

Corporate Governance in Private Healthcare Facilities: A Conceptual Framework for Addressing Family Ownership and Organizational Sustainability

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ABSTRACT

Family-owned private healthcare facilities constitute a significant and expanding component of health systems, particularly in emerging economies. Yet existing corporate governance theories remain conceptually incomplete when applied to these organizations. Dominant governance frameworks are largely grounded in financial performance logic and assume that governance failures produce primarily economic and reversible consequences. In healthcare contexts, however, governance decisions directly affect patient safety, clinical integrity, and ethical accountability, introducing a life-critical asymmetry absent in traditional corporate settings. This paper develops a sector-sensitive conceptual framework that integrates agency theory, stewardship theory, and the socioemotional wealth perspective within a healthcare-specific accountability lens. It argues that family ownership operates as a structurally contingent governance condition: while concentrated control may foster long-term orientation and reputational stewardship, it may also weaken governance independence and compromise clinical oversight under conditions of limited regulatory enforcement. The framework positions governance independence as the primary institutional mechanism linking family ownership to organizational outcomes, with service quality and staff retention identified as central mediating pathways shaping long-term sustainability. By reconceptualizing governance effectiveness beyond financial metrics, this study advances corporate governance theory and provides a structured model for empirical examination of family-controlled healthcare organizations. The analysis offers theoretical refinement and practical guidance for strengthening accountability systems in life-critical service environments.

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KEYWORDS: Family-owned healthcare, Corporate governance, Organizational sustainability, Service quality Staff retention.

1. INTRODUCTION

Private healthcare facilities constitute a critical and rapidly expanding component of health systems globally, particularly in emerging economies where they complement public sector service delivery. In many low- and middle-income countries, private providers address significant access gaps, contribute to service availability, and increasingly shape population health outcomes and economic development (Ahn et al., 2020; Trebicka, 2023). As healthcare demand intensifies amid persistent public resource constraints, private healthcare organizations

have become central actors in health service provision (Gouveia & Fonseca, 2021; Herrera et al., 2025).

A defining characteristic of many private healthcare facilities, especially in emerging markets, is concentrated family-based ownership and control. Unlike publicly listed corporations with dispersed shareholding structures, family-owned healthcare organizations are typically governed by a small group of related individuals who retain substantial authority over strategic and operational decisions (Zaman et al.,

2020). Family ownership can foster continuity, long-term orientation, and reputational stewardship. However, it also introduces distinctive governance dynamics that shape accountability, professional autonomy, and organizational performance in complex ways. These governance tensions are particularly consequential in healthcare, a sector characterized by high ethical standards, regulatory scrutiny, and the imperative to balance financial sustainability with patient welfare and clinical quality.

In family-owned private healthcare facilities, governance challenges frequently stem from centralized decision-making, blurred boundaries between ownership and management, and the prioritization of family-centered objectives alongside, or occasionally above, formal organizational goals (Gouveia & Fonseca, 2021; Hasan et al., 2023; Amin et al., 2022). Such dynamics may weaken internal controls, constrain managerial independence, and reduce transparency. In healthcare contexts, these weaknesses extend beyond administrative inefficiencies; they may directly affect clinical quality, staff morale, patient safety, and public trust (Moussa & Elgiziry, 2019; Zientara, 2015; Ponce et al., 2024). The sensitivity of healthcare delivery amplifies the consequences of governance failure, rendering effective oversight not merely a matter of corporate efficiency but of institutional legitimacy and human welfare.

Although corporate governance scholarship provides substantial insights into ownership structures, board effectiveness, and agency relationships, it remains heavily grounded in the assumptions of publicly traded firms operating under dispersed ownership and strong external monitoring (Hasan et al., 2023; Kuan et al., 2017). These assumptions often do not hold in privately owned, family-controlled healthcare organizations. Moreover, research on family firms frequently emphasizes financial performance or succession dynamics while paying comparatively limited attention to sector-specific environments such as healthcare, where professional norms, ethical obligations, and service outcomes are central (Li, 2018; Upadhyayula & Thomas, 2025). As a result, the governance dynamics of family-owned private healthcare facilities remain theoretically fragmented and insufficiently integrated (Pramono et al., 2023; Rawaf & Alfalih, 2024).

More critically, mainstream governance theory implicitly assumes that the consequences of governance failure are primarily economic and reversible. In healthcare contexts, however, governance decisions directly shape patient safety,

clinical outcomes, and ethical accountability. Failures may result not only in financial loss but in irreversible harm. This life-critical asymmetry fundamentally alters the stakes of ownership concentration and governance design. Existing theoretical lenses, including agency theory, stewardship theory, and the socioemotional wealth (SEW) perspective, each illuminate aspects of family ownership behavior, yet none independently captures the interaction between concentrated control, professional medical norms, and institutional accountability in life-critical service environments.

This paper argues that existing corporate governance theories are conceptually incomplete when applied to family-owned private healthcare facilities. By integrating agency theory, stewardship theory, and the SEW perspective within a healthcare-specific accountability framework, this study reconceptualizes governance effectiveness beyond financial metrics. It positions clinical oversight and workforce stability as central mediating mechanisms linking ownership structure to long-term organizational sustainability. Rather than treating family ownership as inherently beneficial or detrimental, the proposed framework specifies the conditions under which concentrated control enhances or undermines service quality, staff retention, and institutional legitimacy.

The contribution of this paper is therefore twofold. Theoretically, it advances a sector-sensitive conceptual framework that bridges family business governance research with healthcare management scholarship, introducing a life-critical accountability lens to corporate governance analysis. Practically, it offers guidance for family owners, healthcare executives, and policymakers seeking to design governance structures that balance family aspirations with clinical excellence, ethical responsibility, and sustainable service delivery. Unlike prior governance scholarship that evaluates effectiveness primarily through financial performance or reputational preservation, this study contends that governance in healthcare must be judged by its capacity to prevent irreversible clinical harm under concentrated ownership conditions.

