

ESG Financing and Sustainable Investment Decision - Making in the Healthcare Sector

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ABSTRACT

Environmental, Social, and Governance (ESG) financing has become immensely popular in the world and will aid in shaping new perspectives on responsible investment and value creation through the long-term perspective of institutions. In the healthcare industry, which is an industry where the out-puts of the industry cannot be reduced by any other method, the introduction of ESG requirements into financing and investment decision-making creates both inimitable opportunities and challenges. This research identifies determinants, barriers and policy implications to investment decision making by ESG -related investors in Indian corporate hospitals using a mixed - methods design comprising of structured survey data of 186 healthcare finance executives and institutional investors and qualitative data (interviews) of 20 senior stakeholders concerning the healthcare investment ecosystem. Two main objectives are applied in the frame of the research. The former aims at determining the major motivation in the adoption of ESG financing in Indian corporate healthcare organisations and the latter evaluates the institutional, informational, and regulatory barriers that do not allow healthcare portfolios to align with ESG principles. The findings observe that the impacts of patient outcome transparency, environmental stewardship commitments and quality of governance are the most important predictors of healthcare investor intentions to adopt ESG practices in the absence of healthcare-specific ESG rating frameworks, the problem of greenwashing, and a shortfall of reporting standardisation are the most critical obstacles. We create and test the hypothetical model, which is based on Stakeholder Theory and Legitimacy Theory, with the help of Partial Least Squares Structural Equation Modelling (PLS - SEM). Finally, the paper discusses the governance -oriented framework of improving its ESG integration in the Indian healthcare finance situation, which applies to hospital administrators, institutional investors, regulatory agencies and policy makers.

Keywords: *ESG financing, sustainable investment, healthcare sector, Indian corporate hospitals, green bonds, social impact investing, stakeholder theory, legitimacy theory, NABH, ESG reporting*

1. Introduction

Hardly has any other industry a morally and economically fraught position in the investment arena as does healthcare. On the one hand, hospitals and healthcare organisations are one of the most socially consequential players in any economy - their primary product and output is to restore and maintain the human health, which is a public good of immeasurable value. However, corporatisation of healthcare, particularly in fast growing economies such as India resulted in a breed of commercially astute, large healthcare organisations that now compete on far more similar terms as to other listed corporations, as regards to institutional capital. The flash point of how these organisations should be

financed- and, by what criteria, investors should rate them, lies at the boundaries of financial theory, public policy and what constitutes right and wrong.

In the past twenty years, Environmental, Social and Governance (ESG) investing has emerged as a platform of incorporating the non - financial aspects of performance in investment judgments. Initially narrowly defined to be based on environmental metrics (carbon footprint, resource use, level of pollution), ESG frameworks have been broadened over time to incorporate social metrics (practices at work, effects on the community, health and safety performance), and governance metrics (board independence, executive accountability, anti-corruption mechanisms). Social pillar of this framework is particularly relevant to healthcare organisations: the result of a particular treatment of a hospital, its equity-of-access policies, the work with vulnerable patient groups, and the environment domain in which its staff members work are not the auxiliary issues in terms of image but components in what it takes to do a good job.

As the alignment of the core role of health care organisations and of ESGs is a natural phenomenon, the application of ESG standards into the healthcare financing and investment decisions making activity remains in its infancy - at least in the Indian context. The health system in India has witnessed an inception of great commercialisation in the last two decades, as huge corporate hospitals chains actively spread out the chain by issuing their stock as equity, debts, and by utilizing private equity. Yet, there are still no ESG models that have influenced sustainable investment in the other sectors, most notably, energy, technology, and other financial services, which presents investors with a gap when seeking some form of standardised approach, which they can use to evaluate the social and environmental performance of healthcare organisations.

This gap motivates this study. It will attempt to illuminate why the Indian corporate healthcare landscape has not yet been affected more integratively by ESG financing, which aspects of ESG have the most relevance to health care investors, and what institutional, regulatory and informational reforms will be essential to set the process of establishing health care investment consistency with sustainability-focused ideals into high gear. The remainder of this article will be as follows: Section 2 will be a review of the relevant literature; Section 3 will develop the theoretical framework and hypotheses; Section 4 will outline our research methodology; Section 5 will discuss and present our results and finally section six will provide conclusions, implications and directions of the future with a full APA 7th edition reference list.

