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GOVERNANCE GAP IN PROMOTER-DRIVEN HOSPITALS IN INDIA

When Ownership and Accountability Diverge — and What It Costs

A Research-Based Analysis for Hospital Leaders, Promoters, Policymakers, and Consulting Practitioners

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Abstract

India's private hospital sector has expanded with remarkable speed over the past three decades. Much of that expansion has been driven by promoter-owned institutions — built by clinician-entrepreneurs, family business groups, and individual visionaries who combined medical intent with capital. The model created capacity, regional access, and in many cases genuine clinical excellence. It also created a structural governance problem that has not been addressed with sufficient seriousness: the promoter governance gap.

This article examines the nature, causes, manifestations, and consequences of that gap. It analyses India's current regulatory framework and its known limitations. It draws on research in healthcare governance, corporate accountability, and the specific dynamics of the Indian hospital sector to build a coherent picture of why governance fails in promoter-driven institutions — and what must change. The article closes with a consulting perspective on the practical path forward for institutions willing to address this problem seriously.

SECTION 1 ■ THE PROMOTER-DRIVEN HOSPITAL MODEL

How it was built, why it succeeded, and what it left unresolved

The Architecture of India's Private Hospital Sector

India's private healthcare sector today accounts for approximately 70 to 75 percent of all secondary and tertiary care delivered in the country. This dominance was not planned — it was the consequence of chronic under-investment in public health infrastructure, a growing middle class with rising medical expectations, and the entrepreneurial energy of clinicians and business families who recognised both the social need and the commercial opportunity.

The prototypical promoter-driven hospital emerged from one of three archetypes. The first is the clinician-entrepreneur: a senior surgeon or physician of standing who built a hospital around their personal practice and reputation, attracting colleagues, building infrastructure, and expanding incrementally. The second is the family business entry: an industrial or trading family that diversified into healthcare as an investment, typically engaging a medical director for clinical leadership while retaining commercial and financial control. The third is the trust or charitable origin: an institution founded with genuinely non-commercial intent that over decades grew into a large, complex, commercially significant operation without ever developing the governance systems appropriate to that scale.

Each archetype created real value. Hospitals were built in cities and towns that lacked them. Procedures and technologies were introduced at accessible price points. Employment was generated. Patients who could not or would not access public hospitals found an alternative. The contribution of promoter-driven private hospitals to India's healthcare capacity is real and should be acknowledged honestly.

The Governance Structure That Did Not Keep Pace

What the promoter-driven model consistently failed to develop — because success did not demand it, and the regulatory environment did not require it — was governance architecture commensurate with institutional scale and complexity. Boards were constituted but not empowered. Audit committees were formed but not independent. Clinical governance frameworks were adopted in name without being embedded in practice. Professional management was hired but real authority remained with the promoter family.

The governance gap is therefore not primarily a failure of intent. Most hospital promoters believe they are running their institutions well. It is a failure of structure: the absence of institutional checks, independent voices, transparent processes, and accountability mechanisms that would operate regardless of the promoter's personal judgment on any given day.

“A hospital governed by the quality of one person's judgment is not governed by a system. It is governed by a person. And persons change, tire, err, and eventually leave.”

SECTION 2 ■ THE NATURE OF THE GOVERNANCE GAP

What it is, where it lives, and how it compounds

Ownership Without Separation of Powers

In a well-governed institution, ownership, strategy, operations, and clinical decision-making are distinct domains with defined boundaries and accountability relationships between them. The board sets strategic direction and holds management accountable. Management executes within that direction and holds clinical teams accountable. Clinical teams govern their own practice within a framework of protocols, audit, and peer review.

In many promoter-driven hospitals, these domains overlap or collapse into a single locus of control. The promoter may simultaneously chair the board, control the management committee, influence clinical appointments, hold vendor relationships, and set pricing policy. When this concentration is functioning well under a capable, ethical promoter, it can appear efficient. When it is not functioning well — whether from incapacity, self-interest, or the ordinary pressures of a complex business under stress — there is no independent mechanism to identify the problem, escalate it, or correct it.