The remainder of this paper is organized as follows. Section 2 reviews the relevant literature on corporate governance in family firms, theoretical foundations of family ownership, and governance in healthcare organizations. Section 3 presents the conceptual framework and associated propositions. Section 4 outlines the methodological approach underpinning this conceptual analysis. Section 5 discusses theoretical and practical implications, limitations, and

directions for future research, followed by the conclusion.

2. Literature Review

2.1. Corporate Governance in Family-Owned Firms

Corporate governance in family-owned firms has attracted increasing scholarly attention due to its distinctive ownership structures, control mechanisms, and decision-making dynamics. In the context of family-owned private healthcare facilities, governance issues assume heightened importance because organizational decisions directly affect not only financial outcomes but also service quality, ethical standards, patient safety, and staff welfare. Unlike publicly listed healthcare organizations, family-owned private healthcare facilities operate within governance arrangements shaped by concentrated ownership, strong family influence, and limited external monitoring, which jointly create both governance strengths and vulnerabilities.

2.1.1. Ownership Concentration

Ownership concentration is a defining feature of family-owned private healthcare facilities, where equity ownership and control are typically held by founding families or a small group of related individuals. High ownership concentration aligns ownership and control, potentially reducing classic owner–manager (principal–agent) conflicts by enabling family owners to closely monitor operations and ensure long-term commitment (Hasan et al., 2023; Zaman et al., 2020). In healthcare settings, this concentrated ownership can support continuity of vision, reinvestment in clinical infrastructure, and long-term service provision, particularly in environments characterized by weak public healthcare systems.

However, the same concentration of ownership can generate governance challenges when dominant families prioritize socioemotional wealth such as family reputation, legacy, and control over formal governance standards and professional management practices (Gouveia & Fonseca, 2021). In private healthcare facilities, this may translate into resistance to external scrutiny, limited disclosure, and reluctance to delegate authority to non-family professionals. As a result, ownership concentration can constrain managerial autonomy and weaken accountability mechanisms, with potential implications for operational efficiency and quality of care.

2.1.2. Board Control

Board structures in family-owned private healthcare facilities are often characterized by strong family dominance, with board seats occupied by family members or close affiliates. This concentration of

board control allows families to exert significant influence over strategic decisions, executive appointments, and resource allocation (Amin et al., 2022). From a stewardship perspective, family-controlled boards may promote long-term orientation and patient-centered values aligned with the family's legacy goals.

Conversely, excessive family control over boards can undermine board independence and reduce the effectiveness of internal governance mechanisms. Empirical studies suggest that when boards lack independent directors, their capacity to challenge dominant family decisions or enforce professional standards is significantly weakened (Ponce et al., 2024). In healthcare organizations, weak board oversight can have serious consequences, as it may allow non-merit-based appointments, underinvestment in clinical quality, or tolerance of practices that compromise patient safety and staff morale.

2.1.3. Principal–Principal Conflicts

While concentrated ownership may reduce principal–agent conflicts, it often intensifies principal–principal conflicts, particularly between controlling family owners and minority shareholders or other stakeholders (Kuan et al., 2017). In family-owned private healthcare facilities, such conflicts arise when controlling families use their dominant position to pursue private benefits such as family employment, related-party transactions, or preferential resource allocation at the expense of organizational efficiency and stakeholder welfare (Hasan et al., 2023).

These conflicts are especially pronounced in emerging economies where legal protections for minority shareholders and institutional enforcement mechanisms are relatively weak (Li, 2018; Upadhyayula & Thomas, 2025). In healthcare contexts, principal–principal conflicts extend beyond shareholders to include patients, employees, and regulators. Governance failures driven by self-serving family interests can undermine service quality, increase staff turnover, and erode public trust, thereby threatening organizational sustainability (Basly & Saadi, 2020).

2.1.4. Private versus Public Firm Governance

Significant differences exist between governance structures in private family-owned healthcare facilities and publicly listed healthcare firms. Public firms typically operate under dispersed ownership, stronger regulatory oversight, mandatory disclosure requirements, and external market discipline, which collectively enhance transparency and accountability (Zaman et al., 2020). In contrast, private family-owned healthcare facilities face limited external

monitoring and are less constrained by capital market pressures.

While this governance flexibility can allow private healthcare firms to respond quickly to local health needs and pursue long-term strategies, it also increases the risk of governance opacity and entrenchment of family interests (Gouveia & Fonseca, 2021). The absence of strong external governance mechanisms places greater reliance on internal controls, board effectiveness, and ethical leadership. When these internal mechanisms are weak, private healthcare facilities are more vulnerable to governance failures that adversely affect service delivery and long-term viability (Herrera et al., 2025).

Taken together, the literature suggests that corporate governance in family-owned private healthcare facilities is shaped by a complex interaction between ownership concentration, board control, and principal–principal conflicts, all within a governance environment that differs fundamentally from that of public firms. These elements do not operate in isolation; rather, they jointly influence how strategic decisions are made, how accountability is enforced, and how organizational objectives balance financial sustainability with healthcare-specific ethical and professional obligations. An integrative understanding of these governance dynamics is therefore essential for explaining variations in service quality, staff retention, and sustainability outcomes in family-owned private healthcare facilities.

2.2. Theoretical Foundations

Corporate governance in family-owned private healthcare facilities has traditionally been interpreted through three dominant theoretical lenses: agency theory, stewardship theory, and the socioemotional wealth (SEW) perspective. While each framework provides important explanatory leverage, their underlying assumptions become structurally constrained when applied to life-critical service environments.

