PATHFINDER OF RESEARCH

Review Research

Preventable Readmissions and Financial Management in Healthcare: A Comparative Study of Cost Containment in Non-Profit and For-Profit Hospitals

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Abstract: Efficient financial management is crucial for the sustainability and efficacy of contemporary healthcare systems. This analysis rigorously assesses cost containment initiatives implemented by Non-Profit (NFP) and For-Profit (FP) institutions and examines the financial consequences of avoidable hospital readmissions. The study does a narrative synthesis in accordance with PRISMA 2020 guidelines, analyzing 62 peer-reviewed papers published from 2010 to 2025. The assessment classifies cost conservation measures into four principal themes: operational efficiency, technological investment, administrative reorganization, and value-based care delivery. It indicates that FP hospitals primarily employ assertive cost-reduction and revenue-maximization strategies, such as outsourcing, performance-based contracting, and digital billing optimization. NFP hospitals prioritize long-term sustainability by focusing on community-oriented initiatives, care integration, and workforce development. The analysis emphasizes that unnecessary hospital readmissions intensify cost burdens, particularly for disadvantaged populations, affecting reimbursement schemes and institution rankings. The results demonstrate the need to synchronize financial management with fairness, policy adherence, and health outcomes. Policy proposals highlight the integration of value-based incentives, the standardization of readmission penalties, and the assurance of openness in ownership-driven financial practices. The analysis indicates that a hybrid framework for cost reduction that balances efficiency, accountability, and equity is essential for promoting sustainable and equitable healthcare delivery across various institutional systems.

Keywords: Ownership, Readmissions, Efficiency, Policy, Costing

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1. Introduction

The economics of hospital care delivery have been gaining prominence in policy, governance, and management conversations due to escalating healthcare costs, evolving reimbursement models, and demands for enhanced responsibility in clinical outcomes and financial performance. The United States, exemplifying one of the most sophisticated healthcare systems worldwide, is facing an unsustainable increase in healthcare expenditures. In 2022, overall health spending in the United States amounted to around $4.5 trillion, or about 18% of the nation's GDP, with projections indicating growth to 19.6% by 2031 **(Achor et al., 2025)**. Increasing expenses exert significant pressure on public budgets and have heightened the demand for hospitals to enhance financial operations while sustaining or elevating the quality of treatment. Despite these financial limitations, the ownership structure of hospitals, particularly the distinction between for-profit (FP) and non-profit (NFP) entities, has emerged as a central topic of academic and policy examination. Although all categories of hospitals function under comparable legal regimes, their financial incentives and operational methods vary considerably. Non-profit hospitals, due to their tax-exempt status and community-focused administration, typically emphasize fair access to care, public health investments, and the reinvestment of surplus cash into service growth **(Horwitz & Nichols, 2009).** Their administration often comprises a diverse group of physicians, academics, and community leaders whose strategic decisions prioritize the purpose over profit. The structural attributes have traditionally characterized NFP health organizations, emphasizing public service responsibilities over financial outcomes **(Pollock et al., 2007).**

In contrast, for-profit hospitals primarily serve the interests of investors and shareholders. Their business approaches prioritize maximizing return on investment, developing high-margin service lines, and maintaining operational efficiency **(William & Okafor, 2024).** These organizations frequently exhibit a greater propensity for cost-containment methods, such as streamlined personnel models, outsourcing of non-essential activities, and focused capital expenditures in high-revenue technology. The disparity in ownership goals results in concrete variations in budgeting, investment priorities, personnel management, patient involvement, and reactions to regulatory and policy incentives. A significant area where these discrepancies are evident is in avoidable hospital readmissions, which are defined as patient returns within 30 days after discharge for the same or similar conditions. T These unanticipated readmissions signify both a measure of the quality of care and a source of cost inefficiency. F Financially, readmissions impose an annual cost that exceeds $26 billion on the U.S. healthcare system, with approximately $17 billion considered preventable through improved care coordination, efficient discharge planning, and better post-acute support **(Zuckerman et al., 2026).** Certain illnesses, like COPD, have consistently elevated readmission rates and are frequently

