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Hospital Tariff Setting, Patient Experience, and Patient Satisfaction under New Public Management Reforms: A Systematic Review

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ABSTRACT

Public hospitals are under sustained pressure to reconcile fiscal sustainability, service quality, and equitable access. New Public Management (NPM) reforms influence tariff setting by expanding managerial autonomy, output-based financing, performance measurement, and market-like incentives. This review aims to synthesize evidence on how NPM-oriented hospital tariff and provider-payment policies influence patient experience and patient satisfaction in public hospitals. Methods: A systematic review was conducted according to PRISMA 2020. Scopus, Web of Science, PubMed/MEDLINE, ScienceDirect, and SAGE Journals were searched for English-language literature published from January 2019 to June 2026, while seminal older works were retained for theoretical framing. After duplicate removal and screening, 45 sources were included in thematic synthesis, comprising 31 primary empirical studies, 8 review articles, and 6 conceptual or policy analyses. Tariff and payment reforms may improve cost control, technical efficiency, and managerial responsiveness, but the included literature also links poorly calibrated tariffs with cost shifting, service selection, shortened length of stay, coding pressure, and distrust when payment rules are opaque or misaligned with actual service costs. Patient experience described what patients actually encountered during care, including access, waiting, communication, billing clarity, and affordability, whereas patient satisfaction reflected evaluative judgment against expectations and perceived value. Hospital tariff reform is a governance intervention rather than a purely technical pricing exercise. Sustainable reform requires periodic cost review, quality-sensitive payment design, transparent patient-facing communication, and safeguards for equity.

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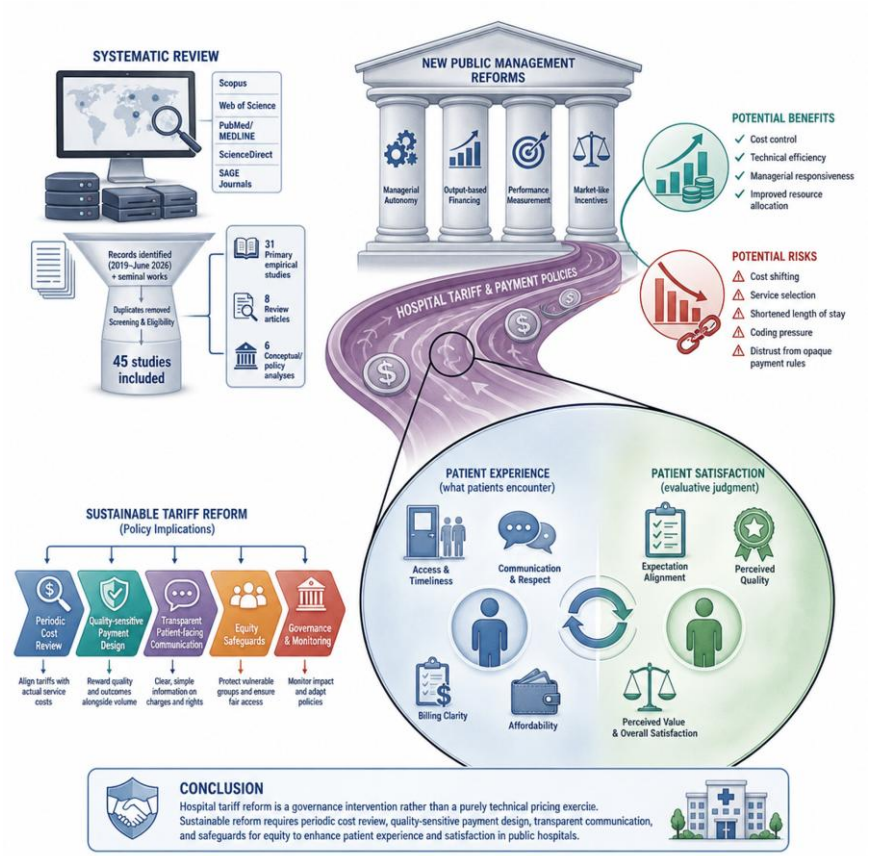
Key Messages:

