	.000	.02442	.21202	.44253	.39369
Collective Efficacy	Equal variances assumed	.148	.701	1.112	197	.000	.20263	.18230	.15687	.56214
	Equal variances not Assumed			1.110	193.309	.000	.20263	.18257	.15745	.56272

Firstly, values of Levene’s test for knowledge presents trivial p-values (0.575), implying that further analysis of data is unnecessary which shows that private and public sector represents slight difference in terms of knowledge. A t-value 0.154, df 197 has a major p-value of 0.000 that shows the public sector is superior at problem solving because the stakeholder environment, involves more groups that need to find solutions to problems. Also, they are operating in a political environment they need to consider fairness and equity, in a way that the private sector generally does not. In public sector hospitals many state actors get involved when it comes to the problem solving. State actors works on different aspects producing the dynamic change which means positive change in one part leads to positive change in other parts too. Yet private sector is more prone to make strategic changes as there are no multiple actors involved, it might be easy for sole owner to be flexible about making changes for his own profit maximization.

Private sector is up for making and changing plans promptly as there is no political environment that restrains their actions and these actions are mostly for their own benefit rather than general public. However the private sector's impact has grown as a result of globalization, with conflicting consequences for the protection of social, economic, and cultural rights. Many of the world's biggest firms' economic output approach the GDP of many nations. Multinational corporations with activities in many countries exert immense leverage (including over countries' internal economic plans), posing a threat to conventional government oversight structures. When countries struggle for investments, frequently lowering environmental and labor conditions, others become reluctant or otherwise unable to uphold human rights sufficiently. In contrast to overt human rights violations, companies and banks face the risk of being involved in human rights violations as they spend in countries where there is armed violence, resource competition, and governmental repression and injustices. Also, the results of Levene's test for skills are registered,

with a small p-value (0.981) indicating a minor discrepancy between both classes. A t-value of 0.372, df 197, and a substantial p-value of 0.000 indicate that capabilities are higher in public hospitals as compared to private hospital.

Public sector doctors are more known to their details aspects and paperwork as some of the high profile organizations represented a high proportion of doctors that are promoted internally, fostering greater understanding of their practice, as well as the sense that there is a clear pathway from initial level to executive/higher positions. Also resource allocation is tough in public sector than private sector because the foundation of decision of allocating resources is outlined with methods assisting in their application. These moralities and techniques don't present an ultimate explanation to the essential budgeting issues. Decisions about where and how public money is to be spent are prepared through political processes of interaction between varied institutions. But the other three parts show that when it comes to resource allocation and budgeting private sector is comparatively more easy-going as there are no tiring paperwork or political processes involved.

However, the role of accountability in the budgetary process is shown by institutional economics strategies. This eliminates intelligence gaps that enable entrenched interests in the legislation, judiciary, and administration to redirect public money for private gain. External regulatory agencies, such as audit institutions and autonomous statistical authority, are critical guardians of accountability and a way to ensure management conformity. These will put a lot of pressure on policymakers to enhance public spending control and achieve the optimal allocation of resources results.

For resource allocation a mixture of different methods is more effective than using them individually. The fundamental reasoning for public investment, relative risks and advantages of various alternatives, and the distribution of income effects of expenditure are then included in

financial decisions. Implementation is easier when evaluating initiatives within a specific sector; implementation in higher-level, inter-sectoral policy distribution assessments is more difficult due to knowledge restrictions. The use of citizen preferences to direct spending is controversial because most democratic mechanisms do not always provide economically effective results. Decisions for allocation of resources are not immediately translated into financial outcomes; budget implementation also influences allocation of resources. It is necessary to discuss the process of budgeting, and also the review of spending policy and the subsequent capital allocations.

Thirdly, the values of Levene's test for ability is stated which displays an unimportant p-values (0.515) donating again the slight difference between two sectors. A t-value 0.478, df 197 has a significant p-value 0.000 which represents that public sector doctors are little up for gaining the support of the public officials to ensure political will which makes public sector more directed towards the commands of upper hierarchical officials. However, the private sector affects some by behaving in a way that delegate work in a coordinated fashion, allowing everyone else to behave in a preferred way independent of government interference. Private officials are more open to the ideas and new strategies that make their organization grow better. The managerial motivation in the private industry is self-interest, but the specified organizational objective is not. The smooth association among an institution's outward view of its successes and its administrative structure's internal view is broken. Self-interest is regarded as corrupt, despite the fact that it can inspire organizational success.

Furthermore, the chief executive of a public corporation does not have a statutory freedom to establish objective; instead, it may well be granted by law. The government sector must recognize targets set by companies from their own, as well as systems built by organizations other than their

own. Work for individuals whose professions are, in many ways, beyond the reach of management. They achieve their objectives in far less duration than is permitted in the private industry. Physicians in the corporate sector are typically recruited from inside organization, and he understands that to shift the course of the company, he must alter the composition and members of the organization. This is always the initial step. Without much question, he creates modifications and adjusts the work of the core people who report to him. In comparison, elected officials may be defined as outsiders who join government with beloved policy goals, achieve nothing, and leave office with unaccomplished aspirations for systemic reform; for, in terms of achieving essential political goals concerning fair trials and sensitivity to the voter.

Private Representatives want a cut of the profits earned from his company's systems. Because this portion cannot involve state profits, he typically wants compensation, perks of office, and the intrinsic rewards of serving the country. Unquantifiable incentives can be transient or actual, because they're as critical morally in the government sector as the profit maximization is in industry. Trying to influence action, altering the course of affairs, and assisting people are examples of intangibles. Both of them have a desire to use their influence for good. Power is both a need for and an incentive for performance. Control is defined as the capacity to affect results that has both long and short- term aspects.

Fourth, the results of Levene's test for accountability are published, which indicate negligible p-values (0.606), indicating that responsibility in the government sector is greater as compared to the private industry. A t-value 1052, df 197 has a significant p-value 0.000 which shows that the public sector uses well designed and organized policies and plans, approved through the authorized processes that are used to make people accountable but on the other hand private sector is not involved in any such political processes and directly asks people to be accountable for their

outcomes. Accountability of public authorities means that they are democratic and transparent at that rate. Besides, when the account of administration systems is taken all over the world show more tendencies to be more transparent and more democratic in the new era, and can easily suggest that accountability will get more important for the countries all over the world.

On the other hand emergence of accountability is not the same in every country. Some factors such as: statue of the government, democratic level of the country, effectiveness of civil society, development level of human rights, political poverty of the government and development level of legal structure play an active role in accountability of both politicians and public administrators and no state actors. Due to many factors being effective on accountability, the level of accountability in different countries is determined by these factors in those countries. People and organizations must be responsible for putting experience and understanding into motion in order to deliver new and meaningful activities. Transparency and accountability are executive compensation values that contribute to the delivery of productivity and performance outside of the organization and to have some beneficial impacts within the organization as well. As stated by Kalkan and Alparslan (2009).

Accountability in government agencies involved with government expenditure is related to principles of democratization and administration's transparency. However, provided that administration processes are continually emerging and transforming in an environment where government structures are increasingly being accessible and democratized according to (Sezer and Kargn, 2002). The accountability concepts will get more and more important (Yalçın, 2009). According to Bovens (2007), social accountability is the most emphasized form of accounting recently. Now, while citizens in non-governmental organizations are one of the most effective actors in both determination of public policies, and ensuring effective public accountability; any

public institution or the public administrators individually feel obligated to give account to public about many of the issues (Biriciklioğlu and Eryılmaz, 2011).

Fifth, the results of Levene's transparency test are published, with negligible p-values (0.413) indicating that the private industry is much more open as compared to the government sector. A t-value of 0.772, df 197, and a large p-value of 0.000 indicate that the allocation of the resources for There is no question that perhaps the government must be fully honest in its transactions when it is working with public funds; moreover, privately owned corporations still have a large shareholder base. They are still in charge of vast sums of public funds. As a result, the need for accountability in the private industry is no less critical than in the government sector. Transparency is viewed as a means of increasing confidence in government according to (Grimmelikhuijsen 2012; Porumbescu 2015a), government credibility (De Fine Licht 2011), public interest (Porumbescu 2015b), and fighting corruption (Bauhr and Grimes 2014).

Two social advances have led to transparency's current popularity. For starters, the growth of the Internet and digital technology has significantly expanded the volume of government data available to the people (Meijer 2009). The digital technology era, as well as the resulting massive growth in the volume of information collected and retrieved by state, has raised the value of transparency: if more data can be obtained, there is greater opportunity for transparency and enhanced clarity. This is partially in line with a second trend: the emergence of New Public Management (NPM) as a method for gathering governments (Hood 1991). NPM-inspired public-sector changes advocate for more accountability in government activities and initiatives, in the hope that improved awareness about how all these services work would boost their effectiveness.

Furthermore, it is widely acknowledged that a certain level of openness is needed for public legitimacy to thrive: without disclosure about political or organizational decision-making, it's

really difficult to hold senators and congressmen accountable (Florini 2007; Roberts 2006). These advances have enhanced the importance of government accountability, and with enhanced technical and managerial capabilities, transparency has been viewed by others as a miracle cure for good governance. So what exactly is transparency? Different individuals use the word in a variety of ways (Meijer 2009). Transparency is broadly described as ‘the degree with which a (public) organization requires external parties to track and evaluate its internal operations and efficiency (Grimmelikhuijsen and Meijer, 2014).