addressed by HRRP-associated penalty mechanisms **(Aduro, 2022).** Avoidable readmissions often indicate fragmented treatment, ineffective communication between inpatient and outpatient clinicians, and socioeconomic determinants of health, including insufficient housing, transportation obstacles, and low health literacy. The Affordable Care Act established the Medicare Hospital Readmissions Reduction Program (HRRP) to address these inefficiencies. The HRRP enforces financial penalties on hospitals with readmission rates beyond established national thresholds. The HRRP aims to promote improved care transitions and post-discharge planning; nonetheless, the strategy has had intricate repercussions, especially for institutions catering to socioeconomically disadvantaged populations. Research indicates that safety-net hospitals, which primarily serve low-income and medically disadvantaged populations, encounter elevated readmission rates attributable to structural and societal obstacles outside their direct influence. These facilities usually lack the means to establish complete transitional care programs, resulting in patients encountering obstacles in getting follow-up treatment, adhering to drug regimens, and receiving health education. Furthermore, the pressure of public reporting has been associated with selective risk avoidance, which may compromise transparency objectives **(Joynt et al., 2012).**

These dynamics pose significant inquiries regarding the fairness and equality of performance-based reimbursement structures. The HRRP, despite its noble intentions, may unintentionally punish hospitals that serve the most vulnerable populations, thereby worsening health inequalities instead of alleviating them. Many scholars have suggested enhancements to the risk adjustment algorithms employed in HRRP to include socioeconomic characteristics such as income, housing stability, and neighborhood disadvantage. The suggested modifications seek to correlate financial penalties more accurately with real performance and manageable factors inside healthcare organizations. The influence of ownership structure transcends readmission rates, affecting larger organizational characteristics such as staff policy and technology implementation. Hospitals exhibiting elevated nurse-to-patient ratios, comprehensive discharge planning procedures, and investment in digital health technologies such as electronic health records (EHRs), predictive analytics, and telemedicine generally report improved results in readmission measures **(Griffiths et al., 2023).** Implementing such systems necessitates significant financial commitment and organizational preparedness, which may pose difficulties for smaller institutions or those operating with limited margins. FP hospitals, in their quest for cost-effectiveness, may implement lean staffing models, automated discharge systems, and telephone outreach tactics that prioritize internal efficiency above outward continuity of care. Although these methods may provide immediate financial advantages, they might jeopardize long-term patient outcomes and elevate the likelihood of preventable readmissions **(Ayaad et al., 2022).** NFP hospitals often allocate resources to extensive transitional care models, which encompass in-home follow-up

visits, social work integration, and community health worker initiatives, all designed to mitigate readmission risk and tackle wider health determinants **(Upadhyay et al., 2019).**

However, NFP hospitals can experience inefficiencies. Numerous affluent non-profit organizations in the U.S. have faced criticism for their inadequate community benefit donations while still retaining their tax-exempt status **(Bruch & Bellamy, 2021).** This dichotomy necessitates a more sophisticated understanding of hospital performance that goes beyond ownership classifications and examines the specific practices, investments, and strategic approaches employed by these institutions. Finance methods in technology further highlight the disparity between for-profit and not-for-profit hospitals. FP hospitals frequently direct resources toward lucrative medical technologies such as robotic surgery, sophisticated imaging equipment, and minimally invasive procedures that serve privately insured or affluent patient populations **(Chowdhury et al., 2020b).** These investments, although possibly augmenting revenue streams, may have minimal impact on advancing health equity. NFP hospitals are more inclined to invest in technology that improves treatment access and coordination, including EHR systems designed for rural health, telemedicine platforms for underserved areas, and data integration systems focused on population health management **(Ashakin et al., 2024)**. Data-driven operational instruments, including real-time analytics dashboards, enhance accuracy in capacity planning and quality control **(Jiang, 2022).** These initiatives may generate lower immediate financial returns but significantly enhance long-term sustainability and community health outcomes. Furthermore, management viewpoints have progressively acknowledged the significance of e-health systems in facilitating the digital transformation of healthcare delivery **(Biancone et al., 2023).** The interaction among ownership type, financial strategy, and governmental response highlights the necessity for a balanced and fair healthcare finance model. Hospitals must receive assistance and incentives to invest in infrastructure, staff, and care models that enhance cost-efficiency while ensuring high-quality and equitable service delivery. This review evaluates existing methods for measuring performance, along with financial penalties and incentive frameworks, to account for contextual factors and institutional limitations.

