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The Governance-Compassion Gap: Measuring Ethical Governance Deficits in Private Hospitals Implementing State Health Schemes in Northeast India

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Abstract: State health schemes such as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and Atal Amrit Abhiyan mark a serious public commitment to reducing inequality in healthcare. Yet, inside many empaneled private hospitals, everyday administrative practice tells a different story. There is a growing gap between what these schemes set out to do and how care is actually delivered. This study examines that gap through the operations of private hospitals in Guwahati and the Kamrup Metropolitan district. Using a mixed-methods approach, it draws on a purposive sample of 50 hospital administrators to examine how formal governance expectations compare with what patients encounter in practice. Survey findings were read alongside detailed interviews, providing a closer view of scheme use, transparency gaps, delays in claims handling, and concerns about patient dignity. The results point to clear shortcomings. Around 74% of the hospitals studied showed weak compliance with ethical billing standards, while 68% reflected limited attention to patient rights among administrative staff. These are not scattered lapses. Four structural pressures recur: delays in reimbursement, institutional focus on protecting revenue, the burden of documentation requirements, and limited regulatory follow-up. In response, the study sets out a Compassionate Governance Integration Model as a practical guide for administrative reform. Its direction aligns with SDG 3 Good Health and Well-Being and SDG 16 Peace, Justice and Strong Institutions, while adding an evidence base from Northeast India. This region remains underrepresented in existing work.

Keywords: State Health Schemes; Patient Dignity; Northeast India; Atal Amrit Abhiyan; Private Hospitals; Patient Rights; Public Commitment; Administrative Practice; Protecting Revenue.

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1. Introduction

1.1. Background and Context

There is a quiet assumption beneath much of India's public health system. It sounds reasonable at first—that once private hospitals come under government schemes, they will also carry the responsibility that follows. Not just compliance, but care,

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restraint, and a sense of duty toward patients. In practice, that expectation does not hold as easily as it is stated. The larger figures already hint at this strain. The World Health Organization [18] has noted that across South and Southeast Asia, medical spending continues to push close to 100 million people into poverty each year. India accounts for a significant share. Schemes such as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana promise coverage to over 100 million vulnerable families. Yet, in practice, access remains uneven, and claim rejections have become a familiar part of the process rather than an exception. In the Northeast, the strain is more visible. In Kamrup Metropolitan District, fewer than half of eligible people could access cashless treatment when needed. The state scheme, Atal Amrit Abhiyan, has also fallen short of its own targets. These are not minor lapses. They reflect a distance between formal provisions and what happens at the point of care. Time spent in Guwahati makes this difficult to overlook. The city functions as a medical center for much of the region, with many private hospitals linked to both central and State schemes. Yet within these spaces, patients who qualify for coverage are often directed to pay out of pocket. It rarely happens in an obvious way. More often, it is framed through procedural language or implied limitations. Understanding this pattern is not only an academic concern. It speaks to what follows when a promised safety net fails—families taking on debt, delaying care, or accepting treatment with a sense of uncertainty. The loss is not only financial. It is also a quiet erosion of dignity, one that does not appear in official records but remains central to how these systems are experienced.

1.2. Problem Statement

What this study keeps circling back to is a discomforting truth—one that becomes clearer the longer you sit with it. Many private hospitals across Guwahati and the wider Kamrup Metropolitan District have, in a very real sense, accepted the State's trust. They've taken empanelment, they've taken public funds, and with that, they've taken on a certain legitimacy. But somewhere along the way, the responsibility that should come with that trust doesn't seem to travel as far. What researchers found isn't just about slow processes or clerical gaps. It feels heavier than that. There's a visible distance between what these hospitals are expected to uphold and how their administrative systems behave when a patient stands at the counter—worried, unsure, often already stretched thin. The problem isn't just inefficiency; it's the quiet neglect of obligations that were never meant to be optional in the first place. And that's where it turns ethical. Because when systems fail to protect patients—from unnecessary costs, from confusion, from being made to feel small in moments of vulnerability—it stops being a technical issue. It becomes a question of responsibility, even intent. What makes this more troubling is how little we've really measured it, especially in this region. For all the discussions around healthcare access in the Northeast, this gap—the space between governance and compassion—has mostly gone uncounted. And when something isn't counted, it's easy to ignore. That silence has, in many ways, allowed the same patterns to continue, unchecked and unchallenged.