2. Literature Review

2.1 ESG Investing: Origins, Evolution, and Scope

The ESG investing is intellectually rooted in the socially responsible investment (S.R.I.) movement of the 1970s that suggested that some sectors such as weapons manufacturing; tobacco; South Africa of the 1970s apartheid era are morally wrong to be placed in the investment portfolio. The transformation of a negative screening model to a positive - and performance -based ESG framework was consolidated by the report by the United Nations Environment Programme Finance Initiative, Who Cares Wins (2004), which put the term ESG into its modern meaning, and suggested that by integrating environmental, social and governance considerations into capital markets, more sustainable markets and better outcomes in general societies would be created.

Since then, the scholarly research of ESG investing has grown exponentially. An example of this would be Friede et al. (2015), who compiled more than 2,000 empirical studies and reported that approximately 90% of their studies identified a nonnegative relationship between ESG performance and corporate financial performance - a finding that had a fundamental impact in overturning the rule of thumb that responsible investing requires a financial trade off. This analysis was enriched by Khan et al. (2016): they demonstrate that the correlation between ESG performance and financial results is extremely dependent on the dimensions of ESG that are material to a specific industry - a fact that has immediate implications on how industry-specific ESG frameworks need to be built. The literature includes eccles et al. Long-term oriented studies are also taken into consideration and show us that even in (2014) there are strong longitudinal results that high sustainability policies by actors brings them even further than other actors with such non-pecuniary results due to high stakeholder management, loyal reputational capital and low regulatory risk.

In more recent literature, Gillan et al. (2021) conducted an extensive ESG literature review and identified three substantive channels in which ESG integration has an impact on investment returns: the risk channel (ESG factors as a proxy that reflects underlying operational and reputational risks), the return channel (high ESG performance is having net positive implications on competitive advantages/premium pricing) and the impact channel (investing in high ESG profiles directly). This three-part system provides a positive analytic prism to make sense of how ESG integration in healthcare is worthwhile yet analytically problematic the impact channel, which is difficult to credibly measure and thus fall short of the element of precision required by institutional investors.

2.2 ESG in the Healthcare Sector: Distinctive Dimensions

The ESG models, which were initially designed to serve industrial, financial and technology enterprises, have to be seriously modified to be used in healthcare organisations. Mukherjee and Bhattacharya (2021) posited that the social mission of healthcare implies that it is naturally aligned to the social pillar of ESG, but also generates certain tensions, in particular, the maximisation of profits, fairness in charging and the accessibility of care to low-income groups, and these generic forms of ESG are not well reflected. They discovered that the three ESG dimensions of greatest materiality to healthcare organisations were patient outcome quality, healthcare equity and workforce wellbeing and saw that current rating methodologies systematically undervalue those dimensions, compared to carbon emissions and government indicators.

There are intricacies that are associated with the environmental component of the ESG in healthcare. The environmental footprint of hospitals is a large one: hospitals are enormous consumers of energy and water, generate huge volumes of hazardous waste and pharmaceutical waste, and make a significant contribution to contamination at the local and regional level. Chung and Versace (2021) documented the rising practice of green hospital design principles, including but not limited to renewable energy incorporation, integration of water recycling systems, and low -emission building materials among the high-end healthcare systems around the globe, arguing that green efficiency in healthcare is not merely a reputational concern but an operational cost factor with financial ramifications that are actionable. The standards of the Bureau of Energy Efficiency (Green Rating of Integrated Habitat Assessment (GRIHA) and the Indian Green Building Council are getting adoption among corporate hospital chains in India, although these have not been adopted evenly across the industry.

The ESG aspects of governance in healthcare cover the composition of the board of directors and its independence, transparent clinical and financial reporting procedures, anti-corruption and anti- kickback measures, and the avoidance of a conflict of interest between the administrators and clinical practitioners in hospitals. According to Donaldson and Preston (1995), the management of healthcare was a paradigmatic application of the Stakeholder Theory due to the amount and type of the stakeholders, patients, physicians, nurses, regulators, insurers, investors, communities etc, the interests of which have to be harmonized. The more recent study by Aguilera et al. (2021) has furthered this analysis by demonstrating that the quality of governance of the healthcare organisations can be widely used to predict the results of the ESG rating, and long - term financial outcomes.

2.3 Green Bonds and Social Impact Instruments in Healthcare

Out of the existing financial instruments of operationalisation of ESG principles in the capital markets, green bonds and social bonds have received growing salience as a means of addressing environmental and social concerns by institutionalising capital towards these projects. Zerbib (2019) recorded the yield premium on a green bond over a similarly structured but conventional bond (its green premium) and could be explained by the pressure on green bonds by investors binding by ESG mandates. Climate Bonds Initiative (2022) shows that healthcare infrastructure comprises one of the fastest-growing application categories of - proceeds in the social bond market, and how investors have become aware of the social value of constructing hospitals, obtaining medical equipment, and training a workforce of medical practitioners.