This review is organized around two primary objectives: to critically assess the financial management practices of for-profit and not-for-profit hospitals, emphasizing budgeting processes, investment strategies, staffing models, and service delivery frameworks; and to analyze the economic ramifications and systemic consequences of preventable hospital readmissions, including policy responses such as the Hospital Readmissions Reduction Program (HRRP) and their effects on institutional sustainability and equity. The study synthesizes empirical data, financial models, and equitable concerns through a methodologically rigorous assessment of 62 peer-reviewed papers and policy sources from the U.S.

and select OECD nations. The objective is to elucidate how ownership models influence hospital performance and to provide pragmatic advice for hospital managers, health economists, and legislators aiming to enhance financially sustainable and patient-centered care systems.

2. Methodology

2.1 Objectives and Application

This study intends to thoroughly investigate the financial management methods of non-profit (NFP) and for-profit (FP) hospitals, specifically emphasizing cost-containment techniques and the financial consequences of needless hospital readmissions. The dual objectives are to investigate the impact of hospital ownership models on budgeting processes, investment behaviors, workforce organization, and technology adoption; and (2) to analyze how these structural variations influence the management and economic burden of 30-day readmissions under policy initiatives like the Hospital Readmissions Reduction Program (HRRP).

Non-profit hospitals are frequently motivated by a dedication to community service, egalitarian healthcare, and reinvestment in marginalized communities **(Chater & Loewenstein, 2023).** Conversely, FP hospitals emphasize performance indicators that enhance shareholder value and cost-effectiveness **(William & Okafor, 2024).** This review aims to evaluate these differences through a comparative analysis, emphasizing the impact of ownership philosophies on institutional performance, health equity outcomes, and systemic sustainability, especially concerning federal readmission penalties and evolving reimbursement structures **(Mithun et al., 2023; Ifty et al., 2023b).**

2.2 Identification Strategy for Literature Review

A thorough and extensive literature search was performed utilizing four principal academic databases: PubMed, Scopus, Web of Science, and Google Scholar. The search was confined to the timeframe from January 2018 to April 2024, encompassing the post-Affordable Care Act landscape and the changing effects of COVID-19 on hospital financial frameworks. We employed Boolean operators to enhance the search queries, incorporating the following key combinations:

- Hospital financial strategy and non-profit readmission fines
- Cost minimization, for-profit hospitals, and value-based reimbursement

Only peer-reviewed articles in English with full-text access were deemed suitable. Supplementary reference chaining, retrospective citation analysis, and examination of grey literature were employed to guarantee thorough coverage of the subject. We also evaluated gray literature sources, despite their restrictions, to identify peer-reviewed gaps, a crucial method in evidence synthesis **(Paez, 2017).** Unpublished material was deemed relevant only if it offered vital policy insights or addressed

significant contextual deficiencies.

2.3 Analytical Inclusion and Exclusion Criteria for Literature Selection

To uphold methodological rigor and ensure relevance, clearly defined inclusion and exclusion criteria were applied, as summarized below:

Table 1. Inclusion and Exclusion Criteria for Literature Selection

Criteria	Inclusion	Exclusion
Type of Publication	Peer-reviewed journal articles	Editorials, dissertations, blogs, non-peer-reviewed sources
Language	English	Non-English
Topical Relevance	Ownership models, hospital finance, workforce policy, and cost containment	Purely clinical studies without financial or policy analysis
Geographic Scope	United States and OECD member countries	Research limited to non-OECD or non-comparative country contexts
Access	Full-text availability	Abstract-only or paywalled/inaccessible articles

Only articles presenting empirical, financial, or policy-based evidence relevant to the comparative study of hospital ownership types were retained for final analysis.

