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Chapter 2

Leadership Competencies As Guardians Of Business Excellence And Human Rights In Corporate Hospitals Of Maharashtra

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Abstract

Healthcare institutions are increasingly recognised as human rights environments where leadership behaviour determines the dignity, wellbeing, and equitable treatment of both employees and patients. This study investigates the role of leadership competencies in driving Business Excellence in corporate hospitals across Maharashtra, India, with particular emphasis on their impact on employee satisfaction and patient care outcomes dimensions fundamentally rooted in human rights principles. Using a quantitative research design, primary data was collected from 450 respondents across 40 corporate hospitals in Mumbai, Pune, and Nashik, achieving a response rate of 93.75%. Five leadership competency dimensions were examined they are Emotional Intelligence, Cross-Culture Communication, Motivation to acquire global skills, Transformational Leadership, and open innovation, through validated instruments yielding a composite reliability coefficient of 0. Regression analysis identified Emotional Intelligence as the strongest predictor of Business Excellence (R^2=0.591), while Mediated Latent Effect Modelling confirmed that competencies influence excellence outcomes through indirect pathways. Findings reveal that empathetic, people-centred leadership significantly enhances employee satisfaction, reduces workplace inequity, and elevates patient safety standards. All critical human rights imperatives in healthcare delivery. Business Excellence frameworks including NABH, EFQM, and Malcolm Baldrige are examined through a human rights lens, demonstrating that organisational excellence and rights-based care are inseparable goals. This paper advocates for embedding human rights literacy within hospital leadership development programmes to ensure equitable, dignified, and inclusive healthcare environments across India's growing corporate hospital sector.

Keywords: Leadership Competencies, Human Rights, Employee Satisfaction, Patient Care, Business Excellence.

INTRODUCTION

The modern healthcare environment is marked by an increasing degree of risk and complexity due to a number of variables, including quickly evolving technologies, rising patient demands, staffing shortages, and increased scrutiny of ethical and high-quality care. This is especially true for corporate hospitals in India, which cater to a significant portion of urban healthcare requirements and function at the intersection of social good and profit-making. Hospitals are now seen as organisations that add value for patients, employees, and society as a whole rather than as service companies, as evidenced by the present discourse. In this regard, healthcare organisations must

be acknowledged as human rights environments where institutional procedures and leadership styles significantly affect people's safety, dignity, and non-discrimination[1].

As stated in Article 21 of the Indian Constitution,[2] the right to health now encompasses conditions that ensure safe working conditions, non-discrimination, and dignified treatment in addition to access to healthcare services[3]. Patients and healthcare professionals consequently acquire rights within the hospital system. Despite advancements in quality improvement methods and health care infrastructure, issues still exist. Health care workers report stress, prejudice, and a lack of support, while patients frequently struggle with communication, informed consent, and quality of care. Although labour rules offer a framework for protecting employees, they are more concerned with ensuring compliance than actual job experience. The current study shows that leadership competences have a major impact on employee happiness, indicating that leadership behaviour beyond legal criteria is necessary for the achievement of employee rights.

The existence of rights is guaranteed by labour legislation, but whether or not such rights are exercised depends on the leadership. These problems imply that while clinical practice is crucial, leadership behaviours that impact organisational culture and decision-making play a major role in a healthcare organization's performance. Therefore, the integration of health care operations with performance and human rights goals is made possible by leadership competencies. In addition to being crucial for managing organisations, leadership characteristics including emotional intelligence, strategic vision, people management, communication skills, and change management are also necessary for providing moral and just healthcare. Emotionally Intelligent leaders foster environments of empathy and respect, protecting the dignity of patients and employees[4].

In accordance with international labour norms against discrimination, people management skills support equity and inclusivity in the workplace. Similarly, protecting patient autonomy through informed consent and communication requires excellent communication skills.

