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# Payment Systems, Cost Information, and Behavioral Responses in Hospital Cost Management: A Bibliometric–Systematic Literature Review

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## ABSTRACT

Hospitals must contain costs while protecting quality, access, equity, and clinical autonomy. Research relevant to this challenge is dispersed across hospital cost accounting, activity-based costing, time-driven activity-based costing, diagnosis-related groups, prospective payment, reimbursement, budgeting, management control, provider behavior, and value-based healthcare. This conference paper develops a protocol-based Bibliometric-Systematic Literature Review (B-SLR) and a provisional integrative framework that connects those streams. Following the logic of Marzi et al. (2025), the study distinguishes a broad candidate corpus from a smaller sample used for interpretive synthesis. The candidate corpus contains 221 records published from 1968 to 2026. A bibliographic audit located 220 records, identified 201 DOI, found no duplicate DOI or normalized titles, and flagged one citation as likely conflated. Sixty theoretically central papers form a provisional core sample. The synthesis identifies four substantive domains: cost-information architecture; payment, reimbursement, and provider response; budgeting, management control, and actor cognition; and value-based healthcare, quality, and organizational outcomes. A fifth set supports review methodology and theory development. The proposed framework argues that payment architecture affects cost-management decisions through cost-information quality, control design, and actor cognition, while governance and professional logics shape intended and unintended outcomes. The contribution is conceptual, methodological, and explicitly provisional. A completed B-SLR still requires reproducible Scopus or Web of Science exports, formal eligibility screening, cited-reference metadata, science mapping, and cluster-based sample selection.

**Keywords:** Hospital cost management, Diagnosis related groups, Prospective payment

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## INTRODUCTION

Hospitals are hybrid organizations in which financial, clinical, professional, ethical, and public-policy logics coexist. Cost decisions are therefore not only technical accounting choices. They are organizational responses to payment incentives, information systems, budget constraints, professional norms, regulation, and uncertainty. A payment reform may increase pressure to reduce resource use, but the response depends on whether managers and clinicians can identify cost drivers, trust the available

information, negotiate competing objectives, and protect quality and access (C. S. Chapman et al., 2022; Hsu & Qu, 2012; Kaplan & Witkowski, 2014; Northcott & Llewellyn, 2002).

The field has moved from aggregated departmental cost reports toward systems that connect resources with activities, capacity, care pathways, patients, and outcomes. Case-mix costing, activity-based costing (ABC), and diagnosis-related groups (DRGs) established an early connection between resource consumption and hospital products (Thompson et al., 1979; Davis & Rhodes, 1988; Chan, 1993) (Chan, 1993; Davis & Rhodes, 1988; Thompson et al., 1979). Later work developed time-driven activity-based costing (TDABC), clinical costing, resource consumption accounting, and patient-level costing to improve transparency and decision relevance (Campanale et al., 2014; Keel et al., 2017; Malmmose & Lydersen, 2021). In parallel, prospective payment, global budgets, and value-based payment changed the risks and incentives under which hospitals organize care (Busse et al., 2013; Leao et al., 2024; Pott et al., 2023).

Despite this development, the literature remains fragmented. Costing studies emphasize allocation accuracy, capacity, and process visibility. Payment studies examine expenditure, length of stay, coding, volume, and quality. Budgeting and management-control studies focus on accountability, participation, cognition, and institutional change. Value-based healthcare (VBHC) studies seek to integrate patient-relevant outcomes and cost, but often use heterogeneous cost measures (Leusder et al., 2022; Malmmose & Fouladi, 2019; Møberg & Malmmose, 2025). These streams examine different links in the same organizational chain, yet they are rarely integrated as one mechanism.

In this paper, hospital financial behavior does not mean behavioral finance in capital markets. It refers to organizational, managerial, and clinical responses generated by cost information, budgets, reimbursement rules, financial risk, and efficiency pressure (Athanassopoulos et al., 1999). Relevant responses include cost-control consciousness, budget cognition, pathway redesign, resource reallocation, coding changes, upcoding, patient selection, cost shifting, altered service intensity, and managerial adaptation (Lowe, 2001; Huang & Lu, 2025; Behzadi et al., 2026) (Behzadi et al., 2026; Huang & Lu, 2025). This definition places behavior between financial architecture and organizational outcomes.

Recent reviews sharpen the opportunity for integration. Keel et al. (2017) and Shakya et al. (2025) synthesize TDABC. Leusder et al. (2022) review cost measurement in VBHC. Pott et al. (2023) examine prospective payment and quality. Homauni et al. (2023) review healthcare budgeting. Barbosa et al. (2026) map healthcare cost-management research. Behzadi et al. (2026) synthesize provider responses to prospective payment. The remaining gap is not a lack of reviews. It is the absence of a mechanism-based synthesis explaining how payment and reimbursement architecture is translated into cost-management decisions through cost information, management control, budgeting, and actor cognition.