2.4.Article Screening and Selection Process

Following PRISMA 2020 guidelines **(Page et al., 2021),** the article selection involved four stages: identification, screening, eligibility assessment, and final inclusion. A total of 1,104 articles were initially retrieved. Duplicate entries (n = 221) were removed using Zotero reference management software. The foundational PRISMA 2009 model also informed the initial design of identification, screening, and eligibility steps **(Moher et al., 2010).**

Two independent reviewers screened the remaining 883 titles and abstracts. Articles that did not meet the inclusion criteria were excluded. Subsequently, 107 full-text papers were evaluated for methodological quality and thematic alignment. Ultimately, 62 articles were retained for synthesis. The PRISMA summary is presented below:

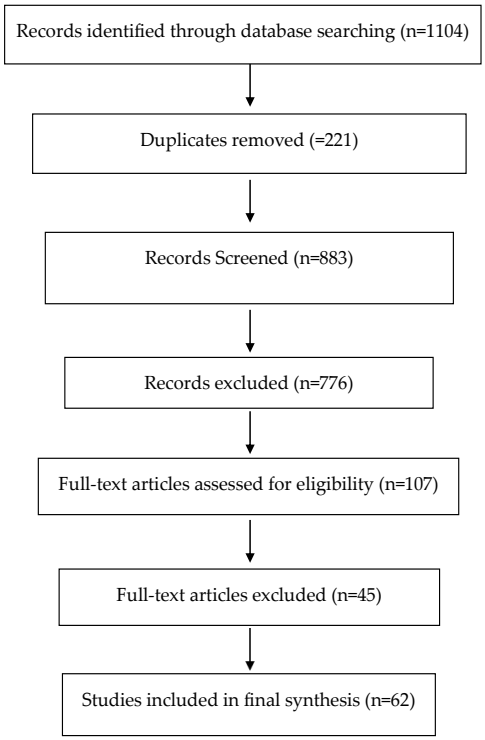

Figure 1. PRISMA Summary of Literature Screening Process

The final dataset comprises empirical investigations, policy analyses, and financial modeling studies that directly address hospital ownership, fiscal governance, or HRRP-associated penalties.

2.5. Data Extraction and Thematic Categorization

A systematic coding matrix in Microsoft Excel guided the data extraction process. Each paper was examined according to the following criteria: publication title, author(s), year, country of research, ownership type (for-profit/non-profit), methodological design, principal financial themes (budgeting, investment, readmissions), and primary findings. An inductive thematic analysis was conducted utilizing the Braun and Clarke (2023) framework **(Braun & Clarke, 2023).** Two researchers separately performed open coding to uncover emerging trends. We subsequently unified the codes by agreement, leading to the finalization of six predominant motifs.

- Fiscal Governance Structures
- Financial Planning and Investment Strategies
- Strategies for Human Capital
- Financial and Technological Investments
- Programs for Reducing Readmission
- Priorities for Equity and Accessibility

Each aspect is associated with performance measures like hospital margins, readmission rates, staff-to-patient ratios, and access to care.

2.6. Quality Assessment

The quality and validity of the chosen studies were evaluated using established assessment instruments. The Critical Appraisal Skills Programme (CASP) checklist was employed for qualitative and policy texts. The AMSTAR 2 tool was utilized for systematic reviews, while the Joanna Briggs Institute (JBI) checklist was used for economic assessments and mixed-methods research. Every paper was evaluated separately by two reviewers. Disputes were settled via dialogue and consensus. Cohen's kappa statistic evaluated inter-rater reliability, yielding a significant agreement value of 0.81 **(Kogan et al., 2023).** Only research classified as high or moderate quality was incorporated into the final synthesis to guarantee analytical rigor and trustworthiness.

2.7. Ethical Considerations

This review did not involve human beings or personal data; hence, it did not need institutional ethical approval. All data sources were obtained from publicly accessible, peer-reviewed journals. The review procedure complied with the ethical standards established by the Committee on Publication Ethics (COPE) and conformed to APA 7th edition citation guidelines. At each stage, measures were implemented to guarantee transparency, repeatability, and academic integrity. No AI-generated, unverifiable, or non-peer-reviewed material was included in the evidence synthesis. The investigation aims to teach healthcare practitioners, hospital managers, and politicians about ownership-driven financial strategies and their systemic effects.