Five Domains Where the Gap Is Most Visible

1. Clinical Governance Under Revenue Pressure

Clinical governance requires that medical decisions be made on clinical grounds, guided by evidence-based protocols, reviewed through mortality and morbidity audit, and insulated from financial incentives. In promoter-driven hospitals where revenue targets, bed occupancy rates, and procedure volumes are communicated as management expectations, the insulation between clinical judgment and commercial pressure becomes thin. Doctors who feel pressure to admit, investigate, or operate in order to meet targets are not making fully independent clinical decisions, even if no explicit instruction was ever given. The pressure operates through culture, through incentive structure, and through the implicit understanding of what is expected.

2. Pricing Opacity and Patient Vulnerability

Healthcare pricing in India's private sector is characterised by a combination of package rates, itemised billing, and variable consumable charges that are not always disclosed fully at admission. The information asymmetry is structural: patients cannot evaluate the clinical necessity of a procedure, compare prices effectively, or negotiate from a position of equivalent knowledge. In governance-weak institutions, this asymmetry is compounded by the absence of pricing policies, disclosure standards, and complaint escalation mechanisms that a strong board would mandate.

3. Related-Party Transactions and Procurement Integrity

Promoter-driven hospital groups frequently operate through multiple related entities: the hospital itself, a diagnostics arm, a pharmacy, an equipment procurement company, a facilities management provider, and in some cases an education or real estate business. These structures can be entirely legitimate and operationally efficient. They become a governance problem when transactions between related parties are not disclosed, not independently reviewed, and not tested against market rates. A hospital purchasing consumables from a promoter-linked supplier at above-market prices, or leasing premises from a promoter family trust without a board-approved valuation, is transferring wealth from the institution to the promoter in a manner that weakens the hospital's financial position and compromises its ability to invest in clinical quality.

4. Human Resources: Clinical Talent and Succession

The governance gap has a significant human dimension. In promoter-controlled institutions, senior clinical and management appointments are often made on the basis of personal relationships, loyalty to the founder, or family preference rather than merit and institutional fit. This pattern produces leadership teams that are loyal to the promoter rather than accountable to the institution, and it systematically disadvantages talented individuals who challenge, question, or disagree.

The succession problem is even more acute. Many promoter-driven hospitals have no succession plan. The founder's departure — through retirement, illness, or death — can destabilise an institution that was entirely dependent on the founder's relationships, credibility, and decision-making authority. Hospitals that have survived their founders' departures without structural crisis are the exception, not the rule. The rest either transition painfully, are sold, or decline.

5. Complaints, Ethics, and Internal Accountability

A well-governed hospital treats patient complaints as a governance function: a source of signal about clinical quality, process failures, and cultural problems that require board-level attention. In governance-weak institutions, complaints are managed as a customer-service activity — to be resolved quickly and quietly, with minimal documentation and no systematic analysis. Ethics committees may exist on paper without operating with independence. Escalation channels for clinical staff with concerns about safety, quality, or conduct may be absent or known to be ineffective. The result is an institution that learns slowly from its failures and accumulates risk silently.

■ The Compounding Dynamic

The governance gap does not remain static. It compounds. A weak board fails to catch a related-party transaction problem, which weakens the hospital's financial position, which creates pressure to increase revenue, which increases clinical pressure on doctors, which increases the risk of over-treatment or adverse events, which generates patient complaints, which are suppressed, which prevents learning, which means the next adverse event arrives without the institution having improved.

Each failure of governance creates the conditions for the next failure. The gap does not hold steady. It widens.

SECTION 3 ■ THE REGULATORY ENVIRONMENT

What the law provides, what it does not, and where the gaps persist

The Framework in Place

India's regulatory framework for private hospitals operates through a combination of central legislation, state-level implementation, voluntary accreditation, and professional self-regulation. The primary instrument is the Clinical Establishments (Registration and Regulation) Act, 2010, which mandates registration of all clinical establishments and empowers state governments to set minimum standards. The Act was a significant step: it created a national framework where none had existed before.

Alongside the Clinical Establishments framework, private hospitals operating as companies are subject to the Companies Act 2013, which prescribes requirements for board composition, audit committees, related-party transaction disclosure, and financial reporting for larger entities. Professional regulation operates through the National Medical Commission (replacing the former Medical Council of India) for medical practitioners, and through the Nursing Council and Pharmacy Council for other healthcare professionals. NABH accreditation, offered by the Quality Council of India, provides a voluntary, quality-oriented standard that addresses clinical and operational processes.

