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Profit Orientation and Equitable Access in Private Hospital Management

Rizka Amalia, Fayola Issalillah

Universitas Sunan Giri Surabaya, Indonesia

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ABSTRACT

Private hospitals expand healthcare capacity, technological investment, and patient choice, yet their commercial orientation raises concerns regarding equitable and affordable access. This article examines how profit orientation influences access to private hospital services and how commercial sustainability can be reconciled with equitable healthcare provision. An integrative literature review was conducted using studies on hospital ownership, private healthcare, healthcare affordability, access, quality, and equity. The synthesis indicates that profit orientation affects access through pricing, service portfolio decisions, geographical investment, patient segmentation, payer relationships, and incentives surrounding service volume. Commercial incentives may improve responsiveness, efficiency, and investment capacity, but can restrict access when ability to pay becomes a dominant determinant of service utilization. A workable balance requires transparent pricing, third-party financing, strategic purchasing, cross-subsidization, independent clinical governance, patient assistance mechanisms, and performance measures that incorporate equity alongside financial outcomes. The findings suggest that profit itself is not inherently incompatible with equitable care. The central issue is how financial incentives are governed and whether clinical need, safety, affordability, and protection of vulnerable patients remain binding principles in private hospital management.

INTRODUCTION

Private hospitals play a vital role in the provision of health care because they increase service capacity, expand facility options, and provide investments that the government cannot fully meet. This role also raises economic issues because hospitals provide services that differ from ordinary consumer goods. Patients often require care while ill, have limited medical knowledge, and rely on healthcare professionals to determine the necessary course of treatment (Chletsos & Saiti, 2019). Arrow (1963) explains that uncertainty regarding the onset of illness and treatment outcomes gives the healthcare market distinct characteristics from those of a typical competitive market. Information asymmetry and patients' dependence on professional expertise mean that healthcare transactions cannot be fully guided by price mechanisms. When hospitals are managed with a commercial orientation, the need to generate revenue must be balanced against the obligation to provide care so that a person's ability to pay does not become the primary determinant of their access to necessary treatment (Lali & Zhanna, 2017). These obligations also include the hospital's institutional responsibility to ensure the safety and quality of care through the supervision of healthcare personnel, risk management, and mechanisms for accountability in the event of medical errors. Thus, a commercial orientation does not negate the hospital's legal and professional responsibilities toward patients (Mening et al., 2023).

The commercialization of health care can be understood as the increasing emphasis on revenue, costs, investment, efficiency, and economic value in the management of medical services. For private hospitals, the ability to generate a surplus serves a practical purpose, as these organizations must fund health care personnel, equipment, technology, medications, building maintenance, capital expenditures, and service development (Martins & Ocké-Reis, 2024). Investment in health technology can also improve service efficiency, expand access to healthcare, and support improvements in service quality, although its implementation still faces challenges related to infrastructure, digital literacy, and regulations. Profits can also serve as a source for

* *Corresponding author, email address:* ***fayolaissalillah@gmail.com***

expanding capacity and improving the quality of facilities. Problems arise when financial targets begin to influence the selection of service types, pricing, the patient groups served, and investment decisions. Hospitals may have a stronger incentive to develop high-margin procedures rather than services that have significant social benefits but generate lower revenue. When commercial decisions cause harm to patients, questions of legal liability become central, since establishing causality and the burden of proof determines whether hospitals and their management can be held accountable (Sopyan et al., 2024). Similar accountability principles extend to health professionals within these institutions, such as pharmacists, whose legal responsibility toward patients remains a safeguard against practices driven purely by profit (Setiawan et al., 2023). This tension between financial sustainability and social function necessitates an analysis of profit orientation in terms of its impact on access, affordability, quality, and the distribution of services to groups with varying economic capabilities.

Access to health care encompasses more than just the availability of hospital facilities. A person is said to have access when the needed services are available, geographically accessible, appropriate for their clinical needs, and can be used without an excessive financial burden (Ha, 2024). In the context of health care, ensuring access is also linked to hospitals' obligation to provide non-discriminatory and timely care, including emergency services. However, fulfilling this obligation may face challenges such as shortages of health care personnel, facilities, funding, and referral systems, particularly in remote areas (Mohamad et al., 2024). Technology-based approaches such as telemedicine have been proposed to narrow this gap by extending the reach of services to underserved areas, though outcomes still depend on infrastructure readiness and how well the system is adopted by users (Khayru & Issalillah, 2022). Access must also account for population groups whose health needs are less visible, including psychological conditions that can remain unaddressed when service outreach is limited (Khayru & Issalillah, 2022). The commercial orientation of private hospitals is directly linked to this issue because the cost of services, payment plans, choices of care levels, deposits, and administrative procedures can influence patients' decisions to seek care. Affordability must therefore be assessed in terms of the relationship between the cost of services and the public's economic capacity, insurance coverage, and the amount patients must pay out of pocket.

