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Beyond Coverage: The Humanized Hospital Governance Framework for Private Hospitals Implementing State Health Schemes in Assam, India

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Abstract: Private hospitals now sit at the centre of secondary and tertiary care in India, holding close to 74% of urban hospital beds. In Assam, schemes like Atal Amrit Abhiyan (AAA) and Ayushman Bharat Pradhan Mantri Jan Arogya Yojana have drawn these hospitals into the public system on paper. On the ground, the experience is less settled. Even with rising enrolment, poorer patients still struggle to get care—not because the schemes are badly written, but because of how hospitals are run, how staff behave, and what quietly becomes routine practice. This paper examines gaps across empanelled private hospitals in Guwahati and Kamrup Metropolitan. It relies on a mixed set of materials: Structured questionnaires from 50 hospital administrators and in-depth interviews that stayed with the small details of patient experience. Three patterns kept appearing—unclear claims processes, weak respect for patient dignity, and fragile financial protection. Reimbursement delays, informal billing, and hurried or missing communication were not rare; they formed a pattern that chipped away at subsidized care. Principal-Agent Theory, Stewardship Theory, and Capability Approach are used to propose Humanised Hospital Governance (HHG). Hospital administration prioritises patient care over economics and throughput. Daily conduct standards—clear claims administration, attentive communication, and equitable patient engagement—meet the standards of Assam hospitals. The report informs public–private healthcare debates and provides evidence-based solutions for SDG 3: Good Health and Well-Being and SDG 10: Reduced Inequalities.

Keywords: Organisational Culture; Organisational Behaviour; Work Motivation; Teacher Performance; Secondary Education; Educational Institutions; Multiple Linear Regression; Teacher Effectiveness.

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1. Introduction

1.1. Background and Context

India's health system has always carried a quiet contradiction. On paper, the state is responsible for public health. In practice, much of the actual care—especially in towns and cities—rests with private providers [4]. Assam makes this tension hard to

ignore. The state continues to report a maternal mortality ratio of 195 per 100,000 live births, far above the national average of 97, and tuberculosis notifications remain higher than the national median. Public facilities struggle to keep pace. In many districts, doctor availability falls short of WHO norms, and district hospitals often lack functioning operating theatres or blood banks. In response, the government has turned to private hospital empanelment. By 2023, 1,247 private facilities were brought under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and Atal Amrit Abhiyan, covering more than 28 lakh households [5]. The idea is simple enough: Use an existing private network to extend care to those who cannot pay. But that assumption often overlooks something basic—the private hospital is not, by default, a humane institution. What happens inside it, especially at admission, billing, and discharge, shapes whether a scheme works in practice or quietly fails. Guwahati, the largest city in Northeast India, sits at the centre of this arrangement [8]. It is both Assam's commercial hub and the main referral point for patients across the seven sister states. Most of the state's secondary and tertiary private hospitals are located here, making it the most telling place to examine how these schemes are carried out in everyday administrative work [9].

1.2. Problem Statement

The core issue here lies in the gap between expanded coverage and the quality of governance inside private hospitals. Enrollment has increased, and more hospitals are listed under government schemes. Yet actual use remains uneven. In 2022–23, AB-PMJAY data from Assam showed a nearly 40% gap between eligible households and those who made claims. Field accounts repeat the same concerns: Patients asked for informal payments, beneficiary cards were turned down without clear reasons, and discharge procedures led to unexpected costs—costs the scheme was meant to absorb. This is less about weak policy design and more about how hospitals are run [20]. The question is not whether private hospitals should be part of public health schemes. It is about how their internal systems can be reshaped so that care is fair, costs are controlled, and patients are treated with basic respect. At present, neither Indian nor Assamese policy discussions offer a grounded answer from within hospital administration itself.

1.3. Objectives

The primary objective of this study is to assess the governance quality of private hospitals impaneled under state health schemes in Guwahati and Kamrup Metropolitan district, and to identify the administrative factors that drive or impede equitable and compassionate scheme implementation. Secondary Objectives are (a) To examine transparency, billing integrity, and patient dignity practices in the sampled hospitals; (b) To analyse the structural causes of claims processing inefficiencies and reimbursement delays from the hospital administrator's perspective; (c) To develop a replicable Humanised Hospital Governance (HHG) Framework applicable to private hospitals implementing state health schemes across Assam and comparable Indian contexts [13].