- Patient financial burden is experienced through affordability, co-payment exposure, and billing clarity.
- Patient experience and patient satisfaction were included because experience captures what happened during care, while satisfaction captures the patient's evaluative judgment against expectations.
- NPM-inspired tariff reforms can support efficiency only when governance, transparency, and equity safeguards prevent financial incentives from undermining trust and patient-centered care

GRAPHICAL ABSTRACT



INTRODUCTION

Hospitals are among the most resource-intensive organizations in health systems. They absorb a large share of health expenditure, deliver complex and high-risk services, and are increasingly expected to demonstrate accountability for cost, quality, equity, and patient-reported outcomes. In this review, the term tariff refers to a provider-facing reimbursement rate or regulated payment signal, while price or cost burden refers to what patients may perceive directly through co-payments, out-of-pocket expenditure, billing uncertainty, or insurance coverage. This distinction is important because a hospital may respond to a tariff as a financial incentive, whereas patients evaluate care through affordability, clarity, and perceived fairness (1,2).

New Public Management (NPM) is one of the most influential reform paradigms behind this shift. NPM encourages public organizations to adopt performance indicators, output controls, operational decentralization, contractual relationships, and managerial accountability. In health care, this logic has contributed to hospital autonomization, corporatization, activity-based funding, and tariff policies that link payment to service outputs. Classical NPM scholarship emphasized managerial discretion and performance control, while later evidence shows that NPM effects vary substantially across institutional settings, especially where public hospitals must pursue efficiency while preserving social protection and equitable access (3,4).

Tariff setting is one of the most visible points at which NPM enters hospital practice. A tariff is not simply a patient price; it is a policy instrument that distributes financial risk between purchasers and providers, signals the value of services, creates incentives for clinical and managerial behavior, and indirectly shapes patients' perceptions of fairness. Payment mechanisms such as DRGs, case-based payments, and activity-based funding can reduce unnecessary length of stay and strengthen cost awareness, but previous studies and reviews also report risks of premature discharge, readmission pressure, upcoding, service selection, and under-provision when tariffs are lower than real costs or are not linked to quality safeguards (5,6).

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The Indonesian context illustrates this dilemma. Hospital autonomy through BLU/BLUD arrangements provides greater flexibility in financial management, while INA-CBGs create bundled payment rates intended to contain expenditure under national health insurance. Recent Indonesian evidence shows that public-service hospitals have experienced mixed efficiency outcomes, and that some INA-CBGs tariffs may lag behind actual costs for high-technology services such as radiotherapy (7,8). These dynamics place hospitals in a difficult position: they must protect fiscal viability without compromising the social mission of public care.

The patient perspective is essential in evaluating tariff reforms, but patient experience and patient satisfaction should not be treated as identical constructs. Patient experience refers to what patients actually encountered during care delivery, such as access, waiting time, interpersonal communication, physical environment, billing explanation, and continuity of care. Patient satisfaction refers to the patient's evaluative judgment after comparing expectations with perceived performance and value. Both constructs were included because tariff reform can alter concrete care processes first, and these experiences may then shape satisfaction, trust, adherence, and service loyalty (9,10).

Previous reviews have examined hospital efficiency, DRG payment, price transparency, governance, and patient satisfaction as separate bodies of evidence, but fewer syntheses explain the pathway linking provider-facing tariff incentives with patient-facing experience and satisfaction. The resulting gap is not whether tariffs influence hospitals, but how tariff design, governance capacity, communication, and equity safeguards convert financing rules into patient-reported outcomes. This article therefore synthesizes the literature around the question: how do NPM-inspired hospital tariff and provider-payment policies influence patient experience and patient satisfaction in public hospitals, and under what governance conditions can efficiency-oriented reforms remain compatible with patient-centered care?

METHODS

Review design and reporting framework

This study was conducted as a systematic literature review and reported according to PRISMA 2020 principles for transparent identification, screening, eligibility assessment, and synthesis of evidence (11). The review was designed to answer a policy-oriented health-services question rather than to estimate a pooled intervention effect. Because the evidence crossed public administration, health financing, health-service quality, and patient-reported outcomes, thematic synthesis was used to integrate heterogeneous quantitative, qualitative, mixed-methods, review, and conceptual literature while retaining an explicit link between included sources and analytic themes (12).