**Table 1.** Positioning against selected prior reviews

| Review | Primary focus | Main contribution | Remaining gap and position of this review |
|---|---|---|---|
| Keel et al. (2017) & Shakya et al. (2025) | TDABC in healthcare | Implementation, applications, and health-economic use | Limited integration with payment incentives, control design, and provider behavior. |
| Leusder et al. (2022) | Cost measurement in VBHC | Shows heterogeneity in costing methods used in value-oriented care | Does not build an organization-level mechanism linking reimbursement, control, and cognition. |
| Pott et al. (2023) | Prospective payment and quality | Synthesizes quality consequences of prospective payment | Internal cost-information architecture and management-control mechanisms remain peripheral. |
| Homauni et al., (2023) | Healthcare budgeting | Reviews budgeting methods and | Limited integration with costing systems, reimbursement behavior, and unintended responses. |

| Review | Primary focus | Main contribution | Remaining gap and position of this review |
|---|---|---|---|
| | | organizational applications | |
| Barbosa et al. (2026) | Healthcare cost management | Broad systematic mapping of international research | Behavioral translation from incentives to decisions requires deeper theorization. |
| Behzadi et al., (2026) | Provider responses to prospective payment | Classifies behavioral responses through a WHO framework | Does not center the mediating roles of cost-information quality and control design. |
| Current review | Integrated hospital cost-decision behavior | Links payment architecture, cost information, control, cognition, decisions, and outcomes | Develops a provisional mechanism-based framework and a transparent validation agenda. |

The review addresses three questions: ***(RQ1)*** *How has the intellectual and thematic structure of hospital cost management and financial decision behavior developed?* ***(RQ2)*** *Through what mechanisms do reimbursement, budgeting, cost accounting, and management control influence hospital cost decisions and provider responses?* ***(RQ3)*** *What integrative conceptual framework can explain the relationships among payment architecture, cost-information quality, actor cognition, decision behavior, and organizational outcomes?*

The intended contribution is threefold. First, the review bridges management-accounting and health-payment research. Second, it shifts attention from the existence of cost information to its credibility, usability, and behavioral translation. Third, it proposes a framework and propositions that can guide empirical research on intended and unintended responses. Because the current corpus is curated and verified rather than derived from a reproducible database export, the paper is positioned as a conference work-in-progress, not as a completed science-mapping study.

## REVIEW DESIGN AND METHOD

### B-SLR positioning and conference scope

The review follows the B-SLR logic proposed by Marzi et al. (2025), which combines bibliometric analysis, systematic qualitative synthesis, and theory development. Bibliometrics identifies relational structure and influence. Close reading interprets mechanisms, contradictions, and boundary conditions. The approach also uses methodological checkpoints to separate data consolidation, preliminary bibliometric assessment, and contribution assessment. The present conference paper has progressed further in bibliographic verification than the earlier draft, but it still stops before formal science mapping.

**Table 2.** Current alignment with the ten-step B-SLR process

| No | Marzi et al. step | Current implementation | Status | Conference interpretation |
|---|---|---|---|---|
| 1. | Research questions and boundaries | Research questions, conceptual perimeter, and eligibility logic specified. | Substantially developed | Suitable for presentation and critique. |
| 2. | Search-query definition | English query drafted and benchmarked against anchor studies. | Developed, not database-tested | Report as a protocol component, not a completed search. |
| 3. | Database selection | Scopus proposed as primary source; Web of | Not executed | Raw database exports remain required. |

| | | | | |
|---|---|---|---|---|
| | | Science and PubMed as checks. | | |
| 4. | Screening and cross-checks | Bibliographic existence and metadata checked for 221 records. | Verification completed; eligibility screening pending | Do not equate verification with inclusion. |
| 5. | Cleaning and export | DOI and title duplicates checked; corrected metadata consolidated. | Candidate corpus cleaned; database-export cleaning pending | Useful for corpus management, not final network analysis. |
| 6. | Bibliometric approach | Performance analysis, co-citation, coupling, and co-word mapping planned. | Not executed | No citation-network claims are made. |
| 7. | Cluster identification | Four substantive domains plus one methodological support set assigned. | Analytical scaffolds, not data-driven clusters | Remain open to merging, splitting, or repositioning. |
| 8. | Sample ordering and selection | Sixty papers selected for relevance, coverage, seminal importance, and recency. | Provisional | Reassess using cluster proportions and normalized influence. |
| 9. | Systematic literature review | Holistic and domain-level synthesis developed using a predefined template. | Provisional; full article-level matrix incomplete | Adequate for work-in-progress discussion, not final auditability. |
| 10. | Theoretical contribution | Framework, propositions, and research agenda developed. | Provisional | Revise if data-driven mapping challenges the current structure. |