Similar to leadership, healthcare quality and performance are increasingly organised using business excellence models such as the Malcolm Baldrige model, EFQM (European Foundation for Quality Management), and NABH (National Accreditation Board for Hospitals). These models ignore the underlying connection to human rights in favour of efficiency, quality control, and consumer happiness. This is problematic since the health system must incorporate the values of accountability, equity, and dignity in order to attain excellence in healthcare. By examining the importance of leadership abilities in promoting Business Excellence in corporate hospitals in the state of Maharashtra while specifically mentioning human rights, the current study aims to address this shortcoming.

Maharashtra is used as an empirical setting in this study due to its high degree of healthcare development, corporate hospitals, and socioeconomic diversity, which presents both opportunities and challenges for the provision of healthcare. Additionally, this study adds to the conversation by making the case that leadership skills have a direct and significant indirect impact on organisational results, particularly through patient care outcomes and employee satisfaction. While patient care outcomes reflect the exterior manifestation of rights-based health care, employee satisfaction indicates the organization's internal rights environment, including fairness, safety, and psychological welfare. The goal of this research is to reframe leadership as a strategic and moral requirement for healthcare systems by combining leadership theory, business excellence, and the rights-based approach to health. The aim of the study will be able to translate constitutional and international human rights obligations into daily practices within hospitals

REVIEW OF LITERATURE

2.1 Leadership Competencies in Healthcare Organisations

Leadership in the healthcare sector has evolved from administrative control to a complex idea that encompasses behavioural, emotional, and strategic abilities. Emotional intelligence (EI) is a critical component in deciding leadership success, particularly in high-stress, human-centred environments like hospitals, according to Daniel Goleman's ground-breaking research from 1998.[5] Similar to this, Bernard Bass (1985) emphasised that leaders must use the Transformational Leadership Theory[6] to motivate, develop, and inspire followers to achieve higher levels of performance and organisational commitment.

Examples of leadership traits in healthcare settings that go beyond routine managerial duties and directly affect both clinical and non-clinical outcomes include people management, communication, and adaptability. According to Yukl (2013), To accomplish organisational goals, good leaders combine task-oriented and relationship-oriented attitudes[7].

Additionally, research indicates that interdepartmental coordination, staff involvement, and the quality of treatment provided are all strongly impacted by leadership abilities. Nevertheless, there is very little research on leadership as a means of guaranteeing moral and rights-based healthcare delivery, especially in corporate hospital settings, despite the fact that leadership literature covers performance and efficiency outcomes in great detail.

2.2 Business Excellence Frameworks in Healthcare

The European Foundation for Quality Management (EFQM), the Malcolm Baldrige National Quality Award (MBNQA), and the National Accreditation Board for Hospitals (NABH) are examples of business excellence frameworks that offer structured methods for enhancing organisational performance, quality, and stakeholder satisfaction[8]. These frameworks highlight important aspects including workforce participation, customer focus, leadership, and continual improvement. strategy, individuals, and procedures to produce long-lasting outcomes. Despite being widely used, these frameworks primarily concentrate on performance indicators and operational excellence, frequently ignoring human rights aspects like equity, dignity, and non-discrimination as implicit rather than explicit components. This leads to a conceptual gap since rights-based principles must be incorporated into organisational evaluation systems in order to fully attain healthcare excellence.

2.3 Employee Satisfaction as a Human Rights Imperative

Employee satisfaction in the healthcare industry is a reflection of workplace conditions that are in line with core human rights, such as equality, dignity, and safe working conditions, rather than just an organisational consequence. International frameworks that prioritise non-discrimination, equitable treatment, and occupational well-being include the norms of the International Labour Organization(ILO) conventions on non-discrimination[9], occupational safety, and fair treatment establish concrete obligations that, when met, produce measurable employee satisfaction outcomes.[10]

Research consistently demonstrates that satisfied healthcare employees deliver superior patient care. [11]

Therefore, creating a reinforcing chain in which leadership quality shapes, the internal rights environment, which in turn shapes the external rights experience of patients.[12]

Accordingto research, contented healthcare workers exhibit increased engagement, decreased burnout, and better service delivery. On the other hand, ineffective leadership techniques can result in stress, unfairness, and discontent, which eventually impacts patient outcomes as well as employee well-being. Theoretically, the relationship between leadership behaviour and organisational performance is mediated by employee satisfaction. However, the majority of current research looks at this relationship from a productivity perspective, paying little attention to how

it supports employee rights in healthcare facilities.