All three perspectives are implicitly grounded in economically bounded evaluative criteria. Governance effectiveness is typically assessed in terms of financial performance, reputational preservation, control retention, or long-term survival. These assumptions are analytically coherent in industries where governance failure produces primarily economic and reversible consequences. However, private healthcare facilities operate under fundamentally different normative conditions. Governance decisions in this sector directly influence patient safety, clinical integrity, ethical accountability, and public trust. Failure may generate irreversible human harm rather than merely financial

inefficiency. Under such conditions, the explanatory scope of dominant governance theories becomes incomplete.

Rather than rejecting these theories, this study treats them as partial explanations whose boundary conditions are exposed in life-critical service contexts. The following subsections critically evaluate each framework in relation to family-owned private healthcare facilities.

2.2.1. Agency Theory

Agency theory is premised on the separation of ownership and control, assuming that managers (agents) are self-interested and inclined to pursue personal objectives unless constrained by monitoring and incentive mechanisms (Jensen & Meckling, 1976). Governance structures—boards, audits, performance contracts—are therefore designed to minimize agency costs and align managerial actions with shareholder interests.

In family-owned firms, agency theory is particularly useful for explaining principal–principal conflicts, where controlling family owners may expropriate minority shareholders or pursue private benefits (Villalonga & Amit, 2006). In private healthcare facilities, concentrated ownership may reduce classic owner–manager conflicts but intensify risks associated with nepotism, related-party transactions, and discretionary resource allocation (Kuan et al., 2017). Under conditions of weak regulatory enforcement, these dynamics can undermine governance independence.

However, agency theory is normatively anchored in financial utility maximization. It conceptualizes governance failure primarily as economic misalignment and resource inefficiency. In healthcare contexts, this framing becomes insufficient. Governance breakdowns may result not merely in financial loss but in compromised patient safety and ethical violations. Agency theory offers limited analytical tools for addressing professional medical norms, clinical accountability structures, or the irreversible consequences of oversight failure (Herrera et al., 2025). Consequently, while agency theory illuminates control conflicts, it under-theorizes the ethical and clinical dimensions central to healthcare governance.

2.2.2. Stewardship Theory

Stewardship theory challenges the opportunistic assumptions of agency theory by positing that managers and owners can act as stewards whose interests are aligned with organizational objectives (Davis et al., 1997). It emphasizes intrinsic

motivation, trust, long-term orientation, and reputational commitment.

This perspective is particularly resonant in family-owned healthcare facilities, where family owners often view the organization as an extension of family identity and legacy. Stewardship logic helps explain sustained reinvestment in infrastructure, continuity of care, and commitment to community service (Gómez-Mejía et al., 2007). In healthcare environments, such long-term orientation may support patient-centered values and service quality improvements.

Yet stewardship theory risks over-romanticizing concentrated control. In life-critical service environments, reliance on presumed benevolence is structurally fragile. Governance systems built primarily on trust may weaken formal oversight, suppress dissent, and obscure power asymmetries. When independent governance mechanisms are underdeveloped, stewardship assumptions may unintentionally legitimize control entrenchment and reduce accountability (Ponce et al., 2024). Moreover, stewardship theory offers limited guidance when family objectives diverge from professional healthcare standards or regulatory expectations. In such cases, alignment cannot be assumed; it must be institutionally safeguarded.

2.2.3. Socioemotional Wealth (SEW) Perspective

The SEW perspective extends governance analysis by recognizing that family owners derive utility from non-financial benefits such as control, identity, reputation, and transgenerational succession (Gómez-Mejía et al., 2007). Preservation of socioemotional wealth often becomes the dominant reference point guiding governance decisions.

In family-owned private healthcare facilities, SEW motivations can positively reinforce ethical conduct and reputational vigilance. Because service failures directly threaten family identity within the community, reputational concerns may incentivize quality improvement and patient-centered care (Hasan et al., 2023).

However, SEW preservation may also generate governance distortions. The desire to maintain family control can discourage transparency, resist professionalization, and limit external scrutiny—even when such reforms are necessary to strengthen clinical governance systems (Moussa & Elgiziry, 2019). In life-critical contexts, excessive control preservation may conflict with institutional safeguards designed to prevent medical error and ensure regulatory compliance. While SEW explains why families value continuity and legacy, it does not fully theorize how these motivations interact with

formalized clinical accountability mechanisms required in healthcare environments.

Synthesis and Theoretical Boundary Conditions

Although agency theory, stewardship theory, and the SEW perspective each illuminate important dimensions of family governance, none independently captures the interaction between concentrated ownership, professional medical norms, and institutionalized clinical oversight. A common limitation across these frameworks is their implicit reliance on economically bounded conceptions of governance performance.

Private healthcare facilities occupy a hybrid organizational space: they are economic enterprises, social institutions, and ethical service providers simultaneously. Governance effectiveness in such settings cannot be evaluated solely through financial resilience, reputational preservation, or alignment assumptions. It must also be assessed through the robustness of independent clinical accountability systems capable of preventing irreversible harm.

The life-critical nature of healthcare thus exposes the boundary conditions of dominant governance theories. Rather than dismissing these frameworks, this study integrates them within a sector-sensitive model that explicitly incorporates governance independence, clinical oversight, and workforce stability as mediating mechanisms linking ownership structure to long-term organizational sustainability.