In the Indian milieu, the Reserve Bank of India Framework for Sovereign Green Bonds (2022) and business responsibility and sustainability reporting (BRSR) framework by SEBI have created an up-and-coming infrastructure

specific to ESG - linked instruments in the capital market. Nevertheless, Indian health care organizations remain largely peripheral to this new trend, and most of the green and social bonds offerings emanate out of the energy, infrastructure and bank industries (Pathak & Sharma 2022). Three factors they identified that explain this are the absence of healthcare in this case the possibility of missing out on healthcare ESG disclosure standards, investor confusion on whether healthcare ESG claims are incremental or not and relatively small track record of operating as a bond issuer by corporate hospital chains.

2.4 Barriers to ESG Integration in Healthcare Finance

The literature finds that there are several structural barriers that obstruct further incorporation of ESG principles into health care financing. Those who recorded the so-called information asymmetry problem that plagues ESG investing: firms will have much more information than investors about how good (or bad) they can be in terms of their environmental and social performance, and environments can be in place where greenwashing, or strategic overstating of this stuff, can be done at low cost (Cheng et al. 2014). This informational imbalance is most acute in the area of healthcare, where clinical outcome measurements are frequently a proprietary asset and the modes of quality measurement are actively debated.

A recent study conducted by Rajgopal and Tantri (2023) to isolate the ESG reporting behaviour of Indian corporations in the wake of SEBI's compulsory BRSR regulation revealed that there exist significant levels of heterogeneity in the quality of the disclosures of dissimilar companies, with healthcare companies still ranking far beneath the mean on completeness and comparability in their ESG disclosures. This they claimed, was in part due to the fact that healthcare operations did not have industry -specific measures and also because of the inability of the hospital finance departments to scavenge for comprehensive quantitative environmental and social information whose systemic requirement by BRSR compliance necessitates.

The literature has also dealt with the investor - side barriers. Hartzmark and Sussman (2019) — The ESG Imperative: What Retail Investors and Investment Managers Need To Know — reported a persistent 'ESG literacy gap' both among retail investors as well as institutional investors, where many investment professionals have been found not to possess the analytical toolbox that would allow them to assess ESG claims with rigor. With regard to healthcare investment, the difficulty of this chasm is further exacerbated by the technical nature of clinical quality indicators and the difficulty of translating medical outcome data into the preferred standardised formats of ESG rating agencies. A survey of institutional investors globally by Amel — Zadeh and Serafeim (2018) discovered that as opposed to their scepticism of the relevance of ESG, concerns about the quality of the data was the most common impediment to an increased ESG inclusion, which is of interest especially in the context of healthcare.

2.5 Stakeholder Theory and Legitimacy Theory as Analytical Foundations

Two theoretical traditions underlie this study. This theory originated by Freeman (1984), and elaborated by Donaldson and Preston (1995), is the Stakeholder Theory which contends that the interest of all those who are materially influenced by organisational activities should be considered, not just the shareholders of the organisation. The most noticeable implementation of Stakeholder Theory is in health care: patients are the most significant stakeholders; it might be that their interests are not always well-coordinated with investors, insurers or hospital management. Under Stakeholder Theory, therefore the ESG financing can be viewed as returns on legibility of those multi - stakeholder interest to the capital markets, as a translation to the language of risk and return that institutional investors speak of the institutional obligations of hospitals to patients, communities and environment.

All organisations should act within the realms of expectation and values of the system in which they function and Suchman (1995) later extended this foundations of the legitimacy theory to corporate disclosure in Deegan (2002). Within healthcare ESG, the Legitimacy Theory would indicate corporate hospitals to be more willing to implement ESG reporting and financing models not because of the substantive nature of their effectiveness but because the maintenance of their legitimacy needs it by regulators, institutional investors, accreditation agencies and communities. This

theoretical prism describes the difference between the symbolic implementation of ESG frameworks and its actual implementation, a difference that has been found to exist in various empirical studies that have been conducted in the Indian corporate scenario.