**Review boundaries and eligibility criteria**

The unit of analysis is the scholarly publication. The substantive context is the hospital or hospital-centered healthcare organization. Eligible studies address hospital cost accounting; ABC or TDABC; clinical or patient-level costing; DRG or case-based payment; prospective payment; reimbursement; global budgeting; management control; budgeting cognition; provider or managerial behavior; VBHC; or relationships among cost, efficiency, quality, access, equity, and organizational sustainability. Clinical studies are relevant only when they illuminate an organizational costing or payment mechanism.

**Table 3.** Provisional inclusion and exclusion criteria

| Dimension | Inclusion rule | Exclusion rule |
|---|---|---|
| Context | Hospitals or hospital-centered healthcare delivery organizations. | Studies without a meaningful hospital or provider-organization context. |
| Concept | Costing, reimbursement, payment, budgeting, management control, organizational behavior, VBHC, or cost-quality relationships. | Purely clinical effectiveness or pharmacoeconomic studies without a hospital-management mechanism. |
| Document | Peer-reviewed journal article or review; influential methodological article retained where essential. | Editorials, news items, trade reports, dissertations, and records without a traceable bibliographic identity. |
| Language | English for final query and synthesis. | Non-English items unless an English title or abstract and essential relevance justify retention. |
| Time | Open historical coverage; complete calendar years for trend claims. | Partial-year 2026 counts are contextual only. |
| Metadata | Title, year, source, authors, and preferably DOI or publisher identifier. | Records that cannot be reliably distinguished or traced. |

**Candidate-corpus construction and bibliographic verification**

Branding and customer engagement are central in digital markets but are frequently treated as outcome The corpus uses a two-tier architecture. The initial candidate set contains 221 records: 60 papers retained from the original draft and targeted high-relevance additions, plus 161 records assembled through structured publisher and database searching, recent-review reference chaining, and backward citation tracing. The expanded pool improves coverage across costing, payment, control, provider behavior, VBHC, and review methodology. It does not replace a reproducible Scopus or Web of Science export.

A record-level bibliographic audit was completed on 5 July 2026 using official publisher pages, journal records, PubMed, or other authoritative bibliographic sources. Of the 221 records, 220 were located and verified. One record was not verified as written and was flagged as likely conflated; a probable replacement is documented in the supplementary workbook and remains subject to author confirmation. The audit identified DOI for 201 records, while 20 records had no DOI located in the checked source. No duplicate DOI or normalized titles were detected. These results improve metadata confidence, but they do not establish Scopus indexing, eligibility, or inclusion in a final B-SLR.

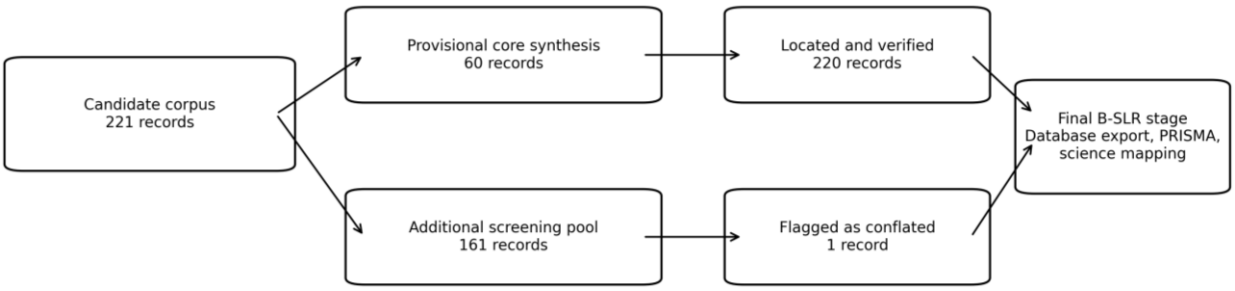



**Figure 1.** Verified candidate-corpus architecture and remaining B-SLR stages

**Table 4.** Candidate-corpus construction and data-quality status

| Indicator | Result | Interpretation |
|---|---|---|
| Candidate records | 221 | Broad pool for coverage management; not 221 finally included studies. |
| Provisional core synthesis sample | 60 (27.1%) | Theoretically curated for conference synthesis; must be reassessed after mapping. |
| Additional screening pool | 161 | Awaiting formal title, abstract, and full-text eligibility decisions. |
| Bibliographically located | 220 (99.5%) | Existence and core metadata verified against authoritative sources. |
| Flagged record | 1 | Citation likely conflated; replacement candidate documented for confirmation. |
| Records with DOI | 201 (91.0%) | Updated figure after metadata synchronization. |
| Records without located DOI | 20 (9.0%) | Retained only where an authoritative record confirms publication identity. |
| Duplicate DOI / titles | 0 / 0 | No duplicates detected after normalization. |
| Scopus or Web of Science indexing | Pending | Publisher presence cannot be treated as indexing evidence. |

