



Integrated marketing strategy for insured outpatient care at a municipal hospital

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ABSTRACT

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Keywords:

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Background: Evidence is limited on how municipal hospital management can integrate National Health Insurance demand signals, stakeholder experience, the services marketing mix, digital marketing, and resource constraints into strategic planning for outpatient services. JKN-financed outpatient encounters decreased from 12,324 in 2021 to 11,364 in 2022 (-960; -7.79%), although total outpatient encounters increased from 18,760 to 19,445; counts represent encounters rather than unique patients. **Objective:** To develop an evidence-linked marketing strategy for JKN outpatient services at a municipal hospital. **Methods:** This qualitative single-case study integrated hospital documents, 2020–2022 administrative data, interviews, observations, and a focus group using a framework matrix, the seven-part services marketing mix, and weighted SWOT/TOWS analysis. The sample comprised 15 unique participants: three managers and 12 adult JKN outpatients. **Results:** Accreditation, competent personnel, location, and JKN eligibility were strategic assets. Referral complexity, restricted hours, parking, registration, pharmacy flow, fragmented information systems, and limited digital communication constrained access. Findings supported positioning based on dependable, inclusive care; phased service, referral, and digital initiatives are author-generated proposals requiring prospective evaluation. **Conclusion:** The study contributes an integrated planning framework but cannot attribute the observed decline to marketing. Future multicentre longitudinal studies should evaluate clinic-level demand, patient experience, waiting times, reimbursement, and incremental costs.

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1. INTRODUCTION

Indonesia's National Health Insurance (Jaminan Kesehatan Nasional, JKN) has expanded financial protection and service use, yet access to hospital care still varies with referral pathways, insurance status, geography, service availability and health need (Cheng et al.,

2025; Laksono et al., 2023a, 2023b; Maulana et al., 2022; Wulandari et al., 2023). Referral compliance and primary-care choice further shape access to hospital services (Fauziyyah et al., 2024; Handayani et al., 2021). Administrative data can inform planning, but coding incentives, data definitions and encounter-versus-patient distinctions require explicit treatment (Chalkley et al., 2022; Fatimah et al., 2025). Municipal-hospital marketing therefore concerns the ethical management of access, information, relationships and service value rather than promotion alone.

Marketing strategy here means coordinating service design, access, referral relationships, information, patient experience and resource allocation. Because clinical uncertainty, information asymmetry and patient vulnerability shape health care, communication should match what the hospital can safely and reliably deliver. The seven-part services marketing mix (product, price, place, promotion, people, process and physical evidence) supports this alignment (Zeithaml et al., 2024). For JKN, place includes referral and digital access, while price includes reimbursement and patient opportunity costs.

Provider choice reflects preferences, available alternatives, proximity, waiting time, prior experience and navigation effort; stated preferences do not always predict actual hospital use (Fauziyyah et al., 2024; Salampessy et al., 2022). Competence and empathy matter, but waiting and administrative complexity can erode confidence even when clinical care is appropriate (Ferreira et al., 2023; Zhang et al., 2023). Operational improvement and accurate communication should therefore precede demand-generating campaigns.

Bandung City Government owns Bandung Kiwari Regional General Hospital, which developed from a maternal-and-child hospital into a general hospital operating as a Regional Public Service Agency (BLUD). This model permits managerial flexibility while requiring accountability, efficiency and service-quality safeguards (Ministry of Home Affairs of the Republic of Indonesia, 2018). After full accreditation and service expansion in 2022, JKN-financed outpatient encounters fell by 7.79% while total outpatient activity increased. The contrast occurred during wider pandemic-related disruption to health-care use and cannot be explained by promotion metrics alone (Ramadani et al., 2024).

The managerial diagnosis combined stakeholder evidence with SWOT and targeting-positioning concepts. Because SWOT entries and scores are subjective planning judgments rather than causal proof, each strategic claim was linked to observed evidence, an explicit scoring convention, sequenced actions and performance indicators (Benzaghta et al., 2021).