2.3. Corporate Governance in Healthcare Organizations

Corporate governance in healthcare organizations differs structurally from governance in most other industries because it operates within a life-critical service environment where organizational decisions may generate irreversible human consequences. While governance models in finance, manufacturing, and retail are largely evaluated through financial performance, shareholder value protection, and market discipline, healthcare governance must simultaneously safeguard patient safety, ethical integrity, and public trust. This distinction introduces a fundamental asymmetry: governance failure in healthcare may result not merely in economic loss, but in clinical harm, morbidity, or mortality. Consequently, traditional governance frameworks require contextual adaptation when applied to private healthcare facilities.

2.3.1. Clinical Governance as a Core Accountability Mechanism

Clinical governance constitutes the institutional architecture through which healthcare organizations ensure quality assurance, risk management, and

professional accountability (Scally & Donaldson, 1998). Unlike operational governance systems focused primarily on financial oversight, clinical governance directly structures the monitoring of patient outcomes, adherence to evidence-based standards, and systemic learning from medical error.

In family-owned private healthcare facilities, concentrated ownership may enable rapid decision-making and long-term investment in infrastructure. However, where clinical oversight mechanisms are subordinated to centralized family authority, quality assurance may become personalized rather than institutionalized. In such contexts, patient safety may depend on individual competence rather than system-level safeguards. This introduces governance fragility, as clinical accountability becomes contingent on family discretion rather than formalized independent review structures (Braithwaite et al., 2017; Walshe & Smith, 2016).

Therefore, governance effectiveness in healthcare cannot be measured solely through financial sustainability; it must also be evaluated through the robustness of clinical monitoring systems capable of functioning independently of ownership influence.

2.3.2. Ethical Accountability Under Concentrated Ownership

Healthcare governance is normatively distinct because it is grounded in ethical principles including beneficence, non-maleficence, justice, and transparency (Emanuel et al., 2020). These ethical imperatives are not peripheral but central to organizational legitimacy. In private healthcare settings, especially family-controlled facilities, ethical accountability intersects directly with ownership power.

Family ownership may reinforce ethical conduct when reputational preservation and community embeddedness align with patient-centered values. However, concentrated authority may also weaken internal dissent mechanisms, reduce whistleblowing capacity, and blur boundaries between economic and clinical decision-making. Where governance structures lack independence, ethical accountability may become subordinated to family control preservation.

The life-and-death asymmetry of healthcare intensifies this risk. In industries where harm is financial and reversible, governance distortions may be absorbed through market correction. In healthcare, ethical governance failures may produce irreversible consequences. This asymmetry demands governance arrangements that embed ethical oversight

structurally rather than relying on personal integrity alone.

2.3.3. Regulation, Public Trust, and Institutional Legitimacy

Regulatory frameworks in healthcare function not merely as compliance mechanisms but as institutional safeguards for public trust (Busse et al., 2019). Trust in healthcare organizations is built on perceptions of transparency, accountability, and adherence to professional standards (Gilson, 2003). In private healthcare environments, particularly within emerging markets, regulatory enforcement may be uneven, increasing reliance on internal governance quality.

Family-owned private healthcare facilities often operate with limited disclosure obligations compared to publicly listed entities. While such flexibility may enhance strategic agility, it may also create opacity and entrenchment risks. In contexts where external oversight is weak, governance quality becomes heavily dependent on internal structures and leadership norms.

Importantly, regulation alone is insufficient. Sustainable legitimacy in healthcare emerges from alignment between regulatory compliance, ethical accountability, and clinical governance systems. Where these pillars are integrated, governance becomes resilient. Where they are fragmented, institutional trust erodes rapidly.

2.4. Family Ownership and Organizational Outcomes

The relationship between family ownership and organizational outcomes has been widely examined in the family business literature, yet its implications for family-owned private healthcare facilities remain only partially understood. Healthcare outcomes extend beyond financial performance to include service quality, staff retention, and organizational sustainability, all of which are deeply influenced by governance choices, professional norms, and ethical responsibilities. Existing studies offer competing explanations as to whether family ownership enhances or undermines these outcomes, revealing important theoretical tensions and contextual gaps.

2.4.1. Family Ownership and Service Quality

A significant strand of the literature argues that family ownership can enhance service quality through long-term orientation, reputational concerns, and strong stewardship incentives. Family owners are often motivated to protect their socioemotional wealth by maintaining a positive public image, which can translate into greater attention to patient satisfaction and continuity of care (Gómez-Mejía et al., 2007;

Rawaf & Alfalih, 2024). In healthcare settings, where failures are highly visible and reputational damage is severe, this long-term reputational logic may encourage investments in quality improvement and patient-centered practices.

However, contrasting evidence suggests that service quality may deteriorate when family control substitutes for professional clinical governance. Studies emphasize that excessive family influence can marginalize clinical expertise, weaken standardized quality assurance systems, and allow non-clinical considerations to dominate decision-making (Braithwaite et al., 2017; Herrera et al., 2025). This tension highlights a critical limitation in the literature: while family ownership may promote commitment to care in principle, it does not automatically ensure adherence to evidence-based clinical standards. The literature therefore explains why family owners may care about service quality but is less effective in explaining how quality is systematically safeguarded in the absence of strong clinical governance structures.

2.4.2. Family Ownership and Staff Retention

Staff retention is a particularly salient outcome in healthcare organizations, given the sector's reliance on skilled professionals and the high costs of turnover. Some scholars argue that family-owned organizations foster relational governance, trust, and a sense of belonging, which can enhance employee loyalty and reduce turnover (Eddleston & Kellermanns, 2007). In private healthcare facilities, close-knit organizational cultures may strengthen interpersonal relationships and informal support systems, contributing to staff stability.