2.4 Patient Care Quality and Rights-Based Healthcare

Models like Donabedian's Structure–Process–Outcome paradigm[13], which connects organisational architecture and care processes to health outcomes, have historically been used to assess the quality of patient care. Although this paradigm offers a solid basis for evaluating the quality of healthcare, current debate include patient rights and experiences in addition to clinical efficacy. Global frameworks, such as the NABH Patient Rights Charter[14] and the WHO Right to Health[15], highlight important concepts like-

The right to give informed consent
The right to anonymity and Privacy
The right to be treated with dignity and without bias.

In order to guarantee that these rights are respected, leadership skills in particular, communication and emotional intelligence are essential. Communication breakdowns, patient discontent, and even ethical and legal transgressions are all consequences of poor leadership. There is no empirical research directly connecting leadership abilities to rights-based patient care results, despite the growing awareness of patient rights.

2.5 Human Rights Approach to Healthcare Leadership

According to the Rights-Based Approach to Health (RBA-H), healthcare systems are obligated to uphold, defend, and fulfil human rights[16]. This strategy moves the emphasis from service delivery to participation, equity, and accountability. According to this concept, the operationalisation of rights at the organisational level is significantly influenced by leadership. Leaders have an impact on organisational culture, resource allocation, and policy, all of which have an impact on how well healthcare facilities respect human rights. However, the majority of the literature now in publication approaches human rights as a legal or policy issue, with little integration into studies of management and leadership. This gap emphasises the necessity of multidisciplinary research that connects rights-based healthcare delivery with leadership competencies.

2.6 Research Gap

A systematic bibliometric analysis conducted for this research across Scopus, Web of Science, and EBSCO databases covering 21,044 merged records using the Sauer and Seuring (2023). Six-stage SLR protocol identified only approximately 250-300 documents globally.at the intersection of leadership competencies, healthcare excellence, and only 63 papers with all three key words present and human rights. This finding confirms that empirical research linking all three domains remains extremely limited, particularly in the Indian corporate hospital context. The specific gaps identified include-

Leadership studies in healthcare predominantly focus on performance outcomes, with limited attention to rights-based implications of leadership behaviour.

Business Excellence frameworks do not explicitly integrate rights-based indicators as evaluative criteria. Employee satisfaction and patient care outcomes are often studied independently, rather than as interconnected mediating variables linking leadership to organisational performance.

No published quantitative study has simultaneously examined all five leadership competency dimensions and their differential impact on Business Excellence in NABH-accredited corporate hospitals in Maharashtra.

The present study directly addresses these gaps by integrating leadership competency theory, Business Excellence frameworks, and the Rights-Based Approach to Health into a unified concep-

tual model. It examines employee satisfaction and patient care outcomes as mediating variables, providing empirical evidence from corporate hospitals across Maharashtra's three major urban centres.

2.7 Positioning of the Present Study

This study addresses the identified gaps by:

Integrating leadership competencies with Business Excellence frameworks.

Embedding human rights as a central analytical dimension.

Examining employee satisfaction and patient care as mediating variables.

Providing empirical evidence from corporate hospitals in Maharashtra.

THEORETICAL FRAMEWORK

This study is anchored in three complementary theoretical traditions, each contributing a distinct analytical layer to the conceptual model.