The Regulatory Gaps

The framework's limitations are well-documented. The Clinical Establishments Act has been adopted by only approximately half of India's states and Union Territories. Several major states — including Delhi — had not fully implemented it as of the time of writing. Maharashtra, despite sustained civil society pressure and an expert committee process, allowed draft state legislation to disappear into bureaucratic inaction in 2015. Where the Act has been adopted, enforcement capacity is frequently inadequate: inspections are infrequent, grievance mechanisms are underdeveloped, and compliance data is rarely published in accessible form.

The Act addresses registration and minimum operational standards. It does not address corporate governance: board independence, related-party disclosure, clinical governance structures, or internal accountability mechanisms. A hospital can be fully compliant with the Clinical Establishments framework while maintaining governance practices that would be regarded as inadequate in any other regulated sector.

NABH accreditation, which does address quality and process standards with more rigour, is voluntary and is typically pursued by larger hospitals seeking to attract the insured middle class or international patients. It is not a universal governance mechanism. As research on India's regulatory environment has observed, the system is characterised by the state being simultaneously present and absent: making detailed procedural demands that are sporadically enforced, while leaving the substantive questions of care quality and institutional accountability largely to self-regulation.

■ INFINITY Perspective

The regulatory environment is not the primary obstacle to better governance in promoter-driven hospitals. Most of the governance improvements that matter most can be made voluntarily, without waiting for a regulatory mandate. The obstacle is more often the promoter's willingness to accept genuine constraints on their own discretion — and the absence, in many cases, of a trusted advisor who can make the case for why those constraints serve the promoter's own long-term interests.

The Companies Act — An Underutilised Instrument

For hospital groups structured as companies — particularly those that have grown to a scale where the Companies Act 2013's more stringent provisions apply — the existing corporate governance framework provides meaningful requirements for independent directors, audit committees, and related-party transaction scrutiny. The challenge is enforcement and cultural genuineness: independent directors who are personally connected to the promoter family, audit committees that meet the legal minimum without genuine

independent scrutiny, and related-party disclosures that satisfy the letter of the requirement without its spirit are common in practice. The law provides the instrument. The governance culture must provide the will to use it honestly.

SECTION 4 ■ THE COST OF THE GOVERNANCE GAP

What institutions and patients lose when accountability is absent

The Institutional Cost

The financial cost of poor governance in hospitals is both direct and indirect. The direct costs include: value lost through above-market related-party transactions; procurement inefficiencies where vendor selection is not competitively governed; litigation costs from patient complaints that escalated because internal resolution failed; and the cost of leadership turnover driven by an unaccountable management culture.

The indirect costs are larger and less visible: the talented clinicians who leave for better-governed institutions; the institutional lenders and investors who price governance risk into their terms or decline to engage; the government empanelment schemes whose requirements cannot be met; and the reputational capital that erodes slowly when quality is variable and accountability is absent.

For institutions dependent on Ayushman Bharat PMJAY empanelment and other government scheme revenue — which requires compliance with quality and documentation standards that governance-weak institutions find difficult to maintain — the governance gap has a direct revenue cost that is easily quantifiable if the analysis is honestly done.

The Patient Cost

The patient cost of the governance gap is the most serious and the least discussed. Patients in India's private hospitals exercise choice on the basis of reputation, doctor relationships, and proximity — not on the basis of verifiable quality data or governance transparency. They arrive in conditions of vulnerability, urgency, and information asymmetry. They trust the institution with their health and their family's financial resources.

When governance fails, that trust is betrayed in ways that range from the financially damaging — opaque billing, unnecessary procedures, variable quality — to the clinically serious. A hospital without functioning adverse event reporting, mortality and morbidity review, and protected escalation channels for clinical staff is a hospital that does not learn from its mistakes. Its patients bear the consequence of that institutional amnesia.

“A hospital that does not learn from its failures does not fail once. It fails the same way repeatedly, each time to a patient who trusted it.”