Conversely, other studies highlight that family dominance can undermine staff retention when non-family employees perceive limited career progression, favoritism, or inequitable reward systems (Hasan et al., 2023; Ponce et al., 2024). In healthcare contexts, such perceptions are particularly damaging because professional autonomy and merit-based advancement are central to clinician motivation. The literature thus presents a divided picture: family ownership can either strengthen or weaken staff retention depending on how governance practices manage inclusivity, fairness, and professional recognition. What remains underexplored is how healthcare-specific professional norms mediate this relationship, especially in environments where family authority overrides formal human resource systems.

2.4.3. Family Ownership and Organizational Sustainability

Organizational sustainability in healthcare encompasses financial viability, service continuity,

regulatory compliance, and long-term societal legitimacy. Family ownership is often associated with resilience and survival due to patient capital, conservative financial policies, and intergenerational commitment (Anderson & Reeb, 2003; Villalonga & Amit, 2006). In healthcare, this long-term orientation may support sustained investment in infrastructure and community-based service provision, particularly in regions underserved by public systems. Nevertheless, sustainability risks emerge when the preservation of family control discourages professionalization, transparency, and adaptation to regulatory or technological change (Moussa & Elgiziry, 2019). Empirical evidence suggests that family firms may resist external financing, independent oversight, or managerial succession reforms, even when such changes are necessary for long-term healthcare sustainability (Zaman et al., 2020). The literature therefore captures the durability advantage of family ownership but inadequately explains why some family-owned healthcare facilities fail despite strong legacy motivations and community embeddedness.

Taken together, the literature indicates that family ownership outcomes in healthcare are contingent upon governance design rather than ownership structure alone. However, existing studies stop short of systematically integrating ownership dynamics with healthcare-specific accountability mechanisms. This limitation motivates the development of a more structured, sector-sensitive framework.

2.5. Identified Gaps and Justification for the Conceptual Framework

Despite extensive research on family business governance, existing scholarship remains theoretically insufficient in explaining governance effectiveness in private healthcare facilities. While agency, stewardship, and socioemotional wealth perspectives offer important insights, they do not independently capture how concentrated ownership interacts with clinical accountability in life-critical service environments.

Although agency theory, stewardship theory, and the socioemotional wealth perspective provide valuable insights into ownership dynamics, each framework remains conceptually incomplete when applied in isolation to healthcare contexts (Gómez-Mejía et al., 2007; Moussa & Elgiziry, 2019). Agency theory emphasizes control conflicts but underestimates professional medical norms and ethical imperatives. Stewardship theory captures long-term orientation but insufficiently accounts for power asymmetries under concentrated ownership. The socioemotional wealth perspective explains non-financial motivations but

does not adequately theorize how legacy preservation interacts with formal clinical governance systems in life-critical environments.

More critically, existing literature fails to sufficiently theorize the mechanisms through which governance decisions translate into healthcare-specific outcomes such as service quality and staff retention. Governance-performance relationships are often treated as financially mediated, with limited attention to how clinical oversight structures, ethical safeguards, and professional autonomy shape operational sustainability. Furthermore, prevailing studies implicitly assume strong regulatory enforcement and institutional oversight, assumptions that are frequently invalid in emerging healthcare markets characterized by uneven compliance and limited monitoring capacity (Braithwaite et al., 2017; Herrera et al., 2025; Li, 2018; Upadhyayula & Thomas, 2025).

These theoretical and contextual limitations underscore the need for a sector-sensitive conceptual framework that reconceptualizes governance effectiveness in family-owned private healthcare facilities. Rather than evaluating governance solely through economic outcomes, such a framework must integrate ownership structure, governance mechanisms, and healthcare-specific accountability systems to explain how concentrated family control influences service quality, workforce stability, and long-term organizational sustainability within a life-critical service environment.

3. Discussion and Conceptual Framework

This chapter synthesizes the preceding literature review and develops an integrative conceptual framework explaining how family ownership influences governance effectiveness and organizational sustainability in private healthcare facilities. Building on insights from agency theory, stewardship theory, and the socioemotional wealth (SEW) perspective, this chapter advances a sector-sensitive reinterpretation of corporate governance by positioning clinical accountability and workforce stability as central mediating mechanisms in life-critical service environments.

The analysis moves beyond descriptive duality to articulate a structured causal logic linking ownership concentration, governance mechanisms, service quality, staff retention, and long-term sustainability.

3.1. Family Ownership as a Structurally Contingent Governance Condition

Building on the theoretical boundary conditions identified in Section 2.2, this study reconceptualizes family ownership not as an inherently beneficial or

detrimental attribute, but as a structurally contingent governance condition. Existing scholarship frequently evaluates family ownership through performance outcomes—either emphasizing alignment advantages (stewardship and SEW logic) or control risks (agency logic). However, such evaluations remain incomplete in life-critical service environments where governance failure may generate irreversible clinical consequences.

In private healthcare facilities, ownership concentration fundamentally shapes the architecture of governance independence. Concentrated family control centralizes decision-making authority, influences board composition, and affects the institutional robustness of oversight mechanisms. Under certain conditions, this concentration can foster long-term investment, reputational stewardship, and strategic continuity, particularly in healthcare systems characterized by public-sector deficiencies (Gómez-Mejía et al., 2007; Rawaf & Alfalih, 2024). Family owners may demonstrate patient capital, reinvest in clinical infrastructure, and maintain service provision during market instability.

Yet the same structural concentration can weaken governance independence when ownership authority substitutes for institutionalized oversight. In the absence of independent board representation, formal clinical governance committees, and transparent accountability systems, control may become personalized rather than institutionalized. Principal-principal conflicts, preferential staffing practices, and blurred ownership-management boundaries may erode professional autonomy and compromise ethical safeguards (Hasan et al., 2023; Herrera et al., 2025).