3.1. Transformational Leadership Theory (Bass, 1985; Bass & Avolio, 1994)

The main theoretical framework for comprehending how leadership competencies function inside companies is Transformational Leadership Theory[17]. Increased follower performance and organisational commitment are a result of transformational leaders' ability to inspire a common vision, foster intellectual engagement, and offer tailored support. These leader traits are thought to predict patient care quality and employee happiness in the healthcare setting, which in turn influences business excellence outcomes.

3.2. Rights-Based Approach to Health (RBA-H)

According to the Rights-Based Approach to Health, healthcare systems have a responsibility to uphold, defend, and fulfil human rights[18]. Five evaluative criteria are introduced by this framework transparency, accountability, participation, and non-discrimination. Each corresponds precisely to a leadership competency that are Emotional Intelligence, Motivation to Acquire Global Skills, operationalises transparency. Transformational Leadership operationalises accountability, Open Innovation operationalises participation and Cross-Cultural Communication operationalises non-discrimination. By guaranteeing inclusive, equitable, and culturally sensitive interactions in both patient care and professional settings. This mapping creates a crucial theoretical link between models of leadership competency and human rights frameworks. It shows that human rights concepts are institutionalised in healthcare systems through leadership, which is more than just an administrative role.

3.3. Resource-Based View of the Firm

According to Jay Barney (1991), the Resource-Based View (RBV) of the company offers a strategic basis for comprehending how internal organisational resources produce long-term competitive advantage.[19] Resources that are valuable, rare, unique, and non-substitutable (VRIN) allow organisations to attain exceptional and long-lasting performance outcomes, according to resource base view. These VRIN resources include leadership competencies in the context of healthcare organisations. Leadership skills, especially Emotional Intelligence, Cross-Cultural Communication, Transformational Leadership, and Innovation Orientation, are deeply ingrained in organisational culture and are challenging to duplicate or transfer, in contrast to physical infrastructure, technology, or financial capital. These skills meet the requirements of inimitability and non-

substitutability since they are built over time by experience, Institutional practice and education. This viewpoint provides a critical reinterpretation for an audience interested in governance and human rights-Leadership competences are institutional capacities that facilitate the implementation of rights-based healthcare delivery, not just management assets.

Therefore, rather than spending in discrete training interventions, developing leadership competency is similar to building organisational rights infrastructure. In healthcare systems, where formal compliance mechanisms like accreditation standards or regulatory frameworks frequently exist without commensurate improvements in the lived experiences of personnel and patients, this distinction is especially crucial. Although policies may specify rights, leadership is ultimately responsible for ensuring that these rights are successfully applied in day-to-day operations. According to RBV, companies that make investments in the development of leadership skills build internal capacities that support fair, moral, and superior care, thereby coordinating business excellence with human rights objectives.

3.4. Objectives of the Study

The present study pursues five research objectives:

- To analyse the role of leadership competencies in driving Business Excellence in corporate hospitals in Maharashtra.

To evaluate the influence of leadership behaviour on employee satisfaction as an internal human rights outcome within healthcare organisations.

To assess the impact of leadership competencies on patient care quality as an external rights-based healthcare delivery outcome.

To examine the mediating role of employee satisfaction and patient care outcomes in the relationship between leadership competencies and Business Excellence.

To interpret healthcare leadership within a rights-based framework that links organisational performance with constitutional and ethical obligations under Article 21 of the Constitution of India and international human rights instruments.

3.5. Hypotheses

H1: Leadership Competencies (composite) have a significant positive impact on Business Excellence.

H2: Motivation to Acquire Global Skills significantly predicts Patient Satisfaction.

H3: Emotional Intelligence significantly predicts Business Excellence.

H4: Open Innovation significantly predicts Impact on Society.

H5: Transformational Leadership significantly predicts Impact on Society.

H6: Cross-Cultural Communication significantly predicts Impact on Society.

H7: Employee Satisfaction significantly predicts Business Excellence.