3. Results and Discussion

This study included 62 peer-reviewed articles in accordance with the PRISMA 2020 guidelines. The dataset comprised empirical research (n = 45), systematic or scoping reviews (n = 10), and financial or policy assessments (n = 17). The thematic study revealed significant disparities across six dimensions between non-profit (NFP) and for-profit (FP) hospitals: financial governance, investment strategies, human resources, technological integration, readmission reduction methods, and health equity alignment. This section examines the findings within subthemes.

3.1. Ownership-Based Cost Reduction

The ownership forms of hospitals considerably affect their financial conduct. Non-profit hospitals often allocate surplus funds toward increasing service capacity, improving access to treatment, and promoting community health programs **(Bruch & Bellamy, 2021).** Their governance systems, associated with their objective, frequently prioritize long-term financial planning rather than short-term profitability. Conversely, for-profit hospitals prioritize shareholder returns and operational efficiency, frequently using assertive cost-containment measures such as outsourcing, personnel

reduction, and targeted service line development **(William & Okafor, 2024).** For-profit hospitals frequently adopt zero-based budgeting methodologies, adjusting financial distributions each cycle to correspond precisely with anticipated ROI. They implement resource optimization strategies that lower fixed costs, including contract-based personnel and reduce capital invested in low-margin services **(Chowdhury et al., 2021).** Research shows that some for-profit hospitals, particularly in behavioral health, may effectively handle high-risk or high-cost patients by closely managing their expenses, which goes against the idea that they avoid complex patient cases.

Moreover, governance timeframes influence financial agility. FP hospitals are required to report quarterly to shareholders, which encourages short investment cycles and swift adaptation to changes in reimbursement **(Fahad & Chowdhury, 2022).** In contrast, NFP governance boards, often consisting of varied stakeholders, implement financially strategic approaches aligned with their goal but may postpone essential actions during economic downturns **(Hirawati et al., 2021).** The COVID-19 pandemic intensified financial inequalities, particularly affecting for-profit hospitals in the U.S., which saw initial declines in operating margins and liquidity, underscoring the vulnerability of ownership structures to global health crises **(Li et al., 2023).**

3.2. Financial Planning and Investment Behavior

Investment strategies are intricately connected to ownership objectives. FP hospitals frequently prioritize high-margin treatments bolstered by new technology, like robotic-assisted surgery, cutting-edge imaging techniques, and catheterization laboratories **(Pai, 2022).** These investments are often directed toward metropolitan or economically viable regions characterized by affluent demographics and advantageous payer compositions.

On the other hand, NFP hospitals often rely on grants, government support, or tax-free loans to fund projects that improve access to healthcare in poorer areas, such as satellite clinics, primary care networks, or trauma centers. Strategic investment planning in nonprofit organizations is more likely to be integrated within multiyear frameworks that link capital allocations with community health goals and nonprofit missions. FP hospitals may collaborate with venture capital companies to expedite growth in lucrative sectors, whereas NFP hospitals typically utilize consortium models or cooperative purchasing to minimize procurement expenses **(Chater & Loewenstein, 2023).** Notwithstanding these differences, both ownership categories commonly employ Group Purchasing Organizations (GPOs) to attain scale efficiencies in supply chain management.

Table 2. Comparative Financial Strategies by Ownership Type

Strategy Theme	Non-Profit Hospitals	For-Profit Hospitals
Financial Governance	Reinvest surpluses into community health and services	Maximize ROI for shareholders
Budgeting Model	Public grants and tax-exempt bonds	Zero-based budgeting focused on margins
Workforce Strategy	Stable full-time employment; training investments	Lean staffing; performance-based contracts
Technology Investment	Digital health tools for rural and underserved communities	Revenue-generating surgical and diagnostic technology
Readmission Strategy	Holistic care coordination and home health programs	Automated discharge; telephonic follow-ups to minimize stay
Equity Commitment	Provision of uncompensated care; support for vulnerable populations	Revenue-driven patient selection; urban market concentration