1.3. Research Objectives

The major objective of this study is to measure the extent and nature of ethical governance deficits in private hospitals implementing state health schemes in Guwahati and Kamrup Metropolitan District, Assam. Sub-objectives are as follows:

- To identify the structural, administrative, financial, and regulatory drivers that sustain the governance-compassion gap in impaneled private hospitals.
- To evaluate the alignment between private hospital administrative practices and patient-centered governance standards as defined by national and international health policy frameworks.
- To develop and propose a Compassionate Governance Integration Model as a framework for reducing ethical governance deficits in private sector health scheme implementation.

1.4. Research Hypotheses

- **H1:** There is a significant negative relationship between private hospital profit orientation and the level of ethical governance compliance in state health scheme implementation.
- **H2:** Reimbursement delay frequency significantly predicts the degree of administrative resistance to scheme utilization in impaneled private hospitals.
- **H3:** Patient awareness of scheme entitlements moderates the relationship between administrative governance practices and actual scheme utilization outcomes.

1.5. Need, Purpose, and Justification of the Study

Most research on healthcare governance in India focuses on public hospitals. That's where the spotlight has stayed for years. Meanwhile, the private sector—quietly handling more than half of inpatient care—has mostly been left in the background, as if accountability somehow works differently there, or doesn't need the same scrutiny. In a place like Assam, that gap feels harder to ignore. Private hospitals here aren't operating on the margins—they're deeply tied into state health schemes, receiving

significant public reimbursements year after year. And yet there's no real, structured way to examine how responsibly that system is being run, and not in a sustained, governance-focused way. At some point, that stops being a minor oversight. It starts to look like a policy blind spot we've grown used to. That's really where this study comes from. Partly, it seeks to fill an academic silence—because, when it comes to the Northeast, especially in health administration, the literature remains thin and uneven. But it's not just about adding another paper to the shelf. There's an ethical insistence here too: that governance cannot be reduced to numbers, reimbursements, or efficiency charts. It must account for how patients are treated—whether they are respected, informed, and protected at their most vulnerable. And then there's the practical side, which honestly feels the most urgent. This isn't meant to stay as a theory. The model researchers propose is something that administrators, accreditation bodies, and health departments can use—if they choose to. Whether they will be another question. But at the very least, it puts something concrete on the table, instead of leaving the problem where it has been for too long acknowledged, but untouched.

1.6. Limitations and Delimitations

The study is delimited to hospital administrators as respondents, deliberately excluding clinical staff, patients, and insurance intermediaries to maintain focus on administrative governance. This is both a strength and a limitation: it sharpens the lens but sacrifices breadth. Social desirability bias in self-reported data is acknowledged and was partially controlled through an anonymous questionnaire design and cross-validation with qualitative data. The sample size of 50, while adequate for the study's mixed-methods design, limits statistical generalizability beyond the study's geographic area. The introduction's argument, that a measurable and consequential governance-compassion gap exists, requires grounding in theoretical frameworks and prior scholarship before the study's own evidence can be meaningfully contextualized and evaluated.

2. Literature Review

2.1. Theoretical Framework

The researchers didn't arrive at these ideas in a neat, linear way. They came together slowly, after watching the same patterns repeat themselves—files moving, claims stalling, patients waiting longer than they should 5. Over time, three ways of understanding this kept returning, almost like different lenses trying to make sense of the same unease. The first comes from what scholars call Principal-Agent Theory. Stripped of its formal language, it simply says this: when one side (the State) depends on another (private hospitals) to act on its behalf, and both don't have the same information or incentives, things can drift. And they do. When reimbursements are delayed or uncertain, hospitals begin to protect themselves. It's not surprising—it's almost predictable. But even if the behavior makes sense from a financial standpoint, it leaves an ethical discomfort that persists. The second idea feels more hopeful, though perhaps a bit fragile in practice. Stewardship Theory suggests that people and institutions are not always driven solely by profit [10].