Scholars contend that while openness increases the availability of knowledge, it does not actually result in higher levels of confidence. After all, according to O'Neill (2002), openness can also weaken confidence. She claims that the Internet has allowed for the disclosure of a large amount of material, resulting not only in a torrent of knowledge but also in a stream of disinformation. Moreover, elected authorities have the ability to ‘stroke' or ‘twist' the letters. Second, there is clarity. The skeptics worry that greater accountability would contribute to more unwarranted criticism of the government, according to (e.g., Worthy, 2010). A third 'dark side' to accountability is that as citizens may see all that goes on behind closed doors of government, they can grow dissatisfied with it. Good governance is often a chaotic but volatile process, and revealing this risked undermining citizen interest and credibility of government activities. This ethical controversy has spawned a slew of academic research attempting to uncover data for the numerous supposed consequences of government accountability.

Sixth, the results of Levene's analysis for responsiveness reveal negligible p-values (0.046), indicating that the governmental and private sectors are somewhat similarly accessible to the public. A t-value of 0.037, df 197 has a strong p-value of 0.000, indicating that private sector when it comes to the stakeholders, public sector is keen towards considering all the stakeholders needs

and priorities and also considers the most the opinions made by them and allocate resources accordingly. But private sector is more about producing output in an effective manner. But on massive level government is obliged to create forums for the general public for their queries about health which private sector doesn't perform as their targeted market is not that on massive public level. Patients value healthcare system sensitivity because it is the target that they might more easily understand. Patients often do not appreciate their diagnosis, the rationale underlying treatment decisions, or the extent of clinical benefits that can be required of a given healthcare system caused by a lack of specialist medical expertise. As a result, when evaluating the success of a healthcare system, patients frequently cannot assess and therefore do not adequately understand the consistency of healthcare outcomes. They can, nevertheless, clearly refer to the aspects of sensitivity that they encounter in all facets of care.

According to WHO, a multitude of reasons can influence how a population ranks the sensitivity of the healthcare they acquire. These considerations also include nation in which health services are provided, the nature of the healthcare system, the quality of services offered, the cultural patterns of the community, and the manner in which healthcare is funded and administered, Professionalism suffers as a result of responsiveness when it requires elected officials to appease people even though doing so contradicts the common interests of the public. Short-term concerns and common actions are overemphasized in order to appease public will, whereas other long-term topics attract almost no exposure at all. Other reports, nevertheless, indicate that governance seems to necessitate officials who are attentive to public will, only by legislators and politicians, if not straight to the public (Stivers, 1994; Stewart and Ranson, 1994).

Although responsiveness is widely regarded as a controversial term in Public Administration discourse, it is unquestionably important to policymakers, bureaucrats, and ordinary people.

Responsible politicians or bureaucrats must be responsive, compassionate, receptive, and conscious of sensing the desires and views of the people. Since the desires and expectations of a linear arrangement are diverse, systemic framework for understanding them is essential. The political pressure placed on elected and appointed representatives. This is, in many respects, the secret to ensuring a decent social compact among people and leaders. According to Anthony and Young (1984, p. 649), regulatory bodies must play a more active role in the profitable and productive operation of public institutions in order to enhance management in non-profit organizations.

Peoples' understanding of governing boards will grow, improving both administrative and operational performance in the public domain. Smith (1993) contrasts the position of public disclosure to stakeholder groups and people with that of financial statements in the corporate of private industry. Like in the private industry, rising external associated results, including such federal agencies' sensitivity to peoples' needs, would have a significant effect on internal management systems, as administrators and civil employees grow more aware of their responsibilities and deeply committed to representing the community. WHO says as the responsiveness of health systems, patient experience represented by the interpersonal relation between the practitioner and the patient was broadened to represent the relationship among the health-care system and the people it affects (Houweling, Kunst, and Mackenbach, 2001).

Responsiveness is described as facets of how people are handled and the context in that they are handled (Fillipo, 2003), it focuses on 'actual' experiences with less dependency than the satisfaction measurements on needs and expectations (Busse, et al., n.d.; Fillipo, 2003). Eight dimensions were identified by WHO that most comprehensively captured responsiveness (Fillipo, 2003; World Health Organization, 2005): prompt focus, integrity, contact, liberty, anonymity,

preference, and facilities of high quality, and access to social support. In literature, the WHO responsiveness concept has been applied to compare health systems (Grol, et al., 2000; Robone, Rice, and Smith, 2011; Saltman, 2018) either application has contributed valuable information indicating the suitability of the responsiveness domains in measuring patient experience with healthcare systems.

Seventh, the results of Levene's test for social connectedness are stated, with negligible p-values (0.729), indicating that the government and private industry display almost identical effects in terms of group dynamics to the public. A t-value of 0.021, df 197 has a large p-value of 0.000, indicating that social connectedness and social support differ in their associations with health depending on individuals' experiences and perceptions in terms of hospitality and formalities, but social support brings up most the effectiveness in healthcare. Mental wellbeing is critical to an individual's physical well-being and is needed for a healthy and effective existence. Mental health issues have been linked to a variety of negative effects in the workplace, including decreased performance, lower motivation, injury, and absenteeism.

Given the negative consequences, it is critical to explore the possible causes and processes that could educate the recovery of mental wellbeing and the retention of healthcare professionals' morale in the midst of the crisis. Social reinforcement has been identified as one of the defense mechanisms for mental wellbeing of all factors influencing. Persons' perceptions or experiences of being a part of a social community in which people mutually support one another are referred to as social assistance. Earlier research has consistently stressed the importance of social reinforcement in promoting mental health. Not just cross-sectional trials, but also a wide body of modern research conducted, have rigorously established the favorable relationship between socioeconomic status and mental health result.

According to Ge, et al. (2014) meta-analysis, mental wellbeing is either weakly or highly weakly correlated with social care in the elderly. According to Fiori, et al. (2011) social care is only linked to mental wellbeing in women but not in men. As a result, it is critical to remember that previous experiments have discovered a connection among social assistance and mental wellbeing based on particular specimens; nevertheless, whether the finding could be replicated to health care staff during the COVID-2019 epidemic remains unknown. Furthermore, the moderating processes (i.e., how does social support interact with mental wellbeing?) and mediating factors (i.e., why is this interaction most powerful?) influencing the relationship among socioeconomic status and mental wellbeing remain widely unclear.

Responding to these concerns may be critical to better understanding health professionals' mental wellbeing and developing more intervention strategies to maintain healthcare professionals' efficiency and performance amidst the COVID-19 pandemic. Therefore, the current study used a study of Chinese healthcare professionals during the COVID-19 epidemic to investigate a theoretical framework wherein, at one place, durability regulated the connection between social wellbeing and emotional health; and then there is, age demographic moderated the implicit associations between environmental health and emotional health through durability. To assess social support, Xiao's Social Support Assessment Tool (SSRS) was used. The 10-item scale has three components: objective support, subjective support, and availability. “How many good friends can you get help and support?” was a descriptive question. Average grades mean greater social assistance.

Previous research has shown that the opportunity to accept health services is affected by a variety of variables, such as the person's state of health, social and economic features, and desire to receive the assistance they may require. Social support has been described as a possible driver

that can either encourage (i.e. increase accumulation) or stabilize (i.e. provide immediate access) healthcare facility use. Social support is characterized as knowledge that leads people to feel they are cared about and respected, respected and appreciated, and part of a connection and shared responsibility network.

Eighth, the findings of Levene's measure for income disparity are published, with negligible p-values (0.533) indicating that the private industry has greater differences between citizens in terms of financial gaps than the government sector. A meaningful p-value is a t-value of 0.114, df 197. 0.000 represents that the health produces positive outside factors for the general public as a whole, and also the equity distresses that lacking of public sector financial support merely the rich section of the population would be capable to pay for sensible health care services. Social health safety is a important instrument leading at fair problem sharing and lessening barrier emphasizing access to health care services.

WHO (2017) States that According to a World Bank and WHO survey, at nearly parts of the global population lacks access to basic health services. Every year, a vast number of families are forced into debt as a result of having to pay for their health care from their personal wallets. At the moment, 800 million households devote at minimum 10% of their household finances on health care for oneself, an ill child, or another member of the family. For above 100 million individuals, these prices are ridiculous enough to drag them into desperate poverty, requiring them to live on $1.90 or much less per day. The results, published earlier today in Tracking Universal Health Coverage: 2017 Global Monitoring Study, were also published concurrently in Lancet Global Health. It is absolutely unfair that majority of the population still needs access to the most basic health care, according to WHO Director-General Dr Tedros Adhanom Ghebreyesus. "It's also needless. There is an answer: universal health care (UHC) helps everybody to access the health

benefits they require, where and when they require them, without economic strain."

"The study clearly shows that whether we are concerned – not so much about improving health conditions, it is also about eradicating poverty – we must rapidly ramp up our initiatives on universal health coverage," said World Bank Group President Dr. Jim Yong Kim. "Investment decisions in health, and more broadly in individuals, are vital for developing human resources and enabling balanced and sustainable economic development. However, the framework is damaged: we need a paradigm change in how we deploy assets for development and personal capital, particularly at the national level. We are operating on a variety of fronts to assist countries in spending ever more efficiently on patients, as well as to accelerate their move to universal health care."

There has been some positive news, however: According to the survey, the people who are willing to access key healthcare services like immunization and planning for a family, and also antiretroviral therapy for HIV and insecticide-treated vaccines to deter malaria, has increased in the twenty-first century.

Ninth, the results of Levene's analysis for collective efficacy are published, with negligible p-values (0.701), indicating that the private industry has greater differences among citizens in terms of collective efficacy than the government sector. A t-value of 1.112, df 197 has a substantial p-value of 0.000, indicating that public sector organizations will often serve as an early alert mechanism for problems that necessitate government policy approaches and the roots of proposals as to how to discuss such problems. They have this expertise due to their roles in service management as well as the fact that they represent organizations of individuals with knowledge and skills who worry about an issue.