3.3. Cultural Workforce Strategy and Human Resources

Human capital management is another area significantly influenced by ownership. NFP hospitals are recognized for their investment in secure, full-time employment models that promote continuity of treatment, collaboration, and professional growth **(Onuigbo, 2024; Akhter et al., 2025).** These facilities frequently uphold superior nurse-to-patient ratios, correlating with greater patient safety, reduced complication rates, and increased satisfaction. This correlation is especially apparent in emergency departments, where patient satisfaction is significantly linked to nurse staffing ratios **(Onuigbo, 2024).**

Conversely, FP hospitals often implement adaptable staffing arrangements, utilizing part-time or temporary personnel to save labor expenses (Bruch & Bellamy, 2021). This strategy may lead to immediate cost reductions; however, it could also increase employee turnover and fatigue, especially during crises such as pandemics or natural disasters. During COVID-19, family planning hospitals with streamlined staffing experienced heightened fatigue and postponed treatment provision **(Chowdhury et al., 2022).** Leadership focused on mission at nonprofit hospitals is frequently associated with increased staff engagement, reduced turnover, and enhanced patient-provider interactions (Mahjabin et al., 2024). Both types of hospitals are increasingly using performance-based pay systems and centralized staffing algorithms to optimize salary structures **(Griffiths et al., 2023).**

3.4. Investments in Infrastructure and Technology

The implementation of technology reflects financial principles. FP hospitals emphasize technology that

directly enhances financial development, such as image-guided procedures, robotic platforms, and high-resolution diagnostics **(Ifty et al., 2024).** These technologies appeal to commercially insured patients and secure elevated reimbursement rates. Pharmacoeconomic evaluations have been employed to substantiate cost-effective pharmacological therapies that enhance overall hospital efficiency techniques **(Rana et al., 2023; Alaklobi et al., 2024).**

Non-profit hospitals, conversely, typically allocate resources toward technology that enhances accessibility and care coordination. This encompasses electronic health records designed for community health, telemedicine platforms for rural engagement, and decision-support instruments focused on population health management **(Ayaad et al., 2022).** Numerous nonprofit hospitals implement platforms that facilitate interoperability with primary care and social service networks, therefore enhancing their community health objectives. This approach corresponds with overarching tendencies in the digital economy, wherein technology integration in hospitals fosters ecological innovation and systemic efficiency **(Chen et al., 2025).** Efficient database administration is crucial for operational analytics, particularly in high-volume hospital environments, as big data issues increasingly influence clinical and financial decision-making **(Chowdhury et al., 2020).** Both ownership models utilize Lean and Six Sigma frameworks for quality improvement; however, FP hospitals generally employ these technologies to optimize billing and minimize operational expenses, whereas NFP hospitals utilize them to enhance clinical workflows and discharge processes (Mahmud et al., 2024). Lean Six Sigma methodologies have demonstrated consistent effectiveness in reducing waste and enhancing service quality within healthcare systems **(Mithun et al., 2023; Rathi et al., 2022).** The incorporation of Internet of Things (IoT)-based systems has demonstrated promise in resource-limited hospital infrastructure, facilitating real-time monitoring of equipment, supplies, and patient mobility **(Ifty et al., 2023a).**

3.5. Preventable Readmissions: Economic Impacts and Strategic Responses

Preventable hospital readmissions continue to be a significant cost and quality concern in healthcare. Under the HRRP, U.S. hospitals with elevated 30-day readmission rates incur fines in Medicare reimbursements. In fiscal year 2022, more than 93% of hospitals faced penalties, resulting in a total loss exceeding $521 million **(Appelbaum et al., 2024).** Multiple studies indicate that FP hospitals frequently demonstrate elevated readmission rates relative to NFP institutions, a phenomenon ascribed to disjointed discharge procedures and inadequate community care connections **(Mittal et al., 2018).** FP hospitals typically implement telephone outreach, automated follow-up systems, and expedited discharge procedures to adhere to policy standards while reducing expenses **(Upadhyay et al., 2019).** The ownership of hospitals affects both their financial practices and their equitable impact. NFP

hospitals are often responsible for providing critical services in resource-limited environments, encompassing trauma treatment, mental health support, and outpatient clinics for uninsured individuals. Nonetheless, criticisms continue about specific high-income nonprofit hospitals that exhibit subpar performance in quantifiable community benefits, despite receiving tax exemptions **(Bruch & Bellamy, 2021; Hossain et al., 2024).** The divergent reactions to readmission fines highlight fundamental institutional philosophies, specifically, profit-driven cost management vs. mission-focused care continuity.