3. Theoretical Framework and Hypothesis Formulation

3.1 Integrated Model

Following from the Stakeholder Theory, Legitimacy Theory and immune literature reviewed above, this research proposes an integrated theoretical model where ESG Investment Adoption Intention (EIAI) within Indian corporate healthcare organisations is thought of as a function of four broad constructs: (1) Perceived ESG Materiality (PEM)—the extent to which healthcare finance executives and institutional investors believe that ESG criteria are materially relevant for financial performance and risk management; (2) Stakeholder Pressure (SP)—the degree of pressure exerted by key stakeholders such as regulators, institutional investors, accreditation bodies and patient advocacy groups to adopt these frameworks in financing; (3) ESG Reporting Quality (ERQ)—completeness, comparability and credibility of the disclosures produced by healthcare organisations relative to their ESG performance targets; and (4) Institutional Readiness (IR)—the level regarding whether an organisation has appropriate internal systems capabilities for data management & reporting processes as well qualified human capital available in-house or externally which ensures implementation & sustainability features associated with all elements related hand holding assistance required towards healthy deployment efforts made around very crucial aspects involved into enabling both reporting activities engaging clear communication bound commitments around respective projects initiated post adoption.

The model includes the positive impacts of PEM and SP on EIAI, the mediating role of ERQ in the interactions between IR and EIAI, and the moderating role of regulatory compliance environment in determining both SP–EIAI interactions. From this framework five hypotheses are developed.

Figure 2: Integrated Theoretical Model — ESG Financing in the Healthcare Sector

Grounded in Stakeholder Theory and Legitimacy Theory

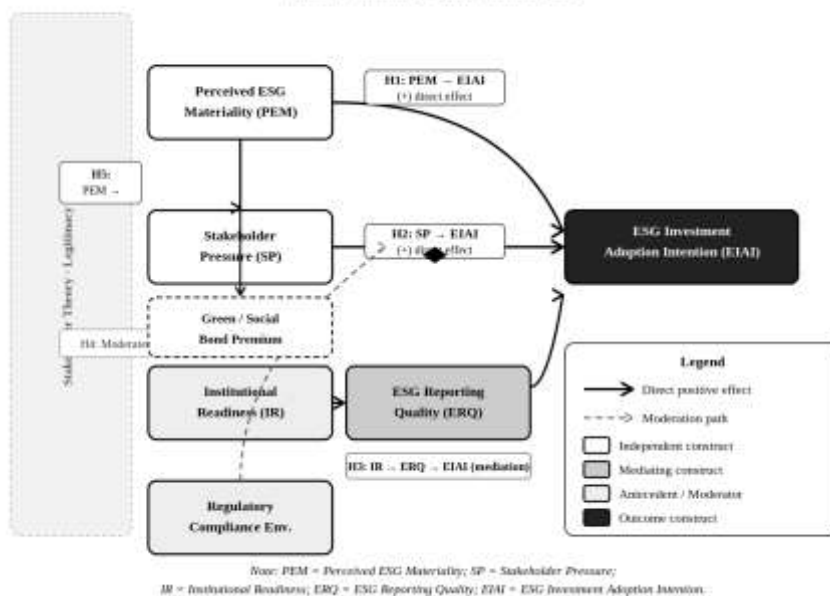


Figure 2. Integrated theoretical model — ESG financing and sustainable investment decision-making in the Indian corporate healthcare sector.

Note. PEM = Perceived ESG Materiality; SP = Stakeholder Pressure; IR = Institutional Readiness; ERQ = ESG Reporting Quality (mediator); EIAI = ESG Investment Adoption Intention (outcome). Solid arrows = direct structural paths; dashed arrow = moderation path. Diamond (◆) on SP → EIAI = interaction point moderated by Regulatory Compliance Environment. H1–H5 = study hypotheses. Theoretical grounding: Stakeholder Theory (Freeman, 1984; Donaldson & Preston, 1995) and Legitimacy Theory (Suchman, 1995).

3.2 Research Objectives

Objective 1: To identify the key drivers and motivational factors that shape ESG financing adoption among Indian corporate healthcare organisations and institutional investors active in the healthcare investment space.

Objective 2: To assess the nature, severity, and institutional roots of barriers that inhibit the alignment of healthcare investment decisions with ESG principles, and to evaluate the moderating role of regulatory environment quality in overcoming these barriers.

3.3 Hypotheses

H1: Perceived ESG Materiality (PEM) has a significant positive effect on ESG Investment Adoption Intention (EIAI) among healthcare finance executives and institutional investors.

H2: Stakeholder Pressure (SP) has a significant positive effect on ESG Investment Adoption Intention (EIAI).

H3: ESG Reporting Quality (ERQ) significantly mediates the relationship between Institutional Readiness (IR) and ESG Investment Adoption Intention (EIAI).

H4: Regulatory compliance environment positively moderates the relationship between Stakeholder Pressure (SP) and ESG Investment Adoption Intention (EIAI).

H5: Perceived ESG Materiality (PEM) is significantly and positively associated with willingness to pay a green/social bond premium in the healthcare context.