### Search strategy for final database validation

The final database search should use Scopus as the primary source, Web of Science for cross-validation, and PubMed to detect medically indexed omissions. A broad identification query is preferable because behavioral mechanisms use heterogeneous language. Behavioral terms should therefore be tested as a supplementary block or screening variable rather than imposed automatically as a mandatory restriction.

TITLE-ABS-KEY((hospital* OR "healthcare organi?ation*" OR "health care organi?s

Pilot testing should confirm retrieval of anchor documents such as Thompson et al. (1979), Hsu and Qu, (2012), Chapman et al. (2014), Kaplan and Witkowski (2014), Malmmose and Lydersen (2021) and Lydersen (2021), Fahlevi et al., (2021), Pott et al. (2023), and Huang and Lu (2025). Each query version should record the database, date, filters, document types, language, time span, number of results, and reasons for revision. The final exports should be merged, deduplicated by DOI and normalized title, and screened by two reviewers or by one reviewer with an expert audit.

### Data preparation, screening, and sample selection

Metadata preparation includes normalization of author names, DOI, source titles, and recurring terms such as DRG, ABC, TDABC, prospective payment, global budget, clinical costing, management control, and VBHC. Formal screening must progress from title and abstract to full text. Exclusion reasons should be retained and reported in a PRISMA flow diagram. Reviewer agreement can be evaluated with Krippendorff's alpha or a comparable coefficient when independent decisions are available.

The current 60-paper core is not a fixed final sample. After mapping the refined database export, studies should be ordered within each empirical cluster using normalized citations or the composite bibliometric influence score proposed by Marzi et al. (2025), combined with substantive relevance. A final in-depth sample should preserve cluster proportions while retaining seminal, boundary-spanning, contradictory, and emerging studies.

### Provisional synthesis procedure

The provisional synthesis operates at holistic and domain-specific levels. The predefined coding template covers country and context, research design, unit of analysis, theoretical lens, payment mechanism, costing method, management-control mechanism, focal actors, behavioral mechanism, cost outcomes, efficiency outcomes, quality and access outcomes, unintended consequences, boundary conditions, and limitations. The conference paper reports findings derived from close reading and structured comparison of the 60 core papers. The complete article-level extraction matrix remains in progress and is disclosed as such. This limits auditability but does not prevent the current framework from being discussed as a revisable theoretical proposition.

## PROVISIONAL CORPUS PROFILE AND THEMATIC SYNTHESIS

### Descriptive profile and interpretation limits

The candidate corpus contains 221 records published from 1968 to 2026. Six records are dated 2026, so the final year is incomplete. The distribution is weighted toward recent studies, including payment-reform evaluation, TDABC, VBHC, cost-information quality, and provider behavior. This pattern describes the curated candidate corpus. It should not be interpreted as a definitive field-level production trend because the corpus was assembled through multiple pathways rather than one reproducible database query.