The issue of affordability becomes increasingly relevant when people have medical needs that cannot be postponed. In a typical market, consumers can delay a purchase when prices are considered too high, whereas patients with acute conditions often do not have a similar option. In such emergency situations, patients are frequently unable to give explicit consent before treatment begins, making legal frameworks on implied consent essential to protect both patients and providers while care is administered (Susanti et al., 2024). This situation gives service providers significant power in determining the cost structure and the types of services offered. Insurance systems can reduce the burden of out-of-pocket payments, but they do not always eliminate disparities if benefit packages, reimbursement rates, facility networks, or additional services result in costs that patients must still bear (Grignon, 2014). Patients with rare diseases illustrate this disparity clearly, as therapy access under national insurance schemes such as BPJS is often constrained by coverage limitations and administrative requirements despite formal entitlement (Rahawain et al., 2024). Private hospitals operating within a mixed healthcare system must therefore be evaluated based on their ability to balance organizational sustainability with services that remain accessible to communities with limited resources.

The literature on hospital ownership shows that a for-profit orientation may be related to the cost structure of care. Devereaux et al. (2004) conducted a systematic review and meta-analysis of studies comparing care payments at for-profit private hospitals and nonprofit private hospitals. Their combined results showed higher payments at for-profit hospitals, although there was considerable variation across studies and these findings stemmed from specific health care systems. Such findings cannot be directly generalized to explain all private hospitals in every country, but they provide a basis for questioning how ownership incentives influence pricing and resource utilization. A profit orientation can drive efficiency and innovation, but the pressure to generate a return on investment can also translate into higher prices, the selection of services that yield larger margins, or cost-control measures that affect the patient experience. Such cost-control pressures also raise concerns about diagnostic accuracy, as legal liability for misdiagnosis has been shown to arise when clinical judgment is compromised by operational constraints (Setiyadi et al., 2023).

The relationship between profits and access is also not straightforward. Private hospitals can increase the capacity of the health care system by building new facilities, acquiring technology, recruiting professionals, and developing specialized services.

The presence of the private sector can even reduce the burden on public hospitals if financing and referral mechanisms are properly designed (Goodair & Reeves, 2024). This requires transparent and accountable governance, as well as coordination among hospitals, the government, and stakeholders, so that service integration can be effective and responsive to the needs of the community (Vitrianingsih et al., 2022). Achieving this level of coordination depends on several organizational factors working together, including leadership, resource allocation, and communication structures, all of which shape how effectively an institution operates (Darmawan, 2024). Under certain circumstances, private healthcare services can be more responsive to patients' needs and offer shorter wait times. Issues of equity arise when such increased capacity is more readily accessible to groups with high incomes, comprehensive insurance coverage, or those living in areas with strong purchasing power. Hospital development tends to be driven by financial viability, making locations with high demand for paid services more attractive to investors. A distribution of facilities based on market capacity may expand services overall but still leaves gaps for poor regions and groups with high health care needs.

The scientific gap in discussions of hospital commercialization lies in the tendency to separate financial sustainability from equitable access. Criticism of private hospitals often identifies profit as a source of injustice, while its defenders emphasize efficiency, innovation, and increased capacity. Neither position sufficiently explains the mechanisms by which a profit-oriented approach translates into managerial decisions that affect patients. Pricing, service portfolio selection, technology investment, bed management, relationships with insurance companies, and patient segmentation are the pathways that link financial goals to the public's experience. Understanding how these pathways are chosen requires attention to the cognitive processes behind managerial decision-making, since the way decision-makers frame and map the available options ultimately determines which pathway is selected (Darmawan, 2024). Studies also need to distinguish between a profit orientation as a necessity for sustaining the organization and practices of excessive commercialization that prioritize revenue over clinical needs. This distinction is necessary to ensure that analyses do not lead to the conclusion that all private hospitals undermine equity or that market mechanisms always improve service efficiency.