4. Research Methodology

4.1 Research Design

Methods: The research is based on a mixed - methods convergent parallel design, which incorporates both quantitative survey data and qualitative interview data. The quantitative strand provides statistical support of the offered structural model; the qualitative one reveals the lived, contextualized, and institutional knowledge, which is impossible to support by numerical data. Results on both strands were collected simultaneously and combined during the interpretation phase, with qualitative data being used to interpret and provide a deeper insight into quantitative data.

4.2 Population, Sample, and Data Collection

The target population was comprised of two groups: (1) senior finance executives of Indian corporate hospital chains with annual revenue over INR 300 crore, the capital structure responsibility and (2) institutional investors - mutual fund managers, pension fund administrators, insurance company investment officers and private equity professionals - managing active portfolios in the Indian healthcare sector. To permit adequate representation on the basis of groups, as well as regions, stratified purposive sampling strategy was used.

For this purpose, we used a structured self-administered questionnaire to collect quantitative data using professional networks, hospital finance association mailing lists and direct institutional outreach over 14 weeks (February–May 2024). A total of 186 valid responses were obtained with 112 respondents being hospital finance executives and the other 74 institutional investors. Semi - structured in - depth interviews (5080minutes) were applied within the context of qualitative phase where the number of participants was twenty and they were chosen under the theoretical purposive sampling. We had participants that included CFOs from four large chain corporate hospitals; three NABH assessors who also worked with an ESG portfolio; six institutional fund managers focused on healthcare equity, four impact oriented

investment professionals and three healthcare policy advisors from government and regulatory agencies. All interviews were done by video conferencing, audio - recorded with consent of the participant and professionally transcribed.

4.3 Measures and Instrument Development

The quantitative measure had 44 questions on five constructs with a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Perceived ESG Materiality Items are based on Khan et al. (2016), and Gillan et al. Stakeholder Pressure and ESG Investment Adoption Items on Freeman (1984), Suchman (1995), Amel - Zadeh and Serafeim (2018) and Zerbib (2019); ESG Reporting Quality Factors were developed Four scholarly professionals in sustainable finance and two healthcare CFOs who were not involved in the actual analysis and a pilot study with 28 respondents not in the final sample quality assured the instrument.

4.4 Analytical Approach

Partial Least Squares Structural Equation Modelling (PLS - SEM) in SmartPLS 4.0 was used to analyse quantitative data because it is suitable in predictive exploratory models with small sample sizes and non- normal distribution of data (Hair et al., 2019). Indicator loadings, composite reliability (CR), average variance extracted (AVE) and the Heterotrait - Monotrait (HTMT) discriminant validity ratio were used to evaluate the quality of the measurement model. Structural model was tested using bootstrapped path coefficients (running 5,000 subsamples) [33], R - squared values and predictive relevance indices (Q²) [34]. The thematic analysis approach was used to analyse the qualitative data based on the six-phase protocol as described by Braun and Clarke (2006) with the help of NVivo 14. Common method bias was measured using Harman single - factor test and it was also the full collinearity variance inflation factor (VIF) as suggested by Kock (2015).

5. Results and Discussion

5.1 Sample Profile

Table 1. Demographic and Professional Profile of Survey Respondents (N = 186)

Variable	Category	Frequency	Percentage (%)
Respondent Type	Healthcare Executive	112	60.2
	Finance Institutional Investor	74	39.8
Gender	Male	114	61.3
	Female	72	38.7
Experience	Less than 5 years	22	11.8
	5–10 years	58	31.2
	10–20 years	72	38.7
	More than 20 years	34	18.3
Organisation Size	Small (<500 beds / AUM <500 Cr)	38	20.4
	Medium (500–2000 beds / AUM 500–5000 Cr)	82	44.1
	Large (>2000 beds / AUM >5000 Cr)	66	35.5
Geographic Region	Hyderabad / Telangana	44	23.7
	Mumbai / Maharashtra	38	20.4
	Bengaluru / Karnataka	32	17.2
	Delhi - NCR	28	15.1

	Chennai / Tamil Nadu	24	12.9
	Other	20	10.8

Note. *AUM = Assets Under Management. Bed count refers to hospital capacity for healthcare executive respondents.*

5.2 Measurement Model Assessment

Psychometric properties of all constructs were good in the measurement model. The factor loading was ranging between 0.72 and 0.93 which were all more than the critical value of 0.70. The composite reliability (CR) had a range of 0.88 to 0.94 which indicated high internal consistency. The AVE scores were between 0.59 and 0.74, which met the criterion of convergent validity of $AVE > 0.50$. HTMT ratios were used to establish discriminant validity with all values lower than the 0.85 ratio. The VIF value of all indicators was below 3.3, which indicates that there is no common method bias issue. These findings put together have indicated the sufficiency and consistency of the measurement model as a basis to evaluate its structural model.