1.4. Research Hypotheses

- **H1:** Hospitals with dedicated scheme implementation teams demonstrate significantly higher claims acceptance rates and lower patient complaints related to billing irregularities.
- **H2:** Reimbursement delay duration is positively correlated with the frequency of informal top-up charge collection from scheme beneficiaries.
- **H3:** The presence of structured patient communication protocols is significantly associated with higher scheme utilisation rates among eligible patients.

1.5. Need, Purpose, and Justification

The need for this study arises at several levels, and the most immediate is hard to ignore. Patients in Assam who are meant to receive cashless treatment under state schemes still end up paying out of pocket. The Economic Survey of Assam (2022–23) states plainly that about 27% of rural households slip into poverty or debt due to health expenses, even when someone in the family is eligible for scheme coverage. The infrastructure exists, but at the point where care is given, financial protection weakens. From an academic standpoint, there is a clear gap. Work in this area has mostly focused on scheme design or usage patterns. What sits in between—hospital administration—has received very little attention, especially in the northeast. This study shifts the focus to that layer, treating hospital governance as the central unit of analysis rather than the schemes themselves.

1.6. Significance and Scope

At the academic level, this study brings stewardship ethics into conversation with hospital administration. While this link is cited in management literature, it rarely appears in discussions of healthcare governance in low- and middle-income settings. For policy actors, the HHG Framework works as a practical tool—something that can be used to review and rethink existing

systems. For hospital administrators, it offers a way to reconsider daily operations, from billing desks to discharge procedures, with clearer intent. Its social weight is harder to quantify but easier to see. The people covered under Atal Amrit Abhiyan and Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in Assam include displaced tribal groups, migrant workers, and families living below the poverty line. When a claim is denied, it is not a minor inconvenience; it can push a household into crisis. The study is limited to Guwahati and the Kamrup Metropolitan district. It looks closely at hospital administration—governance practices, billing systems, patient communication, and claims processing. All clinical areas linked to scheme empanelment are considered, including surgery, oncology, cardiology, and maternity services. There are limits to what this dataset can claim. The sample size (N=50) is modest, and the focus on an urban district means the findings cannot be directly extended to rural Assam. Government hospitals and patients are not included as primary respondents, keeping the lens fixed on administrative practice within private institutions.

2. Literature Review

2.1. Theoretical Framework

Three strands of thought hold this argument together, and each comes from a place anyone who has spent time in hospitals will recognize. The first is Principal-Agent Theory. It speaks to a familiar tension: One side hands over responsibility, the other carries it out on its own terms. Here, the state or the patient stands as the principal, while the private hospital acts as the agent. The imbalance is built in. Hospitals know the fine print—eligibility rules, treatment costs, billing pathways—far better than patients ever will. When revenue sits at the centre of decision-making, that gap is not neutral. It creates room for quiet distortions: Services held back, bills adjusted, explanations kept vague. The second is Stewardship Theory. This line of thinking allows for a different reading of institutional behaviour. It does not assume that every administrator is driven only by personal or organisational gain. Under certain conditions—when leadership, culture, and role expectations align—people act with a sense of responsibility toward others. In this setting, it shifts the image of the hospital administrator. Not just someone managing accounts and approvals, but someone holding public trust, with a duty to protect patients from financial strain. The third is the Capability Approach. This one moves the focus away from formal access and toward lived experience. Health equity is not simply about removing fees on paper. It rests on whether a person can actually receive care with dignity, clarity, and completeness. A patient who is turned away through informal refusals, or asked to pay despite valid coverage, has lost that capability, even if a hospital bed was technically within reach. This frame sets the standard for what meaningful governance should look like from the patient's perspective.

2.2. Review of Existing Research

Forgia and Nagpal [12] offered one of the earliest and most careful accounts of government-funded health insurance in India, highlighting weaknesses in empanelment and provider accountability. They observed that monitoring systems never quite kept pace with the rapid expansion of enrollment. Their work still anchors much of the discussion, even though it comes from a period before the scale reached under AB-PMJAY. Berman and Ahuja [2] traced the rise of the private sector and described what they called a "governance vacuum," in which expansion proceeded with little effective oversight. Their argument—that self-regulation rarely holds without external checks—underpins the approach taken in this paper. Etikan et al. [6] examined AB-PMJAY and noted its tilt toward hospital-based care, which may lead hospitals to favor higher-cost procedures over prevention. They flagged risks of over-treatment and moral hazard, offering a useful way to read irregular billing patterns within the scheme. Verma and Pant [7], using early claims data, found that northeastern states, including Assam, reported lower-than-average utilization. She linked this to gaps in provider readiness, limited awareness, and administrative complexity inside hospitals. This gap is the focus of the present study. Sehgal and Sangita [10], studying empanelled hospitals in Rajasthan, noted that patients were often pushed to buy medicines outside the approved lists, turning cashless treatment into partial out-of-pocket spending.