This paper aims to explain how a profit-oriented approach to private hospital management affects access to and affordability of services, and to identify management mechanisms that can reconcile financial sustainability with the principle of equity in health care. The analysis focuses on the relationship between revenue incentives, cost structures, service selection, patient segmentation, quality, efficiency, and the protection of groups with limited economic means. In this context, transparency regarding the costs and risks of care is a critical aspect, as patients need clear information about the financial and medical consequences before deciding on a course of treatment, so that care decisions are based not only on the patient's ability to pay but also on the patient's understanding and consent (Rachim et al., 2024). Its academic value lies in interpreting commercialization as a managerial process with distributional consequences, rather than merely as a distinction between public and private hospitals. Its practical value lies in formulating management principles that enable hospitals to remain financially viable without reducing healthcare needs to transactions determined solely by the ability to pay. Based on these objectives, the research questions are: (1) How does the profit orientation in the management of private hospitals affect public access to and affordability of health care services? (2) How can private hospital management balance commercial sustainability with the provision of equitable and affordable health care services?

RESEARCH METHOD

This study employs an integrative literature review to synthesize the literature on private hospitals, the commercialization of healthcare services, access to healthcare, affordability, quality, and equity. Whittemore and Knafl (2005) explain that an integrative review allows for the synthesis of studies with diverse methodological designs, enabling an issue to be understood through both empirical evidence and conceptual arguments simultaneously. The search focused on journal articles, systematic reviews, meta-analyses, and academic publications regarding private hospitals, for-profit hospitals, the commercialization of healthcare, healthcare access, affordability, health equity, hospital ownership, and the private healthcare sector. Sources were selected if they directly addressed the relationship between ownership or commercial incentives and costs, service utilization, quality, access for the poor, or service distribution. Literature that only discussed hospital financial performance without any connection to patient access or care was not included as primary material.

A literature review is conducted through the stages of searching, assessing relevance, grouping themes, comparing findings, and interpretive synthesis. Grant and Booth (2009) outline the Search, Appraisal, Synthesis, and Analysis framework as a tool for distinguishing the processes that shape various types of reviews. Snyder (2019) positions the literature review as a methodology that can be used to organize fields of knowledge and develop conceptual understanding when evidence is scattered across various studies. Sources were then divided into two groups based on the research questions. The first group included evidence regarding pricing, access, utilization, patient selection, and the distribution of services in the for-profit private sector. The second group covers service quality, regulation, financing mechanisms, public-private partnerships, and governance that can mitigate conflicts between commercial interests and equity. The synthesis is conducted in an argumentative manner and is not intended to serve as a new meta-analysis.

RESULT AND DISCUSSION

Profit Orientation, Access, and Affordability of Private Hospital Services

A profit-oriented approach affects hospitals through the need to generate sufficient revenue to cover costs and provide a return on capital. In private management, revenue is derived from patient payments, insurance, corporate contracts, health insurance programs, or a combination of various sources. This revenue structure creates incentives for the types of patients and services that are economically attractive (Chletsos & Saiti, 2019). Patouillard, Goodman, Hanson, and Mills (2007) show that the profit-oriented private sector serves as a source of care for various social groups, including the poor, but evidence regarding the success of private-sector interventions in increasing the poor's access to quality services remains limited. These findings indicate that the existence of private hospitals does not automatically result in equitable access. Private capacity can expand options, but its distributional benefits depend on pricing, financing, facility location, and the ability of low-income groups to utilize available services.

Pricing is the most direct link between a profit-oriented approach and access to care. Hospitals require rates that cover operational costs, investments, financial risks, and facility development. High rates may be justified by the use of advanced technology, specialist staff, the quality of accommodations, or specific service standards. Issues of equity arise when pricing becomes a barrier for patients who need medically essential care. Low-income patients may delay treatment, choose cheaper facilities even if they are farther away, or reduce their use of follow-up care after learning the cost (Korobko, 2023). A commercial orientation will exacerbate these issues if pricing decisions are primarily driven by market forces without cross-subsidy mechanisms or the involvement of third-party payers. Hospitals still need revenue, but affordability requires a pricing structure that distinguishes between rational cost recovery and pricing that exploits patients' dependence on services.

Health insurance and coverage can partially sever the link between the ability to pay out-of-pocket and access to care. When private hospitals are linked to social or commercial insurance plans, patients do not have to pay the full cost out of their own pockets. Such partnerships expand the patient base and can reduce the risk that hospitals will serve only high-income groups. New issues arise when reimbursement rates are considered too low by hospitals or when benefit packages do not cover needed services (Thomson et al., 2020). Hospitals may limit the number of certain beds, expand patient-paid ancillary services, or direct investments toward services with more profitable reimbursement rates. From a management perspective, relationships with third-party payers influence revenue strategies and the composition of services. Equitable access therefore depends on whether the payment system provides sufficient incentives for hospitals to remain willing to treat patient groups with lower payment values. This situation is consistent with a study on the pharmaceutical industry within the JKN system, which shows that pricing policies, corporate behavior, and market mechanisms can affect the affordability and equitable distribution of access to health care; therefore, economic interests must be balanced with the goals of equity and sustainability in the health care system (Hartono et al., 2024).

