

Business Process Reengineering in Indonesian Public Hospitals: A Multiple Case Study

Guruh Satriya^{1*}, Mei Vita Ariyani², Melina Budiarti³, Mira Veranita⁴

¹²³⁴Universitas Adhirajasa Reswara Sanjaya

Corresponding author: guruhsatriya13@gmail.com^{1*}, drmeivita23@gmail.com²,
budiartimelina1987@gmail.com³, mira.veranita@ars.ac.id⁴

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Abstract

Business Process Reengineering (BPR) represents a radical and fundamental strategy for improving organizational performance in healthcare settings, yet its implementation dynamics in Indonesian public hospitals remain insufficiently understood. This study employs a qualitative multiple case study design to explore how BPR is implemented across three Type B public hospitals in Indonesia, referred to pseudonymously as RS Alpha, RS Beta, and RS Gamma. Data were collected through 27 in-depth interviews with hospital directors, clinical department heads, administrative managers, and frontline healthcare staff, supplemented by document analysis and non-participant observation conducted over a six-month period. Thematic analysis following Braun and Clarke (2006) revealed four overarching themes: (1) enabling conditions for BPR adoption, (2) process redesign and IT integration challenges, (3) human resource dimensions of BPR implementation, and (4) organizational outcomes and sustainability of reengineered processes. Findings indicate that leadership commitment and change management capacity are pivotal determinants of BPR success, while resistance from clinical staff, inadequate IT infrastructure, and bureaucratic rigidity constitute the primary barriers. Cross-case comparison reveals that hospitals with stronger human resource development programs achieved more sustainable process improvements. The study contributes an empirically grounded, context-sensitive understanding of BPR in Indonesia's public health sector, with implications for hospital management and health system reform policy.

Keywords: Business Process Reengineering, Qualitative Case Study, Hospital Management, Change Management, Indonesia

1. Introduction

Healthcare organizations in Indonesia operate within an increasingly complex institutional environment shaped by the demands of the National Health Insurance (JKN) program, national hospital accreditation requirements, and rapid technological advancement ([Kemenkes RI, 2022](#)). Public hospitals, particularly those at the Type B level serving regional populations, confront persistent challenges of process inefficiency,

prolonged patient waiting times, fragmented inter-departmental coordination, and suboptimal human resource utilization. These systemic challenges demand not incremental adjustment but fundamental organizational transformation.

Business Process Reengineering (BPR), originally articulated by [Hammer and Champy \(1993\)](#) as the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical measures of performance, offers a compelling framework for addressing these challenges. Unlike continuous improvement approaches such as Total Quality Management, BPR advocates a holistic, cross-functional redesign of organizational processes, enabled by information technology and driven by a customer-centric value orientation ([Davenport, 1993](#)). In the hospital context, BPR has been applied to patient registration systems, clinical pathway redesign, supply chain optimization, and administrative process automation ([Nazaria et al, 2024](#); [Veranita & Purwanto, 2023](#)).

Despite a growing international body of literature on BPR in healthcare ([Locock, 2003](#); [Teng et al., 2020](#)), qualitative investigation of how BPR unfolds as an organizational process in the Indonesian public hospital context remains scarce. Existing quantitative studies capture outcomes but are less able to illuminate the social, cultural, and institutional dynamics that shape implementation processes. The experiences of hospital directors, clinical staff, and administrative personnel who navigate BPR implementation remain largely absent from the published literature. This study addresses that gap.

The central research question guiding this study is: How is BPR implemented in Indonesian public hospitals, and what factors enable or constrain its success? Sub-questions include: (1) What organizational conditions precipitate the decision to adopt BPR? (2) How do hospitals manage the human resource dimensions of BPR? (3) What outcomes and challenges emerge across different hospital contexts? The findings are intended to generate theoretically grounded, practically applicable insights for hospital administrators, health policy makers, and scholars of organizational change in healthcare settings.

This study aims to: (1) explore the enabling and constraining conditions for BPR implementation in Indonesian public hospitals; (2) examine the human resource and change management dimensions of BPR processes; (3) identify the organizational outcomes and sustainability challenges of BPR across multiple hospital contexts; and (4) develop a contextually grounded understanding of BPR dynamics that extends existing theoretical frameworks.