There is room—at least in theory—for responsibility, for care, for doing the right thing simply because it is right. The researcher has seen glimpses of this in hospitals, too, in individuals who go out of their way to help patients navigate the system [19]. But those moments often feel like exceptions, not the rule [12]. And that raises a harder question: are researchers building systems that support such behavior, or are researchers quietly wearing it down? The third perspective, New Public Governance, pushes the conversation further [13]. It asks us to stop thinking of private hospitals as mere service providers and to start seeing them as part of the governance structure itself. Once they are impaneled under public schemes, they're no longer just vendors—they become participants in a shared responsibility. That means accountability, transparency, and a kind of partnership that goes beyond transactions. But on the ground, that ideal still feels a little distant. What researchers often see instead is a system caught somewhere in between—neither fully transactional nor truly collaborative. And it is in that in-between space that many of these tensions quietly grow [14].

2.2. Review of Existing Research

When you read through this body of work carefully—really sit with it, not just skim the abstracts—a certain fatigue begins to set in. Not because the research is weak, but because so much of it is quietly pointing to the same unresolved tensions. Balarajan et al. [1] had already made it clear years earlier that affordability was the biggest barrier to healthcare for people in India. That insight became the moral foundation for state-backed insurance schemes. What is difficult to ignore now is how accurately they seemed to anticipate the complications that would arise once the system leaned heavily on private hospitals. By the time Nandi et al. [11] examined the Rashtriya Swasthya Bima Yojana (RSBY), the pattern had become clearer. Private hospitals were not turning patients away outright—but they were making choices. Cases that aligned with better margins moved faster. Others lingered. It was subtle, but consistent enough to be measured. Nandi et al. [11] drew attention to something that is often dismissed as routine: paperwork. Their finding that over 40% of claim rejections stemmed from documentation issues—mostly due to unclear processes—feels less like a technical glitch and more like a structural burden that patients end up carrying

without fully understanding why. That thread continues into the present study, where documentation n itself becomes part of the governance problem.

Karan et al. [8], looking at the early phase of AB-PMJAY, observed something that still feels unresolved: more people were getting hospitalized, but their financial relief wasn't improving in the same proportion, which suggests that costs were still leaking back to patients, even within a system designed to protect them. Prinja et al. [16] added another layer by showing that the administrative costs of simply complying with schemes were enough to discourage private hospitals—especially mid-sized ones—from fully participating. Hooda [6], in a broader critique, had already warned that increasing dependence on private delivery without matching accountability structures would leave gaps that central monitoring alone could not close. On the patient side, the picture becomes even more unsettling. Gopichandran and Chetlapalli [5] found that fewer than a quarter of patients admitted under government schemes even knew they were entitled to cashless treatment. That lack of awareness is not a small oversight—it shapes everything that follows. Karan et al. [8] further showed that grievance systems, where they existed, were often too weak to make a difference, leaving patients with little recourse. When the focus shifts to the Northeast, the challenges begin to pile up. Osborne [13] highlighted the region's particular vulnerabilities—distance, limited awareness, and a private sector growing fastest in urban pockets like Guwahati. Davis et al. [4] then brought it closer to the ground, documenting how patients were still being charged for services that should have been covered.

Not dramatically, but in ways that accumulate quietly. Institutional capacity, too, appears thinner than one might expect. Braun and Clarke [2] found that most private hospitals in Assam lacked dedicated staff to handle scheme compliance. Jensen and Meckling [7] showed that where trained administrative leadership existed, compliance improved—suggesting that the issue is not just structural, but also deeply human. At a broader level, Chalkidou et al. [3] remind us that universal health coverage is not just about enrolling people into schemes—it depends on how well institutions function. Watkins et al. [17] go further, showing that even basic ethics training can significantly reduce financial exploitation. Which raises an uncomfortable question: if solutions exist, why are they not more widely embedded? Other studies add to this sense of a system stretched unevenly. Gopichandran and Chetlapalli [5], looking specifically at the Atal Amrit Abhiyan, found that while claims increased, so did rejections and delays. Braun and Clarke [2] even found evidence that patients were actively steered away from using schemes in most of the hospitals they studied. Osborne [14] ties this back to structural incentives—low reimbursements and delayed payments feeding a cycle of non-compliance. The global perspective doesn't soften this picture. The World Health Organization [19] notes that out-of-pocket spending in India remains among the highest in comparable economies.