Both ownership types have begun employing predictive analytics to identify high-risk patients; however, their purposes differ. For-profit hospitals frequently utilize analytics for capacity planning and financial forecasting, whereas not-for-profit institutions employ similar techniques to enhance equity-focused care planning and resource distribution **(Sunny et al., 2025a; Sazzad et al., 2023).**

3.6. Equity, Ownership, and Policy Implications

The ownership of hospitals affects both their financial practices and their equitable impact. NFP hospitals are often responsible for providing critical services in resource-limited environments, such as trauma treatment, mental health support, and outpatient clinics for uninsured individuals. Nonetheless, criticisms continue about specific high-income nonprofit hospitals that exhibit subpar performance in quantifiable community benefits, despite receiving tax exemptions **(Bruch & Bellamy, 2021).**

However, FP hospitals do not consistently exclude high-risk patients. In some regions, they provide services to Medicaid and psychiatric populations, occasionally incurring financial losses, mitigated by internal cost management and efficiency measures **(Horwitz & Nichols, 2009; Mahin et al., 2021).** However, apprehensions persist that value-based systems such as HRRP unduly disadvantage safety-net hospitals. These hospitals experience increased readmission rates due to reasons outside institutional control, such as socioeconomic disadvantage, patient instability, and regional care deserts **(Qiu et al., 2022).** Recent modifications in the HRRP, including segmentation by dual-eligibility status, demonstrate attempts to alleviate disproportionate penalty loads on hospitals catering to Medicaid-Medicare populations **(Shashikumar et al., 2022; Alam et al., 2023).** Hospitals and rural care units emphasizing biodiversity, especially in fragile wetland regions, frequently encounter challenges with access logistics and climate-induced disruptions **(Sunny et al., 2020).**

Therefore, policy measures must rectify these structural disparities. Risk adjustment in the HRRP must advance to include socioeconomic determinants of health, including housing, education, and income status **(Sunny et al., 2025b; Sazzad et al., 2025).** Tax exemption should depend on measurable

contributions to community benefits to guarantee openness and accountability. Mixed-ownership models are expanding globally in developing nations as a practical strategy to reconcile efficiency and equitable objectives (Yadav et al., 2025). The equity issues mirror those seen in rural aquatic food systems during COVID-19, where institutional resilience was significantly reliant on inclusive governance and adaptive funding **(Sunny et al., 2021).**

Cross-sectoral learning is also essential. For-profit hospitals may use community engagement strategies developed by nonprofit organizations, while nonprofit organizations can gain from the cost-effective innovations of for-profit entities. Ultimately, the alignment of financial governance with clinical quality is essential. Institutions that achieve this equilibrium are more likely to minimize unnecessary expenses, guarantee fair results, and adapt effectively to changing policy environments. Patient views of medical legitimacy and equity frequently differ based on ownership models and transparency norms, particularly across national systems **(Blendon et al., 2014; Rahman et al., 2024).**

4. Conclusions and Policy Recommendations

4.1. Conclusions

This study has thoroughly assessed the different financial strategies of non-profit (NFP) and for-profit (FP) hospitals, focusing on the economic consequences of needless hospital remissions. It emphasizes how institutional ownership significantly influences budgeting decisions, investment practices, personnel structures, technology implementation, and ultimately, the quality and accessibility of patient care. Non-profit hospitals, often overseen by community-oriented missions and tax-exempt status, often emphasize public health investment, fair access, and continuity of treatment. FP hospitals, in contrast, emphasize operational efficiency and return on investment, frequently adopting lean workforce practices, performance-based budgeting, and short-term capital cycles.