Methodological quality appraisal was conducted for the primary empirical studies using the Mixed Methods Appraisal Tool (MMAT), which is suitable for qualitative, quantitative, and mixed-methods evidence (13). Review articles and conceptual or policy analyses were retained only when they directly informed the financing, governance, or patient-outcome pathway; they were coded separately as secondary or contextual evidence to avoid double counting primary findings.

Eligibility criteria

The eligibility criteria were organized using a Population-Concept-Context logic suitable for policy and health-services reviews. The review focused on public hospitals and publicly funded hospital systems because NPM-inspired tariff reforms operate differently from market-driven pricing in purely private hospitals. Table 1 summarizes the inclusion and exclusion criteria.

Table 1. Eligibility criteria for the review

Domain	Inclusion criteria	Exclusion criteria
Population/context	Public hospitals, public health systems, publicly funded or autonomous hospitals, and patients receiving public hospital care.	Purely private hospitals or primary-care facilities without a direct link to tariff, financing, or hospital management reform.
Concept/intervention	Hospital tariff policy, DRG/case-based payment, activity-based funding, hospital autonomy, BLU/BLUD-type financial	Clinical guidelines, workforce policies, or administrative reforms without a financing/tariff component.

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	management, NPM reform.	
Outcomes	Patient satisfaction, patient experience, perceived quality/value, affordability, access, waiting time, billing clarity, financial performance, efficiency, governance, and transparency.	Clinical outcomes only, unless linked to payment reform, hospital behavior, or patient experience.
Study type	Peer-reviewed primary empirical studies, systematic/scoping reviews used as secondary evidence, and high-quality conceptual or policy papers directly linked to tariff/payment reform and patient outcomes.	Opinion pieces, editorials, theses, conference abstracts, or non-peer-reviewed reports unless used only for contextual framing.
Language and date	English-language studies published from January 2019 to June 2026, with seminal older works retained only for theory, measurement, or method.	Non-English articles when translation was unavailable; duplicate records; inaccessible full texts for empirical synthesis.

Search strategy and study selection

The search was conducted in Scopus, Web of Science, PubMed/MEDLINE, ScienceDirect, and SAGE Journals. The final search was completed in June 2026. Search terms combined three blocks: (i) hospital tariff, provider payment, reimbursement, DRG, case-based payment, activity-based funding, or health financing; (ii) patient satisfaction, patient experience, service quality, perceived quality, perceived value, trust, affordability, or billing transparency; and (iii) New Public Management, NPM, public hospital, hospital autonomy, public sector reform, BLU, or BLUD.

The Scopus search syntax was: TITLE-ABS-KEY ("hospital tariff*" OR "hospital reimbursement" OR "provider payment" OR "health financing" OR "DRG" OR "diagnosis-related group*" OR "case-based payment" OR "activity-based funding") AND TITLE-ABS-KEY ("patient satisfaction" OR "patient experience" OR "service quality" OR "perceived quality" OR "perceived value" OR affordability OR trust OR "billing transparency") AND TITLE-ABS-KEY ("new public management" OR NPM OR "public hospital*" OR "hospital autonom*" OR "public sector reform" OR BLU OR BLUD). The syntax was adapted for each database while retaining equivalent concepts.

Two reviewers independently screened titles and abstracts, assessed full texts, and resolved disagreements through discussion; a third reviewer was available when consensus could not be reached. Duplicates were removed before screening. Reasons for exclusion at the full-text stage were recorded. The PRISMA flow diagram reports the number of records identified, screened, excluded, and included in the final thematic synthesis.

Data extraction and synthesis

Data extraction included author, year, country, setting, study design, population, tariff or provider-payment mechanism, NPM/autonomy dimension, patient-experience or satisfaction outcome, key findings, quality appraisal, and policy implications. Thematic synthesis proceeded through familiarization, line-by-line coding of relevant findings, development of descriptive themes, and generation of analytic themes linking policy design, organizational behavior, patient experience, perceived value, and satisfaction [37]. Findings from primary empirical studies were prioritized, while review and conceptual sources were used to strengthen theoretical interpretation and identify cross-study convergence.