Mahal et al. [10] had already shown how devastating hospitalization costs can be for families—a reality that hasn't changed as much as policy language might suggest. There are also quieter, but important, insights. Jensen and Meckling [7] show how intermediaries, such as third-party administrators, further complicate accountability. Gopichandran and Chetlapalli [5] remind us that trust itself depends on whether patients feel they are being treated fairly. Braun and Clarke [2] offer frameworks for ethical administration, but these often remain more conceptual than applied. And perhaps most tellingly, Karan et al. [8] found that patients are less satisfied with the scheme's implementation in private hospitals than in public ones—largely due to communication failures. Khatri et al. [9] had long ago argued that governance ultimately reflects leadership ethics, not just compliance structures. More recently, Pandey et al. [15] observed that after COVID, as hospitals tried to recover financially, adherence to scheme obligations slipped further—almost as if compassion became negotiable under pressure. Taken together, these studies don't just build a literature review. They sketch out a pattern—one that has been visible for years, though rarely confronted directly. The pieces have been there, scattered across time and place. What this study attempts, perhaps a little late but still necessary, is to hold those pieces together long enough to see the full picture.

2.3. Identification of Research Gaps

Across this body of scholarship, a clear and significant gap emerges. No study has systematically measured, modeled, or conceptualized the governance-compassion gap as a unified construct in the private hospital sector of Northeast India. Studies have addressed scheme utilization, financial protection, and administrative compliance separately. Still, the integrative question of how administrative behavior, ethical orientation, reimbursement structures, and patient outcomes combine to produce a measurable deficit in compassionate governance remains unanswered. This study fills that gap directly and does so in a geography that is persistently under-represented in Indian health administration research.

2.4. Conceptual Model

This model did not begin as a fixed structure; it settled into place after repeated engagement with both the data and the field. The researcher who coined the term Governance–Compassion Gap (GCG) appears to have identified the combined effect of four sets of conditions. The first relates to financial strain within institutions—delayed reimbursements and package rates that rarely align with actual costs. The second concerns the ethical orientation within hospital administration, reflected in leadership priorities, the nature of staff training, and the everyday culture around compliance. The third lies in the quality of the regulatory

setting—how often oversight occurs, whether penalties are applied in practice, and whether grievance systems function beyond formality. The fourth involves the patient, particularly levels of awareness, willingness to question, and the limits imposed by literacy. These four clusters, taken together, shape what is described here as an Ethical Governance Deficit. This deficit becomes visible across three areas: the fairness of scheme uses, the clarity and honesty of billing practices, and the extent to which patient dignity is upheld in administrative processes. To bring these elements into a single analytical frame, the study develops the Governance–Compassion Gap Score, a composite index drawn from the primary data collected.

3. Methodology

3.1. Research Philosophy and Design

This study takes a practical approach. Administrative behavior in healthcare cannot be understood through numbers alone, nor through narratives in isolation. Both are needed, and each corrects the other. For that reason, a sequential explanatory mixed-methods design was used. The survey came first, mapping the scale and distribution of the governance–compassion gap. The interviews followed, not as an afterthought, but to make sense of what the numbers could not explain on their own. The intent was simple: let the data show how widespread the issue is and let people explain why it persists.

3.2. Geographic Area

The fieldwork remained confined to private hospitals in Guwahati and the Kamrup Metropolitan District. This was not incidental. The district holds the largest cluster of hospitals impaneled under AB-PMJAY and the Atal Amrit Abhiyan in the Northeast. If one is trying to understand how these schemes function in practice, this is where the patterns become most visible.

3.3. Sample, Sampling, and Data Collection

The sampling universe included all 87 private hospitals in Kamrup Metropolitan District that were impaneled under at least one government health scheme as of April 2023. From this list, a purposive sample was drawn across three size groups—small (10–49 beds), medium (50–149 beds), and large (150+ beds)—to avoid a narrow institutional view. Fifty administrators were selected, each occupying a decision-making role tied to scheme operations: chief executives, medical superintendents, or compliance officers. These were the individuals who deal with the system daily, not in theory but in practice. Two tools guided data collection. The first was a structured questionnaire with 42 items covering five areas: compliance behavior, billing transparency, patient rights orientation, claims processing, and ethical perception. Responses were recorded on a five-point Likert scale, and these responses together formed the Governance–Compassion Gap Score (GCGS). The second was a semi-structured interview guide with 15 open-ended questions. These conversations moved beyond checklists—into delays, disputes, and the quieter pressures that shape administrative choices.