Accomplishing health equality, or the best possible wellbeing for all residents, necessitates fixing the cultural, financial, and environmental deficits that disadvantaged populations face. To achieve the improvements in legislation, corporate policies, and social structures required eliminating population health inequalities, societal intervention is required. Supporting multistory transition necessitates teamwork, which is commonly described as the cooperation of several entities and/or organizations to achieve some kind of change in the system.

. Researchers are interested in assessing cooperation (or partnership function) in order to understand how to improve the recognition program of the alliance, and that there is proof that “collective efficacy” is a partial mediator in public healthcare outcomes. According to Bandura, self-efficacy is the confidence in one's abilities to act in order to achieve optimal outcomes, while collective efficacy is the widespread perception that a group's decisions can affect the future they want. Sampson et al. broadened the definition of collective efficacy from communities to neighborhoods, describing neighborhood collective efficacy as "social solidarity among neighbors coupled with their ability to act on favor of the greater good." Sampson's description was used.

Social networks and social trust are important for social stability. Social networks are characterized as vague relationships between individuals in community collective effectiveness. By putting together disjointed communities, social networks unite the society and create social capital. The presumption of reliable, truthful, and collaborative conduct between people in the community is referred to as social trust. Informal social management requires a collective's ability to intervene or work for the greater good. In collective effectiveness, social control is described as "the ability of a community to govern its representatives according to preferred values."

Neighborhood collective effectiveness research has its origins in sociology and crime, and research has found a clear correlation between low collective efficacy and higher community

crime levels. When contrasted to comparable populations with poor collective effectiveness, societies with greater collective efficacy have reduced levels of overweight, stress, and risk-taking habits, as well as lower rates of morbidity and mortality. Collective effectiveness has also been associated with improved community-level healthcare outcomes, wellness promoting attitudes, and attendance at the school. Aside from cities, the term has been studied with a variety of social systems, such as school systems, corporate associations, and sports teams.

Interventions that increase local or group mutual effectiveness to resolve health inequalities have been proposed and promoted. However, it is difficult to explain the definition as a subject of progress and a unit of measurement in intervention studies, and interventions to improve mutual effectiveness have not been well defined. Building social capital (which involves socialization, social linking, and social leveraging) has been shown in studies to improve social stability and ability to act/intervene, both of which are essential parts of mutual effectiveness. According to research, motivation (the willingness of groups to make decisions and turn those decisions into desirable outcomes) is a driver in the desire to interfere, which affects social effectiveness.

Civic participation has also been related to collective effectiveness, with more civically active people reporting greater concentrations of collective efficacy. Involvement events such as education, capacity building, and focus forums, as well as engaging members of the group in foundational studies, collaborative initiatives, volunteering, and activism, will help to increase social capital, political participation, and emotions of empowerment.

Nevertheless, these “foundations” of mutual effectiveness are analyzed and operationally defined differently by various researchers. An analysis of the literature examined collective efficacy as an aspect of psychosocial stress factors impacting community wellbeing, the degree to which overweight approaches address social networks and collective efficacy to achieve

improvement (very little), and the importance of network processes (including collective efficacy) in enhancing chronic disease prevention. There were, however, no studies that concentrated on initiatives targeted at reducing population health inequalities by first enhancing group effectiveness.

Focused on our analysis of the literature, we proposed a “mechanism of action” framework to explain how social capital (social networking, social bridging, and social consolidating), empowerment, and political participation can enhance an organization's social solidarity and ability to respond, which can contribute to better healthcare outcomes and decreases in health inequalities. Intervention practices (for example, capacity development, focus groups, and community projects) were classified according to the tier of the intended population (individual, organization, and community) and the mutual effectiveness key components (social capital, mobilization, and public engagement) they tackled.

CHAPTER 5

DISCUSSION AND FINDINGS

INDEPENDENT VARIABLE: LEADERSHIP AND SOCIO-ECONOMIC FACTORS

DIMENSION 1: KNOWLEDGE

The overall analysis shows minimal difference between both private and public hospitals but detailed interviews demonstrate that, the public sector healthcare workers are better in understanding and knowledge about their specific fields as compared to the private sector. There could be many possibilities of this but largely; they are more effective at problem solving due to their exposure and amount of work they have experienced. They have easy access to top hierarchy and can seek help from upper hierarchal doctors/specialist. Whereas in the private sector, doctors or other healthcare professionals face a little hurdles in problem solving as the clinics or other healthcare units This is due to the nature of the institute as people working in such hospitals have less exposure to patients and do not have established systems like public sector organizations.

The doctors and medical staff said that both sectors immediately act in response to any issue/problem, for instance, both sector use knowledge for innovations or updating technologies however, the public sector has edge in terms of funding; the public sector can avail funding and implement the solution. For making strategic plans public sector is comparatively less progressive due to the involvement of multiple actors which cause the policy making or strategic planning consume more time. Whereas policy making in private sector is quicker than the public because of sole ownership or involvement of a smaller number of actors. Organizational values can be refined by discussing the policies and philosophies with the management and sometimes through discussions with entire team weather medical or admin staff; this could be applicable in both the sectors. Further qualitative findings suggest that changes in the public organizations are always

made through a lengthy process and through numerous policy makers so coming to the common ground is usually delayed but in the private sector changes are comparatively easier to be made because authority resides in the hands of sole owner. Medical and health care experts are experiencing the fast changes in the technology and innovation so in this race of innovation both the public and private sector need to have trainings and knowledgeable seminars so that the doctors and the other staff are aware of the current need and usage of the changes in question, yet in the battle of technology and innovation, doctors need to have the required information and knowledge. In the health care industry, the correct information and knowledge about the problem would save numerous lives that can be acquired through trainings or seminars etc. Nonetheless, specialists and doctors need to make their choices according to that newly gained knowledge (e.g., "at what stage that medical procedure is and needs to be done next?" "Is this a matter to worry or not is it under control?" "What drug ought to be recommended?" and so on. Moreover doctors need to perform a complete screening of the data based on their knowledge and experience, and check whether this information is right as per patient condition.

In public sector of AJK, specialists and doctors require internal meetings and trainings sessions in order to have a detailed discussion over the patients' needs based on the updated knowledge but unfortunately this is contrary to the reality because doctors and staff remain busy with the patients because public sector hospitals are flooded with patient. For instance a specialist is always occupied in dealing with patients the private sector, on the other hands, have regular training sessions to bring innovations and new technologies. Without a doubt, the specialist in the public sector will be having a busy schedule of dealing with a huge number of people as the patient inflow is always higher in public as that of private instructed, and give recommendations or compose a remedy to the patient's problems.

According to the observations and discussion with the relevant stakeholders, in the public sector, the knowledge of every clinical expert or doctor is seen to be correlated with the knowledge and information of other specialist. As they have been seen sharing the valuable ideas to each other as to reach the best solution. With that knowledge, the specialists can make a more determined strategy and suggest a more compelling treatment plan.

However the outcomes of the survey and findings of the interviews being conducted portray that private sector is more inclined to roll out essential improvements because of the involvement of just few actors , and it is easy for the sole proprietor to be adaptable for making changes as he deems required Private sector is better able to make changes and arrangements because of flexible structure unlike a hierarchical structure in government that limits their actions and these endeavors are for the most part for their very own advantages as opposed to overall population.

The provision of improved Health and better healthcare services in AJK, can be accomplished by upgrading the significant and important knowledge-based trainings for educating the medical services staff, field staff and other administrative staff and informative sessions over the healthcare frameworks and how to improve the health of public.

DIMENSION 2: SKILLS

The discussions with doctors and medical staff show that the public sector, specialists and doctors are more effective to the detailed aspects of their work as there is proper channel through which all the doctors and other staff get promotions and seek the upper positions. Whereas in the private sector effectiveness in terms of detailed work are questionable because of the less interactions and discussions with the other staff as there are always less number of doctors as compared to the public sector. More the number of patients more will doctor get experience and ultimately skills will be improved. According to the findings the process of filling out forms and

workings with the detailed documentations is again a barrier in the public sector. As people wait in queues for their turn. Managing people and resources is one of the very dark side of public sector as people face a lot of hurdles in paperwork, their turns and reports and get examined. After facing all these barriers, and these cumbersome processes people tend to go the private sector clinics and hospitals. In private sector the requests and concerns of the people are answered and responded timely and in a respected manner as this include in the basic training of the private sector doctors. Public sector lacks skill of managing people and responding to their issues Allocating resources skill is also not easily doable because of the number of actors involved in the process whereas in the private sector allocating resources is not as problematic as in public sector because the decision taken by few shareholders. Obtaining resources for programs in term of funding is not easy in private sector so it has to rise funding on their own. But getting resources and funds is comparatively easier for the public sector but implementing the changes is not.

In private sector of AJK, the power of using authority had a tremendous effect on health system governance by empowering their staff to know about the changes, clarify why the changes are significant and tell the staff and doctors the best way to execute the authority and implement changes in their everyday schedules. There is one procedure to achieve a smooth progress in public sector of AJK to get effective health system governance is to provide doctors and other medical staff with the skills and abilities they need through training sessions. Subsequently these sessions will help them to prepare, oversee and put forward objectives and issues, and give beneficial considerations to colleagues and reach to the productive solutions. This uplifts proficient advancement for the whole group of doctors and medical staff, instead of only a couple of people in administration positions as in the public sector. In the public sector doctors and staff get exhausted by their everyday schedules and thorough rules that appear to block their productivity and urge to their contribution to the organization's prosperity.

In private sector of AJK emergency clinics, top faculty attempt to discover approaches to draw out the best in every single specialist/staff member and increase their degree of productivity. Significant skill to use power and authority can make a measureable deviation in understanding considerations about the patients and how every staff member evaluates their work. The patients will identify the sensitivities in their way when an association or hospital runs accurately and smoothly. In the public sector the workers are more independent, in this way permitting regulatory authorities to implement the decisions. These qualities in medical services activities and representative administration make an Aura that imparts certainty, trust and confidence in the patients and their relatives.