The implications of these dynamics are amplified in healthcare contexts. Unlike industries where governance breakdowns result primarily in financial inefficiencies, private healthcare facilities operate within a life-critical environment. Governance failures may directly affect patient safety, quality of care, and public trust. The structural stakes of ownership concentration are therefore elevated: what might constitute an economic inefficiency in other sectors may constitute institutional fragility in healthcare.

Accordingly, the effect of family ownership on organizational sustainability is conditional upon the institutionalization of governance independence. Family ownership becomes performance-enhancing when independent oversight mechanisms are embedded within the governance structure; it becomes performance-constraining when control concentration overrides formal accountability systems. This conditional logic reframes family

ownership as a variable whose consequences are mediated by governance design rather than determined by ownership structure alone.

This reconceptualization establishes the analytical foundation for the proposed framework, which positions governance independence as the primary institutional mechanism linking ownership concentration to healthcare-specific outcomes.

3.2. Regulatory Context and Governance Fragility as Boundary Conditions

The governance effects of family ownership concentration do not operate in isolation; they are structurally conditioned by the regulatory and institutional environment within which private healthcare facilities function. Regulatory strength therefore operates not merely as contextual background, but as a formal boundary condition shaping the direction and magnitude of ownership effects.

In environments characterized by strong regulatory enforcement, accreditation systems, and external monitoring mechanisms, concentrated family ownership may coexist with independent governance safeguards. External oversight can constrain opportunistic behavior, reinforce disclosure standards, and mandate compliance with clinical governance protocols. Under such conditions, the risks associated with ownership concentration are partially mitigated through institutional counterbalances.

However, in emerging healthcare markets where regulatory enforcement is uneven or weak (Li, 2018; Upadhyayula & Thomas, 2025), the structural risks of concentrated control become amplified. Limited monitoring capacity, discretionary enforcement, and weak minority protections increase reliance on internal governance systems. When such internal systems lack independence, ownership concentration may substitute for formal oversight rather than operate alongside it.

This dynamic is particularly consequential in life-critical service environments. In industries where regulatory weaknesses primarily expose firms to financial risk, market correction mechanisms may absorb governance distortions over time. In healthcare, however, governance fragility can produce immediate and irreversible clinical consequences. The absence of effective regulatory constraints thus increases the probability that concentrated ownership translates into compromised clinical oversight and diminished accountability.

Regulatory strength therefore moderates the relationship between family ownership concentration and governance independence. Under strong

enforcement conditions, the negative association proposed in P1 is attenuated; under weak enforcement conditions, it is intensified. Similarly, the positive sustainability effects of family ownership (P6) are contingent upon the simultaneous presence of institutional safeguards that prevent control entrenchment from undermining professional standards.

Importantly, regulatory frameworks alone are insufficient to guarantee governance effectiveness. Sustainable healthcare governance emerges from alignment between external regulation and internal institutionalization of accountability mechanisms. Where regulation and governance independence reinforce one another, concentrated ownership may coexist with clinical integrity. Where both are weak, governance fragility becomes systemic.

By positioning regulatory strength as a structural moderator, the framework clarifies why family ownership produces divergent outcomes across institutional contexts. It is not ownership concentration per se that determines sustainability, but the interplay between control structures and institutional safeguards in environments where the cost of governance failure extends beyond financial loss.

3.3. Theoretical Integration: Reframing Governance Effectiveness in Life-Critical Service Environments

The limitations identified in Section 2.2 do not invalidate agency theory, stewardship theory, or the socioemotional wealth (SEW) perspective; rather, they reveal the boundary conditions under which each framework operates. The theoretical challenge, therefore, is not to privilege one perspective over another, but to specify how their explanatory logics interact within life-critical service environments.

Agency theory foregrounds structural risk. It explains how concentrated ownership may generate principal–principal conflicts, entrenchment, and weakened minority protection under conditions of limited monitoring (Jensen & Meckling, 1976; Villalonga & Amit, 2006). In private healthcare facilities, this risk logic is magnified because diminished oversight may compromise clinical governance rather than merely financial reporting. Agency theory thus highlights why governance independence is structurally necessary under ownership concentration.

Stewardship theory, in contrast, foregrounds alignment and intrinsic motivation (Davis et al., 1997). It explains why family owners may prioritize long-term survival, reputational continuity, and reinvestment in care infrastructure. In healthcare

settings, stewardship motivations can support investments in clinical quality and workforce development even in the absence of short-term financial incentives. However, stewardship logic presumes benevolence and alignment; it does not resolve the structural necessity for independent accountability mechanisms in environments where harm is irreversible.

The SEW perspective introduces a third dimension by explaining why family owners may prioritize control preservation, identity, and legacy over purely economic outcomes (Gómez-Mejía et al., 2007). In healthcare, reputational SEW can reinforce ethical conduct and community trust. Yet SEW preservation may also generate resistance to professionalization, transparency, or external scrutiny when these threaten family control. Thus, SEW motivations can simultaneously enhance and undermine governance robustness.

Rather than treating these theories as competing explanations, this study conceptualizes them as complementary but incomplete. Agency theory explains structural risk, stewardship theory explains motivational alignment and SEW explains identity-driven decision logic. None independently captures how concentrated control interacts with formalized clinical accountability systems in life-critical environments.

This integration leads to a reconceptualization of governance effectiveness. In private healthcare facilities, governance cannot be evaluated solely through financial performance, continuity, or legacy preservation. Instead, governance effectiveness must be assessed through its capacity to institutionalize:

- Structural independence from ownership dominance
- Robust clinical oversight systems
- Ethical accountability mechanisms
- Professional autonomy and workforce stability
- Sustained institutional legitimacy

In this multidimensional framing, governance independence becomes the central institutional mechanism through which ownership structure translates into healthcare-specific outcomes. Agency logic justifies its necessity; stewardship logic explains when it may be voluntarily supported; SEW logic clarifies when it may be resisted.