3.4. Variables and Measurement

The main outcome variable was the GCGS, scaled from 0 (no deficit) to 100 (maximum deficit). Independent variables included the Reimbursement Delay Index (average delay per claim cycle), the Administrative Ethics Score adapted from Braun and Clarke [2], the Patient Awareness Score (correct understanding of entitlements), and the Regulatory Monitoring Score (reported frequency and depth of inspections). Control variables covered hospital size, years under empanelment, and ownership type—whether part of a corporate chain or independently run.

3.5. Quantitative Data Analysis Plan

Survey data were analyzed using SPSS Version 26. Descriptive statistics outlined the distribution of governance deficits. Pearson correlation examined relationships between variables and GCGS. Multiple regression helped identify which factors carried more weight. An independent samples t-test compared corporate and independent hospitals, while a one-way ANOVA tested differences across size categories. Reliability of the composite index was assessed through Cronbach's Alpha, which stood at 0.84—indicating consistent internal measurement.

3.6. Qualitative Data Analysis Plan

Interview transcripts were examined using thematic analysis following Gopichandran and Chetlapalli [5]. Coding began from the data itself and gradually formed three broader themes: structural compulsion, ethical dissonance, and patient deprioritization. NVivo Version 12 was used to manage the material. To check the interpretation, eight respondents reviewed the themes. Their feedback did not overturn the findings, but it sharpened them. The qualitative side was not meant to decorate the numbers; it was meant to explain them and, at times, question them.

3.7. Ethical Considerations

Ethics clearance was secured before fieldwork began. Participation was voluntary, and all respondents provided written consent. Survey data remained anonymous, and interviews were coded without identifiers. No patient-level data were collected to avoid clinical risk. Given the sensitivity around scheme compliance, confidentiality was treated not as a formality but as a condition of the research itself.

4. Results and Findings

4.1. Demographic Profile of Respondents

Table 1 shows the demographic profile of the 50 respondents. The respondents were mostly male (72%), while females accounted for 28%. Most participants were in the 41–50-year age group (44%) and were Medical Superintendents (40%). Most hospitals were independently owned (68%), and the largest share (44%) was medium-sized (50–149 beds). In addition, nearly half of the respondents (48%) had been empaneled for 4–7 years, indicating significant experience with the empanelment process.

Table 1: Demographic profile of respondents (N = 50)

Characteristic	Category / Value	Frequency (%)
Gender	Male	36 (72%)
	Female	14 (28%)
Age Group	30-40 years	12 (24%)
	41-50 years	22 (44%)
	51-60 years	16 (32%)
Designation	CEO / Director	18 (36%)
	Medical Superintendent	20 (40%)
	Scheme Compliance Officer	12 (24%)
Hospital Size	Small (10-49 beds)	18 (36%)
	Medium (50-149 beds)	22 (44%)
	Large (150+ beds)	10 (20%)
Ownership Type	Independent	34 (68%)
	Corporate Chain	16 (32%)
Years of Empanelment	1-3 years	14 (28%)
	4-7 years	24 (48%)
	8+ years	12 (24%)

4.2. Governance-Compassion Gap Score: Descriptive Statistics

The mean Governance-Compassion Gap Score across the full sample was 61.4 out of 100 (SD = 12.8), indicating a substantial and statistically robust ethical governance deficit. A score above 50 was considered indicative of a significant deficit based on the instrument's normative cutpoints. Large hospitals (mean GCGS = 47.2) showed significantly lower deficits than small hospitals (mean GCGS = 71.6), a pattern consistent with larger facilities' greater administrative capacity and reputational stakes in scheme compliance (Table 2).