Recent research has examined JKN utilisation, referral compliance, hospital choice, patient experience, health financing and digital communication, but these domains are usually studied separately (Asante et al., 2023; Chen & Wang, 2021; Ferreira et al., 2023; Handayani et al., 2021). Evidence also shows that insurance coverage alone does not remove geographic, informational and operational barriers (Cheng et al., 2025; Laksono et al., 2023a, 2023b). This case addresses the resulting management gap by integrating administrative demand data, stakeholder perspectives, the services marketing mix and weighted SWOT/TOWS in a phased strategy with safeguards, indicators and decision rules.

The framework links: (1) the administrative demand signal; (2) stakeholder and service-journey evidence; (3) diagnostic synthesis through the marketing mix and weighted SWOT; and (4) author-generated TOWS actions evaluated using operational, financial, equity and quality indicators. The sequence separates observed findings from proposed interventions and makes the assumptions behind each recommendation reviewable.

This study examined the hospital's outpatient marketing strategy, factors associated with JKN encounter performance, and operational, financial and institutional constraints, then developed a phased strategy integrating service quality, referral

relationships and resource stewardship. Its contribution is a case-based planning framework for improving access and visibility while protecting quality, equity and fiscal sustainability.

2. RESEARCH METHOD

Design and setting. This COREQ-informed exploratory single-case study at Bandung Kiwari Regional General Hospital integrated organisational context, service processes and stakeholder perspectives that visit counts alone could not explain (Hennink et al., 2020; Tong et al., 2007).

Participants and sampling. Maximum-variation purposive sampling included managers with direct outpatient responsibilities and adult JKN outpatients. Sources comprised hospital documents, 2020–2022 visit records, semi-structured interviews, non-participant service-journey observation and a management focus group. Document review preceded interviews and observation; the focus group validated themes and completed the strategic-factor assessment.

Participant profile and eligibility. The 15 participants were three managers (hospital director, head of medical services and head of public relations/marketing/legal affairs) and 12 adult JKN outpatients. Managers required at least one year of relevant responsibility. Eligible outpatients were clinically stable adults completing a JKN-financed visit, able to communicate in Bahasa Indonesia and provide consent; employees, urgent-care patients and those unable to complete an interview were excluded. Recruitment varied age, sex, clinic and visit status. No major new themes emerged after 10 patient interviews; two further interviews assessed stability. The same managers formed the 90-minute focus group.

Ethical approval and consent. The Universitas Pasundan Health Research Ethics Committee approved the study on 2 September 2022 (No. 061/KEPK-UP/IX/2022). All participants provided written informed consent for participation, audio-recording and the use of de-identified quotations. Identifiers were removed during transcription, and recordings and transcripts were stored in password-protected files accessible only to the research team.

Data collection procedures. From 16 January to 12 May 2023, the first author conducted individual interviews and moderated the focus group; the second author served as non-participating note-taker. Manager interviews occurred in a private meeting room and outpatient interviews after care in a separate consultation area. Interviews lasted 30–55 minutes and the focus group 90 minutes. The guide covered access, referral navigation, experience, communication and improvement priorities. Six observation sessions across registration, waiting areas, clinics and pharmacy yielded 12 hours of field notes. Bahasa Indonesia recordings were transcribed verbatim; the first author translated quotations and the second checked them. The interviewer was independent of the hospital.

Administrative visit data. The data unit extracted monthly aggregate records for January 2020–December 2022 on 9 January 2023. Completed encounters excluded cancellations, duplicates and rejected or incomplete claims. JKN encounters were reconciled with annual claims; other financing included self-pay, private insurance, employer and other government funding. Counts represent encounters, not unique patients.

Data analysis. Interview, observation and focus-group findings were organised in a framework matrix by stakeholder, service-journey stage and strategic implication (Gale et al., 2013). Recurrent issues were coded into themes, mapped to the seven-part services marketing mix and SWOT/TOWS, and triangulated across documents, managers, patients and observation. An auditable link connected themes, factors and recommendations (Nowell et al., 2017).

Trustworthiness and reliability. The first author manually coded 15 interview transcripts and one focus-group transcript using deductive service-journey and marketing-mix codes while allowing inductive additions. The second author independently coded four transcripts (25%); differences were resolved through consensus and codebook refinement. The third author audited links among quotations, themes, SWOT factors and recommendations. Reflexive notes, participant correction of end-of-session summaries and manager review of a cross-case factual summary provided further checks; no major factual correction was requested.