A profit-oriented approach can also influence the service portfolio. Hospital management faces choices regarding which services to expand, maintain, or reduce. Elective surgical services, certain diagnostic tests, premium care, and high-volume procedures may attract investment because they offer clearer revenue prospects. Conversely, services that require significant resources but generate low reimbursement may be viewed as less attractive (Horwitz & Nichols, 2022). Basu et al. (2012) found that comparative evidence from low- and middle-income countries does not support the simplistic assumption that the private sector is always more efficient, more accountable, or more medically effective, even though private services are often reported to be faster and more patient-friendly. These

findings suggest that investment decisions need to be evaluated based on a balance between commercial appeal and public health needs. The need to maintain this balance is becoming increasingly important because limited resources and barriers to accessing health care can affect the fulfillment of patients' rights and their legal protection in obtaining health care (Tampil et al., 2023).

The selection of hospital locations also has distributional consequences. Private investors rationally consider population density, purchasing power, transportation access, the presence of insurance companies, the availability of professionals, and potential demand. Urban areas with high economic activity can more easily meet these requirements compared to regions with a dispersed population or low incomes. As a result, private-sector expansion may increase the number of hospitals but concentrate them in areas that already have better healthcare resources (Ghatak, 2024). Geographical disparities then go hand in hand with financial disparities. Patients in commercially less attractive regions face higher travel costs and longer delays in receiving care. Market mechanisms can rapidly provide facilities in areas with high demand, but equitable distribution of services requires additional incentives to ensure that investment also reaches regions with high needs but lower revenue potential.

Service segmentation is another strategy that may emerge in commercial management. Hospitals can offer different room classes, examination packages, executive services, and additional facilities at varying price points. Segmentation can have a positive impact because revenue from premium services has the potential to support the overall development of the facility. This model becomes problematic if class distinctions lead to disparities in access to essential clinical services, wait times, physician availability, or medical quality (Sepehri, 2014). Equity does not require all patients to receive the same non-medical amenities, but clinical needs should be the primary basis for prioritizing care. Distinguishing between differentiation based on comfort and differentiation based on the right to care is a crucial element in assessing commercialization. Hospitals can offer service options based on patients' financial capacity without using payment status as a basis for lowering safety and medical quality standards.

Commercialization can also influence patterns of diagnostic and therapeutic use. Fee-for-service payment systems can provide incentives to increase the volume of tests or procedures because each procedure generates revenue (Bradley & Bradley, 2014). Basu et al. (2012) found in their literature review reports of unnecessary testing and treatment in some private healthcare settings, which were linked to fee-for-service payment incentives. This phenomenon is significant because costs do not always rise due to higher fees; costs can increase through greater use of services. Patients have limited ability to assess whether a test is truly necessary, so professional integrity and clinical governance become the primary safeguards. A profit-oriented approach without clinical evaluation mechanisms can create a conflict between organizational revenue and patient interests.

The relationship between profit and quality must be interpreted with caution, as commercial incentives can have varying effects. Competition for patients can encourage hospitals to improve comfort, hospitality, medication availability, timeliness, and investment in technology. Poor service can damage a hospital's reputation and reduce revenue, giving management an economic incentive to improve the patient experience. At the same time, pressure to improve efficiency can result in staff reductions, shorter treatment times, or excessive cost-cutting if financial indicators take precedence over safety (Goodair & Reeves, 2024). Basu et al. (2012) found that the private sector in the studies they reviewed often demonstrated better timeliness and friendliness, but evidence regarding medical standards and clinical outcomes does not always support the superiority of the private sector. Financial gains and quality, therefore, do not have an automatic relationship that is consistently positive or negative.

Access for the poor is greatly influenced by the design of interventions that link the private sector with public health goals. Patouillard et al. (2007) examined various approaches such as vouchers, social marketing, contracting out, accreditation, training, and regulation to increase the use of private services by the poor. They found that some programs work in poor communities, but evidence regarding the distribution of benefits according to socioeconomic status remains limited. These findings are important because they show that for-profit hospitals do not necessarily have to be positioned in absolute opposition to equity. Financial incentives can be designed so that providing services to the poor still generates adequate revenue. Subsidies, government procurement of services, vouchers, and service contracts can transform groups that were previously commercially unattractive into patients who can be served financially.

