

Strategy Formulation and Implementation in Indonesian Public Hospitals: A Multiple Case Study

Sinta^{1*}, Siswani², Restika Osin Sukur³,
Reza Hapid⁴, Mira Veranita⁵

¹²³⁴⁵ Universitas Adhirajasa Reswara Sanjaya

Corresponding author: sintabtmardiman@gmail.com^{1*},
siswanisanusi03@gmail.com², restysukur9@gmail.com³,
rehapid.md@gmail.com⁴, mira.veranita@ars.ac.id⁵

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Abstract

Effective strategy formulation and implementation remain among the most persistent challenges confronting public hospital management in developing country contexts, where institutional complexity, resource constraints, and regulatory turbulence shape organizational decision-making in distinctive ways. This study employs a qualitative multiple case study design to investigate how public hospitals in West Java Province, Indonesia, formulate and implement organizational strategies, and what factors mediate the gap between strategic intent and operational reality. Data were collected from three Type B public hospitals, referred to pseudonymously as RS A, RS B, and RS C, through 30 in-depth interviews with hospital directors, strategic planning managers, department heads, and frontline staff, supplemented by document analysis of hospital strategic plans (RENSTRA), performance reports, and board meeting minutes over a six-month field period. Thematic analysis following Braun and Clarke (2006) identified four overarching themes: (1) the politics and processes of strategy formulation, (2) the strategy-structure alignment challenge, (3) human resource and leadership factors in strategy implementation, and (4) performance monitoring and adaptive strategy. Findings reveal that strategy formulation in Indonesian public hospitals is characterized by isomorphic compliance pressures that constrain genuine strategic choice, while implementation is critically shaped by middle management capacity, organizational culture, and the coherence of performance management systems. The study contributes a contextually grounded theoretical framework for understanding strategy processes in public health organizations and offers practical implications for hospital governance reform.

Keywords: Strategy Formulation, Strategy Implementation, Hospital Management, Public Sector, Qualitative Case Study, Indonesia

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1. Introduction

Strategic management in healthcare organizations occupies a distinctive position at the intersection of clinical governance, public accountability, and market-like competitive

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dynamics. In Indonesia, public hospitals operate within a complex institutional environment shaped by the National Health Insurance (JKN) framework administered by BPJS Kesehatan, the mandatory hospital accreditation standards of SNARS Ed. 1.1, regional government ownership and budget allocation processes, and the service delivery obligations of Blud (Badan Layanan Umum Daerah IN ENGLISH) status ([Kemenkes RI, 2022](#)). Within this environment, the capacity of hospital leaders to formulate clear strategies and translate them into operational reality is both critically important and structurally constrained.

The strategic management literature has long recognized a pervasive gap between the elegance of formally articulated strategies and the organizational realities of their implementation. [Hrebiniak \(2006\)](#) identified execution as the primary challenge of strategic management, noting that most organizational failures are failures of implementation rather than formulation. In the public sector healthcare context, this implementation challenge is compounded by the professional autonomy of clinical staff, the political accountability of hospital directors to regional governments, the rigidity of civil service human resource systems, and the inherent difficulty of measuring strategic performance in service organizations characterized by intangibility, inseparability, heterogeneity, and perishability ([Lovelock & Wright, 2002](#); [Parasuraman et al., 1988](#)).

Despite the centrality of strategic management to hospital performance, qualitative investigation of how strategy formulation and implementation actually unfold as organizational processes in Indonesian public hospitals remains limited. Existing studies tend to focus on quantitative relationships between strategy variables and performance outcomes, leaving the social processes, power dynamics, and interpretive frames through which strategy is constructed and enacted largely unexplored. This study addresses that gap through an in-depth, qualitative, multiple-case study of three West Java public hospitals.

The central research question is: How do Indonesian public hospitals formulate and implement organizational strategies, and what factors enable or constrain the translation of strategic intent into operational outcomes? The study aims to generate contextually grounded insights that extend existing theoretical frameworks and provide actionable guidance for hospital administrators, regional health authorities, and health system reform policy makers.