This theoretical synthesis establishes the causal architecture for the proposed framework. Family ownership concentration shapes governance independence; governance independence structures clinical oversight and professional autonomy; and these mechanisms ultimately determine service quality, staff retention, and organizational

sustainability within life-critical service environments.

3.4. Mediating Mechanisms: Specifying the Causal Transmission Pathways

The preceding analysis establishes that family ownership concentration influences organizational sustainability indirectly rather than deterministically. The effect of ownership structure is transmitted through institutional governance mechanisms that shape operational and human capital outcomes. Accordingly, this framework conceptualizes service quality and staff retention as mediating variables linking governance independence to long-term organizational sustainability.

Mediation implies that ownership concentration does not directly determine sustainability outcomes; instead, it affects governance independence, which in turn shapes healthcare-specific performance dimensions. These performance dimensions then condition organizational resilience, legitimacy, and continuity.

3.4.1. Governance Independence → Clinical Accountability → Service Quality

Governance independence strengthens the institutional separation between ownership authority and oversight mechanisms. Independent boards, formal clinical governance committees, structured reporting systems, and transparent audit processes enhance monitoring capacity and reduce discretionary control.

This structural independence improves the robustness of clinical accountability systems (P2). Robust accountability systems institutionalize adherence to evidence-based standards, systematic error reporting, peer review processes, and continuous quality improvement. In life-critical environments, such mechanisms directly affect patient safety and care outcomes.

Service quality therefore functions as a **transmission mechanism** (P3). Where governance independence enhances clinical oversight, improvements in service quality follow. Conversely, where ownership concentration erodes governance independence, clinical governance becomes personalized rather than institutionalized, increasing vulnerability to error and reputational damage.

Importantly, in healthcare contexts, service quality is not merely an operational metric—it is a structural determinant of institutional legitimacy. Sustained service quality enhances public trust, reduces regulatory intervention risk, and supports financial continuity, thereby contributing directly to organizational sustainability.

3.4.2. Governance Fairness → Professional Autonomy → Staff Retention

Parallel to clinical oversight mechanisms, governance independence also shapes internal workforce dynamics. Independent governance structures are more likely to institutionalize merit-based recruitment, transparent promotion systems, equitable incentive frameworks, and protections against nepotism or favoritism.

Such institutionalization strengthens perceptions of procedural fairness and professional autonomy (P4). In healthcare organizations—where skilled professionals represent the core productive asset—perceived fairness and autonomy significantly influence morale, commitment, and turnover intentions.

Staff retention thus operates as a second mediating channel (P5). Stable workforces preserve tacit clinical knowledge, maintain continuity of care, and reduce recruitment and training costs. Conversely, governance systems perceived as biased or control-dominated may generate turnover, erode morale, and weaken service delivery capacity.

3.4.3. Dual Mediation and Organizational Sustainability

Together, service quality and staff retention constitute **parallel mediators** translating governance design into sustainability outcomes. Governance independence improves clinical accountability and professional fairness; these improvements enhance service quality and workforce stability; and these operational outcomes collectively determine long-term organizational sustainability.

This dual mediation structure clarifies an important theoretical point: family ownership does not influence sustainability directly. Rather, ownership concentration alters governance independence, which shapes institutionalized accountability systems. Sustainability emerges only when these institutional mechanisms effectively translate governance structure into healthcare-specific performance outcomes.

The mediation logic therefore provides the structural bridge between ownership theory and healthcare outcomes, transforming the framework from descriptive synthesis into a causal explanatory model suitable for empirical testing.

3.5. From Conceptual Architecture to Propositional Specification

The preceding sections have articulated the structural logic of the proposed framework. Family ownership concentration influences governance independence: governance independence shapes the robustness of

clinical accountability systems and institutional fairness; and these mechanisms transmit effects through service quality and staff retention to determine long-term organizational sustainability. Regulatory strength and institutional enforcement capacity operate as boundary conditions that condition these relationships.

To advance this framework from conceptual synthesis to formal theory development, the relationships specified above must be articulated as testable propositions. The following propositions translate the causal architecture into directional statements that can guide empirical investigation across diverse regulatory contexts. Each proposition corresponds to a defined structural pathway within the model and reflects the conditional and mediated nature of governance effects in life-critical service environments.

3.6. Propositional Development

Based on the preceding analysis, the following propositions are advanced:

P1:

Higher levels of family ownership concentration are negatively associated with governance independence in private healthcare facilities under conditions of weak regulatory enforcement.

P2:

Governance independence is positively associated with the robustness of clinical accountability systems.

P3:

Robust clinical governance systems are positively associated with service quality in family-owned private healthcare facilities.

P4:

Governance fairness and professional autonomy are positively associated with staff retention.

P5:

Service quality and staff retention mediate the relationship between governance independence and organizational sustainability.

P6:

The positive effects of family ownership on organizational sustainability are contingent upon the institutionalization of independent clinical governance mechanisms.

3.7. Theoretical Contribution of the Framework

This chapter advances governance scholarship in three principal ways:

1. It introduces a life-critical accountability lens to corporate governance theory.

2. It reframes governance effectiveness beyond financial metrics to incorporate clinical and ethical dimensions.
3. It articulates explicit mediating and moderating mechanisms linking family ownership to healthcare-specific outcomes.

By doing so, the framework moves beyond fragmented explanations and offers a coherent model capable of guiding empirical testing across diverse regulatory contexts.