Table 2: Governance-compassion gap score by dimension (N = 50)

Governance Dimension	Mean Score	SD.	Min.	Max.
Scheme Compliance Behaviour	58.3	14.2	22	91
Billing Transparency	64.7	13.6	31	95
Patient Rights Orientation	67.2	11.8	38	92
Claims Processing Practices	55.9	16.1	18	88
Administrative Ethics Perception	60.1	12.9	25	90
Composite GCGS	61.4	12.8	28	93

4.3. Correlation and Regression Analysis

Pearson correlation analysis revealed significant associations between all four independent variable clusters and the composite GCGS. Reimbursement Delay Index showed the strongest positive correlation with GCGS ($r = 0.71$, $p < 0.001$), confirming that longer payment delays are directly associated with deeper governance deficits. The Administrative Ethics Score showed a strong negative correlation ($r = -0.65$, $p < 0.001$), indicating that hospitals with stronger internal ethics cultures had lower governance deficits. Patient Awareness Score showed a moderate negative correlation ($r = -0.48$, $p < 0.01$), and Regulatory Monitoring Score showed a negative correlation ($r = -0.53$, $p < 0.001$) (Table 3).

Table 3: Multiple regression analysis predicting governance-compassion gap score

Variable	B	Beta	t	p-value
Reimbursement Delay Index	0.43	0.39	4.82	< 0.001
Administrative Ethics Score	-0.38	-0.34	-4.21	< 0.001
Regulatory Monitoring Score	-0.29	-0.26	-3.14	0.003
Patient Awareness Score	-0.22	-0.20	-2.47	0.017
$R^2 = 0.69$; Adjusted $R^2 = 0.66$; $F(4,45) = 25.2$; $p < 0.001$				

The regression model explained 69% of variance in the GCGS ($R2 = 0.69$, adjusted $R2 = 0.66$, $F(4,45) = 25.2$, $p < 0.001$). Reimbursement delay was the single strongest predictor, with the largest standardized beta coefficient in the model. The data, the raw data itself, shows that structural financial pressures exert a more powerful effect on administrative governance behavior than any other single factor, including the ethics orientation of administrators. However, the ethics culture remains a highly significant predictor.

4.4. Key Qualitative Findings

Three broad themes kept returning during the qualitative analysis, and none of them came as a surprise, though seeing them so consistently was still unsettling. The first, structural compulsion, reflects what many administrators described with almost resigned acceptance. The financial design of the schemes positions them so that doing the right thing often feels economically unworkable. One medical superintendent from a mid-sized independent hospital spoke about waiting more than 180 days for a set of AB-PMJAY claims to be cleared, adding, “the government expects us to behave like a charity while paying us like a business.” This does not excuse unfair practices toward patients. Still, it helps explain why the gap between policy and practice persists, even when administrators themselves admit it should not. The second theme, ethical dissonance, is harder to sit with. Several administrators spoke of knowing what ought to be done yet finding themselves unable to act on it. Instructions from management to give preference to private-paying patients in bed allocation came up more than once. Those involved were clear that such decisions crossed both legal and ethical lines, but within the hospital's structure, resistance did not feel like a real option. The third theme, patient deprioritization, was quieter but perhaps more telling. Patient voices rarely find a place in administrative thinking. Of the 50 hospitals studied, only 12 had an active grievance committee to address scheme-related complaints. In 29 hospitals, there was no visible notice board explaining patient entitlements in Assamese or other local languages, despite this being a required condition for empanelment. It is in these small absences that the larger pattern becomes visible.

5. Discussion

5.1. Interpretation and Comparison with Existing Literature

The result that reimbursement delay is the strongest predictor of governance deficit aligns with Davis et al. [4], who argued that delayed payments push institutions toward non-compliance, though without field-based measurement. The regression coefficient reported here (Beta = 0.39, $p < 0.001$) provides numerical support for that claim in a Northeast India setting. It brings the Assam state health agency’s payment cycle into sharp focus as a core site of reform. The negative association between administrative ethics orientation and governance deficit (Beta = -0.34, $p < 0.001$) is consistent with Khatri et al. [9]. Leadership values and internal culture carry real weight. Even under financial strain, they shape decision-making. This finding unsettles the common view, often voiced in interviews, that delayed payments make ethical conduct unrealistic. Ethics culture is not an afterthought. It is the choice institutions make, regardless of constraints. The role of patient awareness is also clear. Higher levels of beneficiary knowledge appear to reduce governance deficits, supporting Hooda's [6] demand-side accountability argument and confirming Hypothesis H3. Where patients understood their entitlements, informal payments were lower. This was less about administrators becoming more ethical and more about patients becoming harder to mislead. The implication for policy is direct—communication matters.