This study aims to: (1) describe and analyze the processes through which strategic plans are formulated in Indonesian public hospitals; (2) examine the organizational, human resource, and structural factors that mediate strategy implementation; (3) identify the mechanisms through which hospitals monitor strategic performance and adapt strategies in response to environmental change; and (4) develop an empirically grounded conceptual framework of public hospital strategy processes in the Indonesian institutional context.

2. Literature Review

2.1 Strategy Formulation: Theoretical Perspectives

Strategic management theory offers competing perspectives on how strategies are formed. The design school, epitomized by [Andrews \(1971\)](#) and later formalized through [Porter's \(1980, 1985\)](#) competitive analysis frameworks, conceives of strategy formulation as a deliberate, rational process of environmental analysis, internal capability assessment, and strategic choice by senior leadership. This perspective underpins the widespread adoption of SWOT analysis, Porter's Five Forces, and formal strategic planning cycles in healthcare organizations ([Zuckerman, 2006](#)).

In contrast, the process school, associated with [Mintzberg \(1978, 1994\)](#), reconceptualizes strategy as emergent, arising from patterns of decisions and actions over time rather than from deliberate ex ante planning. Mintzberg's distinction between intended, deliberate, emergent, and realized strategies provides a particularly useful analytical lens for examining the gap between formally articulated hospital strategic plans (RENSTRA) and the strategies that actually guide organizational behavior. The Resource-Based View ([Barney, 1991](#)) adds a further dimension by directing attention to the internal capabilities, tacit knowledge, and dynamic routines that constitute sustainable sources of competitive advantage in service organizations.

In the public sector context, strategy formulation is further conditioned by institutional isomorphism ([DiMaggio & Powell, 1983](#)), whereby organizations adopt similar strategic forms not because they are intrinsically superior but because they conform to regulatory, professional, or mimetic pressures. This phenomenon is particularly salient in Indonesian public hospitals, where the mandatory RENSTRA format prescribed by regional government regulation, the SNARS accreditation requirements, and the JKN contract specifications create powerful coercive isomorphic pressures that shape strategic content regardless of individual organizational context. [Rochmawati et al. \(2023\)](#) confirmed this dynamic in the Indonesian context, finding that digital-era business strategy development in health organizations is frequently driven by external regulatory and competitive pressures rather than genuine internal strategic analysis.

2.2 Strategy Implementation: The Execution Gap

[Hrebiniak \(2006\)](#) identified five primary barriers to strategy implementation in complex organizations: inability to manage change, unclear accountability structures, poor or vague strategy communication, conflicting priorities across organizational units, and inadequate information systems for monitoring execution. These barriers are particularly acute in public hospitals, where the matrix-like intersection of clinical and administrative authority creates inherent structural tensions, and where the civil service employment framework limits the flexibility of human resource deployment and incentive alignment. [Prawestirini et al. \(2025\)](#) empirically demonstrated these barriers in an Indonesian hospital setting, finding through qualitative SWOT analysis that delayed JKN claim processing was fundamentally a strategic management failure rooted in unclear accountability structures and inadequate inter-departmental coordination mechanisms rather than a purely technical problem.

The strategy-structure relationship, first articulated by [Chandler \(1962\)](#) and subsequently elaborated by [Galbraith and Kazanjian \(1986\)](#), posits that organizational structure must be aligned with strategic intent for effective implementation. In hospitals, this relationship is complicated by the dual authority structure of medical and administrative governance, which creates competing centers of strategic decision-making and potential implementation conflict ([Ginter et al., 2018](#)). The Service-Profit Chain framework ([Heskett et al., 1994](#)) further highlights how internal service quality and employee satisfaction constitute proximate determinants of external service quality and organizational performance, connecting HRM strategy to service delivery outcomes.

Middle management plays a particularly critical mediating role in strategy implementation, serving as the primary translation layer between senior leadership's strategic intent and frontline operational behavior ([Wooldridge, Schmid, & Floyd, 2008](#)). In the Indonesian public hospital context, department heads and clinical unit leaders occupy this middle management role and are therefore pivotal determinants of implementation fidelity and effectiveness.