Delegating resources in the hands of workers and doctors normally establishes climate that empowers every individual to utilize their full capacity and skills. Confidence increases in light of the fact that the workers and medical staff have a feeling of pride in managing their responsibilities to the best of their skills and capacities while using authority. This has a positive impact on patients who are being treated with information, sympathy and benevolence. Taking in this fundamental power of management of responsibilities by doctors can have the effect in running a flourishing, fruitful medical clinic, specialist's office, hospital or other medical and health care unit.

DIMENSION 3: ABILITY

According to the interview findings, the private sector health care workers have an ability to actively control patients and people to act in a desired way whereas the public sector health workers lack such ability as the management of the patients in the public sector is difficult because of huge number of coming patients. Results also show that in the public sector the queries of the patients are also not listened properly and their opinion does not matter in the decisions of the higher authority. But in the private sector the ideas and opinions of the general public matters

as the organizational reputation depends upon the opinion of the people. So listening to the opinions and ideas of the people is also important for the profit maximization for the organization or hospital or clinic. Further findings show that the in private sector hospitals the proper caching for the staff and doctors and also for the patients how to be the part of organizational proceedings. The private sector act in way that they have ability to make others to follow their ways by becoming a role model for them and make them act in a desired way through better patient management. This makes the private health care workers to make others act in the desired way whereas the public sector works in different way, where these abilities to make others work are done by using the authority and power

In the public sector health governance works by acquiring the help of the public authorities, as this is the one best way to guarantee political will which discloses the reality of public sector that means that the public sector is bound to act according to the political will as it works for the general public and many steps get involved in the process as this is more coordinated towards the orders of upper hierarchal authorities. The private sector pays little focus to any political pressing factor. Private authorities have more assets, novel thoughts and procedures that uplift their association in a superior manner.

In AJK emergency clinics, numerous doctors in an association are reluctant to change, however when they persuaded or pushed to attempt to learn new abilities, they would definitely understand that change isn't generally troublesome. Essentially an inflexible organization that doesn't take into account any space for new changes such kind of organization does not live for long. The top medical staff have the abilities they have mastered, others can take help from them report back about any hurdles they experience. When the health care workers are ready to make positive differences, it will increase their urge to give others the creative thoughts and ideas based on the abilities they have gained from the top staff members ultimately increasing the

organizational value.

Legislature of AJK needs to provide their doctors and medical staff an opportunity to rehearse their abilities timely and frequently. They can do this by utilizing important and relatable medical services centered sessions. It's significant that health care workers get openness to the medical care clear circumstances they'll really look at work. Making choice by health care staff that can be adjusted to the necessities of the patients and extraordinary setting of the medical services association. The more critical and relatable the preparation by the health care workers, more certainly will doctors/workers be adapt to the changing environment.

DIMENSION 4: SOCIAL CONNECTEDNESS

Construct like social connectedness and social support vary in their relationship with healthcare relying upon people's encounters and insights, as private sector in AJK emergency clinics is generally more productive, and therapeutically viable than the public sector; as the public sector typically needs to have good manners and generosity towards patients. Longer awaited queues, filling necessities is unsolved for patients in the public sector. Social connectedness is a significant indicator of healthcare productivity and undertakes a fundamental part in the physical and emotional wellness of an individual.

The presence of a working healthcare center with a healthcare specialist, yield better healthcare results if there is enhanced social connectedness of the public sector as well as giving direct discreet considerations on the productive health services. Social connectedness and social support intercession may straightforwardly impact the overall social separation of a public sector occupants which means that if the people have social life with the positive interaction with the society and not living alone then the general health of that person will be better as compared to the person living alone. The social connectedness of the public sector is a significant standard that should be viewed as when assessing and arranging healthcare intercessions.

People with weak social connectedness by all accounts seem to be at more serious risk of health due to not participating in the full scope of health system governance and administrations than people with better social connectedness. Improvement in giving access to social contacts, an organization is now suggested for keeping good psychological well-being with the people. Findings show that the private sector hospitality is better than the public sector and this has a strong impact on the psychological health of the people. Public sector lacks the hospitality factor due to increased number of patients. These findings recommend that social connectedness in private sector of AJK private clinics or hospitals improve assurance of social support in a wide scope of health system governance, and thus improve utilization of the medical services by the general public in a way that the people interacting with each other increase the civic sense amongst them move towards better general health and improve healthcare reforms.

Social connections and social support impacts not just the outside world but also general imperceptible functions of the mind and body. Summing up the writing distributed somewhere in the 1970 and 1998, Seaman (2000) reasoned that profoundly socially coordinated people (as reflected in a more noteworthy number of ties with a life partner, dear companions and family members, alliance with strict and different gatherings) live essentially more than that of socially disconnected people. The people with less social support are at more at serious danger of healthcare and also are more expected to have life loss, for example, occurrence of infectious diseases and helpless recovery from infections. The negative impacts of social isolation are very disastrous but in the scale to the effects of perceived healthcare hazard issues like smoking and lethargy and are fundamentally free of social and hereditary danger factors in anticipating expansive based healthcare impacts.

These discoveries have accelerated new lines of examination that look at pathways by which social connectedness and social support work together to impact healthcare and prosperity.

Discernments and acceptance of social support, for example, have been appeared to add better health care results.

DIMENTION 5: INCOME INEQUALITY

Healthcare makes hopeful externalities for the people of society overall, just as the thought that without the existence of public sector, money only help just the rich part of the occupants who are capable to pay for sound medical care administrations. Lamiraud, et al. (2005). Social health care security and social support is a serious factor coordinating with reasonable amount of obstacles in the access to health care services. In the rural areas of AJK people with low income have no or little access to the transportation to reach to any healthcare unit. General public prefer to avail public sector health services so to avoid heavy amount of fee charges by the private doctors.

Within the community the people with the high income will prefer to seek the private sector health care service to avoid long queues and paperwork. While the public sector is for the people with low net income. Free or minimal charges for the basic checkup allows the poor segment of society to have access to the medical care. As long as the biasness in the access to the healthcare services are concerned it will remain because of the inflation in the country. And no such measures are taken to the equal opportunity for the rich and poor. But in the natural crises like COVID-19 the first steps for better general health is always taken by the public sector. The public sector compared to the private sector target not just a specific segment of society but the nation as whole by securing the nationwide health.

High level income clearly affects health to the extent that it generates the methods for getting the essential requirements for healthcare, like asylum, food, warmth and the capacity to take part in the public health units. Low pay, subsequently, expands people's openness to unsafe conditions, like deficient lodging, and diminishes a family's capacity to buy fundamental assets necessities

like a sound eating routine. The outcomes of poverty are weak nourishment, congestion, moist and deficiently warmed lodging, expanded risk of diseases and failure to keep up norms of cleanliness (Davey Smith, 1998).

Congested accommodation, for instance, is related with respiratory illnesses, and congestion is connected with more serious risk of fire and mishaps. Pay levels additionally influence the manner in which guardians can really focus on their own and their kids' healthcare (Blackburn, 1991). Just as influencing where individuals reside and where their kids go to class, living on a low pay makes it hard to practice authority over family health care, and subsequently the healthcare needs of guardians, especially ladies/mothers, are regularly destabilized comparative with those of their kids means that the children health is set priority the parents and ignore their own health. All things apart, deprivation reduces the capacity to practice decision over kids' eating schedule.

Where money is less and demands are more, families will purchase food sources that are high in calories however low in nourishment to fulfill their cravings (Leather, 1992). This adds to unhealthiness, elevated cholesterol, stoutness and tooth rot among youngsters. Moreover, the impact of constrained financial conditions in adolescence, including unhealthy eating routine, can gather for the duration of the existence course into adulthood and produce enduring expansions in the danger of circulatory illness generally known as coronary episode.

There are two types of events in any kind of healthcare decision that may occur as a component of the income and health care relationship. For example a person in chronic weakness condition probably is not able to earn. . Due to such incapability to work as well as medical affliction one loosens interest in the life.

Besides, somebody with sick and chronic weakness needs to take a less difficult or unpleasant work, which causes lower pay or wage. Consequently, not assessing healthcare determination

impacts may exaggerate the causal connection among income and health care.

DIMENSION 6: COLLECTIVE EFFICACY

In the private sector, doctors and staff have an opinion that if the people would work together in a community they will gain the better health conditions. But in the public sector the responsibility lies with the government. In private sector patients are treated well as by the collective efforts of all the staff and even the patients. But the public sector as the duty lies in the hands of public officials who are generally reluctant for adding any value to the better health care. Whereas the behavior of general public while obtaining any government services and entitlement will be highly active. Public sector point of views regarding health care are usually on the larger scale than private as they are dealing with the entire nation than a specific sector. With philosophical focus, capability and collective efficacy to occupants' opinions on the ground of private medical services sector of AJKs can usually take as an early notice framework for complexities that require public strategy reactions and establishments of thoughts regarding how to address those difficulties. Thus it is assumed collective efficacy has a strong impact on the strategy planning and implementing it.

By analyzing the findings it is concluded that a referenced doctor in private sector, have better assets, and all around prepared staff and workforce, is able treat patients well , with more accommodation than in public sector of AJK. Accomplishing healthcare value, the most significant level of healthcare for all individuals, requires focusing on the social, monetary, and ecological values experienced in their networks. Cultural level activity in health care is expected to recognize the advances in terms of updated knowledge and skills in law, authoritative arrangement, and social frameworks which then expected to lessen public sector healthcare variations.