The pattern is uncomfortably familiar in Assam as well. Garg et al. [17] approached the issue through cost-effectiveness analysis and showed that once informal charges are included, the financial protection offered by AB-PMJAY weakens considerably. Their findings support the claim that coverage on paper does not always translate into real protection. Gnanadhas et al. [21] focused on administrators in district hospitals in Uttar Pradesh. They found that knowledge of scheme procedures—more than clinical quality—shaped patient satisfaction. This insight highlights administrators as key actors in governance. Sen [19] looked at the political economy behind these schemes. They argued that empanelment creates a dependence where private hospitals gain financial influence over state agencies, often weakening regulatory action. Reddy et al. [18], working with RSBY data, reported wide variation in care quality across private hospitals, linked to differences in administrative capacity and professionalism. Governance, in their account, is not a side issue; it shapes outcomes directly. Onyina and Baye [1], writing more broadly on social protection, argued that success or failure often turns on what happens at the last mile. In healthcare, the last mile lies within the hospital itself, in everyday decisions at the point of care. Kutzin [11] laid out the principles of strategic purchasing, stressing that payment systems work only when backed by transparent information and enforceable accountability.

The gaps seen in claims management here reflect the absence of such conditions. Peters et al. [16] warned that market forces alone would not maintain quality in private healthcare. They argued instead for structured integration with clear accountability, a point that still feels unresolved in many settings. The World Health Organization [23], reflecting on four decades of primary healthcare, suggested that public–private arrangements hold only when built on trust and shared purpose, rather than on fear of punishment. That expectation remains uneven in practice. The Office of the Registrar General and Census Commissioner [22] highlighted high levels of fraud and misuse in claims under AB-PMJAY and called for stronger hospital-level governance, including improved documentation and internal audits. Papanicolas et al. [14], in a cross-country comparison of hospital systems, found that transparency in governance consistently aligned with better patient outcomes, regardless of how hospitals were funded. Patel et al. [15] argued that in India's mixed system, weak governance norms in private hospitals make ethical lapses less an exception and more a predictable outcome. This is the position from which the present paper begins.

2.3. Research Gap

The existing literature offers detailed accounts at the level of schemes and health systems, yet says very little about what happens inside hospitals, where these schemes are carried out. This absence is sharper in Assam and across the northeast. No study sets out a governance framework for private hospitals in this setting, built from both administrative data and the lived accounts of those running these institutions. What remains missing is a tested, region-sensitive model that speaks to accountability and basic human conduct in scheme implementation. This gap is where the present study places itself.

2.4. Conceptual Model

The model treats the private hospital as a point where three relationships meet: The state, which funds and regulates; the patient, who depends on the scheme; and the hospital itself, which delivers care while holding a degree of responsibility toward both. When governance weakens at this point, the strain shows in two directions. The hospital's accountability to the state becomes uneven, and the patient's experience of care begins to fray. The Humanized Hospital Governance Framework reworks this point of contact through four areas of practice: integrity in billing, clarity in administrative processes, and respect for patient dignity, and communication that does not reduce people to mere paperwork.

3. Research Methodology

3.1. Research Philosophy and Design

The study follows a pragmatist line of thinking, in which the choice of method arises from the question at hand rather than from loyalty to any single school of thought. A concurrent mixed-methods design was used. Quantitative data were collected through a structured questionnaire, while qualitative data were collected through semi-structured interviews. Both sets were examined side by side and brought together during interpretation. The problem itself has two sides: One that can be counted—how often governance failures occur—and another that needs to be understood through experience—why they happen and how they are carried out within institutions.

3.2. Geographic Area

The study is limited to private hospitals in Guwahati and the wider Kamrup Metropolitan district of Assam. This setting was chosen because it has the highest concentration of hospitals empanelled under AB-PMJAY and AAA in the state, making it the most appropriate place to observe how administrative practices shape scheme implementation.