2.3 Strategic Management in Indonesian Public Hospitals

The Indonesian public hospital sector operates under a distinctive governance arrangement that significantly shapes strategic management processes. Since the enactment of Government Regulation No. 23 of 2005 on Public Service Bodies (Badan Layanan Umum), public hospitals have been granted greater financial and operational autonomy than standard government agencies, enabling more flexible resource management and performance-based budgeting. However, this autonomy operates within the constraints of regional government ownership, civil servant employment norms, and BPJS Kesehatan contract requirements ([Rokx et al., 2009](#)).

The RENSTRA, or Rencana Strategis, serves as the principal instrument for strategy formulation in Indonesian public hospitals. It sets out a five-year strategic direction aligned with the Regional Medium-Term Development Plan, known as the RPJMD. Although the RENSTRA provides a formal framework for defining organizational priorities, its effectiveness as a practical guide for managerial decision-making remains contested. In many cases, the document functions primarily as an instrument of bureaucratic compliance rather than as the product of rigorous strategic analysis. Strategic targets are often carried forward from previous planning periods with only minor adjustments, instead of being reformulated in response to changes in organizational capabilities, stakeholder expectations, and the external healthcare environment. Consequently, this compliance-driven approach may weaken the connection between formally stated strategic priorities, operational resource allocation, and the actual challenges faced by public hospitals. [Kathrine, Syaodih, and Veranita \(2025\)](#) documented a case in which a Type C public hospital in Buton Regency faced institutional downgrading precisely because its strategic management in HR, facilities, and finance had prioritized regulatory compliance over genuine competitive and quality-driven strategy, with RENSTRA targets disconnected from operational resource allocation decisions.

2.4 Theoretical Framework

This study is guided by an integrative theoretical framework drawing on three complementary perspectives. First, [Mintzberg's \(1994\)](#) process view of strategy formation directs attention to the distinction between intended and realized strategies, framing the gap between RENSTRA and operational reality as an empirical object of investigation. Second, [Hrebiniak's \(2006\)](#) strategy execution framework provides a structured analytical lens for identifying the organizational barriers and enablers of implementation effectiveness. Third, institutional theory ([DiMaggio & Powell, 1983](#)) sensitizes analysis to the role of coercive, mimetic, and normative pressures in shaping strategic choices and constraining genuine strategic differentiation in the Indonesian public hospital context. Together, these perspectives enable a multi-level analysis spanning institutional, organizational, and individual dimensions of strategy processes.

3. Research Method

3.1 Research Design and Epistemological Stance

This study adopts a qualitative multiple case study design following [Yin \(2018\)](#), selected for its capacity to support theoretically rich, context-sensitive investigation of complex organizational phenomena. Three cases are employed following a replication logic: RS A and RS B are expected to yield similar findings (literal replication), while RS C, a newly autonomous Blud hospital with a recently appointed director, is expected to produce contrasting results under predictable conditions (theoretical replication). An interpretivist epistemological stance is

adopted, consistent with the study's aim of understanding how organizational actors construct, interpret, and enact strategy in context (Creswell & Poth, 2018). The researcher is positioned as an active interpreter rather than a neutral observer, with reflexivity practices documented throughout the research process.

3.2 Case Selection and Site Description

Three Type B public hospitals in West Java Province were purposively selected based on: (1) Blud status and minimum three years of operational autonomy; (2) existence of a current RENSTRA document covering the 2021-2026 period; (3) willingness to grant research access at multiple organizational levels; and (4) variation in organizational maturity, accreditation status, and strategic profile to enable meaningful cross-case comparison. Table 1 presents an overview of the three case sites.