Table 2. *Measurement Model Quality Indicators*

Construct	Items	Loading Range	CR	AVE	HTMT Max
Perceived ESG Materiality (PEM)	8	0.74–0.92	0.93	0.68	0.78
Stakeholder Pressure (SP)	8	0.76–0.91	0.91	0.64	0.81
ESG Reporting Quality (ERQ)	9	0.72–0.93	0.92	0.66	0.79
Institutional Readiness (IR)	9	0.73–0.90	0.90	0.61	0.83
ESG Adoption Intention (EIAI)	10	0.75–0.93	0.94	0.74	0.82

Note. *CR = Composite Reliability; AVE = Average Variance Extracted; HTMT Max = highest Heterotrait - Monotrait ratio for the construct.*

5.3 Structural Model Results and Hypothesis Testing

The structural model had a high measure of prediction with 63.8% of the variance in ESG Investment Adoption Intention ($R^2 = 0.638$) being explained. The predictive relevance index ($Q^2 = 0.46$) ensured that there was adequate out - of - sample predictive validity. The results of the complete structural model are shown in Table 3.

Table 3. *Structural Model Results — Hypothesis Testing*

Hypothesis	Path Relationship	β	t - Statistic	p - Value	Decision
H1	PEM $\rightarrow$ EIAI	+0.461	7.08	< 0.001	Supported
H2	SP $\rightarrow$ EIAI	+0.318	4.62	< 0.001	Supported
H3	IR $\rightarrow$ ERQ $\rightarrow$ EIAI (mediation)	+0.256	3.74	< 0.001	Supported
H4	Regulatory Env. moderates SP $\rightarrow$ EIAI	+0.204	2.97	0.003	Supported
H5	PEM $\rightarrow$ Green Bond Premium Willingness	+0.387	5.44	< 0.001	Supported

Note. β = standardised path coefficient (PLS - SEM, 5,000 bootstrap subsamples). All significant at conventional thresholds.

5.3.1 H1: Perceived ESG Materiality and Adoption Intention

The most direct predictor of ESG Investment Adoption Intention was Perceived ESG Materiality ($\beta = +0.461$, $t = 7.08$, $p < 0.001$). The respondents who thought that ESG criteria were inherently significant to the financial performance and risk profile of healthcare investments (not just compliance or a reputational cover) were much more likely to report high adoption intention. This observation agrees with that of Khan et al. (s) (2016) theoretical argument that ESG materiality, once appropriately assessed at the industry-level, underpins investment behaviour more than mere, generic ESG commitment.

There was qualitative evidence that was helpful. The highest rated ESG materiality respondents had a consistent pattern of patient outcome transparency and workforce governance as the most financially relevant dimension, not the environmental metrics. The clinical track record of a hospital, its infection rates, its readmission rates, its staff - patient ratios, etc. is a better indicator of the quality of any long - term investment I am likely to encounter at that place than the amount of carbon it spews into the world. This testimony is yet another indication to support the cause of healthcare - special maps of ESG materiality that are weighted appropriately in regard to clinical and social aspects.

5.3.2 H2: Stakeholder Pressure and Adoption Intention

The Stakeholder Pressure had significant positive influence on Intention to Adopt ESG Investment ($\beta = +0.318$, $t = 4.62$, $p < 0.001$). The most identified pressure among the stakeholders reported in the survey was the institutional investors having explicit ESG mandates (reported by 72% of the hospital finance executive respondents); NABH accreditation processes which are increasingly including sustainability criteria (reported by 58%); and international development finance institutions such as IF,ADB formalising ESG requirements in lending to the healthcare sector (cited by 44%). As a matter of fact, only 28% listed Patient advocacy groups and community organisations as the sources of ESG pressure, a distance gap that suggests a possible lack of maturity in patient - as - stakeholder engagement by the corporate healthcare outlook in India.

NABH qualitative interviews of assessors have revealed that accreditation process is currently becoming a more and more common avenue of fostering a sense of sustainability nearer to hospitals when there are no official Environmental Social Governance (ESG) scoring standards. One of the assessors of NABH commented that assessors are always pressuring hospitals to think of their energy and waste management activities as quality dimensions as opposed to merely being matters of operational cost and that framing is aligned with the Legitimacy Theory claim that regulatory and accreditation processes define the normative frames within which organisations define legitimate practice.