Efforts to align the private sector with the goal of social justice are consistent with the national legal framework as stipulated in Article 3 of Law No. 17 of 2023 on Health, which states that the provision of

health services aims to: a. promote healthy lifestyles; b. improve access to and the quality of health services and health resources; c. enhance the effective and efficient management of human resources; d. meet the public's needs for health services; e. enhance health resilience in the face of public health emergencies or outbreaks; f. ensuring the availability of sustainable and equitable health financing that is managed transparently, effectively, and efficiently; g. realizing the sustainable development and utilization of health technology; and h. providing legal protection and certainty for patients, health human resources, and the public. These provisions reinforce the principles of non-discrimination and equity in health care, requiring every health care facility to provide services that are equitable, dignified, and do not restrict patients' access based on their health status or social characteristics (Napu et al., 2024).

The ability to pay also influences behavior before patients are admitted to the hospital. The public may perceive private hospitals as expensive facilities and avoid them even when services are available at rates that are actually covered by insurance or health insurance programs. Perceptions of cost act as a psychological barrier that reinforces actual financial barriers. Transparency regarding rates and insurance coverage information can help reduce this uncertainty. Hospitals that develop a pre-procedure cost information system allow patients to better estimate their financial obligations. Transparency also limits the possibility of unexpected bills that can erode trust (Bucatariu & George, 2017). Long-term commercial management has a vested interest in maintaining reputation and patient relationships; therefore, openness regarding rates should be viewed as an investment in trust, not a barrier to pricing flexibility.

A profit-oriented approach can also generate efficiencies that contribute to affordability if management is able to reduce costs without compromising quality. The digitization of administrative processes, inventory management, optimal utilization of operational capacity, reduction of wait times, and efficient procurement can lower the cost per unit of service (Korchagina, 2021). Such efficiencies differ from cost-cutting measures that reduce basic clinical needs. Private hospitals have managerial flexibility that can support operational innovation because investment decisions are often made more quickly than in organizations with lengthy bureaucratic procedures. Problems arise when efficiency gains are entirely translated into increased margins and do not result in improved affordability. Equity-based management metrics can assess whether efficiency creates room for more reasonable rates, increased capacity, services for the indigent, or investment in services with high social benefits.

A profit-oriented approach affects access and affordability through several interrelated mechanisms, namely pricing, investment location, service portfolio selection, patient segmentation, relationships with payers, and incentives for procedure volume. Evidence discussed by Patouillard et al. (2007) and Basu et al. (2012) shows that the private sector has the capacity to expand services and improve responsiveness, but these benefits are not automatically distributed equitably. Profit becomes an issue when the ability to pay takes precedence over clinical need as the basis for access. Conversely, financial sustainability can support equity if financing systems, service contracts, subsidies, and governance ensure that services for vulnerable groups remain economically viable for hospitals.

Balancing Commercial Sustainability and Equity in Health Care

Striking a balance between commercial interests and fairness requires recognizing that private hospitals cannot operate continuously without adequate revenue. Professional staff, medical technology, medications, energy, facility maintenance, accreditation, and safety investments all require a sustainable source of funding. The issue of management is not about eliminating profit, but about setting limits and determining the use of financial incentives so that revenue goals do not undermine service delivery (Patne & Kanyal, 2024). Investment in medical technology also plays a role in improving the efficiency of healthcare services, expanding access to healthcare, and supporting the diagnostic process and medical decision-making, although its implementation still faces challenges related to infrastructure, access disparities, and regulations (Sarif & Issalillah 2022). Eggleston et al. (2008) demonstrated through a systematic review that the relationship between hospital ownership and quality yielded mixed findings and was strongly influenced by region, time period, data sources, and research methods. This variability precludes the generalization that for-profit status always results in lower or higher quality. The effects of ownership must be examined through the lens of governance and the institutional environment that shapes hospital decision-making.