2. Literature Review

2.1 Business Process Reengineering: Conceptual Foundations

BPR emerged in the early 1990s as a radical departure from incremental process improvement paradigms. [Hammer \(1990\)](#) introduced the concept in a seminal Harvard Business Review article advocating the elimination of non-value-adding work rather than its automation, a provocative proposition later elaborated in the canonical text by [Hammer and Champy \(1993\)](#). [Davenport \(1993\)](#) provided a complementary perspective emphasizing information technology as an enabler of process innovation, while [Zairi and Sinclair \(1995\)](#) identified the alignment of strategy, process, people, and technology as the critical success factor for BPR.

The principal dimensions of BPR have been variously conceptualized in the literature.

Drawing on [Hammer and Champy \(1993\)](#), [Davenport \(1993\)](#), and [Al-Mashari and Zairi \(1999\)](#), four core dimensions can be identified: process redesign, referring to the fundamental reconceptualization of workflow and activity sequences; information technology integration, encompassing the deployment of hospital information systems and electronic health records; organizational restructuring, involving changes to departmental boundaries and authority structures; and change management, comprising leadership, communication, training, and resistance management strategies. [Kusharini et al. \(2024\)](#) further confirm through systematic literature analysis that these dimensions operate interdependently rather than sequentially in healthcare BPR.

Critics of BPR have noted its tendency toward implementation failure when applied mechanistically without sensitivity to organizational culture and professional identity ([Locock, 2003](#)). In healthcare specifically, the professional autonomy of clinical staff, the inherently non-standardizable nature of patient care, and the public sector accountability environment create distinctive implementation challenges that distinguish hospital BPR from its manufacturing or financial services counterparts ([Walston & Kimberly, 1997](#)).

2.2 BPR in Healthcare: International and Indonesian Evidence

International evidence on BPR in healthcare is mixed but broadly supportive of its potential when implemented with adequate change management support. [Walston and Kimberly \(1997\)](#) documented significant reductions in administrative cycle times in US hospitals post-BPR, while [Teng et al. \(2020\)](#) demonstrated that IT-enabled BPR improved patient throughput and clinical decision support in Southeast Asian tertiary hospitals. [Nazaria et al. \(2024\)](#) synthesized evidence from Indonesian hospital settings, identifying patient registration simplification, pharmaceutical supply chain redesign, and clinical pathway standardization as the most commonly reengineered processes.

In the Indonesian context, the implementation of BPR in public hospitals intersects with broader health system reform dynamics, including the transition to the INA-CBGs payment system under JKN, the mandatory implementation of Hospital Management Information Systems (SIMRS) under Ministerial Regulation No. 1171/MENKES/PER/VI/2021, and the Paripurna hospital accreditation framework. [Veranita and Purwanto \(2023\)](#) found that BPR implementation in Indonesian service organizations significantly improved service quality perceptions across reliability and responsiveness dimensions, while [Rahayu, Purwadhi, and Veranita \(2025\)](#) documented how process optimization strategies at a West Java public hospital produced tangible improvements in JKN claim accuracy and processing efficiency.

2.3 Human Resource Dimensions of BPR

The human resource dimension of BPR is consistently identified as both its most critical enabler and its most common point of failure. [Hammer and Stanton \(1995\)](#) emphasized that BPR requires a fundamental shift in employee roles, skills, and mindsets, from task performers to process owners. This transition demands substantial investment in training and development, as well as alignment of performance management and incentive systems with redesigned processes ([Heskett et al., 1994](#)).

Resistance to BPR is a pervasive phenomenon, particularly in professional organizations such as hospitals where staff possess high occupational identity and specialized expertise ([Locock, 2003](#)). Effective change management, encompassing participatory process

design, transparent communication, and visible leadership commitment, has been identified as the primary strategy for managing resistance ([Al-Mashari & Zairi, 1999](#)). [Efawati et al. \(2025\)](#) found that digital literacy mediated the relationship between digital transformation and organizational resilience, suggesting that human capital development is a critical precondition for sustainable process change in Indonesian organizational contexts.