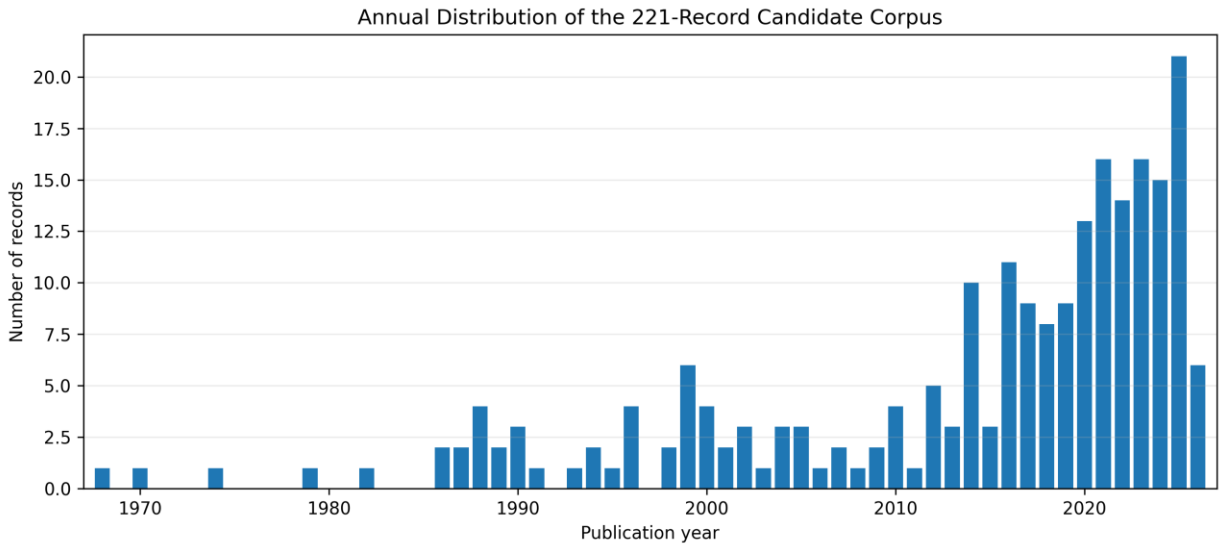



**Figure 2.** Annual distribution of the 221-record candidate corpus

The corpus contains four substantive domains and one methodological support set. The methodological papers guide database integration, bibliometric analysis, sample selection, and theory development. They should not be interpreted as a substantive hospital cost-management cluster. Excluding the 15 methodological records, the 206 substantive candidates are distributed across cost-information architecture (30.6%), payment and provider response (30.1%), budgeting, control, and cognition (22.3%), and VBHC, quality, and outcomes (17.0%).

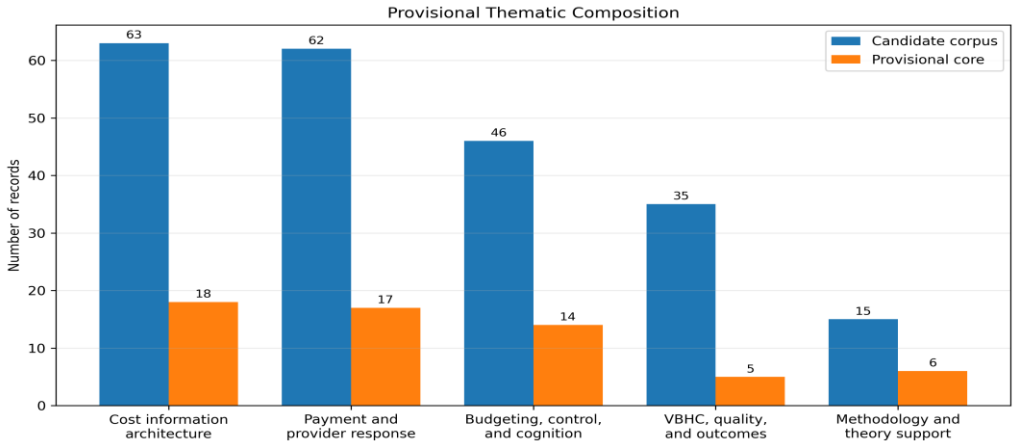



**Figure 3.** Candidate-corpus and provisional core composition by analytical category

These categories are analytical scaffolds, not bibliometric clusters. Their sizes reflect deliberate breadth and the theoretical composition of the current core. Co-citation, bibliographic-coupling, and co-word analyses may merge, split, or reposition them. The categories must therefore remain open to revision.

### Cost-information architecture and costing systems

The first domain shows a movement from aggregated allocation toward decision-oriented cost intelligence. Early case-mix and ABC studies linked resources to hospital products and improved overhead allocation (Aird, 1996; Chan, 1993; Thompson et al., 1979; Udpa, 1996). The adoption of costing systems in hospitals can also be understood as an organizational innovation process that develops over time rather than as a purely technical accounting decision (Hill, 2000). Later research showed that technical accuracy depends on the definition of cost objects, cost pools, drivers, capacity, and clinical pathways, as well as the organization's ability to maintain the system (Northcott & Llewellyn, 2002;

Chapman et al., 2014). Resource consumption accounting extends this concern by emphasizing the relationship between resources, capacity, and cost behavior in healthcare costing systems (Ozyapici & Tanis, 2016).

TDABC extends this movement by linking practical capacity, time, activities, and patient pathways. ABC and TDABC studies further indicate that costing methods can support healthcare performance improvement when they are connected to process analysis and managerial use (Niñerola et al., 2021). Reviews and implementation frameworks identify its value for process redesign, waste identification, and pathway-level economic analysis (Etges et al., 2024; Etges et al., 2019; Keel et al., 2017; Shakya et al., 2025). Granularity, however, is not automatically superior. Time estimates, capacity assumptions, data integration, and maintenance costs may create false precision. The costing method should follow the decision problem rather than methodological fashion.

A central insight is that cost information has technical and social quality. Technical quality concerns accuracy, granularity, comparability, and timeliness. Social quality concerns credibility, interpretability, and perceived clinical relevance. Cross-country evidence and studies of enabling cost information show that technically sophisticated systems remain behaviorally weak when users distrust them or cannot connect them to clinical practice (C. S. Chapman et al., 2022; Heberle et al., 2025; Pavlatos & Kostakis, 2023).