The first principle of this balance is the separation between the goal of generating a surplus and clinical decisions. Management can set budgets, investments, and efficiency targets, but decisions

regarding the need for treatment must still be based on professional judgment and the patient's best interests. This principle is consistent with the importance of legal protection for physicians in performing medical procedures based on patients' needs and professional standards, particularly in situations that require immediate medical intervention (Juliarto et al., 2023). Conflicts of interest arise when physicians or service units receive financial incentives that are too strong to increase the volume of procedures without adequate indicators of clinical need. Governance can mitigate this risk through clinical pathways, peer review, audits of service utilization, and medical committees that are independent of revenue targets. These controls do not eliminate the obligation to operate efficiently. Healthcare professionals must still consider resource utilization, but decisions to cut costs must be based on clinical benefits and safety. The separation of financial and clinical functions protects patients from becoming mere objects of transaction maximization.

The second principle is the development of a transparent and accountable pricing structure. Hospitals have the right to set prices that reflect the costs and value of services in accordance with the applicable system, but patients need to receive adequate information regarding estimated costs, service components, and potential additional charges. Cost uncertainty has a greater impact on people with limited savings. Transparency can be achieved through package information, pre-procedure estimates, explanations of insurance benefits, and mechanisms for disputing bills. The pricing structure can also utilize internal cross-subsidies, whereby premium services help finance services with lower profit margins. This model requires oversight to ensure that subsidies are truly used to expand access and do not merely serve as a social narrative that is not reflected in the actual distribution of services.

The third principle is the integration of private hospitals into a financing system that expands financial protection. Contracts with public health insurance programs, insurance companies, or government service purchasers can ensure that patients with low out-of-pocket payment capacity still have institutional purchasing power. Under this scheme, hospitals receive revenue through predetermined reimbursement mechanisms. The financing mechanism must be accompanied by governance and oversight to prevent claim manipulation, data falsification, and service irregularities, so that JKN financing continues to protect participants' rights (Jamiri et al., 2023). The challenge is to ensure that payment rates are realistic enough to cover efficient care without encouraging hospitals to avoid certain cases. The payment design can include adjustments based on patient complexity and quality indicators. Strategic procurement of services by payers can steer private hospitals toward public goals because payments are linked to compliance with standards, patient access, and service outcomes. Hospitals continue to generate revenue, while the government uses its purchasing power to expand coverage.

Quality must be the primary constraint on efforts to achieve commercial efficiency. Berendes et al. (2011) reviewed 80 studies comparing private and public ambulatory care in low- and middle-income countries. They found that technical quality in both groups was often still low, while the formal private sector tended to demonstrate better medication availability, responsiveness, and service efforts across a number of indicators. These results show that ownership status is not a sufficient measure of quality. Service standards, professional oversight, accreditation, indicator reporting, and clinical learning mechanisms are necessary across all types of hospitals. For commercial hospitals, quality also has economic value because safety and reputation determine the ability to retain patients in the long term (Crump & Chaudhury, 2010).

Human resource management is a key factor in maintaining balance. Hospitals can control costs through productivity and staff scheduling, but reducing staff beyond safe levels has the potential to increase workloads, wait times, and the risk of errors (Bryce & Christensen, 2011). Conversely, an overly inefficient structure drives up costs and ultimately increases the price of services. Management needs to use data on workload, patient complexity, safety standards, and competency requirements to determine workforce composition. The quality of human resources itself has been shown to influence job performance and employee loyalty, which in turn affects how consistently service standards are maintained (Darmawan et al., 2020). Work incentives should also be designed so that rewards for productivity align with quality indicators. If rewards depend solely on the number of procedures or revenue, staff behavior may be driven toward the overuse of services. Heavy dependence on digital systems for scheduling and internal communication also carries psychological consequences for staff, a concern reflected in research on the mental health effects of intensive digital and social media use (Aisyah & Issalillah, 2021). A performance system that combines efficiency, safety, patient satisfaction, and clinical

outcomes is more in line with the nature of a hospital as a business organization with social responsibility.

Investment in technology is another area where the goals of profit and equity can either support or conflict with one another. Medical technology can improve diagnostic accuracy, speed up processes, and expand the range of services, but costly investments also create pressure to use equipment intensively to generate a financial return. Management needs to evaluate technology based on clinical benefits, population needs, patient volume, and costs throughout the entire lifecycle (Baselski et al., 2014). Telemedicine illustrates this trade-off well: while regulation aims to safeguard patient safety in remote consultations, weaknesses in oversight can leave diagnostic errors without a clear compensation mechanism for affected patients (Sasmita et al., 2023; Mokoginta et al., 2024). Purchasing high-tech equipment solely to enhance a hospital's premium image can drive up costs without providing proportional benefits to the majority of patients. Conversely, investments in information systems, telemedicine, inventory management, and administrative automation have the potential to reduce the cost of care. Equity in investment means that resources are directed toward technologies that improve access to or health outcomes, rather than merely enhancing commercial differentiation.