3.3. Sampling Framework

The initial pool included all private hospitals registered with the Assam State Health Agency (ASHA) under AB-PMJAY and AAA in Kamrup Metropolitan as of December 2023, totalling 84. This was narrowed to hospitals with at least 30 beds, on the assumption that a minimum level of administrative structure would be present. The number then stood at 67. From this group, 50 administrators were selected through purposive sampling. These included Medical Superintendents, CEOs, COOs, and designated Hospital Administrators. The sample size aligns with accepted practice in healthcare management studies that combine qualitative emphasis with quantitative support. A power analysis (alpha = 0.05, power = 0.80) indicated that the sample size was sufficient for the statistical tests.

3.4. Data Collection Tools

The quantitative tool was a 45-item questionnaire divided into five sections: (a) scheme implementation infrastructure (10 items), (b) claims processing and reimbursement (9 items), (c) billing transparency and financial protection (8 items), (d) patient

dignity and communication (10 items), and (e) institutional ethics and accountability (8 items). Responses were recorded on a five-point Likert scale ranging from strongly disagree to agree strongly. The tool was tested on 5 administrators outside the main sample. Cronbach's alpha was calculated at 0.87, indicating acceptable internal consistency. The qualitative tool consisted of a semi-structured interview guide with 12 open-ended questions. These focused on day-to-day administrative experience, barriers to humane governance, and views on accountability. Interviews were conducted in English and Assamese, lasted 35-50 minutes, and were recorded with consent. Transcriptions were done word-for-word.

3.5. Data Analysis Plan

Quantitative data were processed using IBM SPSS Statistics 27. Basic descriptive measures—means, standard deviations, and frequency distributions—were calculated for all variables. Analytical tests included independent-samples t-tests, Pearson correlations, and one-way ANOVAs, all of which were aligned with the three research hypotheses. For the qualitative part, 20 interview transcripts were analysed thematically using the six-step approach of Braun and Clarke [3]. This produced five main themes, which were then read alongside the quantitative findings using a convergence model.

3.6. Ethical Considerations

Ethical clearance was obtained before fieldwork began. All participants gave written consent. Identities were protected through coded labels, and participation was voluntary. Respondents could withdraw from the study at any stage without consequences.

4. Results and Findings

4.1. Respondent Demography

Table 1 summarises the demographic profile of the 50 hospital administrators who participated in the study.

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

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	34	68.0
	Female	16	32.0
Age Group	30 - 40 years	14	28.0
	41 - 50 years	22	44.0
	51 years and above	14	28.0
Educational Qualification	MBBS / MD	18	36.0
	MBA (Hospital Administration)	20	40.0
	MHA / MPhil / PhD	12	24.0
Role / Designation	Medical Superintendent	21	42.0
	CEO / COO	14	28.0
	Hospital Administrator	15	30.0
Years of Experience	Less than 5 years	9	18.0
	5 - 10 years	23	46.0
	More than 10 years	18	36.0
Hospital Bed Capacity	30 - 99 beds	19	38.0
	100 - 299 beds	21	42.0
	300 beds and above	10	20.0

4.2. Governance Practice Findings

Table 2 presents mean scores across the five governance modules. A score below 3.0 indicates general disagreement or inadequacy; a score above 3.5 indicates moderate to strong adequacy.

Table 2: Mean scores across governance modules (N = 50)

Governance Module	Mean (M)	Std. Deviation (SD)	Adequacy Rating
Scheme Implementation Infrastructure	3.42	0.74	Moderate
Claims Processing and Reimbursement Management	2.61	0.88	Inadequate

Billing Transparency and Patient Financial Protection	2.48	0.91	Inadequate
Patient Dignity and Communication Protocols	2.73	0.82	Inadequate
Institutional Ethics and Accountability Mechanisms	2.89	0.79	Below Adequate

The data is striking. Of the five governance modules, only the scheme implementation infrastructure reached a moderate adequacy rating. The three most patient-critical modules, claims management, billing transparency, and patient dignity, all fell below the threshold of adequacy. These are not marginal deficits; mean scores of 2.48 and 2.61 on a five-point scale indicate that most administrators either disagreed or were uncertain about adequate practice in these areas.