3.7. Conceptual Model

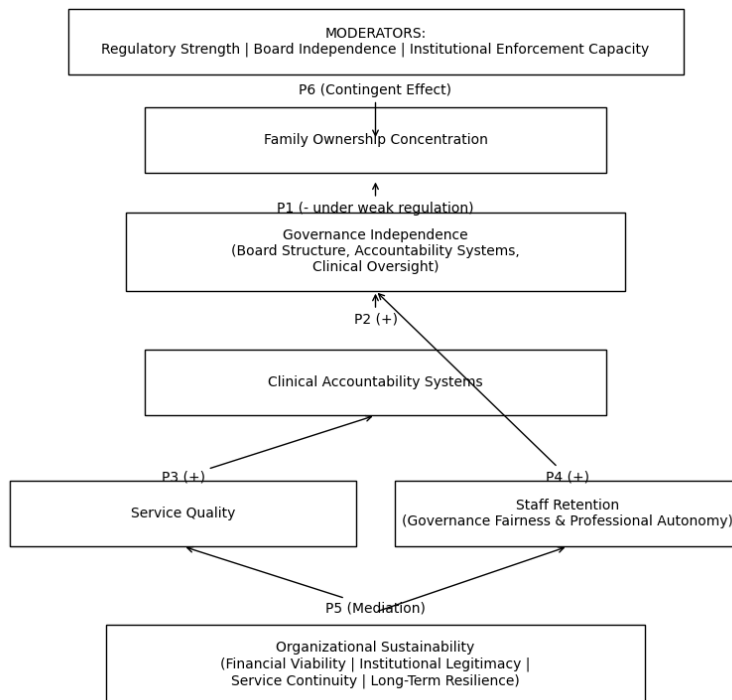


Figure 1. Conceptual Framework of Governance Dynamics in Family-Owned Private Healthcare Facilities

Figure 1 Source: *Conceptualized by the Researchers (2024)*

The preceding propositions are synthesized into the conceptual model depicted in Figure 1. The framework specifies the causal architecture through which family ownership concentration shapes organizational sustainability, mediated by governance independence and transmitted through service quality and staff retention. Regulatory strength and institutional enforcement capacity operate as boundary conditions that moderate these relationships within life-critical service environments.

3.8. Chapter Summary

This chapter synthesized existing theoretical perspectives and advanced a sector-sensitive conceptual framework clarifying how governance independence mediates the relationship between family ownership concentration and organizational sustainability in private healthcare facilities. The analysis underscores that sustainability in life-critical service environments depends on institutionalized accountability systems rather than ownership structure alone. The following chapter outlines the methodological approach for examining the proposed relationships.

4. Practical and Policy Implications

Building on the conceptual framework and propositions advanced in this study, this section outlines governance and regulatory implications for

strengthening accountability and sustainability in family-owned private healthcare facilities.

➤ Institutionalize governance independence.

Establish independent boards, formal clinical governance committees, transparent reporting systems, and audit mechanisms to prevent excessive ownership concentration from undermining oversight and accountability.

➤ Professionalize managerial and clinical leadership structures.

Appoint qualified non-family executives and healthcare professionals to strategic and operational roles, supported by merit-based recruitment, structured delegation, and standardized performance evaluation systems to mitigate principal–principal conflicts.

➤ **Separate family influence from clinical oversight mechanisms.**

Create formal governance interfaces, such as family councils or advisory boards, to preserve strategic family participation while safeguarding independent clinical accountability.

➤ **Strengthen regulatory and accreditation alignment.**

Proactively engage with sector-specific regulatory frameworks, accreditation standards, and ethical governance guidelines to reinforce institutional legitimacy and public trust, particularly in weak enforcement contexts.

➤ **Prioritize workforce stability as a governance objective.**

Embed professional development systems, equitable incentive structures, and transparent career progression pathways to enhance staff retention as a mediating mechanism of organizational sustainability.

➤ **Institutionalize performance monitoring systems.**

Implement structured monitoring of service quality, clinical outcomes, staff satisfaction, and sustainability indicators to ensure that governance design translates into measurable healthcare outcomes.

5. Conclusion

This paper reconceptualizes governance effectiveness in family-owned private healthcare facilities by integrating corporate governance theory, family business scholarship, and healthcare management perspectives within a life-critical accountability framework. It establishes that family ownership operates as a structurally contingent force: while concentrated control can promote long-term orientation, stewardship behavior, and reputational commitment, it may also weaken governance independence and generate institutional fragility when professional accountability systems are insufficiently institutionalized.

The analysis demonstrates that governance dynamics in family-owned healthcare facilities cannot be adequately explained through single-theory lenses or models derived from publicly listed firms. Conventional governance frameworks assume financially bounded and reversible consequences of failure. In healthcare contexts, however, governance decisions directly shape patient safety, clinical integrity, workforce stability, and institutional legitimacy. This asymmetry fundamentally elevates the structural stakes of ownership concentration and necessitates a sector-sensitive reinterpretation of governance effectiveness.

By positioning service quality and staff retention as mediating mechanisms linking ownership structure to sustainability, this study clarifies the causal pathways through which governance arrangements translate into healthcare-specific outcomes. Organizational sustainability in this setting depends not merely on financial resilience or legacy preservation, but on the institutionalization of independent clinical oversight and professional autonomy under conditions of concentrated family control.

Theoretically, the study extends corporate governance scholarship by introducing a healthcare-specific accountability lens that bridges fragmented literatures and challenges economically bounded conceptions of governance performance. Practically, it underscores that strengthening governance in family-owned healthcare facilities is not an administrative refinement but a structural imperative. Future empirical research should examine the proposed framework across diverse regulatory contexts to assess how institutional strength moderates the relationship between ownership concentration, governance independence, and healthcare outcomes.

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