Although both types of hospitals aim for financial sustainability, their strategies differ, particularly in the management of preventable readmissions. The HRRP, while intended to improve quality, may unintentionally disadvantage mission-driven organizations that cater to underprivileged communities. For-profit hospitals react to these incentives by optimizing internal procedures, whereas not-for-profit healthcare facilities allocate resources to extensive transitional care programs that tackle socioeconomic determinants of health. Notwithstanding these disparities, each paradigm presents chances for reciprocal learning: FP institutions can augment equity and outreach via mission-oriented initiatives, whereas NFP hospitals may raise resource utilization through efficiency-centered administration. The results emphasize the need to combine economic responsibility with patient-centered values to create robust and equitable healthcare systems. An equitable strategy that accounts for institutional diversity,

patient demographics, and geographical inequities is crucial for formulating sustainable policies. Moreover, synchronizing payment structures, community responsibility, and equity objectives is essential for cultivating health systems that are both financially sustainable and socially equitable.

4.2. Policy Recommendations

This review's findings suggest the following recommendations for policy to reconcile financial sustainability with fair healthcare outcomes across various ownership models:

- **Integrate Risk Adjustment into HRRP Metrics**

Revise the existing HRRP penalty framework to incorporate socioeconomic risk variables, including poverty, housing instability, and health literacy. This modification would guarantee a more equitable allocation of financial penalties and more accurately represent the operational reality of hospitals catering to disadvantaged populations **(Sunny et al., 2025b; Sazzad et al., 2025).**

- **Advocate for Hybrid Financial Models**

Promote the creation of institutional frameworks that integrate the social objectives of non-profit organizations with the efficiency-oriented approaches of for-profit entities. Public-private partnerships, accountable care groups, and mission-aligned joint ventures can promote innovation while maintaining access and equity. These models correspond with sustainable competitiveness objectives in health-sector industrial strategy throughout the EU and beyond **(Bartl et al., 2024; Alam et al., 2024).**

- **Associate Tax Exemption with Quantifiable Community Advantage**

Mandate non-profit hospitals to provide standardized measures on community health effects, charity care delivery, and investments in marginalized communities. Enhancing this accountability method would augment openness and promote genuine community involvement **(Bruch & Bellamy, 2021).**

- **Enhance Support for Transitional Care Infrastructure**

Establish financial incentives or grants for initiatives that integrate inpatient and outpatient treatment, especially in resource-limited environments. This includes home health services, social work integration, community navigators, and mobile follow-up teams, which have demonstrated effectiveness in mitigating readmission risks **(Sunny et al., 2025a; Sazzad et al., 2023).**

- **Standardize Financial and Operational Metrics**

Establish industry-wide standards for financial success, personnel ratios, technology return on investment, and readmission strategies. To provide equitable performance evaluations and policy analyses, it is necessary to publicly disclose and modify these measures for hospital classification and geographical challenges.

- **Ensure Equitable Access to Technology**

Establish financial tools to assist technology implementation in underfunded nonprofit hospitals, especially in rural and isolated regions. Policymakers must guarantee that digital transformation including EHR systems, telemedicine, and predictive analytics is equally allocated across all ownership frameworks **(Ashakin et al., 2024; Hossain et al., 2024; Tiva et al., 2025).**

- **Invest in Workforce Resilience and Development**

Promote frameworks that enhance employee well-being, encompassing flexible scheduling, mental health assistance, and professional growth. Federal or state-level matching incentives may motivate hospitals to decrease turnover and fatigue while preserving quality of treatment **(Griffiths et al., 2023; Chowdhury et al., 2025).**

- **Support Longitudinal Research and Evaluation**

Fund thorough research to assess the long-term impacts of ownership types, cost-saving strategies, and readmission rules on public health, financial stability, and health fairness. This evidence will guide future improvements and assist in aligning fiscal policy with patient outcomes.

These ideas seek to cultivate a balanced and sustainable hospital environment that harmonizes financial discipline with clinical excellence and social responsibility. The objectives of efficiency and equality should not be perceived as incompatible; instead, they must be reconciled via adaptive, evidence-informed legislation that acknowledges the increasing complexity of healthcare delivery.

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Author Contribution

The authors were involved in the creation of the study design, data analysis, and execution stages. Every writer gave their consent after seeing the final work.

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Data Availability Statement

This review utilized only publicly available data from peer-reviewed literature. No new datasets were created or analyzed during the study. All sources are cited accordingly

A statement of conflicting interests

The authors declare that none of the work reported in this study could have been impacted by any known competing financial interests or personal relationships.

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