4.3. Hypothesis Testing

All three hypotheses were supported. The correlation between reimbursement delay and informal top-up charges ($r = 0.62$) is particularly diagnostic: It suggests that, under financial pressure from delayed reimbursements, the hospital shifts that burden informally onto patients who are legally entitled to cashless care (Table 3).

Table 3: Hypothesis testing results

Hypothesis	Test Used	Statistic	p-value	Result
H1: Dedicated team vs claims acceptance/patient complaints	Independent Samples T-test	$t = 3.87$	$p = 0.001$	Supported
H2: Reimbursement delay vs informal top-up charge frequency	Pearson Correlation	$r = 0.62$	$p < 0.001$	Supported
H3: Patient communication protocol vs scheme utilisation rate	Pearson Correlation	$r = 0.54$	$p = 0.003$	Supported

The correlation between patient communication protocols and scheme utilization ($r = 0.54$) confirms that governance behavior at the communication level directly translates into access outcomes.

4.4. Qualitative Findings

The qualitative material fills in what the numbers only hint at. Theme T2—ethical ambivalence—keeps returning in the interviews. Administrators were not blind to the effects of informal billing; many spoke about it with a certain unease. That detail matters. It shifts the problem away from simple claims of ignorance or bad intent.

Table 4: Summary of qualitative themes from administrator interviews (n = 20)

Theme	Description	Representative Quote (Paraphrased)	Frequency of Mention
T1: Reimbursement Frustration	Administrators described the claiming processes as opaque and exhausting, creating an imperative to build a financial buffer.	"Researchers cannot run operations on empty promises; the delay forces decisions researchers are not proud of."	17/20
T2: Ethical Ambivalence	Awareness of ethical violations coexisting with justifications rooted in institutional survival	"Researchers know patients should not pay, but when the government owes us money, the staff salary does not wait."	15/20
T3: Documentation Overload	Compliance requirements are perceived as administratively punitive and understaffed.	"The paperwork for one claim takes two days; researchers have one person handling fifty claims."	18/20
T4: Patient Awareness Deficit	Patients arriving without understanding of scheme entitlements, enabling informal billing	"Most patients do not know what the scheme covers; they accept whatever researchers say."	14/20
T5: Regulatory Distance	Monitoring by state agencies is described as infrequent and non-constructive	"An inspection happens once in eighteen months, and even then it is largely a paper exercise."	16/20

What comes through instead is a system that puts people in a corner, where doing what feels right does not always sit easily with keeping the institution running. At that point, the issue is less about individual choices and more about how the system is put together. This is the level at which the HHG Framework is set in Table 4.

5. Discussions

5.1. Interpretation and Comparison with Literature

The patterns observed here do not stand apart from earlier work; they sit alongside it. The billing irregularities closely match those reported by Sehgal and Sangita [10] in Rajasthan, suggesting a wider pattern across empanelled private hospitals rather than a problem limited to one state. The link between delayed reimbursements and informal charges ($r = 0.62$) also mirrors Garg et al. [17] findings of weakened financial protection and provides primary evidence of the same relationship within Assam. Accounts from administrators in Theme T5, which speak to distance from regulators, reflect Sen [19] description of the uneven balance between hospitals and oversight bodies. Where this study adds something new is in how ethical ambivalence (T2) appears in the data. Earlier work often treats informal billing as either fraud or carelessness. The accounts here are less straightforward. Administrators describe being caught between keeping their institutions afloat and doing what they recognise as fair. The structure they work within leaves little room to resolve that tension cleanly. This shifts the question. It is no longer only about identifying and penalising wrongdoing but about changing the conditions so that acting ethically does not come at the cost of institutional survival.

5.2. The Humanised Hospital Governance (HHG) Framework

With that in view, the study moves from identifying the problem to setting out a response. The Humanised Hospital Governance (HHG) Framework is presented as a four-part model for private hospitals working under state schemes. It draws from the three theoretical strands outlined earlier and is shaped by the governance failures described. Dimension D1 takes up the most immediate problem—informal billing—by placing accountability directly at the point where money changes hands. D2 goes after what administrators themselves pointed to: Delays in reimbursement. When claims management is handled more structurally, the quiet justification for passing costs to patients begins to weaken. D3 brings the Capability Approach into everyday practice by treating informed and dignified access as a requirement, not an option. D4 holds the structure together; it keeps the other three from depending on individual goodwill by building them into routine processes (Table 5).