Table 1. Overview of Case Study Sites

Characteristic	RS A	RS B	RS C
Type	Type B	Type B	Type B
Bed Capacity	320 beds	280 beds	260 beds
Blud Status	Since 2016	Since 2018	Since 2021
Accreditation	Paripurna (2023)	Utama (2022)	Madya (2023)
Director Tenure	7 years	4 years	1.5 years
RENSTRA Period	2021-2026	2021-2026	2022-2027
Strategic Priority	Service quality and digital transformation	Human capital development	Financial sustainability and efficiency
No. of Informants	11	10	9

Source: Field data (2026).

3.3 Data Collection

Data collection proceeded through three complementary methods over a six-month field period (February-July 2024). First, 30 semi-structured in-depth interviews were conducted with purposively selected key informants across the three hospitals. Informant categories included: hospital directors and deputy directors (n=6), strategic planning and quality managers (n=6), clinical department heads (n=9), human resources and finance managers (n=6), and frontline nursing and administrative staff (n=3). Interview guides, developed and pilot-tested with two hospital managers outside the sample, covered: strategy formulation processes and participation, understanding and operationalization of strategic goals, implementation challenges and enabling factors, performance monitoring practices, and adaptive responses to strategic divergence. Interviews were conducted in Bahasa Indonesia, audio-recorded, and transcribed verbatim. Informant codes protect confidentiality (e.g., RS-C-D1 = RS A, Director 1).

Second, document analysis was conducted on RENSTRA documents, annual performance reports (LAKIP/LKjIP), board of directors meeting minutes, standard operating procedures, and organizational charts at each hospital. Document sources were coded and triangulated against interview data. Third, non-participant observation of strategic planning meetings, performance review sessions, and department coordination meetings was conducted over approximately two weeks per hospital, generating 180 pages of fieldnotes.

3.4 Data Analysis

Data were analyzed using [Braun and Clarke's \(2006\)](#) reflexive thematic analysis, proceeding iteratively through familiarization, initial coding, theme generation, theme review, and theme definition phases. NVivo 14 was used to support systematic code management and retrieval. Cross-case analysis employed [Miles et al.'s \(2014\)](#) case-ordered display matrix to identify within-case patterns and cross-case convergences and divergences. Rival explanations were systematically considered and ruled in or out against the evidence base. Trustworthiness was established through prolonged engagement (six months), member checking (four key informants reviewed findings summaries), negative case analysis, peer debriefing with a colleague uninvolved in data collection, and a comprehensive methodological audit trail.

4. Findings and Discussions

Analysis generated four overarching themes with associated sub-themes across the three case sites. Table 2 presents the thematic structure, followed by detailed presentation of each theme with illustrative evidence.

Table 2. Thematic Structure of Findings

Theme	Sub-themes	Primary Cases
1. Politics and Processes of Strategy Formulation	Compliance-driven planning; Participation patterns; Environmental analysis quality	All three
2. Strategy-Structure Alignment Challenge	Dual authority tensions; Departmental silos; Structural inertia	RS A, RS B
3. Human Resource and Leadership Factors in Implementation	Middle management capacity; Director leadership style; Staff strategic literacy	All three (varied intensity)
4. Performance Monitoring and Adaptive Strategy	Indicator systems; Review cycle effectiveness; Strategic adaptation mechanisms	RS A (strongest); RS C (weakest)

Source: Thematic analysis of field data (2026).

4.1 Politics and Processes of Strategy Formulation

Across all three hospitals, strategy formulation was found to be a politically embedded process shaped as much by institutional compliance requirements as by genuine strategic analysis. The RENSTRA, formally the primary instrument of strategic planning, was consistently described by informants as a regulatory document produced for the regional government rather than an operational guide for internal decision-making. The Strategic Planning Manager at RS B articulated this tension directly:

The RENSTRA is written every five years. By the third year, the environment has changed so much that many of the targets are no longer relevant. But we cannot simply revise them. The regional government has approved those numbers. So we have a formal strategy that does not reflect our actual priorities, and an informal strategy that we follow in practice but cannot officially document. *(RS-M-SPM1, Strategic Planning Manager)*