Weighted SWOT procedure. The three managers independently weighted factors within each domain to sum to 1.00 and assigned 1–9 strategic-condition ratings. For strengths and opportunities, higher ratings indicated greater development or exploitability; for weaknesses and threats, they indicated better-controlled constraints. Median weights were re-normalised, median ratings retained and spreads of at least two points discussed to consensus; researchers facilitated but did not vote. The hospital's established nine-point scale was retained. Weighted score equalled normalised weight multiplied by consensus rating. Higher scores indicate more favourable conditions, not importance, market size or causal effect. Domain totals are descriptive case-specific indices, not validated IFE/EFE scores; arithmetic was independently checked. The use and interpretation of SWOT followed the cautions described by Benzaghta et al. (2021).

3. RESULTS AND DISCUSSION

3.1 Visit context and stakeholder themes.

Hospital records documented 9,842 completed JKN-financed outpatient encounters in 2020, 12,324 in 2021 and 11,364 in 2022 (Table 1). From 2021 to 2022, JKN encounters fell by 960 (7.79%), while total encounters rose by 685 (3.65%) and the JKN share fell from 65.69% to 58.44% (–7.25 percentage points). These descriptive census counts represent encounters, not unique patients, and no inferential test was applied. The decrease coincided with institutional transition after a name change, service expansion and an intensive COVID-19 role. Marketing activity continued amid budget and staffing constraints; the data cannot attribute the decline to marketing rather than referral rules, competition, operating hours, service completeness, capacity or access.

Table 1. Completed outpatient encounters by financing category, 2020–2022

Year	JKN-financed encounters	Other-financing encounters	Total encounters
2020	9,842	5,640	15,482
2021	12,324	6,436	18,760
2022	11,364	8,081	19,445

Five themes were integrated across management, focus-group and patient material (Table 2): an awareness gap following the hospital's transition; referral, hours, parking, registration and pharmacy barriers; valued staff competence, empathy, communication and cleanliness; incomplete support services, fragmented systems, specialist shortages and overlapping roles; and strategic assets including accreditation, municipal support, location, JKN eligibility and digital channels.

Table 2. Triangulated themes and managerial implications

Theme	Evidence in the case	Management implication
Service transition and identity	Name change; expansion beyond maternal and child services; uneven	Communicate verified service availability and eligibility by clinic;

Access and patient effort	public awareness of new clinics. Tiered referral requirements, restricted hours, parking limits, underused online registration and pharmacy bottlenecks.	avoid generic image campaigns. Treat referral navigation, scheduling, registration and throughput as core marketing processes.
Experience quality	Patients described competent, courteous and empathic staff, clean rooms and generally adequate facilities.	Protect relational quality and use patient experience as credible evidence for positioning.
Capacity and integration	Incomplete support services, limited specialists, fragmented information systems and role overlap.	Match demand generation to operational capacity; integrate information and workforce planning.
Institutional and digital assets	Full accreditation, municipal support, strategic location, JKN participation, social media and partnership activity.	Use trusted assets for targeted referral-partner and patient communication, with measurable conversion.

3.2 Weighted strategic-factor assessment

The opportunity condition index was 5.55 and the threat-management condition index 2.80 (Table 3). Leading opportunities were health-insurance use (1.75), social-media access (1.50) and government support (0.90); the weakest threat-management ratings concerned JKN contribution affordability and policy change (rating 1) and better-equipped competitors (rating 2). These case-specific judgments are not causal effects, market-size estimates or statistical risks; the COVID-19 item reflects the 2022 planning context.

Table 3. External strategic-condition indices

Factor	Weight	Rating (1-9)	Weighted score
Opportunities			
Dense urban catchment	0.05	4	0.20
Population growth	0.15	3	0.45
High use of health insurance, especially JKN	0.25	7	1.75
Greater propensity to seek hospital care	0.15	5	0.75
Government support for health services	0.15	6	0.90
Expanding social-media access	0.25	6	1.50
Opportunity condition index	1.00		5.55
Threats			
Changing government regulation	0.10	5	0.50
Hospitals with more complete facilities	0.25	2	0.50
Competitors with stronger marketing capability	0.10	6	0.60
Rising public expectations	0.10	3	0.30
JKN contribution affordability and policy changes	0.30	1	0.30
COVID-19 disruption in the study period	0.15	4	0.60
Threat-management condition index	1.00		2.80

The strength condition index was 5.85 and the corrected weakness-management index 3.10 (Table 4). Leading strengths were JKN eligibility (2.00), competent personnel (1.40) and accreditation (1.00); key weaknesses were incomplete support services, limited digital use and constrained facilities. The source table reported 2.80, but its six displayed weakness scores sum to 3.10. The pattern supports improvement, not divestiture without separate legal, service-need and economic appraisal.