RESULTS

Search and selection of studies

The database search identified 1,245 records. After removal of 267 duplicates, 978 records were screened by title and abstract, and 841 were excluded. A total of 137 full-text articles were assessed for eligibility, of which 92 were excluded because they did not address tariff or provider-payment reform, did not report patient-experience or satisfaction outcomes, did not focus on public hospital contexts, or were not eligible peer-reviewed sources. The final synthesis included 45 sources.

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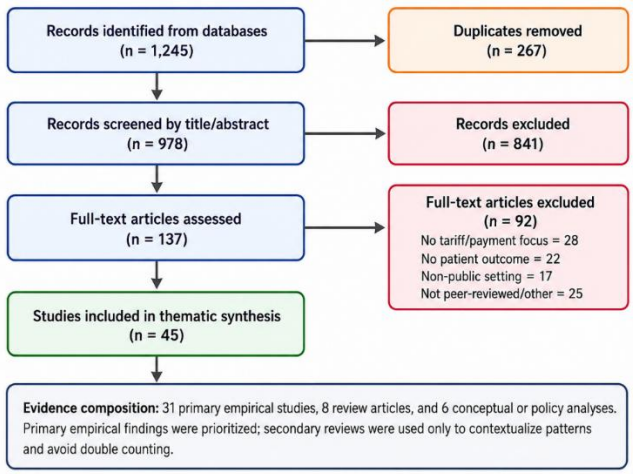

Figure 1. PRISMA flow diagram of study identification, screening, eligibility assessment, and inclusion.

Study characteristics and quality appraisal

The included sources consisted of 31 primary empirical studies, 8 review articles, and 6 conceptual or policy analyses. Geographically, the evidence was concentrated in Europe, North America, and Asia, with a smaller number of studies from low- and middle-income country contexts. Payment mechanisms most frequently addressed DRGs, case-based payment, activity-based funding, public hospital autonomy, reimbursement tariff adequacy, and price or billing transparency. Among the primary empirical studies appraised with MMAT, 21 met all appraisal criteria, 8 met four criteria, and 2 met three criteria. No primary study was excluded solely on the basis of appraisal score, but lower-quality evidence was interpreted cautiously.

Table 2. Characteristics of included evidence and appraisal summary.

Evidence domain	Summary	Use in synthesis
Primary empirical studies	31 studies; quantitative, qualitative, and mixed-methods designs across public hospital and publicly funded hospital settings.	Prioritized for identifying mechanisms linking payment reform, organizational behavior, patient experience, and satisfaction.
Review articles	8 systematic, scoping, or narrative reviews on DRG payment, patient satisfaction, price transparency, hospital efficiency, and governance.	Used as secondary evidence and contextual mapping; not double counted as primary findings.
Conceptual/policy analyses	6 sources addressing NPM, health financing, governance, patient involvement, and value or satisfaction theory.	Used to support theoretical interpretation and conceptual framework development.
Payment mechanisms	DRG/case-based payment, activity-based funding, reimbursement tariffs, BLU/BLUD-type autonomy, and price/billing transparency.	Coded as provider-facing incentives and patient-facing burden/communication pathways.
Quality appraisal	Among 31 primary empirical studies, 21 met all MMAT criteria, 8 met four criteria, and 2 met three criteria.	Appraisal informed confidence in themes but was not used as the sole exclusion criterion.

Overview of the evidence base

Across the included evidence base, tariff and provider-payment reforms affected hospitals through both financial and behavioral pathways. At the macro level, health financing reforms sought to improve equity, quality, and financial protection (2). At the meso level, hospital autonomy and provider-payment arrangements shaped how organizations responded to incentives (5,6). At the micro level, patients judged the legitimacy of financing rules through concrete experiences of care, including access, waiting time, billing clarity, communication, affordability, and perceived fairness (10,14). The evidence did not support a simple conclusion that higher tariffs automatically reduce patient satisfaction or that stronger cost control necessarily improves quality. The relationship was conditional on tariff adequacy, quality-sensitive

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payment design, governance capacity, transparency of billing communication, and protection against unaffordable patient-facing costs (8,15).

Theme 1: NPM reforms increase managerial flexibility but intensify mission tension

Previous studies of hospital autonomy and payment reform indicated that NPM reforms can increase organizational flexibility by allowing managers to use resources more responsively, retain surpluses, adjust internal processes, and link performance to outputs (7,16). However, these benefits appeared strongest when managerial decision space was supported by reliable information systems, credible cost accounting, and coherent accountability mechanisms.