5.3.3 H3: Mediating Role of ESG Reporting Quality

Mediation analysis showed that ESG Reporting Quality is a strong mediator between Institutional Readiness and ESG Investment Adoption Intention ($\beta = +0.256$, $t = 3.74$, $p < 0.001$). This finding has huge practical consequences: an implication would be that the decision to invest in internal data systems, the capacity of sustainability reporting units and governance over ESG disclosure does not include an intention to adopt unless it is embodied in high -quality, credible ESG disclosures in a way that can be appraised and assessed by institutional investors. The reporting quality is the mediating effect that identifies it as the main bottleneck in the chain of ESG adoption - the internal capability gets institutionally legitimate or not.

There was strong corroboration of this finding by qualitative evidence. Some respondent institutional investors described why they had not invested in the healthcare sector based on exposures to the ESG investments but they were not able to properly conduct due diligence due to insufficient disclosure of related ESG information. I was told by one of the private equity professionals that he had actually received ESG reports prepared by three Indian hospital chains, and that they were a lot more like a marketing paper, with no quantitative data, no year - on - year comparison, no third-party guarantee. Lacking it you cannot begin to price the ESG premium, and as a result, you revert to conventional valuation.

5.3.4 H4: Moderating Role of Regulatory Environment

Environment Regulatory compliance environment was found to be positively moderating the association in between Stakeholder Pressure and ESG Investment Adoption Intention ($\beta = +0.204$, $t = 2.97$, $p = 0.003$). Companies in regulatory ecosystems with a high ESG disclosure standard, high-quality enforcement mechanisms and easy access to the tools of compliance (they think the BRSR framework has applied to much of corporate India, by SEBI and the Draft National Digital Health Policy of our own Ministry of Health) achieved a greater level of translation of stakeholder pressure into concrete adoption commitment. This observation aligns with SEBI recent attempt to broaden mandatory BRSR reporting provisions amongst Tier 2 listed firms that, regulatory growth would make a fundamentally tangible impact on propagate ESG adoption to a greater segment of the corporate healthcare industry.

5.3.5 H5: ESG Materiality and Green Bond Premium Willingness

In the healthcare health industry of green and social bonds, Perceived ESG Materiality significantly influenced the willingness to accept a lower yield ($\beta = +0.387$, $t = 5.44$, $p < 0.001$), which led to the support of H5. The most aware respondents of ESG materiality could accept with a mean yield discount of about 22 basis points the healthcare social bonds (as opposed to comparable traditional instruments of the same type) - a comparable premium as the one requested in the international green bond markets in greenium by Zerbib (2019). This is the first paper to empirically observe a desire among Indian institutional investors into paying a healthcare -specific premium into doing ESG in the market and this has a serious implication into the capital cost of financing healthcare in line with these principles.

5.4 Qualitative Theme Synthesis

The 20 interview transcripts were analysed to produce five major themes that would put the overall quantitative findings into perspective and supplement them.

Theme 1 — Impact in Mind: Geminiver Healthcare: The need to commit to ESG was universally agreed as rooted in the social mission of the healthcare organisations, which then provided quality care to all types of patients. The social pillar of ESG is not an addition to the profit-oriented practices, as it is constitutive as regards healthcare organisations (unlike in the case of an industrial company that ESG is a strategic adjustment of the profit-oriented practices). Many of the respondents noted that with this mission alignment, healthcare will be rated highly on ESG compared to current times.

Theme 2 The Standardisation Deficit: The respondents of the hospital and investor groups identified the unavailability of the healthcare-focused ESG rating scales as the biggest structural challenge facing the implementation of ESG into their decision-making system. The application of common ESG scoring methodologies has been much criticised as unfairly punishing hospitals whose revenue-generating clinical activities - such as emergency surgery and intensive care - have a (possibly large) environmental footprint but a (proven possible) social value.

Theme 3 — Investor Worry-fest On Greenwashing: Institutional investor respondents repeatedly reported being worried about greenwashing in the healthcare industry, and several of them talked about how they experienced assessing ESG-labeled healthcare investment products whose sustainability assertions were not backed up by data they could verify. This nervousness has been cited as one of the obstacles to institutional ESG investment to the sector.

Theme 4 — NABH and BRSR as Catalysts: The two most popular institutional drivers listed by the respondent in both the hospital and investor camp (according to the list) and observed as the most effective catalysts to foster ESG use in the industry were NABH accreditation and the BRSR framework of SEBI Business Responsibility and Sustainability Report. A number of CFOs noted that the BRSR reporting process had spurred the creation of internal data systems, which previously did not exist, which supports the quantitative result of mediation by institutional preparedness and quality of reporting.