5.2. Solutions to the Research Problem

The governance–compassion gap visible in Guwahati is not beyond repair. Its causes are identifiable, its patterns measurable. What is required is a set of changes that speak to those realities. The Compassionate Governance Integration Model (CGIM) is offered here as one such framework, built around four areas of intervention—the first concerns financial design. The Assam State Health Agency needs to reduce claim processing times from the current average of 112 days to 30 days or less, introduce interim monthly payments, and impose penalties for delays beyond 45 days. Without this shift, financial pressure will continue to pull behavior away from compliance—the second addresses administrative ethics. Hospitals with more than 50 beds should have a dedicated Scheme Ethics Officer, with authority over admissions, billing checks, and grievance handling. Ethics training, developed in collaboration with the National Institute of Health and Family Welfare, should be part of the re-empanelment process. The interviews leave little doubt—administrators often feel the conflict but lack the space to act differently. The third relates to transparency and patient rights. Clear, multilingual boards in Assamese, Bengali, Hindi, and Bodo need to be visible at reception and billing points. Patients should receive simple, written information on scheme benefits at admission. The current paper-based grievance process, still used by most hospitals, should be replaced with a QR-linked system tied directly to the ASHA monitoring dashboard—the fourth concerns regulatory follow-through. At present, the inspection frequency in Kamrup Metropolitan District is about 1.2 visits per year, which offers little deterrence. Quarterly surprise audits, backed by the power to suspend empanelment, would alter how risk is perceived. Independent patient satisfaction surveys should also be tied to renewal decisions.

5.3. Theoretical and Practical Implications

From a theoretical standpoint, the findings suggest that Principal-Agent Theory alone cannot account for what is happening. Financial incentives do matter, as expected, but they do not fully determine behavior. The independent role of ethics culture points to the relevance of Stewardship Theory, which helps explain why some administrators continue to act responsibly under pressure. A more useful view holds both together—structure and values, each shaping the other. On the practical side, the CGIM framework does not depend on new laws. It fits within existing administrative arrangements. What it calls for is a shift in how empanelment is understood—not as access to public funds, but as a responsibility toward the patients those funds are meant to support. That shift, more than any technical adjustment, remains the harder task.

6. Conclusion

The study demonstrates a significant gap between governance and compassion in private hospitals implementing state healthcare plans in Guwahati and Kamrup Metropolitan District. The Governance–Compassion Gap Score of 61.4 is based on 50 administrator replies and reflects a deficit embedded in organizational structures, reflected in routine administrative activities, and most keenly felt by patients who rely on these systems. This gap persists due to delayed reimbursements, insufficient ethical culture within institutions, limited regulatory enforcement, and low patient awareness. These issues, however, are not permanent and can be overcome by proper solutions. The current study adds to the extant information in three crucial ways. It proposes the Governance–Compassion Gap Score as an aggregated measure to assess ethical governance in private hospitals operating under public health care schemes, grounded in theoretical underpinnings and supported by empirical data. It also gives a detailed mixed-methods analysis from Northeast India, a region that has been relatively understudied in this field of research.

Moreover, the Compassionate Governance Integration Model established in this study translates the findings into practical administrative actions rather than just academic discussion. Future studies should apply the Governance–Compassion Gap Score paradigm to other Northeastern states, such as Meghalaya, Manipur, and Tripura, where similar difficulties may exist under different conditions. Longitudinal studies would help assess the effectiveness and sustainability of the proposed model over time. This study focused on administrative processes, and future research should include more direct patient input to gain a broader perspective on healthcare governance. Goal 3 of the Sustainable Development Goals focuses on ensuring access to affordable, high-quality health care, whereas Goal 16 focuses on institutions that serve the public interest. Private hospitals that are part of public healthcare plans are meeting both expectations. The gap highlighted in this study is the discrepancy between these goals and current practice. The first step is to measure this gap. The real test is whether institutions are willing to act on concerns they’ve previously identified.

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