The same evidence also showed that NPM reforms can intensify tension between financial accountability and the public-service mission. When hospitals are pressured to recover costs under inadequate tariffs, managers may prioritize high-volume or better-reimbursed services, delay investment in unprofitable services, or restrict discretionary support for low-income patients. Therefore, tariff reform changes not only administrative routines but also the moral economy of public hospitals: patients may experience care as more transactional when financial targets dominate relational care.

Theme 2: Tariff adequacy and payment design shape organizational behavior

Evidence on DRG and case-based payment showed that prospective tariffs can reduce length of stay and encourage resource awareness, but their effects on readmission, mortality, and quality were mixed (17,18). Payment reforms are therefore powerful but blunt tools. If provider-facing tariffs are too low, hospitals may reduce inputs, shift costs, increase coding intensity, or limit access to complex cases. If tariffs reward volume without quality adjustment, the system may stimulate activity rather than value. The Indonesian radiotherapy evidence demonstrates the importance of tariff updating. When reimbursement tariffs remain unchanged while actual input costs rise, the payment gap can threaten service sustainability and access (8). For high-cost technologies, the problem is not merely whether a tariff exists, but whether it is periodically recalibrated, transparently justified, and linked to realistic cost data.

Theme 3: Patient satisfaction is mediated by perceived value and fairness

Patient satisfaction emerged as a multidimensional evaluative judgment shaped by expectations, perceived performance, interpersonal care, accessibility, affordability, and communication (19,20). Patient experience, in contrast, described the observable or reported process of care, such as waiting time, billing explanation, staff communication, navigation, and service continuity. The satisfaction literature suggests that patients form satisfaction judgments through expectation disconfirmation and perceived value; therefore, financial burden becomes especially salient when it appears inconsistent with quality, empathy, or fairness (21,22). This distinction is important for tariff policy. A provider-facing tariff change may not directly affect satisfaction unless it changes care processes or patient-facing financial burden. Conversely, even subsidized care can produce dissatisfaction if patients encounter opaque bills, long queues, fragmented information, or disrespectful treatment. Thus, tariff legitimacy is partly constructed through the care encounter and then translated into satisfaction through perceived quality and value.

Theme 4: Price transparency is necessary but insufficient

Recent price-transparency literature indicated that publishing prices or reimbursement information can reduce information asymmetry, but its effects were limited when data were incomplete, difficult to interpret, poorly standardized, or disconnected from patient decision-making (23,24). Transparency is therefore not equivalent to comprehension. Patients need actionable explanations of expected costs, benefits, insurance coverage, alternative options, and financial assistance. Price and billing transparency also had a governance dimension. Transparent billing increased trust when it was accurate and accompanied by patient navigation, but it could undermine trust when it exposed unexplained variation or revealed charges that appeared arbitrary. Therefore, tariff communication should be treated as part of patient-centered care rather than as a back-office administrative task.

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Theme 5: Governance moderates the impact of tariff reform

Governance moderated whether tariff reform became a narrow cost-control instrument or a balanced strategy for sustainable quality. Hospital governance literature emphasized accountability structures, board attention to quality, clinical participation, transparency, patient involvement, and alignment between financial and clinical priorities (25,26). These dimensions were particularly important in NPM environments because autonomy without accountability may amplify inequity, while accountability without autonomy may limit managerial responsiveness. The synthesis indicated that hospitals were more likely to maintain positive patient experience and satisfaction under tariff pressure when they had: (i) credible cost-accounting systems; (ii) formal mechanisms for patient feedback and complaint resolution; (iii) transparent billing and financial counseling; (iv) quality-sensitive performance indicators; and (v) leadership that explicitly protected the social mission of public care. Table 3 summarizes the core themes and implications for policy and management.

Table 3. Thematic synthesis of the relationship between NPM tariff policy, patient experience, and patient satisfaction.