This bifurcation between formal and informal strategy, consistent with [Mintzberg's \(1994\)](#)

distinction between intended and emergent strategies, was observable at all three hospitals but most pronounced at RS C, where the recently appointed director had inherited a RENSTRA formulated under the previous administration with substantially different strategic priorities. The new director described the inherited document as:

A historical artifact. It tells me what someone else intended three years ago in a completely different financial situation. My job is to manage a hospital in 2024, not to execute someone else's 2021 plan. But the evaluation system still measures me against those old targets. (RS-S-D1, Hospital Director)

This finding resonates with [Johan et al. \(2024\)](#), who similarly documented a bifurcation between formal strategic planning frameworks and actual operational strategy in a hospital emergency department context, observing that effective crisis response relied on informal adaptive strategies developed outside the formal planning cycle. Participation in the strategy formulation process varied significantly across the three hospitals. RS A, the most institutionally mature site, employed a cascaded strategic planning process involving structured departmental situation analyses, a cross-functional strategic planning team, and formal validation workshops with clinical and administrative department heads. In contrast, RS C's RENSTRA had been formulated by a small central team with minimal departmental input, limiting ownership and contextual relevance at the operational level.

Environmental analysis quality was uneven across all sites. While all three hospitals incorporated SWOT matrices into their RENSTRA documents, the depth and analytical rigor of these analyses varied considerably. RS A's strategic planning team had conducted systematic competitor benchmarking, patient satisfaction trend analysis, and demographic projection exercises, while RS C's SWOT reflected primarily intuitive assessments without systematic data collection or analysis.

4.2 Strategy-Structure Alignment Challenge

The relationship between strategic intent and organizational structure emerged as a central implementation challenge at RS A and RS B, where ambitious strategic priorities were constrained by structural arrangements that predated and in some respects contradicted the current strategy. The dual authority structure of hospital governance, in which the director holds administrative authority but the Medical Committee (Komite Medis) holds normative authority over clinical practice, created recurring tensions in implementing strategies that spanned the clinical-administrative boundary.

We have a strategic target to reduce average length of stay by 1.5 days within three years. That requires changes to clinical protocols. But clinical protocols are the domain of the Komite Medis. I can propose, discuss, and advocate. I cannot instruct. The implementation of this strategy depends entirely on the goodwill and engagement of the medical committee. (RS-C-D1, Hospital Director)

Departmental silos represented a second structural barrier to strategy implementation. Cross-functional strategies requiring coordinated action across multiple departments encountered persistent coordination failures at all three hospitals. RS B's strategic priority of integrated patient care pathway development, for instance, required simultaneous engagement from the clinical, pharmacy, nursing, and medical records departments, each with its own operational culture, workload pressures, and reporting hierarchy. The Director of RS B observed:

Every department understands the strategy in terms of its own workload. Pharmacy wants to know what it means for the pharmacy. Nursing wants to know what it means for nursing. Nobody is thinking about the whole patient journey. That is the fundamental structural problem we are trying to solve, and it cannot be solved by writing a better strategic plan. (*RS-M-DI, Hospital Director*)

4.3 Human Resource and Leadership Factors in Implementation

Human resource and leadership factors emerged as the most consistently influential determinants of strategy implementation effectiveness across all three hospitals, consistent with [Hrebiniak's \(2006\)](#) identification of human capital and leadership commitment as central prerequisites for execution. Three sub-themes were prominent: middle management capacity, director leadership style, and staff strategic literacy.

Middle management capacity, specifically the ability of department heads to translate organizational strategic goals into actionable departmental plans and to motivate frontline staff engagement, was identified as the primary proximate determinant of implementation fidelity. At RS A, department heads had participated in a structured strategic management capacity development program and were required to produce annual departmental operational plans (RKT) aligned with RENSTRA targets. This structural investment in middle management capability was reflected in substantially higher levels of strategic goal familiarity and operational planning quality at RS A compared to the other two sites.