**Payment, reimbursement, and provider responses**

DRGs, prospective payment, global budgets, and value-based payment redistribute financial risk and alter organizational attention. Activity-based hospital payment reforms also show that payment change is often adopted incrementally and shaped by institutional, policy, and implementation constraints (Brammli-Greenberg et al., 2016). Prospective payment can encourage shorter stays, standardization, reduced unnecessary resource use, and service redesign because providers bear more marginal-cost risk (Busse et al., 2013; Davis & Rhodes, 1988; Pott et al., 2023). Payment systems also create opportunities for strategic adaptation. Coding changes, upcoding, patient selection, cost shifting, volume responses, discharge substitution, and reduced service intensity may improve measured efficiency without improving underlying value (Behzadi et al., 2026; Li et al., 2022; Lowe, 2001).

Recent evidence emphasizes heterogeneity. Effects vary by hospital ownership, level, patient mix, coding capacity, and complementary budget rules (Messerle & Schreyögg, 2024; Munoz et al., 1989; Tang et al., 2023). Cross-country evidence from European DRG systems shows that similar payment arrangements may rely on different cost-accounting infrastructures, which can shape how hospitals interpret and respond to reimbursement rules (Tan et al., 2014). Studies of DRG payment under global budgets with price adjustment show that expenditure can fall while unintended responses remain possible (Dong et al., 2025; Dong & Wu, 2025). Disease-specific evidence also shows that DRG payment can affect medical expenditure and treatment efficiency, although the direction and strength of the effect depend on the clinical condition, patient complexity, and implementation context (Xiong et al., 2025). Payment architecture should therefore be treated as a stimulus rather than a deterministic cause. Information, control, professional judgment, and governance mediate the organizational response. Early implementation experience in German hospitals also shows that DRG-based payment reform can create practical difficulties for clinical departments and requires context-sensitive adaptation (Wilke et al., 2001).

The same payment mechanism may improve efficiency in one context and threaten access or quality in another. When quality, equity, and complexity are weakly measured, the lowest-cost response may not be socially optimal. Payment reform therefore requires balanced monitoring, credible risk adjustment, audit capacity, ethical safeguards, and transparent clinical engagement.

**Budgeting, management control, and actor cognition**

Budgeting and management control translate external incentives into internal responsibility, targets, conversations, and decisions. Earlier hospital management-control literature also linked cost accounting, management control, and planning as interdependent tools for resource coordination and accountability (Junior & Blish, 1988). Budgets communicate priorities and coordinate units, but they can also intensify conflict between clinical autonomy and financial (Lachmann et al., 2013; Robson, 2008). Their effects depend on participation, forecasting, communication, controllability, feedback, and the perceived legitimacy of the target.

Cognition is a key missing mechanism. Cost and budget information affect behavior only when actors notice, understand, trust, and use it. Pavlatos and Kostakis (2023) show that cost-information quality strengthens budgeting use under crisis conditions. Huang and Lu (2025)connect budgeting-system characteristics with physician-executives' budget cognition and medical decisions. Lüdemann et al. (2024) associate cost awareness with economic knowledge and working conditions. These findings challenge the assumption that information availability automatically produces cost-conscious behavior.

Management-accounting change is also institutional. Fahlevi et al., (2021) show that DRG payment can stimulate accounting change and data-analytics roles in an Indonesian public hospital. Wang et al., (2025) show how private hospitals negotiate state, market, professional, and managerial logics during DRG reform. Schreyögg et al. (2006) show how reimbursement arrangements shape the design and use of cost systems in an Australian non-profit hospital. Management control is therefore not a neutral transmission device. It is the organizational arena in which payment pressure is interpreted and contested.

**Value-based healthcare, quality, efficiency, and outcomes**

VBHC seeks to connect patient-relevant outcomes with resources consumed across a care cycle. Its promise is integrative, but the literature shows an asymmetry: outcome measurement is often more developed than cost measurement. This integration also requires stronger links between clinical evidence and economic evidence in healthcare decision-making and guideline development (Knies et al., 2019). Leusder et al. (2022) identify substantial variation in costing approaches, while Møberg and Malmmose (2025) show that managerial interpretations of value may reflect only partly institutionalized logics. Value can become a quality slogan unless cost, pathway, outcome, and payment information are operationally connected.

Value-based payment adds requirements for outcome definition, data infrastructure, stakeholder participation, risk adjustment, attribution, contract duration, and risk sharing (Leao et al., 2024). Cost control and quality improvement are not automatically complementary. They become complementary when information and governance make process improvement more attractive than gaming, avoidance, or service reduction.