Theme	Mechanism	Risk	Policy/management response
NPM and autonomy	Greater discretion in resource use and performance management can improve responsiveness when accountability is strong.	Financial targets may crowd out public-service values and relational care.	Link autonomy to accountability, equity safeguards, and quality-sensitive indicators.
Tariff adequacy	Provider-facing reimbursement rates shape hospital incentives, cost recovery, and service-mix decisions.	Underpayment may cause cost shifting, service selection, reduced inputs, or coding pressure.	Use periodic cost studies, technology-specific reviews, and transparent tariff revision.
Patient experience	Patients encounter tariff reform through access, waiting time, communication, billing clarity, and affordability.	Poor experience converts financing pressure into distrust even when clinical care is technically adequate.	Improve navigation, communication, billing counseling, waiting time, empathy, and service reliability.
Perceived quality/value and satisfaction	Patients compare experienced care and financial burden with expectations and perceived value.	Perceived unfairness reduces satisfaction, trust, adherence, and loyalty.	Measure satisfaction separately from experience and use feedback for quality improvement.
Governance	Boards, managers, clinicians, and patient-relations units mediate the balance between finance and care.	Autonomy without oversight may increase inequity and weaken public trust.	Strengthen board quality oversight, patient voice, integrated financial-clinical governance, and complaint resolution.

DISCUSSION

This review shows, based on the 45 included sources, that NPM-inspired tariff reform contains a structural paradox. The reforms are introduced to improve efficiency, responsiveness, and fiscal sustainability, yet the same mechanisms may weaken patient experience and satisfaction when implemented as narrow financial controls. This paradox is not accidental. NPM translates public care into measurable outputs and payment categories, while patient-centered care depends on relational trust, individualized judgment, and responsiveness to needs that are not always captured by tariffs.

The main contribution of this synthesis is to locate patient satisfaction after, not inside, patient experience. Tariffs influence hospitals by shaping provider-facing incentives, but patients encounter those incentives indirectly through service availability, waiting time, staff behavior, billing clarity, affordability, and perceived fairness. This interpretation is consistent with evidence on hospital autonomy, DRG payment, activity-based funding, and Indonesian tariff adequacy, which reported mixed effects depending on governance capacity, cost adequacy, local autonomy, and communication practices (5,27).

The included price-transparency and governance literature also qualifies the assumption that transparency alone can solve dissatisfaction related to hospital tariffs. Transparency is useful only when

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patients can understand and act on information. In complex hospital care, patients frequently cannot shop for services like ordinary consumers because illness, urgency, referral pathways, insurance rules, and trust in clinicians constrain choice. Therefore, transparency policies should be complemented by financial counseling, standardized billing language, patient advocates, and protection against catastrophic out-of-pocket costs (28,29).

For policymakers, these findings indicate that tariff design must be iterative and quality-sensitive. The reviewed studies on DRG payment, case-based payment, and Indonesian reimbursement gaps suggest that payment rates should be regularly updated using real cost data, especially for high-cost and technology-intensive services (8,27). Tariff formulas should be accompanied by quality indicators, readmission monitoring, equity analysis, and mechanisms to protect hospitals serving complex or low-income populations. Payment reform should reward value, not merely volume or cost reduction.

For hospital managers, these findings indicate that financial management cannot be separated from patient-experience management. Evidence on patient satisfaction, patient experience, quality communication, and governance suggests that a hospital can comply with tariff policy and still lose public trust if patients perceive bills as unfair, explanations as unclear, or care as rushed (19,30). Managers should therefore invest in cost-accounting systems, staff communication training, patient-feedback loops, and cross-functional committees that include finance, clinicians, patient-relations units, and quality teams.

This evidence also suggests that future research should distinguish between provider-facing reimbursement incentives, patient-facing financial burden, patient experience, perceived quality/value, and satisfaction. Quantitative studies can estimate changes in length of stay, cost, readmission, or satisfaction scores, but qualitative and mixed-methods designs are needed to explain how patients interpret billing events and how managers negotiate ethical trade-offs under tariff pressure.

Conceptual Framework

The conceptual framework was developed by the authors from the thematic synthesis and informed by NPM theory, provider-payment literature, patient-experience studies, and expectation-disconfirmation/value theory (21,22). The model separates four concepts that were previously blurred: (i) NPM reform as the policy logic; (ii) tariff and payment design as provider-facing incentives; (iii) patient experience as what patients actually encounter during care; and (iv) patient satisfaction as an evaluative judgment formed after comparing expectations, experience, perceived quality, and perceived value. In this model, perceived quality and perceived value are not treated as patient experience itself; they are cognitive appraisal dimensions that mediate the pathway from experience to satisfaction. Governance and institutional context moderate the entire pathway.