Services for indigent patients must be managed as a clearly defined institutional function. The legal basis for this obligation is set forth in Article 189(1) of Law No. 17 of 2023 on Health, which stipulates that every hospital has the obligation to: e. provide facilities and services for the underprivileged or indigent; and f. to carry out social functions, including by providing service facilities for the indigent or poor, emergency care without an upfront payment, free ambulances, services for victims of disasters and public health emergencies, or social service activities for humanitarian missions. This obligation cannot be separated from patients' basic legal rights, particularly the right to give informed consent before any medical action is taken (Chairul Z et al., 2023), as well as legal protection against negligence by medical personnel who provide their care (Lethy et al., 2023). The fulfillment of these obligations, particularly those outlined in subparagraphs e and f, underscores the importance of structured governance, given that social programs dependent on ad hoc decisions can result in uncertain access and make evaluation difficult. This is especially relevant for patients with terminal conditions who depend on home-based and palliative care, where clarity on legal rights determines the quality of care they receive (Mengga et al., 2024), and for population groups with distinct social characteristics, such as indigenous communities in urban settings, whose access patterns may differ from the general population (Amri & Khayru, 2022). Hospitals may establish policies regarding cost assistance, social funds, partnerships with philanthropic organizations, or contracts with the government for specific patients. Eligibility criteria must be transparent so that assistance does not depend on a patient's ability to negotiate (Rifla & Syam, 2024). Managing beneficiary data also allows hospitals to assess the extent of their social contribution and determine which services are most needed by vulnerable groups. This policy can be viewed as part of a hospital's social legitimacy. Healthcare organizations earn public trust by addressing needs of high humanitarian value; consequently, their responsibility toward those unable to pay has a stronger foundation than that of typical corporate social responsibility programs (Sari et al., 2024).

Collaboration between the public sector and private hospitals can align investment capacity with equity goals. The government can purchase services, provide subsidies, offer investment incentives for specific regions, or enter into contracts for services where public capacity is limited. Hospitals gain a more predictable revenue stream, while the government gains additional facilities without having to build the entire capacity itself. The reliability of this scheme depends heavily on the health insurance system functioning properly, since failures in claim payment can undermine hospitals' financial planning and ultimately affect service continuity (Ambarwati et al., 2024). Weak oversight in this arrangement can also open the door to fraudulent practices within the national insurance program, which carries its own legal consequences for hospitals found responsible (Eskandar et al., 2025). This balance requires clear contracts regarding patient volume, quality standards, rates, reporting, and penalties in the event of unreasonable restrictions on access. Public services purchased from private facilities must not result in lower medical standards for publicly funded patients compared to those who pay privately. Differences in amenities may still exist, but safety and clinical adequacy must be maintained to the same standard.

Competition among hospitals can promote equity when patients have genuine choices and information on prices and quality is available. Competition can encourage hospitals to improve efficiency, service, and reputation. This is why medical advertising must remain within regulatory limits, so that patients as consumers of health services are not misled by promotional claims when choosing a facility (Sahidu et al., 2023). However, the hospital market has limitations because patients

cannot always choose a facility in an emergency, and clinical information is difficult to compare (Singer et al., 2012). The concentration of hospitals within large corporate groups can also reduce competitive pressure when the number of providers is limited. This pattern often reflects broader urban inequality, where facility distribution follows purchasing power rather than actual health needs (Mardikaningsih, 2021). Equity-oriented management, therefore, cannot rely on competition alone. Transparency regarding quality indicators, safety standards, patient protection, and financing systems remains essential. Business interests must be allowed room to grow, but institutional safeguards are needed to ensure that competition does not lead to patient selection or the expansion of high-cost services that do not meet the population's needs.

Hospital performance measurements should include indicators of access and equity alongside financial indicators. Management typically monitors revenue, margins, cash flow, occupancy rates, length of stay, and productivity. These metrics are necessary to ensure the organization remains financially sound (Hadian et al., 2024). Patient satisfaction should be included as a core indicator as well, since it is shaped not only by clinical outcomes but also by service quality and facility location (Mardikaningsih, 2022), a pattern also observed among BPJS patients at public health centers where satisfaction levels track closely with perceived service quality (Darmawan et al., 2022). The evaluation can be expanded to include the number of patients receiving financial assistance, the distribution of payer groups, wait times by service class, the rate of patient refusal due to financial factors, billing complaints, and access for vulnerable groups. Eggleston et al. (2008) demonstrate that research findings on ownership and quality are highly sensitive to the methods used and the characteristics of the markets under study. This serves as a reminder that a single indicator cannot represent a hospital's overall performance. A balanced scorecard that incorporates social dimensions can help leaders see the consequences of commercial decisions on public access.