To deal with sudden change requires joint effort, extensively characterized as the cooperating of numerous people or potentially associations to achieve some type of health care change. Examiners have shown progress in estimating coordinated effort (or alliance work), with an objective of figuring out how to build the collective efficacy of the cooperation and there is proof recommending that “collective efficacy " is an intervening factor in public sector healthcare results.

Collective efficacy is the confidence in one's capacity to act to create wanted health advancement for its own betterment. And also collective efficacy is the common conviction that activities by a gathering will impact the future they look for. Mediations to address healthcare incongruities by expanding neighborhood or public sector aggregate adequacy have been suggested and empowered. However, operationalizing of the collective efficacy as a focal point of progress and a unit of measure in and techniques to expand collective efficacy have not been all around represented.

The building of social capital (which incorporates social holding, social connecting, and social utilizing) can expand social union and readiness to act/intercede, that will acquire positive changes in the society which are key segments of collective efficacy. Strengthening (the networks to settle on decisions and change decisions into desired results) through engaging people by giving appropriate assets or rights so they assume their vital role in achieving the collective efficacy. Intercession exercises like schooling, preparing abilities, and gatherings, conversations influential examination, public sector projects, chipping in, and backing, can build social capital, municipal commitment, and sensations of approval.

DEPENDENT VARIABLE: EFFECTIVE HEALTH GOVERNANCE

DIMENSION 1: ACCOUNTABILITY

As per the findings, private sector health care workers raise the funds by themselves, and are profit oriented. By doing so private sector workers are held more accountable because a few mistakes could affect organizational value in the market. Private sector healthcare workers strongly rely on the public opinion by directly telling them what are the procedures being followed. The public sector of AJK clinics utilized well conscious and coordinated approaches and plans, endorsed through the approved cycles that are utilized to make individuals accountable to the government not the public yet on contrast private sector isn't tangled in any such political cycles and straightforwardly asks individuals to be accountable for their actions. In any case, private sector is more open towards ideas and creation and mirror the overall assessment of individuals that may benefit the private sector hospitals.

Furthermore, there are regular differences among public and private advantages and motivations, which can increase accountability (see Bennett et al. 1997). For instance, Shaw (1999) outlines contrasts among public and private sector health care providers as far as the degree to which they acknowledge and face influences to follow up on help client criticism and how the people react. The problems of execution of plans by public sector workers and sponsors protected from customer accountability but not from government accountability (for instance, Goetz and Gaventa 2001), just like the experiences opposing accountability plan for the private sector (see Bennett et al. 1997; Brugha and Zwi 1998).

Another difference of public versus private sectors emerges between policymakers on reassuring the degree of care for people as the public sector policy targets the public as whole but the policies in the private sector targets the specific group of people who can easily afford the high health care charges. And also differ in individual help for the clients or patients with an

interest in getting the greatest measure of care related to address their healthcare need. This difference can influence accountability improvement in that which can creates requests for accountability.

At the government level or public sector, accountability is coordinated towards allocated choices and the institutional plans to support assets are assigned suitably. At the specialist organization level, the accountability challenges happen among patient and doctors, and the home for accountability center around the nature of administration, proficient morals, and not the expenses. (Emmanuel and Emmanuel, 1996; Fuchs, 1996). Thirdly, institutional accountability regularly obliges or undermines workers to rise responsibility for each of the three purposes.

The inability of healthcare units to follow and make a report on financial plans, assortment of charges, drug supply inventories, ambulances and hardware, etc. limits opportunities for accountability for control and confirmation purposes. It brings about misuse in the healthcare system governance and can set ground for ignorance in accountability. Also, failure to practice oversight of office and expert sanctioning hampers efforts at accountability.

This accountability ignorance is incited by the trouble in isolating the commitments of different health care actors to accomplishing execution of accountability objectives. Numerous developing nations that have moved away from transcendently from public sector of medical care toward private sector models have fragile administrative limit, making it complicated to practice quality confirmation (see Standing and Bloom 2003).

Health care units that lacks in the capacity or ability to distinguish who works at cap, where they are at a given time, and what they are doing can't move toward considering staff accountable for execution. Protection subsidizes that can't develop an information base on expenses of care that can illuminate dealings with private suppliers can't utilize contracts as a compelling assent for either monetary or execution accountability.

The public sector of AJK attempts to conduct administration, oversight and accountability through execution of analytical and accountability systems. Advancement and execution of accountability designs like governance tools and series of events and execution of value adding instruments and conventions just as creating and connecting of medical staff through accountability to these structures both at public as well as at private level.

Limited working of different units of the healthcare staff on these agreements of accountability while keeping people held accountable will be a fundamental piece of the technique. Customer satisfaction, promotion and direction of the government officials and parliamentarians on the one side of accountability and request this creation at the public sector level will uphold the viable smoothing out of methodology of hospital management as a need plan in accomplishing the medical care objectives in AJK.

The current issue with accountability and health system governance uncovers various variables. According to the WHO (2013) first is dissatisfaction of people with healthcare governance in both developed and developing nations as the doctors and medical staff not held accountable for their actions. This dissatisfaction has lessened the value of health care units in the costs, quality affirmation, administrative access, and evenhanded dispersion of administrations. This ultimately damages the potency, monetary mismanage and debasement, and absence of responsiveness. Furthermore, accountability has grown on a serious level of significance in light of the fact that the size and nature of medical care units in both the public sector and private sectors. Accordingly both the sectors either public or private have critical ability to influence individuals' lives and prosperity. Also, healthcare systems establish a significant budgetary consumption in all nations, and legitimate representing the utilization of these assets is a high need. All healthcare system governance contains accountability connections of various sorts. Healthcare services, protection offices, public and private suppliers, assemblies, money services,

administrative organizations and administration office boards are completely related to one another in organizations of rheostat, oversight, participation and announcing. In any case, the accountability has the great impact on government decisions which helps these actors to analyze their work properly. For instance, public sector has a significant diverse accountability center from that of private health system governance and administrative organizations. The previous are keen on clear representing the utilization of citizen assets just as exhibiting accountability to their voting demographics.

. Healthcare service organization has a wide variety of responsibility concerns because the matter of concern is the health of people. In the health care event, the services are required to incorporate with paying suppliers to get the update of the work procedure. The healthcare service likewise has strategy obligation and subsequently has responsibility interests and pressing factors associated to general healthcare results and questions. As often as possible, it is the impression of unsuccessful or deficient accountability that outfits the catalyst for change. For instance, for public sector decentralization, changes are the need to initiate more grounded accountability linkages among residents, policymakers and specialist organizations. Hutchinson, et al. (1999

DIMENSION 2: TRANSPARENCY

At the point when it refers to the quality portion and transparency in health and medical care of private sector of AJK is limited to articulating arrangements as per the requirements that emerge with no political intervention which shows that the transparency in the public sector of AJK is not as per the need of society. Yet, then again public sector of AJK takes longer time frame and loads of obstacles to make and break any approach due to the involvement of numerous actors. Due to the involvement of these actors procedures gets complicated. Adequacy of healthcare relies upon the fast reaction to any need that emerges for example in the event of COVID approaches should have been changed and executed rapidly for the general strength of

country. According to the findings both the public and private sector have health service providers who formulate policies and plans, rules and regulations, procedures and standards on the basis of evidence about the effectiveness of health interventions and allocation of resources but these procedures are not as smooth as in the bookish world. Processes are not as smooth as they look like not as transparent as they are supposed to be, both for public and private sector. This lack of transparency arises from the appropriate resource allocation or may be the budget for health services could be more. And spending could be less. The policies are there but the implementation is not. General public is always in some kind of vacuum by not knowing the actual doing by the health care actors.

Transparency is a crucial element of good governance, and a method for identifying maltreatment of actions by the healthcare actors in the public sector as well as in the private sector. Ensuring transparency in medical and health services associations necessitates that concerned partners initially foster a typical comprehension of transparency, prior to choosing needs and methodologies for execution. By characterizing the data to be revealed, the onlooker, the discloser, and the methods for conveying data, associations can achieve agreement on what transparency means and how to execute it adequately. Lack of transparency is connected with disreputable strategies of cooperation that compel people energies to consider medical services governance precisely responsible. Public sector commitment is a frequently referred to component of operational medical and healthcare, tallying supporting case for sensible help access and program exercises, especially after moment (regularly outer) financing stops. It is e therefore associated with better health results; however the significance of such proof stays poor.

Transparency is a dynamic part of proficient and powerful health system governance. As worries about the nature of medical care in the AJK wait to develop and huge bosses investigate imaginative approaches to deal with their medical and healthcare benefits in a quickly evolving

climate, the requirement for extraordinarily improved transparency is broadly perceived for its capacity to encourage improved administration of the nature of the AJK health system governance.

The affirmation of medical and healthcare transparency is definitely not another wonder. Both private sector and public policymakers have looked to improve data accessible to buyers with respect to the general nature of care all through the medical and healthcare inventory network. In any case, disregarding long periods of exertion, the devices and data accessible in the market today miss the mark regarding what is required by the two patients and doctors the requirement for strong transparency is mounting.

DIMENSION 3: RESPONSIVENESS

According to the findings, in the public sector there is more responsive behavior as the government is obliged to respond to the public opinion because it works in the favor of public and responsible for the overall betterment of health rather than the profit maximization. Public pressure is one major factor that is being exerted on the government whereas in private sector there is no direct pressure of general public on private sector in terms of making their policies and strategic planning. In the private sector the people will never get a chance to intervene in the managerial process and get the insight of the internal proceedings

In the public sector the response of the public towards the actions of government is so impactful that the government is liable to conduct such programs where the health care activities could be molded accordingly. Although the situation is not as strong as it should be. Government sector is even more practically liable to the questions and problems faced by the general public. It is patent from all the above outcomes that in public sector of AJK with regards to the partners, public sector is enthusiastic towards considering every one of the partner’s desires and needs and furthermore thinks about the conclusions made by them and distributes resources as medical

equipment etc. appropriately. In any case, private sector of AJK is more about creating yield in a viable way. However, on big level government is reveled to make discussions for the overall population for their enquiries about health care which private sector do not focus because it is more oriented towards market not towards society at large. Patient association in treatment dynamic, improvement of the patients' entitlement to supporter decision and diminishing holding up time by re-sorting out HR, electronic arrangement framework and re-designing patients' confirmation cycle can prompt responsiveness.