Table 5: The humanised hospital governance (HHG) framework

Dimension	Core Principle	Operational Standards	SDG Alignment
D1: Ethical Billing Integrity	Stewardship over profitability at the billing interface	Zero informal top-up charges; monthly internal billing audits; transparent rate display in ward language; patient receipt for all charges	SDG 3.8, SDG 10.4
D2: Claims Transparency Management	Principal-Agent accountability in claims processing	Dedicated claims officer per 50 beds; real-time claims status portal for patients; maximum 15-day internal claims preparation cycle	SDG 16.6, SDG 3.8
D3: Patient Dignity and Communication	Capability Approach: Real access requires an informed agency	Scheme orientation for all admissions (vernacular language); bedside entitlement card; discharge counselling; patient grievance mechanism with 48-hour resolution	SDG 3, SDG 10.2
D4: Institutional Ethics Infrastructure	Governance culture as a structural, not individual, variable	Hospital Ethics Committee with patient representative; annual administrator training on scheme ethics; public accountability charter; grievance escalation pathway to ASHA	SDG 16.7, SDG 17.17

The HHG Framework does not tie hospitals to a single format. It sets standards and expected outcomes, leaving room for variation in how they are carried out. A 50-bed hospital will not work in the same way as a 300-bed one, but both are expected to meet the same benchmarks. That flexibility makes it workable across the varied hospital settings in Assam.

5.3. Addressing the Research Problem: Strategies for Change

The problem outlined earlier was the gap between expanding coverage and the actual protection it provides to patients. The evidence shows that this gap is not incidental; it is built into existing arrangements. The HHG Framework responds through three connected moves. First, structural decoupling: By strengthening claims management (D2), it separates hospital financial strain from what patients are asked to pay, interrupting the link identified in H2. Second, information equalisation: By setting

clear communication practices (D3), it reduces the information gap that leaves patients at a disadvantage. Third, institutional culture change: The ethics infrastructure (D4) shifts governance away from occasional compliance checks toward something that runs through daily operations.

5.4. Theoretical and Practical Implications

On the theoretical side, the study shows that Principal-Agent Theory, Stewardship Theory, and the Capability Approach can be read together rather than against each other. One helps explain where the problem begins, another points to how institutional behavior might change, and the third sets the standard for what counts as meaningful care from the patient's perspective. Taken together, they offer a fuller account than any single approach alone. In practice, the findings speak directly to the Assam State Health Agency. The HHG Framework can be used as part of empanelment renewal, with hospitals asked to show how D1 through D4 are put into operation, not just stated on paper. This aligns with the direction outlined by the Office of the Registrar General and Census Commissioner [22], which called for stronger governance at the hospital level but did not specify what that should look like.

6. Conclusion

This paper began with an observation that is difficult to ignore: In Assam, many households hold valid entitlements under state health schemes and still fall into heavy health-related debt. The argument that follows places the problem less in policy design and more in how hospitals are run. It is in billing sections, admission counters, and administrative offices that the promise of a scheme is either carried through or quietly set aside. The evidence, both numerical and drawn from administrator accounts, points to recurring weaknesses in billing practices, claims handling, patient communication, and institutional ethics. These are not isolated lapses. They appear as part of a pattern shaped by the system itself. Administrators work within conditions where delayed reimbursements make informal billing seem like a practical response, and where no clear institutional path exists to balance financial pressure with ethical responsibility. The Humanised Hospital Governance Framework is offered as a response to this condition. It shifts the role of the private hospital, drawing on stewardship theory, toward one that holds responsibility for public resources.

It also brings the Capability Approach into everyday administrative work by treating dignified and informed access as a basic expectation. At the same time, it gives state agencies a concrete way to review and guide hospital governance during empanelment and renewal. What this study adds is quite specific. The HHG Framework stands as an empirically grounded model shaped by the conditions of Assam's private hospital sector. It redirects attention from scheme design to institutional practice, from outcomes alone to the conduct that produces them, and from coverage Figures to what patients can receive. Further work could test the framework through a controlled pilot across selected hospitals, tracking its effect on claims approval, patient complaints, and overall scheme use. Its relevance is not limited to Assam. Any setting that depends on private hospitals for subsidised care faces similar strains. The framework offers a starting point, shaped by evidence and local conditions, and keeps the patient at the center of what hospital administration is meant to serve.

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