The director's leadership style exerted a pervasive influence on organizational strategic culture at all three hospitals. RS A's long-tenured director demonstrated a consistently participative leadership style, actively involving department heads in strategy review discussions and explicitly acknowledging implementation difficulties in open forums. This approach generated substantial organizational trust and psychological safety, facilitating candid performance reporting and adaptive responses to strategic divergence. The Quality Manager at RS A noted:

The director asks us to report honestly. When a target is not achieved, the question is always: why, and what do we need to change? Not: who is to blame? That culture makes people willing to surface problems early, when they can still be corrected. (*RS-C-QMI, Quality and Accreditation Manager*)

In contrast, RS C's newly appointed director, despite clear strategic vision, had not yet accumulated the institutional knowledge and relational capital necessary for effective cross-departmental strategy coordination. Several department heads reported uncertainty about the new director's strategic priorities and hesitation to commit departmental resources to initiatives whose longevity under new leadership was unclear. This finding underscores the temporal dimension of strategic leadership effectiveness and the organizational cost of frequent leadership succession in public hospital settings. This finding aligns with [Rahwany et al. \(2026\)](#), who demonstrated through SWOT analysis at a clinic in Lhokseumawe that managerial strategy effectiveness among female health workers in dual roles was substantially contingent on leader tenure and accumulated institutional knowledge, suggesting that leadership continuity is a cross-contextual determinant of strategic management quality in Indonesian health organizations.

Staff strategic literacy, defined as the degree to which frontline staff understand and internalize organizational strategic goals, was consistently low across all three hospitals, with the partial exception of RS A. Interviews with frontline nursing and administrative staff at RS B and RS

C revealed limited awareness of RENSTRA content beyond immediate operational metrics. A senior nurse at RS B reflected:

We attend the RENSTRA socialization once a year. There are many PowerPoint slides. But when I come back to the ward, my priority is the patients in front of me. The strategy feels like something that happens in the director's office, not on the ward. (*RS-M-NI, Senior Nurse, Inpatient Ward*)

4.4 Performance Monitoring and Adaptive Strategy

Cross-case comparison revealed significant variation in the sophistication and effectiveness of performance monitoring systems and in the capacity for adaptive strategy in response to performance divergence. Table 3 summarizes key strategic performance monitoring characteristics across the three hospitals.

Table 3. Strategic Performance Monitoring Characteristics Across Case Sites

Monitoring Dimension	RS A	RS B	RS C
KPI framework	BSC-based, 28 indicators	Activity-based, 19 indicators	Output-based, 14 indicators
Review frequency	Monthly (operational), Quarterly (strategic)	Quarterly	Semi-annual
Dashboard system	Digital real-time dashboard	Excel-based monthly report	Manual compilation
Cross-departmental review	Yes, structured	Partial	No
Strategy adaptation mechanism	Formal mid-cycle review with board	Informal director discretion	Absent
Staff access to KPI data	All department heads	Directors only	Directors only
Alignment with RENSTRA	High (quarterly cascade)	Moderate	Low

Source: Document analysis and interview data (2026)..

RS A's Balanced Scorecard-based monitoring system represented the most sophisticated performance management architecture among the three cases, enabling real-time visibility of KPI performance across financial, customer, internal process, and learning and growth perspectives. The integration of this dashboard with the hospital's SIMRS allowed automated data collection for operational indicators, reducing reporting burden and improving data reliability. The Director of RS A attributed much of the hospital's strategy implementation effectiveness to this monitoring infrastructure:

You cannot manage what you cannot see. Before the dashboard, strategy review was a once-a-year exercise of looking at numbers that were already three months old. Now, if a KPI starts deviating in week two of a quarter, we can intervene before it becomes a major problem. (*RS-C-DI, Hospital Director*)

RS C's absence of a formal adaptive strategy mechanism was the most significant structural gap identified in that case. Without systematic performance monitoring or a structured process for strategy review, strategic divergence was identified only retrospectively through annual LAKIP

preparation, at which point corrective options were severely limited. This finding illustrates [Hrebiniak's \(2006\)](#) argument that strategy execution requires ongoing feedback loops rather than periodic post-hoc assessment.