For patients, health system governance responsiveness is a huge thought as the objective they can most promptly grasp. Because of an absence of master clinical information, patients don't normally comprehend their guess, the thinking behind clinical choices and the degree of healthcare results that ought not to out of the ordinary of specific health system governance. In that capacity, patients regularly can't quantify and don't completely consider the nature of healthcare results when making decisions on a health system governance exhibition. Notwithstanding, they can undoubtedly identify with the components of responsiveness, which they experience all through all parts of treatment. Since acquainting the idea of responsiveness, the WHO directed the Multi Country research Survey Study in 2000-2001 and the World Health Survey in 2002-2004 across a numeral nation, like Bangladesh, Sweden, and China.

Be that as it may, this has essentially centered in evolved nations, with generally minute work contemplating health care governance responsiveness in creating countries. Accessible writing proposes that a various component may decide how a given populace rates the responsiveness of the health care they get. These components incorporate the country in which the health care is passed on, the design of the health governance framework, the classification of therapy which is being obtained socio-segment qualities of the populace and the manner by which medical care is financed and passed on. This has suggestions while working on discoveries about

responsiveness that have been acquired from examines directed in other healthcare frameworks to the AJK system.

Although the idea is still at an underlying phase of improvement, responsiveness accepts parts of regard of basic liberties, for example, esteeming patient self-rule and respect, just as intuitive parts of care, like the nature of fundamental conveniences. The estimation of wellbeing framework responsiveness has generally been founded on overviews of client sees where respondents are approached to rate their latest experience of contact with healthcare administrations. There is no single commonly acknowledged hypothetical structure with which to straightforwardly manage examination to responsiveness of healthcare administration. Valentine et al. (2009), which finds responsiveness inside more extensive structures on, for example, the clinical consideration system (Donabedian 1973), admittance to mind (Aday and Andersen 1974), and utilization of care (e.g., Andersen 1995).

The good governance structure joins responsiveness to medical services access through the influence of nature of care on use decisions and examples. The structure of Valentine et al. (2009) has three wide parts: the climate; specialists characterizing need for care; and the interaction of care and resulting results. The principal components characterize the setting of administration through the attributes of government assistance arrangement, the design of the healthcare governance, and open assets. The subsequent factor portrays the job of clients and suppliers in characterizing the requirement for care and setting the setting for care for instance, through indicative cycles, dynamic, social traditions, and assumptions and patient inundation in choice for care. The last segment, which is to be discussed with the interaction of seeking after and getting care at the miniature (singular) level, means to the cycle of care and results experienced when an individual travels through the degrees of perceiving a healthcare need, choosing to seek after mind, mixing with the framework, and the inclusion of care obtained. Responsiveness is seen as a

proper result of the consideration of the interaction.

The initial two modules of the structure offer a helpful point of view in breaking down the impact of total nation level appearances on responsiveness. The segments draw significantly on crafted by Aday and Andersen (1974) in raising a hypothetical structure for the investigation of clinical consideration access. It continues then through the highlights of the healthcare services framework which is impacted by realistic assets and how these assets are utilized (additionally sees Andersen, Smedby, and Anderson 1970). The system at that point considers the attributes of the populace in danger covering medical care needs, the inclination of people to utilize administrations, and the methods people need to get to administrations (Andersen and Newman 1973). The end stage considers the results of the consideration interaction, by means of use of administrations (type, area, and reason for administration) and patient fulfillment (perspectives towards the clinical consideration arrangement of the individuals who have encountered contact).

By government explicit consideration is paid to the part of healthcare costs per capita. This has been broadly utilized as a determinant of healthcare frameworks' exhibition and has been appeared to have an idealistic relationship with responsiveness (World Health Organization 2000; Anderson and Hussey 2001) and is fearless by the hierarchical and political cycles inside nations. Be that as it may, responsiveness may not exclusively involve the degree of healthcare spending: while a few components of responsiveness are probably going to be exorbitant (e.g., nature of offices), different components are (e.g., respect and correspondence) and may require a reasonably augmented degree of preparing and mindfulness (World Health Organization 2000; Blendon, Kim, and Benson 2001). Also, as assigned by Azfar and Gurgur (2008), an increment in subsidizing for the healthcare area doesn't really prompt the arrangement of improved administrations where establishments neglect to work skillfully.

It has been proposed that medical care spending may differentially affect responsiveness

across nations it could be more prominent in more monetarily created nations because of an expanded accessibility of human resources and better created foundation (Valentine et al. 2003b, 2009). Other medical equipment that have been prescribed in structures on access raise to work and capital committed to medical services (Aday and Andersen 1974),, healthcare staff and devices and materials used in giving medical care. In any case, extensive data on these sorts of attributes is hard to find across different nations.

A few examinations have tried to clarify variety across nations in delivering medical services in a transparent manner (Epple and Romano 1996; Gouveia 1997), its redistributive effect (Besley and Coate 1991; Castro-Leal et al. 2000; Sahn and Younger 2000; O'Donnell et al. 2007), and the similar effectiveness of public versus private arrangement (Besley and Gouveia 1994; Hanson et al. 2008). Patouillard et al. (2007), Bennett et al. (2005), Brugha and Zwi (1998), and Angelopoulou, Kangis, and Babis (1998) have proposed that freely and openly financed medical services are attributed to higher specialized quality than secretly supported arrangement.

Since private sector is not generally finance by governments and relies on profit and personal earnings. Thus, the healthcare providers in private sector are more likely than public suppliers to live up to patients' desires about nontechnical parts of care (Andaleeb 2000). To examine variables of responsiveness, an evaluated subordinate variable model must be considered. (Lewis and Linzer 2005. These coefficients include data on the near degrees of responsiveness present across nations.

Summarizing the discussions on my findings and results, in the first variable ‘knowledge’, the public sector is held better than private. As discussed above the public sector doctors have the better understanding of their work as they are promoted through a long process and by going these processes, they gain lot knowledge accordingly. Also, they work with numerous other doctors, in this way the ratio of knowledge gain is higher comparative to the private sector. Private sector

hospitals or clinics are usually made by single owner or few groups of doctors, so their knowledge span is bit confined.

Though the public sector doctors are more knowledgeable but when it comes the ‘skills’ the pressure to maintain a clinic or hospital is always higher on private sector because they have to deal with the problems by themselves on external funds or help is provided to them as in public sector. So, improving the skills by regular training sessions in private sector is their basic proceeding.

As the private sector is more skilled in their proceedings their ‘Ability’ ratio gets automatically high compared to the public. They are capable to mold the people attractions towards the services they want them take by becoming their role model.

According to the discussion and findings, the accountability in the private sector is more than the public because the public sector policies are usually vague and also not shown to the general public, as there are complex and lengthy procedures that public sector needs to follow, Whereas the private sector directly gets effected by the general public criticism as they work on profit maximization

While talking about transparency, the private and public sector both acts in a way that the proceedings are transparent in a way that the hospitals and clinics are bound to operate in a clean way which claims that the no doubtful medical services need to be implemented in terms of medicines and equipment.

As both the sector are more or less equally responsive to the public, as the public is now getting aware of their rights and duties. They have a better know-how about the medical services. People nowadays exert lot of pressure on the medical unit in terms of how the unit executes their proceedings.

Social connectedness is one of the variables which implies on both sectors equally. It is more related to the society than that of the sector. More the people are socially connected to each other in productive way more will be they develop a civic sense and better health care reforms.

Further interviews show that the income inequality is result of inflation and people with more money could afford better health care than the people with low income. The public sector will be preferred by the people with less money than the private exceptions apart.

While collective efficacy directly comes from the civic sense and also from how much people are aware of the health care services. People seeking the private sector services are seemed to have more self or collective efficacy than people seeking public health care services.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Structure the above results and conversation; the exact discoveries are clear that private sector clinics are proposed at giving better medical services in terms of leadership and socio-economic factors to the patients and furthermore giving a positive part to bring down the public sector units. This approves the examination that private clinics in Azad Jammu and Kashmir are giving better nature of administrations and governance as the doctors of private sectors are more skilled and have better abilities to deal with the patients as the patient flow is comparatively low compared with public medical clinics (Mostafa, 2005). Likewise, the transparency and accountability is also of the private sector appears to be better than public sector in Azad Jammu and Kashmir (Andaleeb, 2000).

The low quality of healthcare services by the public sector is due to numerous factors as discussed like the low-income population prefers to go the public sector which makes it highly busy and stressful. Few more elements may include in the low-quality services of public sector: low government funding, absence of government interest in developing the new medical care projects however the skills to manage the new technology is there but the maintenance and the funds are always questionable. These components are influencing health system governance and of public and private hospitals of Azad Jammu & Kashmir in general.

In any case, an examination coordinated to quantify the effect of leadership and socioeconomic factors for successful health system governance in Azad Jammu and Kashmir detailed that public sector as contrast with private sector are very slight different. The public sector hospitals and medical units are situated in the city of Azad Jammu and Kashmir and having better availability as contrast with other private sector units. Private sector hospitals in Azad

Jammu and Kashmir are improving and developing day by day. As the private clinics need to rely on clients to run into the monetary requirements.