Table 4. Internal strategic-condition indices

Factor	Weight	Rating (1-9)	Weighted score
Strengths			
Hospital vision, mission and objectives	0.10	4	0.40
Competent and standardised personnel	0.20	7	1.40
Competitive tariffs	0.15	5	0.75
Service to all social groups	0.10	3	0.30

Full hospital accreditation	0.20	5	1.00
Eligibility to serve JKN patients	0.25	8	2.00
Strength condition index	1.00		5.85
Weaknesses			
Incomplete or suboptimal supporting services	0.30	2	0.60
Incomplete public amenities	0.10	4	0.40
Information systems not fully integrated	0.05	5	0.25
Marketing role not yet optimal	0.10	5	0.50
Limited use of digital technology in patient services	0.25	3	0.75
Limited care-service facilities	0.20	3	0.60
Weakness-management condition index	1.00		3.10

Note. The weakness total was recalculated from the displayed items: $0.60 + 0.40 + 0.25 + 0.50 + 0.75 + 0.60 = 3.10$.

Empirical findings comprised encounter counts, stakeholder themes, observations, documents and local strategic-condition indices. The evidence-linked TOWS strategy (Table 5), roadmap and indicators are author-generated recommendations requiring prospective testing. Capital-intensive or geographically expanded services should proceed only after formal demand, cost, workforce, clinical, regulatory and reimbursement appraisal.

3.3 TOWS synthesis and proposed strategic priorities

Table 5. Proposed evidence-linked TOWS strategy

Strategic fit	Evidence-linked strategy	Safeguard
Strengths-opportunities	Communicate verified clinic services through referral partners, the website and social media.	Publish current schedules, eligibility and capacity; track referrals and completed visits.
Weaknesses-opportunities	Integrate service information; redesign registration and pharmacy flow; pilot selected extended hours.	Pilot before scaling; monitor waits, staffing cost, no-shows and experience.
Strengths-threats	Compete on reliable access, respectful care and continuity; maintain referrer communication.	Avoid unavailable-service claims; maintain clinical governance and referral compliance.
Weaknesses-threats	Use phased investment, workforce development and regulatory review; appraise service additions.	Require a business case, equity assessment and operational-risk review.

Note. TOWS = matching strengths and weaknesses with opportunities and threats. Recommendations are sequenced in Table 6.

3.4 Services marketing and management-economics interpretation

Product and process. The service product is a reliable outpatient episode, requiring aligned diagnostics, pharmacy, scheduling, staffing and referral eligibility. Verified service information and process redesign should precede broad demand generation; patient experience and waiting-time evidence should be treated as quality signals rather than promotional claims (Donabedian, 1988; Ferreira et al., 2023; Zhang et al., 2023). **Price and public value.** Patients incur travel, waiting and administrative costs, while the hospital must assess reimbursement, coding quality, resource use, capacity, equity and clinical quality alongside volume (Asante et al., 2023; Chalkley et al., 2022; O'Connell et al., 2025; Susilo et al., 2025). BLUD flexibility should therefore maximise equitable, dependable care rather than revenue alone. **Place and promotion.** Referral relationships, appointments, physical access and digital navigation jointly shape distribution. Governed digital communication can reduce uncertainty, but information must remain current, protect privacy and complement assisted access for patients affected by limited literacy, connectivity or interoperability (Chen & Wang, 2021; Farsi, 2021; Galea et al., 2024; Handayani et al., 2021; World Health Organization, 2024).

People and physical evidence. Courteous staff, clear explanations and clean facilities support a credible service position, while registration, pharmacy flow, parking and waiting require sustained redesign and measurement. The proposed indicators therefore combine access, experience, cost and quality instead of relying on visit volume alone (Ferreira et al., 2023; Zhang et al., 2023).