H8: Patient Satisfaction significantly predicts Business Excellence.

H9: Impact on Society significantly predicts Business Excellence.

RESEARCH METHODOLOGY

6.1 Research Design and Paradigm

The study adopts a quantitative, cross-sectional survey design grounded in a positivist paradigm and a hypothetico-deductive approach. This design enables systematic hypothesis testing across a large, geographically dispersed sample while maintaining analytical replicability. Ethical clearance was obtained from the institutional review board; all participation was voluntary and anonymous, consistent with the principles of research ethics and participant rights.

6.2 Sample and Data Collection

Primary data was collected from 450 healthcare professionals across 40 corporate hospitals in Maharashtra Mumbai (metropolitan), Pune (Tier I), and Nashik (Tier II) through stratified random sampling. Respondents included senior administrators, department heads, medical superintendents, and quality managers. The achieved response rate was 93.75%, indicating high engagement and data quality. A five-point Likert scale instrument of 40 items was administered, covering eight constructs across two conceptual domains: leadership competencies and business excellence outcomes.

6.3 Construct Operationalisation

The five leadership competency dimensions examined are: Emotional Intelligence (EI), Cross-Cultural Communication (CC), Motivation to Acquire Global Skills (MGS), Transformational Leadership (TL), and Open Innovation (OI). Business Excellence outcomes are assessed through three mediating constructs Patient Satisfaction (PS), Employee Satisfaction (ES), and Impact on Society (IOS) and one dependent variable, Business Excellence (BE). This operationalisation is consistent with the human rights framework: PS represents the external rights environment experienced by patients, ES represents the internal rights environment experienced by employees; IOS represents the organisation's systemic contribution to societal rights and wellbeing.

6.4 Instrument Reliability

Construct	No. of Items	Cronbach Alpha	Interpretation
Emotional Intelligence (EI)	5	0.89	Reliable
Cross-Cultural Communication (CC)	5	0.87	Reliable
Motivation to Acquire Global Skills (MGS)	5	0.84	Reliable
Transformational Leadership (TL)	5	0.87	Reliable
Open Innovation (OI)	5	0.76	Reliable
Patient Satisfaction (PS)	5	0.81	Reliable
Employee Satisfaction (ES)	5	0.83	Reliable
Impact on Society (IOS)	5	0.80	Reliable
Overall Instrument (40 items)	40	0.843	Good Overall Reliability

Table 1: Cronbach's Alpha Reliability Coefficients by Construct (n = 450)

All constructs exceeded the minimum acceptable threshold[20] of $\alpha = 0.70$ (Nunnally, 1978), with values ranging from 0.76 (Open Innovation) to 0.89 (Emotional Intelligence). The overall instrument returned a Cronbach's Alpha of 0.843 across all 40 items, with a combined reliability coefficient of 0.908, indicating excellent internal consistency.

6.5 Analytical Techniques

Analysis proceeded through five stages: (1) reliability analysis (Cronbach's Alpha); (2) normality and homogeneity testing via one-way ANOVA across demographic categories; (3) Principal Component Analysis (PCA) with Varimax rotation- KMO = 0.820, Bartlett's chi² = 1820, df = 28, $p < .001$, two components retained explaining 65.73% of total variance[21] (4) Pearson correlation analysis; (5) simple linear regression for direct hypothesis testing (H1–H8); and (6) Structural Equation Modelling (SEM) using path analysis with observed variables (Jamovi semlj, ML estimation) to test mediation and confirm the full structural model.[22]

FINDINGS

7.1 Regression Analysis — Direct Hypotheses

Table 2 presents the complete regression results for all nine hypotheses.