After effects of this investigation show that private sector is determined to solve the patient's troubles and creating themselves to strongly convey the medical services conveniences to their patients. From the outcomes bantered above likewise depict that in private sector hospitals every one of the people including clinicians, medical caretakers and auxiliary staff has the determination to convey care to their patients, giving accountable, transparent and responsive setting to both which are patients and their attendants. Every one of these endeavors including aggregate adequacy drove these private sector units towards steady improvement. Additionally, give unendingly nature of health system governance to their patients.

These variables are upsetting the health system governance of public sector units in view of clinicians, medical attendants and optional staff. Absence of responsiveness in public sector units showed a low responsive level to their duties. Additionally, it needs government authorities to advance the current health system technology and develop more emergency clinics to safeguard the medical services needs of individuals

6.1 Recommendations

The government should carefully allocate the available resources among the rural and urban population of AJ&K. The Government should take initiatives in the development of human resources like doctors, nurses, and well-trained lady health workers. The stakeholders and the Ministry participate in the process of planning to implementation of healthcare program to maintain the sustainability of the health policies. The health care providers either public or private to be trained in the use of modern technology, and policies to develop for E-health and promote development in the profession. Budget to be increased so that both sectors can become able to provide effective and efficient health to its population and achieve goals and expectations. The Government creates conditions whereby the people

have the opportunity to reach and maintain the highest attainable level of health. Above all health system providers of AJ&K should immediately translate its health policies into action to benefit the people by ensuring humanity, equity, accessibility, and disease alleviation. In the light of the findings of this paper, it can be fairly argued that AJ&K faces a lot of challenges in its health system. These challenges must be resolved in order to improve the existing health system so that the disadvantaged and vulnerable people can get better access to health care services. Moreover, Health cannot be separated from political, economic, social and human development contexts. The health system of AJ&K desperately needs a dynamic leadership, governance that is prepared to design and enforce evidence-based policies and programs and taking care of the system. Furthermore, the leader of the health system must have a strategic vision and determination to improve and strengthen both the public and private health sectors of the country. In addition, equity must be the overarching guiding principle underpinning the health systems.

6.2 Recommendations for Future Research

This current research is founded on the comparative analysis of private and public health system of Azad Jammu & Kashmir. The study used variables like leadership and socio-economic factors to check the impact on effective health governance at secondary level. Due to the time constraints the stud is only confined to the secondary level but in the future, it can be done on other health levels too. Also, cross- sectional studies can also be carried out where the implementation of health policy can be studied before and after the implementation.

References

1. Adam, T. et al. (2012). Evaluating health systems strengthening interventions in low-income and middle income countries: Are we asking the right questions? *Health Policy and Planning*. 27(4).
2. Balabanova, et al. (2013). Good health at low cost 25 years on: Lessons for the future of health systems strengthening. *Lancet*. 381 (9883): 2118-2133.
3. Ballard, M. et al. (2017). Supporting better evidence generation and use within social innovation in health in low- and middle-income countries: A qualitative study. *Plos One*. 12(1).
4. Berkman, L. et al. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine.* 51:843–857.
5. Brinkerhoff, D. (2003). Accountability and health systems: Overview, framework, and strategies. *Partners for Health Reform Plus.* Retrieved from: https://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf.
6. Brinkerhoff, D. et al. (2009). Good governance and health: Assessing progress in Rwanda. Twubakane. Decentralization and Health Program Rwanda. USAID. Retrieved from: http://www.intrahealth.org/~intrahea/files/media/good-governance-and-healthassessing-progress-in-rwanda/goodgovandhealth.pdf.
7. Britnell, M. et al. (2017). Through the looking glass: A practical path to improving healthcare through transparency. KPMG International. Retrieved from: https://home.kpmg/content/dam/kpmg/nz/pdf/April/through-the-looking-glass-healthcare-transparency-kpmg-nz.pdf.
8. Burrell, B. (2000). Team competencies questionnaire. Retrieved from http://web.mit.edu/10.26/www/Team-Building/Forms/leadership_competencies.html.
9. Calhoun, J. et al. (2008). Development of an inter-professional competency model for healthcare leadership. *Journal of Healthcare Management.* 53(6):375.
10. Chokshi, D. (2018). Income, Poverty, and Health Inequality. *JAMA Forum*. 319(13):1312-1313.
11. Counte, M. and Newman, J. (2000). Competency-based health services management education: Contemporary issues and emerging challenges. *The Journal of Health Administration Education.* 20(2):113-122.

12. Darrell, M. et al. (2017). Health governance capacity: Enhancing private sector investment in global health. The Brookings Private Sector Global Health R&D Project. Retrieved from:https://www.brookings.edu/wpcontent/uploads/2017/03/cti_20170329_health_governance_capacity.pdf.
13. Dodgson, R. et al. (2002). Discussion paper No. 1: Global health governance; a conceptual review. Centre on Global Change and Health, Department of Health and Development London School of Hygiene and Tropical Medicine and World Health Organization.
14. Foege, W. et al. (2005). Global health leadership and management (1st edition). *US: Jossey Bass Ltd.*
15. Fraser, M. et al. (2017). Public health leadership and management in the era of public health. *Journal of Public Health Management and Practice*. 23(1): 90-92.
16. Frenk, J. and Moon, S. (2013). Governance Challenges in Global Health. *The New England Journal of Medicine,* 42, 368-936.
17. Frieden, T. J. (2014). "Six components necessary for effective public health program implementation". *American Journal of Public Health.* 104(1): 17-22.
18. Garman, A. and Scribner, L. (2011). Leading for quality in healthcare: Development and validation of a competency model. *Journal of Healthcare Management.* 56(6):373.
19. Gertner, E. et al. (2010). Developing a culturally competent health network: A planning framework and guide/practitioner application. *Journal of Healthcare Management.* 55(3):190.
20. Gide, E. and Wu, M. (2005). A survey framework based on Neuman's research method in E-commerce study. *IEEE International Conference on Service Operations and Logistics, and Informatics.*
21. Graham, J. et al. (2003). Principles for good governance in the 21st century. Policy brief No.15. Ottawa, Canada: Institute on Governance Retrieved from http://iog.ca/publications/policy briefs.
22. Guo, K. and Anderson, D. (2005). The new health care paradigm: Roles and competencies of leaders in the service line management approach. *Leadership in Health Services.* 18(4):12-20.
23. Harris, M. and Bleakley, M. (1991). Competencies required of health service managers in the 1990s. *Australian Health Review.* 14(4):363-379.
24. Hintea, C., Cristina, M. and Țiclau, T. (2009). Leadership and management in the health care system: Leadership perception in Cluj County children's hospital. *Transylvanian Review of Administrative Sciences.* 5(27):89-104.

25. Iciaszczyk, N. (2016). Social connectedness, social support and the health of older adults: A comparison of immigrant and native-born Canadians. *Electronic Thesis and Dissertation Repository, 4042.* Retrieved from https://ir.lib.uwo.ca/etd/4042.
26. Joshi, A. and Moore, M. (2004). Institutionalized co-production: Unorthodox public service delivery in challenging environments. *Journal of Development Studies.* 40(4): 31–49.
27. Kaufmann, D. and Kraay, A. (2003). Governance and growth: Causality which way?—Evidence for the world, in brief. World Bank. http://www.worldbank.org/wbi/governance/govdata2001.html.
28. Kuhlmann et al. (2017). Women's and Health Workers' Voices in Open, Inclusive Communities and Effective Spaces (VOICES): Measuring Governance Outcomes in Reproductive and Maternal Health Programmes. *Special Issue: Themed Issue: "Women and Development"*, 35(2), 289-311
29. Leggat, S. (2007). Teaching and learning teamwork: Competency requirements for healthcare managers. *The Journal of Health Administration Education.* 24(2):135-149.
30. Liang, Z. and Howard, P. (2010). Competencies required by senior health executives in new South Wales, 1990-1999. *Australian Health Review.* 34(1):52-58.
31. Lockhart, W. and Backman, A. (2009). Health care management competencies: Identifying the GAPs. *Health Management Forum.* 22(2):30-37.
32. MacKinnon, N. et al. (2004). Management competencies for Canadian health executives: Views from the field. *Health Management Forum.* 17(4):15-20
33. Marrelli, A., Tondora, J. and Hoge, M. (2005). Strategies for developing competency models. *Administration and Policy in Mental Health and Mental Health Services Research.* 32(5):533-561.
34. Maureen, L. and Gunilla, P. (2009). Governance in health care delivery: Raising performance. *Policy Research,* Working paper no. WPS 5074.
35. Menyah K. (2013). Stewardship theory. *Encyclopedia of Corporate Social Responsibility.* Springer, Berlin, Heidelberg.
36. Mikkelsen-Lopez, I. et al. (2011). An approach to addressing governance from a health system framework perspective. *BMC International Health and Human Rights,* 11-13.
37. Mirzoev, T. and Kane, S. (2017). What is health systems responsiveness? Review of existing knowledge and proposed conceptual framework. *BMJ Global Health.* 2.
38. Multiyear Plan (2014-2018). Report by department of health AJK, Directorate of health department Muzafrrabad. Retrieved from http://epi.gov.pk/wp-content/uploads/2018/04/AJK.pdf.