The Sector Cost

At the sector level, the governance gap in promoter-driven hospitals contributes to the erosion of public trust in private healthcare — a trust that, once lost, is recovered only slowly and with great effort. It creates the conditions for adversarial regulation: state governments that cannot distinguish between well-governed and poorly-governed private hospitals tend to regulate all of them with the instruments designed for the worst. Hospitals that govern themselves well are penalised, in regulatory burden and reputational proximity, by the behaviour of those that do not.

SECTION 5 ■ THE PATH TO GENUINE GOVERNANCE

What well-governed hospitals do — and how to get there

The Board: From Formality to Function

The starting point for any governance improvement in a promoter-driven hospital is the board. Not the constitution of the board — most hospitals already have one — but its function. A board that functions is one that meets regularly with adequate preparation time for members, operates with a formal agenda and documented minutes, receives management information sufficient to exercise independent judgment, includes at least two or three genuinely independent directors with no commercial or personal relationship with the promoter family, and has a documented, board-approved policy on related-party transactions that requires independent director approval before any such transaction is entered into.

The test of board independence is not the composition of the board on paper. It is whether the board has ever said no to the promoter about something that mattered. Boards that have never disagreed with the promoter are boards that are not functioning independently, regardless of their formal structure.

Clinical Governance: Protecting the Medical Core

Clinical governance must be established as a domain that is insulated from commercial pressure by design, not by goodwill. The instruments for this are well understood: written clinical protocols for common high-risk conditions, mandatory mortality and morbidity review meetings with documented outcomes and corrective actions, an adverse event reporting system that is non-punitive and genuinely used, a Medical Advisory Committee that operates with defined authority and reports to the board, and protected escalation channels for clinical staff to raise safety or quality concerns without fear of retaliation.

The separation between clinical decision-making and revenue expectation must be expressed in the incentive structure as well as in policy. Doctors whose compensation is directly and predominantly tied to procedure volumes face a structural conflict of interest that no amount of ethical guidance will fully resolve. Incentive structures that reward quality outcomes, patient experience, and appropriate utilisation are more consistent with genuine clinical governance.

Financial Transparency and Related-Party Discipline

Financial governance in a well-governed hospital requires, at minimum: regular board-level review of audited financial statements with independent commentary; a documented procurement policy that specifies competitive bidding requirements and approval thresholds; a related-party transaction register that is

maintained and reviewed by the audit committee quarterly; and an internal audit function that reports to the audit committee rather than to management.

Where promoter-linked entities supply goods or services to the hospital, the terms of those transactions should be tested against market rates annually, documented, and approved by independent directors. This is not merely good governance practice — it is the minimum that institutional lenders, external investors, and accreditation bodies will increasingly require as the sector matures.

Patient-Centric Transparency

Patient-centric governance translates the abstract principles of accountability into the direct experience of the person in the hospital bed. It requires: standardised admission estimates with written disclosure of package inclusions and exclusions; itemised final bills with the right to request explanation; a complaint process that is documented, time-bound, and escalable to the board level; and a patient satisfaction measurement system whose results are reviewed at board level and acted upon.

Hospitals that treat patient feedback as a governance function rather than a marketing tool develop a learning loop that continuously improves clinical and operational quality. Those that suppress, manage, or ignore patient feedback accumulate institutional risk that eventually surfaces in forms that are far more damaging: media investigations, consumer forum proceedings, NABH non-renewals, or regulatory action.

Succession: The Governance Test That Cannot Be Deferred

Succession planning is the ultimate test of governance maturity in a promoter-driven institution. An institution that has a documented succession plan, a leadership pipeline that has been developed deliberately, and a board capable of managing the transition is an institution that has genuinely separated its identity from any one individual. An institution that has not done this work is one significant personal event away from a leadership crisis.

The succession plan should cover the promoter's role, the Medical Director or CMO role, and the CEO or COO role as a minimum. It should identify internal development priorities and external search requirements. It should be reviewed by the board annually. And it should be treated as a governance document, not a personal family matter.

■ INFINITY Perspective

In our consulting experience, the most productive entry point for governance improvement in a promoter-driven hospital is often not the board composition or the financial controls — it is the quality of management information. A promoter who begins receiving structured, comparable, trend-based reporting on clinical quality indicators, financial performance, and patient experience typically becomes a more informed decision-maker and, over time, a more receptive advocate for the governance structures that can sustain that information quality at scale.