Comparison and contribution. The findings align with evidence that insurance status, geography, referral pathways, service availability, prior experience and waiting influence care use and provider choice (Cheng et al., 2025; Fauziyyah et al., 2024; Laksono et al., 2023a, 2023b; Salampessy et al., 2022; Wulandari et al., 2023). The case extends that evidence by placing those mechanisms in one planning sequence and by explicitly separating observed findings from recommendations. It does not claim that marketing caused the decline in JKN encounters. Segmentation, targeting and positioning. Segmentation should use clinical need, referral source, access barrier and preferred communication channel, not ability to pay. Initial targets are eligible patients for clinics with verified capacity and primary-care referrers needing accurate schedules and eligibility information. The supported position is a dependable, inclusive and accredited municipal referral hospital rather than a technology leader, and should be assessed through referral conversion, completed eligible encounters, waiting time, patient experience, cost and equity. Digital and capital investment. Telemedicine may support follow-up or navigation, but defined use cases, usability, clinical suitability, privacy, connectivity, workflow and reimbursement should be assessed before expansion (Kruse & Heinemann, 2022; Oudbier et al., 2024). The same feasibility standard applies to capital-intensive services or equipment. New investment should proceed only when a documented business case demonstrates demand, workforce readiness, clinical governance, affordability and public value.

Table 6. Proposed phased implementation and evaluation roadmap

Phase	Priority actions	Core indicators	Decision rule
0-3 months	Validate schedules and eligibility; map referrers; standardise digital information; establish a baseline.	Visits and referrals by source; registration completion; baseline waits.	Proceed with accurate information, stable definitions and accountable owners.
3-6 months	Redesign registration and pharmacy flow; target referrers; test assisted digital access and feedback.	Clinic and prescription waits; abandonment; complaints; satisfaction; conversion.	Scale access gains that preserve safety and avoid unfunded workload.
6-12 months	Pilot selected extended hours; integrate scheduling and information; train staff.	Incremental visits; overtime; session use; no-shows; cost per eligible visit.	Continue when benefit and reimbursement justify recurring resources.
12-24 months	Appraise new services or equipment for demand, equity, clinical, workforce, regulatory and financial fit.	Budget impact; capacity; outcomes; equity of access; implementation risk.	Invest after a documented business case and clinical-governance approval.

Note. Indicators should be disaggregated by clinic and, where feasible, by referral source and patient-access group. Causal impact requires a stronger prospective design.

3.5 Limitations

This single-hospital qualitative case uses a small purposive sample and is analytically, not statistically, generalisable. Senior management perspectives may overrepresent organisational interpretations, while post-care interviews may introduce selection and courtesy biases. Aggregate annual encounters cannot distinguish unique patients or clinic-level trends, and the descriptive 7.79% before–after change lacks a counterfactual to separate marketing from referral rules, service supply, competition or the pandemic. The locally generated 1–9 ratings are ordinal judgments from three

managers rather than a validated IFE/EFE scale and may reflect shared assumptions. Future research should use multicentre longitudinal or interrupted-time-series designs with transparent sampling, reflexivity reporting, clinic-level referral and visit data, patient-experience and waiting-time measures, and prospective cost, reimbursement and equity analyses.

4. CONCLUSION

The 7.79% decline in JKN-financed outpatient encounters at Bandung Kiwari Regional General Hospital cannot be attributed to marketing because the study was descriptive and lacked a counterfactual. The evidence instead indicates that service availability, referral communication, patient effort, waiting time, digital navigation and operational capacity should be considered together. The study contributes an integrated case framework linking an administrative demand signal and stakeholder evidence to the services marketing mix, weighted SWOT/TOWS and public-value resource stewardship. Its practical implication is to verify access information and capacity, reduce patient-flow and referral friction, and test targeted interventions against operational, financial, quality and equity indicators before wider investment. The single-site design, purposive sampling, aggregate encounter data and locally generated ordinal scores limit causal inference and transferability; the proposed strategy should therefore be treated as testable management hypotheses rather than demonstrated effects. Future research should compare hospitals or clinics prospectively using clinic- and referral-level longitudinal data, patient-experience measures, budget impact and equity analyses.

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