Table 2: Summary of Regression Results — All Hypotheses (n = 450)

Hyp.	Predictor (IV)	Outcome (DV)	β	R^2	F	p	Decision
H1	LC_Mean	BE_Mean	0.756	0.568	590	< .001	Supported
H2	MGS_Mean	PS_Mean	0.668	0.446	361	< .001	Supported
H3	EI_Mean	BE_Mean	0.769	0.591	648	< .001	Supported
H4	OI_Mean	IOS_Mean	0.672	0.451	368	< .001	Supported
H5	TL_Mean	IOS_Mean	0.561	0.315	206	< .001	Supported
H6	CC_Mean	IOS_Mean	0.667	0.445	360	< .001	Supported
H7a	ES_Mean	BE_Mean	0.594	0.353	245	< .001	Supported
H7b	PS_Mean	BE_Mean	0.783	0.613	710	< .001	Supported
H8	IOS_Mean	BE_Mean	0.764	0.584	629	< .001	Supported

All nine hypotheses are supported at $p < .001$. Three findings are of particular significance for the human rights framing of this paper. First, Emotional Intelligence is the strongest individual predictor of Business Excellence ($\beta = 0.769$, $R^2 = 0.591$, $F = 648$), confirming that the capacity for empathic, dignity-respecting leadership is the single most powerful driver of organisational performance. Second, Patient Satisfaction is the most powerful mediating predictor of Business Excellence ($\beta = 0.783$, $R^2 = 0.613$, $F = 710$), establishing that rights-based patient experience is the primary pathway from leadership quality to institutional excellence. Third, Cross-Cultural Communication significantly predicts Impact on Society ($\beta = 0.667$, $R^2 = 0.445$), directly linking culturally competent leadership to community-level rights and equity outcomes.

7.2 Structural Equation Modelling — Full Mediation

Table 3 presents the SEM path coefficients for the full structural model.

Table 3: SEM Path Coefficients — Full Structural Model (n = 450)

Predictor	Outcome	B	R^2	z	p	Interpretation
OI_Mean	IOS_Mean	0.388	0.547	9.45	< .001	Significant
CC_Mean	IOS_Mean	0.340	0.547	7.27	< .001	Significant
TL_Mean	IOS_Mean	0.120	0.547	2.75	0.006	Significant
MGS_Mean	PS_Mean	0.668	0.446	19.04	< .001	Significant

IOS_Mean	BE_Mean	0.481	0.999	277.9	< .001	Significant
PS_Mean	BE_Mean	0.505	0.999	344.3	< .001	Significant
ES_Mean	BE_Mean	0.509	0.999	376.8	< .001	Significant
LC_Mean	BE_Mean	-0.001	0.999	-0.62	0.537	Not Significant Full Mediation

The most consequential finding for the human rights argument of this paper is the non-significant direct path from Leadership Competencies to Business Excellence ($\beta = -0.001$, $p = 0.537$). This confirms full mediation: leadership competencies have no statistically significant direct effect on Business Excellence when the three mediating variables are present in the model. Leadership influences excellence entirely through Patient Satisfaction ($\beta = 0.505$), Employee Satisfaction ($\beta = 0.509$), and Impact on Society ($\beta = 0.481$), which together explain 99.9% of variance in Business Excellence ($R^2 = 0.999$).

In the rights-based frame, this is a pivotal finding. It establishes that leadership produces excellence not by controlling operations but by creating the conditions under which patients experience dignity and rights-compliant care, employees experience fair and safe working environments, and the organisation contributes positively to societal wellbeing. Business Excellence, in this model, is the aggregate product of rights fulfilment not its precondition.

7.3 CFA Model Fit

Table 4 presents the confirmatory factor analysis fit statistics.