Organizational outcomes should be assessed as a portfolio: cost, technical efficiency, allocative efficiency, quality, safety, access, equity, staff burden, and financial sustainability. Earlier evidence also suggests that cost, efficiency, and quality should be evaluated together because efficiency gains may not automatically represent better hospital performance (Broyles, 1990). A cost reduction that transfers expenditure to another setting, excludes complex patients, or increases staff strain is not equivalent to productivity improvement.

**Methodological support set**

The methodological support set clarifies the different functions of bibliometric mapping and systematic synthesis. Bibliometrics identifies influence, relational structure, and conceptual proximity. Systematic review interprets mechanisms, contradictions, and boundary conditions (Donthu et al., 2021; Mukherjee et al., 2022). Marzi et al. (2025) integrate these functions with theory development. Hiebl, (2023), Caputo

and Kargina (2022), and Klarin (2024) further emphasize sample selection, database integration, and the connection between co-word mapping and content analysis. The implication is direct: the empirical network must be allowed to challenge the current categories rather than being forced to reproduce them.

## DISCUSSION

### From cost reporting to cost intelligence

The central transition is from cost reporting to cost intelligence. Cost reporting records expenditure and allocates overhead. Cost intelligence connects resources, processes, capacity, patient pathways, outcomes, and managerial choices. Its value lies in decision relevance, not maximum detail. A useful system helps actors identify avoidable variation, capacity constraints, cross-subsidization, process bottlenecks, and the consequences of alternative service designs.

This transition explains why payment reform without information reform is unstable. DRG or global-budget pressure increases the need to understand marginal and pathway costs. When that need is not met, hospitals may rely on broad cuts, bargaining power, coding, or patient selection. Cost-information architecture therefore mediates the relationship between external incentives and internal decisions.

### Management control as behavioral infrastructure

Management control determines how cost intelligence enters action. Budgets, responsibility centers, indicators, meetings, forecasts, and service-line reviews define who sees information, when deviations become visible, and how trade-offs are discussed. A coercive design can produce defensive behavior and gaming. An enabling design can support learning, cross-functional problem solving, and shared cost-quality accountability.

Actor cognition is the proximal mechanism. Cost-control consciousness is not a stable personal trait. It is shaped by information quality, professional identity, participation, perceived controllability, stress, incentives, and ethical framing. This explains why identical dashboards or budgets can generate different responses across departments and hospitals.

### Clinical-financial tension and unintended consequences

Hospital cost decisions occur under persistent tension between clinical and financial logics. The tension can be productive when it prompts scrutiny of low-value care, pathway variation, and capacity use. It becomes harmful when financial metrics dominate clinically meaningful outcomes, targets are not risk adjusted, or professionals perceive accounting information as detached from patient care.

Unintended consequences are not anomalies outside the model. They are predictable responses to incomplete measurement and asymmetric incentives. Upcoding, selection, cost shifting, and inappropriate intensity reduction become more likely when revenue is sensitive to coding, quality is imperfectly observed, complex cases are undercompensated, or accountability is fragmented. Ethical governance and balanced measurement should therefore be treated as structural components of cost-management design.

### What the verified corpus adds at the conference stage

The metadata audit does not solve the central limitations of the B-SLR, but it removes avoidable uncertainty about whether the cited records exist and whether their basic bibliographic identities are coherent. The revised corpus also separates metadata verification from indexing and eligibility. This distinction strengthens the paper's credibility because it prevents a common category error: treating a located publication as automatically indexed, eligible, included, or influential.

The conference version therefore offers a defensible middle position. It presents a transparent corpus, a mechanism-based synthesis, and a framework ready for criticism. It does not claim that descriptive counts are field-level bibliometrics or that the provisional categories are empirical clusters. That modesty is not a weakness. It creates a clear agenda for converting the paper into a completed B-SLR after the conference.