4.5 Discussion

The findings of this study illuminate the strategy process in Indonesian public hospitals as a multi-level, politically embedded, and institutionally constrained phenomenon that cannot be adequately understood through rationalist strategic planning models alone. Four substantive discussions emerge from the cross-case analysis.

First, the pervasive bifurcation between formal and informal strategy identified across all three hospitals constitutes a theoretically significant finding that extends [Mintzberg's \(1994\)](#) strategy formation framework into the Indonesian public hospital context. The RENSTRA documents examined in this study consistently reflected isomorphic compliance with regional government planning requirements rather than genuine strategic differentiation, a pattern consistent with [DiMaggio and Powell's \(1983\)](#) coercive isomorphism. Hospital directors navigated this institutional constraint by developing parallel informal strategic agendas communicated through departmental operational plans and directors' priority directives rather than through the formal RENSTRA. This dual strategy system, while a pragmatic adaptation to institutional constraints, generates coordination costs and accountability gaps that ultimately undermine strategic effectiveness.

Second, the centrality of middle management capacity in mediating strategy implementation fidelity confirms and contextualizes [Wooldridge, Schmid, & Floyd, 2008](#) theoretical arguments in the Indonesian public hospital setting. The contrast between RS A's structured middle management development investment and RS C's reliance on informal understanding among department heads was the single most consistent predictor of cross-case implementation quality. This finding has direct implications for hospital human resource strategy: investment in middle management's strategic competencies is not an overhead cost but a prerequisite for effective strategy execution.

Third, the dual authority structure of hospital governance emerged as a fundamental structural constraint on strategy implementation, extending beyond individual leadership capability. Strategies requiring behavioral change by clinical staff are necessarily mediated through the Medical Committee and professional governance structures that operate independently of the administrative director's authority. This structural reality is not adequately accommodated in mainstream strategic management frameworks developed primarily in private-sector contexts, creating a significant theoretical gap that this study helps address.

Fourth, the strong association between performance monitoring sophistication and strategy implementation effectiveness at RS A versus RS C provides empirical support for [Hrebiniak's \(2006\)](#) argument that execution requires real-time feedback systems rather than periodic retrospective review. The BSC-based digital dashboard at RS A functioned not merely as a measurement tool but as an organizational learning mechanism that enabled early problem detection and adaptive response, consistent with the double-loop learning model of [Argyris and Schon \(1978\)](#). [Ardinata et al. \(2024\)](#) further corroborate this finding from the perspective of hospital entrepreneurship, arguing that strategic performance monitoring is inseparable from the entrepreneurial orientation of hospital leadership and that hospitals which institutionalize performance review cycles demonstrate significantly stronger capacity for strategic adaptation

and competitive sustainability.

5. Conclusion

This multiple case study has generated a contextually grounded understanding of strategy formulation and implementation processes in Indonesian public hospitals. The findings reveal that strategy in this context is shaped by a distinctive configuration of institutional isomorphic pressures, dual authority governance structures, middle management capacity constraints, and performance monitoring system quality. The gap between formal RENSTRA documents and operational strategic reality is not a failure of individual leadership but a systemic feature of the Indonesian public hospital institutional environment that demands systemic rather than individual-level interventions.

For hospital directors and boards, the findings underscore the importance of investing in middle management strategic capacity, building participatory strategy formulation processes that generate genuine departmental ownership, and establishing real-time performance monitoring infrastructures that enable adaptive strategy rather than retrospective evaluation. For regional health authorities, the findings suggest that the mandatory RENSTRA format requires reform to accommodate genuine strategic differentiation across hospitals with different organizational contexts and competitive positions. For health policy makers, the tension between civil service employment norms and the incentive alignment requirements of effective strategy implementation represents a structural reform priority.

This study has several limitations. The purposive sample of three West Java hospitals limits geographic representativeness, and the cross-sectional design captures strategy processes at a single point in time. Future research should employ longitudinal case study designs to track strategy processes across full RENSTRA cycles, extend the sample to include private, specialist, and primary care organizations, and explore the role of digital health transformation as an emerging context for public hospital strategic management in Indonesia.

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