Fit Index	Obtained Value	Threshold	Verdict	Reference
CFI	0.995	≥ 0.95	Excellent	Hu & Bentler (1999)
TLI	0.989	≥ 0.95	Excellent	Tucker & Lewis (1973)
SRMR	0.007	≤ 0.08	Excellent	Kline (2016)
RMSEA	0.057	≤ 0.06	Acceptable	Browne & Cudeck (1993)
Chi^2/df	2.48	≤ 3.0	Acceptable	Hair et al. (2019)
Composite Reliability	0.908	> 0.70	Excellent	Fornell & Larcker (1981)

Table 4: CFA Model Fit Indices (Eight-Factor Model, n = 450)

The measurement model demonstrates excellent fit [23]across all primary indices (CFI = 0.995, TLI = 0.989, SRMR = 0.007). The RMSEA value of 0.057 falls within the acceptable range[24] (≤ 0.06). All standardised factor loadings exceeded 0.90, substantially above the recommended threshold of 0.70 (Hair et al., 2019), confirming strong convergent validity. The Composite Reliability of 0.908 confirms the internal consistency and construct validity of the measurement model. These values were computed using multivariate analysis[25] consistent with Hair et al.'s (2019) recommendations for structural modelling.

DISCUSSION AND HUMAN RIGHTS ANALYSIS

8.1 Emotional Intelligence as a Mechanism of Compliance

Emotional Intelligence's status as the best predictor of Business Excellence ($R^2 = 0.591$) is not from the perspective of human rights[26]. This is simply a management insight. When leaders have emo-

tional intelligence the ability to perceive, manage and understand emotions with empathy and self-control they establish institutional contexts of dignity, psychological safety and civil interaction. The Supreme Court of India defined the right to live with dignity in Francis Coralie Mullin v. Union Territory of Delhi (1981) [27]and expounded upon it in Olga Tellis v. Bombay Municipal Corporation (1985)[28]. These are not workplace benefits, but rather the practical application of Article 21's guarantees of that right. Emotionally intelligent hospital leadership is, constitutionally speaking, the key factor in the protection and denial of the right to dignity for patients and doctors alike in the everyday operations of the hospital.

8.2 Cross-Cultural Communication and the Right to Non-Discriminatory Care

Cross-Cultural Communication is a significant predictor of Impact on Society ($\beta = 0.667$, $R^2 = 0.445$) and its correlation with Transformational Leadership ($r = 0.669$) and Impact on Society ($r = 0.658$) confirms it as a ”leveraging” right-enablers competency. The International Labour Organisation's (ILO) Convention[29] 111 on non-discrimination in employment and the National Accreditation Board for Hospitals and Healthcare Providers' (NABH) Patient Rights Charter's[30] guarantee of care free from discrimination on the grounds of gender, religion, caste or socio-economic status, both need institutional mechanisms to operationalise these protections. Cross-cultural communication competency is just such a mechanism: leaders who navigate cultural and language diversity in patient care and clinical teams institutionalise reductions in discriminatory care practices, increase the quality of informed consent across diverse groups, and foster trust and access to health care for marginal groups[31].

8.3 Full Mediation and the Architecture of Rights Compliance

The SEM result of full mediation is the major contribution of the study to the human rights perspective. The non-significant direct leadership path to business excellence ($\beta = -0.001$, $p = 0.537$) shows that leadership does not impact institutional excellence as a leader who controls the institution. It does so by producing or failing to produce three rights environments i.e the patient rights environment (Patient Satisfaction), the employee rights environment (Employee Satisfaction) and the society rights environment (Impact on Society). This design is identical with the RBA-H's distinction between process and outcome accountability[32]. Rights are not realised by a hospital's policies and procedures or by its accreditation, they are realised by the quality of processes that the rights-holders experience in a given institutional context[33]. As the SEM evidence confirms, in corporate hospitals in Maharashtra, these processes are dominated by the competency of leadership making leadership the primary site of both rights' fulfilment and rights failure for the health institution.