SECTION 6 ■ POLICY DIRECTIONS

What government and regulators can do to close the gap

At the Hospital Level

Voluntary governance codes for private hospitals, developed with industry participation and linked to accreditation and empanelment incentives, could establish a meaningful standard without requiring new legislation. Minimum board independence requirements, related-party disclosure obligations, mandatory clinical governance committee structures, and annual patient outcome reporting could be incorporated into NABH accreditation criteria and into the conditions of Ayushman Bharat empanelment. Institutions that meet higher governance standards should receive tangible benefits: faster empanelment processing, higher tariff recognition, preferred status in public-private partnerships.

At the Regulatory Level

The Clinical Establishments framework should be uniformly adopted and meaningfully enforced across all states. This requires investment in enforcement capacity: trained inspectors, digitised registration and inspection systems, published compliance data, and functioning grievance mechanisms. The National Medical Commission should strengthen its oversight of clinical practice standards and create clearer pathways for complaints about systemic institutional failures, not just individual practitioner misconduct.

At the System Level

India needs to move, over time, toward a model of public reporting of clinical quality indicators by hospital. Not the promotional metrics that hospitals currently publish, but standardised, independently verified data on mortality rates, infection rates, complication rates, and patient experience scores. This transparency transforms governance from a private institutional concern into a public accountability mechanism — and it gives patients the information they need to make genuinely informed choices.

Would you like to know more?

This article presents the governance challenge. INFINITY works with hospital promoters, boards, and management teams on the practical response: how to close the governance gap while protecting what the institution has built, how to structure boards that genuinely function, how to build clinical governance frameworks that work in the Indian hospital environment, and how to achieve the operational improvements — cost control, ROI optimisation, and sustainable growth — that better governance enables.

We have developed research-based frameworks for hospital governance optimisation, operational cost control, patient-centric service redesign, and sustainable financial performance. If any aspect of the governance challenge described in this article is relevant to your institution — whether as a promoter, a board member, a clinical leader, or a policy practitioner — we invite you to reach out.

Contact us at infinitynixai.com — and let us begin that conversation.

Quick Reference: India's Key Regulatory Instruments for Private Hospitals

Clinical Establishments Act 2010	Central legislation mandating registration and minimum standards for all clinical establishments. Adopted by approximately half of states. Enforced variably.
Companies Act 2013	Applies to hospital entities incorporated as companies. Prescribes board composition, audit committee, related-party transaction disclosure, and financial reporting requirements.
NABH Accreditation	Voluntary quality accreditation from the Quality Council of India. Addresses clinical and operational standards. Required for some empanelment schemes. Not universal.
National Medical Commission	Successor to the Medical Council of India. Regulates medical education and professional conduct. Limited direct jurisdiction over institutional governance.
Ayushman Bharat PMJAY	Government health insurance scheme. Empanelment conditions include quality and documentation requirements. A potential lever for governance incentives.
Consumer Protection Act 2019	Provides patients recourse through consumer forums for negligence and service deficiency. An external accountability mechanism of growing significance.
State-Level Regulations	Several states — including Tamil Nadu, Karnataka, Kerala, and West Bengal — have enacted their own clinical establishment or private hospital regulation laws, with varying scope and enforcement.

Closing Observation

The promoter-driven hospital has been one of the most important institutional forms in India's healthcare landscape. It built capacity where none existed. It served patients who had nowhere else to go. It produced, in many cases, genuinely excellent clinical outcomes and real social value.

That contribution is not diminished by acknowledging its governance limitations. It is, in fact, honoured by taking those limitations seriously — because the institutions that address them will be the ones that endure, grow, and continue to serve patients with integrity across the decades ahead.

The governance gap in India's promoter-driven hospitals is not an unsolvable problem. It is a structural one, and structural problems have structural solutions. The instruments are available. The knowledge is accessible. What is needed, in most cases, is the willingness to use them honestly — and the trusted guidance to navigate the transition without disrupting what the institution has worked hard to build.

“Governance is not a constraint on what a hospital can become. It is the foundation on which everything it aspires to be must be built.”

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