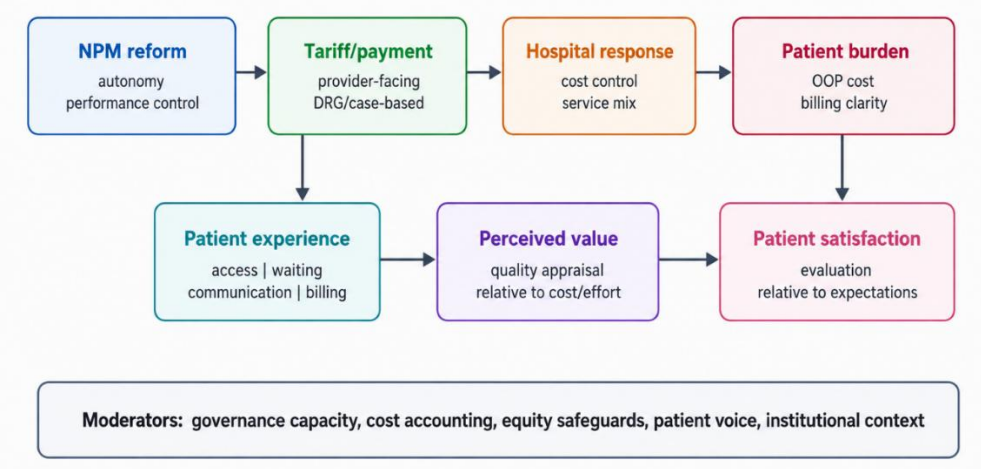

Figure 2. Author-developed conceptual framework distinguishing provider-facing tariff incentives, patient experience, perceived quality/value, and patient satisfaction.

Limitations

This review has several limitations. First, heterogeneity in study design, country context, payment

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model, and patient-reported outcome measurement prevented quantitative meta-analysis. Second, the evidence base was stronger for DRG and activity-based payment in high-income settings than for BLU/BLUD-type autonomy and INA-CBGs in Indonesia or other emerging economies, which limits transferability. Third, patient satisfaction and patient experience were measured inconsistently across studies; consequently, the synthesis emphasizes mechanisms and conceptual boundaries rather than pooled effect sizes. Fourth, because review articles and conceptual policy analyses were retained as secondary or contextual evidence, the conclusions should be interpreted as a systematic thematic synthesis rather than an effect-size meta-analysis. To reduce the risk of double counting, primary empirical studies were prioritized when deriving themes, while secondary reviews were used to contextualize and compare findings across broader literatures.

CONCLUSION

Hospital tariff policy under New Public Management reforms is a governance intervention, not merely a technical pricing instrument. Based on the included evidence, provider-facing tariff and payment reforms can support efficiency and sustainability, particularly when payment rates are periodically updated and linked to quality safeguards. However, these reforms may weaken patient experience and satisfaction when tariffs are inadequate, incentives are poorly aligned, billing communication is opaque, or patient-facing financial burden is not protected. The central policy challenge is therefore balance. Public hospitals need enough managerial and financial flexibility to respond to cost pressures, yet they also require strong governance, patient-centered communication, equity safeguards, and quality-sensitive payment design. Current evidence is strongest for DRG and activity-based payment systems in high-income settings, while evidence from emerging economies remains thinner. Future qualitative, mixed-methods, and comparative studies should examine how patients interpret billing events and how managers negotiate ethical trade-offs under tariff pressure. Successful reform depends less on adopting NPM tools and more on implementing them in ways that preserve the relational, equitable, and public character of hospital care.

DECLARATION OF THE USE OF AI

The authors declare that no artificial intelligence (AI), AI-assisted technologies, or large language models (LLMs) were used in the conception of the study, data analysis, or the drafting, writing, and editing of this manuscript. The only exception is the graphical abstract, which was created using the design platform Illustrae (https://illustrae.co/). The authors take full responsibility for the content and accuracy of the graphical abstract and the entire manuscript.

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CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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