8.4 Employee Satisfaction as an Internal Rights Barometer

Employee Satisfaction accounts for 35.3% of variance in Business Excellence ($R^2 = 0.353$) and is the second strongest mediating variable in the SEM ($\beta = 0.509$). One-way ANOVA findings show that there is a statistically significant gender difference in Employee Satisfaction ($p < .001$) and no other significant gender differences across all the leadership competency constructs, which confirm that the internal rights environment, including gender equity in employee satisfaction, is a systemic rather than individual phenomenon and is caused by the structural practices of leadership[34]. This finding carries direct implications for compliance with ILO Convention 111[35] and the Government of Maharashtra's gender equality policies in public employment.[36]

IMPLICATIONS

9.1 For Governance and Leadership Development

The research evidence shows that leadership competency development in corporate hospitals is a not a luxury training expense but a rights governance. The WHO's framework on transformational leadership in health underscores that systematic, multi-competency leadership assessment is a prerequisite for organisational quality and rights compliance.[37] Hospital management and boards should ensure systematic, multi-competency leadership assessment based on the five-dimension framework developed in this study. Emotional Intelligence development should be the top priority as the most valuable individual competency. Cross-Cultural Communication should be directly addressed as part of non-discrimination and informed consent requirements in NABH accreditation standards.

9.2 NABH Accreditation Policy

NABH standards should include explicit indicators of leadership competency in addition to governance and process criteria[38]. The full mediation finding (that leadership only affects excellence through patient, employee and social rights outcomes) implies that NABH assessors should not only check that leadership is in place but that it produces the patient and staff rights outcomes. Composite Reliability (0.908) and CFA fit (CFI = 0.995) validate the measurement model as a test.

9.3 Maharashtra Health Care Regulation

The Maharashtra Clinical Establishments (Registration and Regulation) Act, 2010[39] should be amended to institutionalise minimum competency standards for Chief Medical Officers, Hospital Directors and Quality Managers in NABH-accredited hospitals. Human rights sensitisation - to Article 21 principles, ILO workplace rights and NABH patient rights - should be mandated as part of the registration renewal process. The difference in Employee Satisfaction (ANOVA $p < .001$) by gender also suggests that gender equity audits of hospital leadership should be included in the compliance process.

Conclusion

This study provides empirical evidence that leadership competencies are the primary organisational mechanism through which human rights are operationalised or undermined in corporate hospitals in Maharashtra. The full mediation confirmed by Structural Equation Modelling — the non-significant direct path from Leadership Competencies to Business Excellence ($\beta = -0.001$, $p = 0.537$) alongside highly significant mediated pathways through Patient Satisfaction ($\beta = 0.505$), Employee Satisfaction ($\beta = 0.509$), and Impact on Society ($\beta = 0.481$) — establishes that institutional excellence is the product of rights-based leadership processes, not of operational directives administered around them.

Emotional Intelligence ($R^2 = 0.591$) and Cross-Cultural Communication ($R^2 = 0.445$ for societal impact) emerge as the two leadership competency dimensions with the strongest human rights implications, directly enabling constitutional rights under Article 21 and international obligations under ILO Convention 111 and the WHO Right to Health framework. Motivation to Acquire Global Skills ($\beta = 0.668 \rightarrow$ Patient Satisfaction), Transformational Leadership ($\beta = 0.561 \rightarrow$ societal impact), and Open Innovation ($\beta = 0.388 \rightarrow$ societal impact) provide complementary rights-enabling pathways through which hospital leaders shape equitable, participatory, and accountable institutional environments.

The study's central conclusion for a legal and governance audience is this: in Maharashtra's corporate hospitals, the protection or violation of patient rights and employee rights is not primarily a function of formal policy documents, accreditation certificates, or regulatory inspections. It is a function of leadership. Leaders who are emotionally intelligent, cross-culturally competent,

globally oriented, transformational motivated, and open to innovation structurally produce rights-compliant institutions. Leaders who lack these competencies structurally produce rights deficits — regardless of what their compliance documentation states. Treating leadership competency development as a rights obligation, not a management option, is the single most actionable reform available to hospital governance bodies, accreditation authorities, and healthcare regulators in Maharashtra.

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