**Integrated Hospital Cost-Decision and Behavioral Framework**

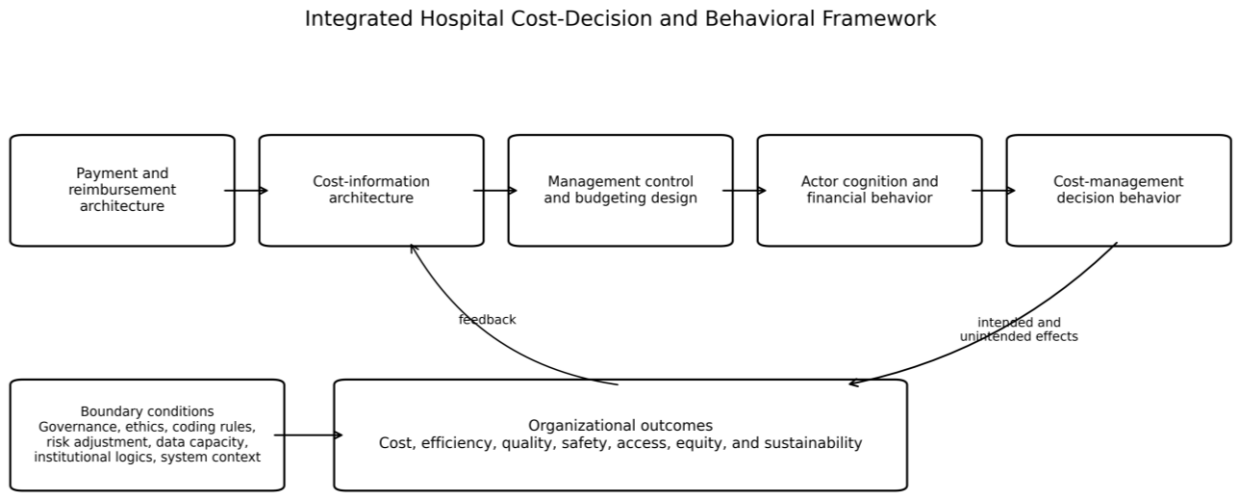



**Figure 4.** Integrated Hospital Cost-Decision and Behavioral Framework

The framework places payment and reimbursement architecture at the beginning of the causal sequence. It defines revenue rules, financial risk, incentives, and constraints. Cost-information architecture determines whether the organization can translate those rules into credible knowledge about activities, capacity, patients, pathways, and outcomes. Management-control and budgeting design determine how that knowledge is distributed, debated, and connected with responsibility. Actor cognition and financial behavior capture attention, understanding, trust, cost consciousness, professional interpretation, and strategic response. These mechanisms generate cost-management decisions involving pathway redesign, capacity allocation, procurement, staffing, coding, volume, patient selection, and service intensity.

Organizational outcomes include cost, efficiency, quality, safety, access, equity, and sustainability. Outcomes may be intended or unintended. Governance, ethical control, coding rules, risk adjustment, data capacity, institutional logics, and health-system context operate as boundary conditions. Feedback matters because realized outcomes can reshape payment rules, information systems, budgets, and actor beliefs. The framework is therefore dynamic rather than a one-way pipeline.

**Provisional theoretical propositions**

**Table 6.** Provisional theoretical propositions

| Proposition | Statement |
|---|---|
| P1 | Greater prospective-payment or global-budget pressure increases organizational demand for granular and clinically meaningful cost information, particularly where providers bear substantial marginal-cost risk. |
| P2 | Cost-information quality mediates the relationship between payment architecture and cost-management decision quality. Technical accuracy is insufficient without interpretability, credibility, and timeliness. |
| P3 | Enabling budgeting and management-control design strengthens the translation of cost information into constructive cost-conscious behavior. Coercive or poorly controllable systems increase defensive behavior and gaming. |

| Proposition | Statement |
|---|---|
| P4 | Actor cognition, especially perceived relevance, trust, budget usefulness, professional compatibility, and cost-control consciousness, mediates the effect of cost and budget information on clinical and managerial decisions. |
| P5 | When efficiency pressure is not balanced by risk adjustment, quality monitoring, ethical governance, and cross-setting accountability, the probability of upcoding, patient selection, cost shifting, and inappropriate intensity reduction increases. |
| P6 | VBHC improves the alignment of efficiency and quality only when outcome measurement, cost architecture, payment design, and clinical governance are operationally integrated across the care cycle. |

## CONCLUSION

Hospital cost management is not simply the calculation and allocation of expenditure. It is an organizational process in which payment incentives, cost-information systems, budgeting and control, professional cognition, and governance interact to shape decisions. The literature has progressed from case-mix and aggregated reporting toward patient-, pathway-, capacity-, and value-oriented information. Better information, however, matters only when actors trust it, understand it, and embed it in decision processes.

The provisional synthesis suggests a layered mechanism. Cost information makes financial pressure intelligible. Management control assigns attention and responsibility. Actor cognition translates information into acceptance, resistance, learning, or strategic adaptation. Decision behavior then produces intended and unintended outcomes. The framework integrates technical costing, organizational behavior, and health-payment policy.

Methodologically, the revised conference paper improves transparency by distinguishing 221 candidate records from 60 provisional core papers, documenting that 220 records were located, updating DOI coverage to 201 records, and disclosing one conflated citation. These improvements make the paper more defensible for conference discussion. They do not make it a completed B-SLR. The strongest final version will allow data-driven clusters to challenge the current framework and will report the complete search, screening, mapping, selection, and coding process as supplementary material.

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