Organizational culture also determines how profit targets are translated into service levels. Two hospitals with the same ownership status may exhibit different behaviors if their management values and accountability mechanisms differ (Chletsos & Saiti, 2019). Weak ethical culture can manifest in serious violations, ranging from malpractice and misconduct in traditional medicine practices (Sirenden et al., 2024) to the falsification of health certificates (Hartika et al., 2023), both of which point to gaps in professional ethics that formal ownership status alone cannot explain. Proper management of electronic medical records is likewise a legal matter that reflects how seriously an institution treats patient data and accountability (Kholis et al., 2023). Hospitals that prioritize safety, professional ethics, and access as part of their organizational identity may pursue a surplus through efficiency and innovation, while other hospitals may rely on sales pressure or service selection. Berendes et al. (2011) show that the formal private sector has some advantages in terms of responsiveness and medication availability, but technical quality across various facilities still requires improvement. These findings support the view that the quality of management is more decisive than the ownership label alone. Leadership must ensure that financial targets are subject to clear ethical and clinical boundaries so that professionals do not receive the message that revenue is the sole measure of success.

A balance between commercial interests and equity ultimately requires the proper structuring of incentives, not the rejection of hospitals' economic activities. Private hospitals need revenue to survive, while the public needs assurance that access to medical care is not determined solely by the ability to pay (Levaggi & Levaggi, 2020). This balance is part of a larger legal and policy landscape shaping national health development, covering service access and the handling of infectious disease alongside economic considerations (Harianto et al., 2024), as well as institutional obligations that are often overlooked, such as medical waste governance, which remains essential for protecting public health regardless of a hospital's financial standing (Khayru et al., 2024). Management can reconcile these two goals by separating clinical decisions from financial pressures, implementing transparent pricing, integrating with health financing systems, utilizing cross-subsidies, purchasing services, auditing the use of medical procedures, and measuring access. Such a framework shifts the focus on profit from a sole objective to one of the conditions for organizational sustainability. Profits can still be generated as long as revenue mechanisms do not undermine clinical standards and do not systematically exclude groups with limited resources. Hospitals can then function as both service institutions and economic organizations without positioning these two identities as irreconcilable opposites.

The balance between commercial sustainability and equity is not achieved by eliminating profits, but through governance that regulates how profits are generated (Çavmak, 2024). Evidence from Eggleston et al. (2008) and Berendes et al. (2011) shows that private ownership or a profit orientation does not

guarantee consistent quality outcomes; thus, management, market, and institutional arrangements play a significant role in determining service outcomes. Private hospitals can support access when financing, rates, clinical governance, service contracts, and assistance policies are designed to include low-income groups. Equity is maintained when clinical needs remain the primary basis for service, while financial surpluses are generated through efficiency, innovation, convenience segmentation, and resource management that do not lower medical standards.

CONCLUSION

The profit-driven nature of private hospital management affects public access through pricing structures, service options, investment locations, patient segmentation, relationships with payers, and incentives for the use of medical procedures. Profit can strengthen capacity, innovation, responsiveness, and investment, but it can create barriers when the ability to pay becomes the dominant factor in accessing care. Equity, therefore, depends on how commercial incentives are managed. A balance can be achieved through transparent pricing, third-party financing, cross-subsidies, government procurement of services, oversight of clinical decisions, patient assistance policies, and social performance indicators. Private hospitals do not need to lose their business character to fulfill their social functions. Profit should be viewed as a source of organizational sustainability, while clinical needs, safety, affordability, and access for vulnerable groups serve as the boundaries that guide how that profit is generated.

The commercialization of health care services is best analyzed through managerial decision-making mechanisms rather than through a simple dichotomy between private and public hospitals. A profit-oriented approach influences service delivery through pricing, investment, health worker incentives, and financing arrangements, while its ultimate impact is determined by governance and the institutional environment. These findings open the door to linking health economics, hospital management, health equity, and financing policies within a single framework for discussion. Private hospitals need to include indicators of access, affordability, and quality alongside financial indicators in their management evaluations. The government and health care payers can use contracts, rates, accreditation, and purchasing mechanisms to direct the capacity of private hospitals toward community needs without eliminating incentives for investment and efficiency.

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