Theme 5 - The ESG - Finance Skills Gap: Both hospital/investor groups had participants who noted the presence of significant skills gaps in the capability of their teams to create, assess and value ESG - linked financial products. The lack of healthcare -specific ESG training programmes was recognised as an important gap that needed to be addressed urgently by academic institutions, professional bodies and regulatory agencies.

6. Conclusions and Future Research Directions

6.1 Principal Conclusions

This mixed - methods paper evaluates the motivation factors, impediments and policy consequences of ESG financing and sustainable investment decision - making in Indian corporate healthcare organisations using quantitative survey data on 186 respondents, and qualitative data on 20 senior stakeholders gathered using interviews. The results contribute to three key areas of knowledge about ESG integration in health care.

First, the study makes two key imputations — it finds Perceived ESG Materiality is the strongest driver of intension to adopt an ESG approach in healthcare investment contexts, and that high values on materiality dimensions that are most pertinent to investors' interests relate to patient outcomes, governance of workforce issues and clinical quality metrics (rather than environmental measures which have been shown increasingly dominant as drivers in genericized ESG rating frameworks). Direct implications of the findings on health care are also evident too; that is, the development of particular ESG rating methodologies and disclosure frameworks.

Second, ESG Reporting Quality plays a mediating role in the relationship that identifies high - quality, verifiable and comparable ESG disclosure as the main bottleneck in the adoption chain. The internal aptitude of hospitals to produce a workable ESG data, known as institutional readiness, is a sufficient, yet not necessary prerequisite to adoption; before it can impact investment behaviour, corporate discretion has to be transformed into a plausible external disclosure. Such results are a call to the urgent need to create BRSR guidelines tailored to the healthcare area, and the standards of third party certification of clinical and social performance measures.

Third, the moderating result (H4) proves that regulatory environment quality to turn stakeholder pressure into commitment to adopt it (a finding with urgency to policy) is about to be demonstrated. SEBI BRSR, and the sovereign green bond framework created by RBI, constitute a regulatory framework that has an exploratory potential of multiplied ESG forces in corporate healthcare in India so long as they are intentional made to match each other.

6.2 Practical Recommendations

To the hospital admins and CFOs, the study identifies three priority actions; (i) establish ESG data infrastructure quickly - one that is able to produce the standardised, auditable sustainability metrics the institutional investors seek (ii) participate in NABH accreditation procedures as a way of ascending up the considered institutionalisation of ESG in healthcare as a part of financial planning processes and (iii) explore social bond issuance as an inexp

To institutional investors, the paper proposes the creation of frameworks of health care - particular due diligence frameworks that consider clinical quality and equity - of - access measures weighted accordingly as part of integrated assessment, and the introduction of standardised ESG data request frameworks to its portfolio companies in the healthcare sector that go beyond generic BRSR requirements which incorporate measures of materiality in their own dimension specific to their industry.

To policymakers and regulators, the study recommends that a particular healthcare ESG disclosure norm be created in the context of BRSR; A comprehensive national level healthcare social bond taxonomy aligned with the social bond principles of Climate Bonds Initiative should be developed, and third -party verification of healthcare ESG claims by SEBI should be invented.

There are several limitations which impact the generalisability of the findings of this study. Although the sample was chosen deliberately on expertise, it is biased geographically to the five largest cities in India and might fail to present the full picture of ESG investment landscape in smaller urban centres, or rural healthcare markets. One reason why the use of self - reported survey data is subject to social desirability bias - participants may have exaggerated their

engagement in or concern with ESG, whereas procedural interventions have been implemented to prevent this - however, when it comes to the messy business of corporate disclosure, we need of programs that provide clarity. The cross-sectional type also does not allow causal inference as the relationships observed were only associational and need to be taken as making such. And finally, the research focuses on the Indian corporate healthcare industry and its findings could only be used with caution when extrapolated to the other national healthcare systems or to the profit-making medical organizations.

6.3 Future Research Directions

Findings in this book give rise to a number of fruitful research questions in the future. Longitudinal research designs would also enable the examination of how far the ESG adoption trend progresses with the regulatory maturity and institutional investor demand, a trend that, over the next five years, will very likely gain increased momentum. Comparison of the health systems across South Asia would assist in the better comprehension of how regulatory environment acts as a structural enabler or disabler to integrate ESG to different degrees and varying degrees of rigour. Another opportunity reforming research in the future is the direct correlation between healthcare ESG performance and patient outcome quality - an implied relationship in the Stakeholder Theory that cannot be empirically proved in India to date. Lastly, establishing and approving a healthcare - exclusive ESG materiality map, a framework that balances quantitatively clinical quality, health equity, environmental performance, is a methodological contribution that has a significant potential to be useful to both academic literature and investment practice.

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