39. Murray, CJ and Frenk, J (2000). A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*. 78(6): 717–31.
40. Neumann, W. (2005). *Social research methods: Qualitative and quantitative approaches (6th edition)*. Boston, MA: Allyn and Bacon.
41. Northouse, P. (2011). Introduction to leadership: Concepts and practice. *2nd Edition, Sage*.
42. Olveira, G. et al. (2003). Hospital discharge records under-report the prevalence of diabetes in inpatients. *Diabetes Research and Clinical Practice,* 59 (2), 145-151.
43. Prahalad, C. and Hamel, G. (1990). The core competence of the corporation. *Havard Business Review*. 68(3):79-91.
44. Punch, K. (2005). *Introduction to social research quantitative and qualitative approaches (2nd edition).* Sage, UK.
45. Saltman, RB and Ferroussier-Davis, O. (2000). The concept of stewardship in health policy. Geneva. *Bulletin of the World Health Organization.* 78(6): 732–9.
46. Sheikh, B. (n.d). The district health system: A challenge that remains. Retrieved from: https://www.researchgate.net/publication/7562976_The_district_health_system_A_Challange_that_remains.
47. Shewchuk, R., O'Connor, S. and Fine, D. (2005). Building an understanding of the competencies needed for health administration practice. *Journal of Healthcare Management.* 50(1):32-347.
48. Shrum, W. (2001). Science and development. *International Encyclopedia of the Social and Behavioral Sciences,* 13607-13610.
49. Siddiqia, S. et al. (2009). Framework for assessing governance of the health system in developing countries: Gateway to good governance. *Health Policy*. 90(1): 13–25.
50. Stafford, M. et al. (2018). Social connectedness and engagement in preventive health services: An analysis of data from a prospective cohort study. *Lancet Public Health.* 3(9): 438–446
51. Stefl, M. (2008). Common competencies for all healthcare managers: The healthcare leadership alliance model. *Journal of Healthcare Management.* 53(6):360.
52. Tasa, K. Taggar, S. and Seijts, G. (2007). The development of collective efficacy in teams: A multilevel and longitudinal perspective. *Journal of Applied Psychology*. 92(1): 17–27.
53. Thiel, S. (2014). Research methods in public administration and public management: An introduction (1st Edition). London Routledge.

54. Thomas, E. and Magilvy, J. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, 16, 151–155.
55. Travis, P. et al. (2001). Towards better stewardship: Concepts and critical issues. Geneva: World Health Organization. Retrieved from: http://www.who.int/healthinfo/paper48.pdf.
56. Umberson, D. (1992). Gender, marital status and the social control of health behavior. *Social Science & Medicine.* 34: 907–917.
57. Veenstra, G. (2002). Social, capital and health (plus wealth, income inequality and regional health governance). *Social Science and Medicine*, 54, 849–846.
58. Vriesendorp, et al. (2010). Enhancing leadership and governance competencies to strengthen health systems in Nigeria: Assessment of organizational human resources development. *Healthcare Policy*, 7(3), 73-84.
59. Wajid, G. et al. (2002). Prospects, prerequisites and challenges for developing a healthcare quality improvement strategy for Pakistani healthcare system. Pakistan's Seventh International Convention on Quality Improvement (ICQI'2002). Retrieved from: https://piqc.edu.pk/casestudies/Dr_Gohar_Wajid_Healthcare_Quality_Improvement_in_Pakistani_Hospitals_TQM_Case_Study_PIQC.pdf.
60. Wallick, W. and Stager, K. (2002). Healthcare managers' roles, competencies, and outputs in organizational performance improvement/practitioner response. *Journal of Healthcare Management.* 47(6):390.
61. Weil, D. (2005). Accounting for the effect of health on economic growth. Working Paper 11455, *NBER working paper series*. 1–60.
62. World Health Organization (2004). A glossary of terms for community health care and services. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/68896/WHO_WKC_Tech.Ser._04.2.pdf?sequence=1.
63. World Health Organization (2007). Everybody business: Strengthening health systems to improve health system to improve health outcomes: WHO's framework for action. Retrieved from: http://www.who.int/healthsystems/strategy/everybodys_business.pdf.
64. World Health Organization (2010). Report on leadership and governance. Retrieved from https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_section6_web.pdf.

65. World Health Organization (2014). Governance for health in the 21st century. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf.

66. World Health Organization (2019). Economic and social impacts and benefits of health systems. Retrieved from http://www.euro.who.int/___data/assets/pdf_file/0006/395718/Economic-Social-Impact-Health-FINAL.pdf?ua=1.

67. Yamey, G. (2012). What are the barriers to scaling up health interventions in low- and middle-income countries? A qualitative study of academic leaders in implementation science. *Globalization and Health*. 8(1): 1.

68. Yin, R.K. (2003). Case study research: Design and methods. *3rd Edition, Sage, Thousand Oaks.*

Interview guide

Name of the organization:_____ Interviewee's position:_____

Department:_____ Date:_____

The topic of my research is 'comparative analysis of public and private health system governance at secondary level; A case study of AJK.' This research seeks to explore the following questions.

1: How leadership impact the effectiveness of health system governance?

2: How socio economic factors raise the overall health of general public?

3: Which sector (public and private) hospitals are more effective?

Module 1: Impact of leadership on effectiveness of health system governance		
Indicators	Follow up questions	Specific questions
Knowledge skills and abilities of the leaders	Do you make strategic plans for the hospitals?	1. Do your abilities help you to solve the problems? 2. Does managing resources come easier for you? 3. Are you open to ideas?

Module 2: Impact of Socio economic factors on health system governance		
Indicators	Follow up questions	Specific questions
Social connectedness, income inequality and collective efficacy	Do people in your community could work together to improve how patients are treated at the health facility?	1. Do you think residents have equal access to resources, services and opportunities within the community? 2. Is social connectedness and social support associated with the health of individuals?

Module 3: Which sector (public and private) hospitals are more effective		
Indicators	Follow up questions	Specific questions
Accountability, responsiveness and transparency	Do you think government and health provider organizations regularly organize forums to take ideas from people?	1. Do you think health service providers formulate policies, plans, regulations, procedures and standards on the basis of need? 2. Do you think people are able to make hospitals and doctors accountable?

QUESTIONNAIRE

Instructions to complete the questionnaire:

i. Please do not write your name and organization's name.
ii. Please fill all the questions and do not leave anything blank.
iii. The questions are in two general formats (Appendix A & B).
iv. One format requires to circle a choice, for example:

Married	(Single)	Others

v. The second format is based on different scales to select the option, for example:

Strongly Disagree	Disagree	Neutral	Agree		Strongly Agree		
1	2	3	4		5		
1. Honesty is the best policy.			**1**	**2**	**3**	**4**	(5)

If you are strongly agreed with the above statement you would circle number 5.

Appendix A

The following information is concerned about your position and other personal information. Please encircle the appropriate one.

1. Gender	Male	Female	Others		
2. Age	20-29	30-39	40-49	50-59	60 & Above
3. Sector	Private	Public	Others		
4. Designation	CEO	Doctors	Admin	Medical Staff	
5. Work Experience	1-5	6-10	11-15	16-20	21 & Above

Appendix B

Strongly Disagree	**SD**
Disagree	**D**
Neutral	**N**
Agree	**A**
Strongly Agree	**SA**

KNOWLEDGE						
Statements		**SD**	**D**	**N**	**A**	**SA**
K1	I am effective at problem solving.					
K2	When problems arise, I immediately address them.					
K3	Seeing the big picture comes easily for me.					
K4	Making strategic plans for my company appeals to me.					
K5	I enjoy discussing organizational values and philosophy.					
K6	I am flexible about making changes in our organization.					
SKILLS						
S1	I am effective with the detailed aspects of my work.					
S2	Filling out forms and working with details comes easily for me.					
S3	Managing people and resources is one of my strengths.					
S4	In my work, I enjoy responding to people's requests and concerns.					
S5	Obtaining and allocating resources is a challenging aspect of my job.					
S6	I am effective at obtaining resources to support our programs.					
ABILITY						
A1	Actively attempts to sway others through direct commands to act in a desired way.					
A2	Open to other ideas and listens actively to others before directing them to act in a desired way.					
A3	Coaches others in desired ways to act.					
A4	Influences others by acting in desired way themselves and delegates work in an organized manner which allows others to act in a desired way.					
ACCOUNTABILITY						
ACC 1	Is able to establish commitment through directly telling people what to do.					
ACC 2	Listens to others ideas and then directs members to be accountable.					
ACC 3	Use well organized action plans and delegates tasks through collaboration and situational management to make people accountable.					
TRANSPARENCY						
T1	Health service providers formulate policies, plans, regulations, procedures and standards on the basis of evidence about the effectiveness of health interventions and allocation of resources.					

T2	Health service providers make decisions about resource allocation for health services on the basis of evidence regarding needs and effectiveness of services and in conformity with policies.					
T3	Service providers regularly review and update the mix of services they deliver on the basis of evidence about the effectiveness of health services, client needs and health problems.					
T4	Protocols, standards, and codes of conduct, including certification procedures for training institutions, health service facilities, and health providers, have been developed for all actors involved in health services delivery and have been widely disseminated.					
RESPONSIVENESS						
R1	Structures and procedures exist to allow/encourage the public, technical experts and local communities to review and comment upon health priorities, resource allocation decisions and service quality during government strategic planning processes.					
R2	Government and health provider organizations regularly organize forums to solicit input/views/ideas from the public and concerned stakeholders about priorities, services and resources.					
R3	The public or concerned stakeholders have regular opportunities to meet with management of health service organizations to raise issues about service efficiency or quality.					
SOCIAL CONNECTEDNESS						
SC1	Is social connectedness and social support associated with the health of individuals?					
SC2	Do these constructs differ in their associations with health depending on individuals' experiences and perceptions?					
INCOME INEQUALITIES						
II1	Minimizing inequalities/disparities in responsiveness (the health system is equally responsive to all people, no matter their wealth, social status, sex, age or religious or other beliefs).					
II2	Residents have equal access to resources, services and opportunities within the community.					
II3	Procedures/systems exist to reduce/eliminate/control bias and inequity in accessing health services.					
COLLECTIVE EFFICACY						
CE1	People in your community could work together to improve health services in this community.					

CE2	People in your community could work together to improve how patients are treated at the health facility.					
CE3	People in your community could work together to obtain government services and entitlements.					