2.4 Theoretical Framework

This study is guided by three complementary theoretical lenses. First, [Hammer and Champy's \(1993\)](#) BPR framework provides the primary analytical scaffold, directing attention to the four implementation dimensions described above. Second, [Kotter's \(1996\)](#) eight-stage change model informs analysis of the change management process, particularly the sequencing of urgency creation, coalition building, vision communication, and institutionalization. Third, [Barney's \(1991\)](#) Resource-Based View (RBV) underpins analysis of organizational capabilities as determinants of BPR sustainability, drawing attention to the tacit, path-dependent knowledge and routines that constitute durable competitive advantage in healthcare settings.

3. Research Method

3.1 Research Design

This study adopts a qualitative multiple case study design, following [Yin's \(2018\)](#) replication logic in which multiple cases serve to either predict similar results (literal replication) or produce contrasting results for predictable reasons (theoretical replication). The multiple case design was selected in preference to a single case because it enables cross-case comparison, strengthens the transferability of findings, and reduces the risk of idiosyncratic case-specific explanations. An interpretivist epistemological stance was adopted, consistent with the study's aim of understanding subjective meanings, social processes, and contextual dynamics rather than establishing causal laws ([Creswell & Poth, 2018](#)).

3.2 Case Selection

Three Type B public hospitals in Indonesia were selected through purposive sampling based on the following criteria: (1) documented engagement with BPR or equivalent process improvement initiatives within the preceding three years; (2) accreditation status of Paripurna or Utama under SNARS Ed. 1.1; (3) presence of a functioning Hospital Management Information System (SIMRS); and (4) willingness to participate in the study. The hospitals are referred to pseudonymously as RS Alpha (a 300-bed urban district hospital), RS Beta (a 250-bed semi-urban referral hospital), and RS Gamma (a 350-bed provincial referral hospital). Table 1 presents an overview of the case sites.

Table 1. Overview of Case Study Sites

Characteristic	RS Alpha	RS Beta	RS Gamma
Type	Type B Public	Type B Public	Type B Public
Bed Capacity	300 beds	250 beds	350 beds
Location	East Kalimantan	South Kalimantan	East Java
Accreditation	Paripurna	Utama	Paripurna
BPR Focus Area	Patient registration &	Clinical pathway	Supply chain &

	pharmacy	redesign	HRM
SIMRS Status	Fully integrated	Partially integrated	Fully integrated
BPR Duration	2.5 years	1.5 years	3 years
No. of Informants	9	8	10

3.3 Data Collection

Data were collected through three primary methods. First, 27 semi-structured in-depth interviews were conducted with key informants across the three hospitals, comprising hospital directors and deputy directors (n=6), clinical department heads (n=9), quality and accreditation managers (n=6), and frontline staff (nurses, administrative personnel) (n=6). Interview guides were developed based on the theoretical framework and refined through two pilot interviews. Interviews lasted between 45 and 90 minutes and were conducted in Bahasa Indonesia with audio recording and verbatim transcription. Informant codes are used throughout to protect confidentiality (e.g., RS-A-D1 = RS Alpha, Director 1). Second, document analysis was conducted on hospital strategic plans, BPR implementation reports, standard operating procedure (SOP) revisions, accreditation documentation, and internal performance data. Third, non-participant observation of operational processes was conducted at each site over a two-week period per hospital.

3.4 Data Analysis

Data were analyzed using [Braun and Clarke's \(2006\)](#) reflexive thematic analysis, proceeding through six phases: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Atlas TI version 9 was used to support systematic coding and retrieval. Cross-case analysis followed [Miles, Huberman, and Saldana's \(2014\)](#) within-case and cross-case display matrix approach to identify patterns, divergences, and rival explanations across the three sites. Trustworthiness was established through prolonged engagement, member checking with five key informants, peer debriefing, and an audit trail documenting methodological decisions.

4. Findings and Discussions

Analysis of interview transcripts, documents, and observational fieldnotes generated four overarching themes that cut across the three case sites, each with distinct sub-themes reflecting within-case and cross-case variation. Table 2 provides an overview of the thematic structure.

Table 2. Thematic Structure of Findings

Theme	Sub-themes	Cases
1. Enabling Conditions for BPR Adoption	Accreditation pressure; JKN payment reform; Leadership vision	All three
2. Process Redesign and IT Integration Challenges	Workflow mapping; SIMRS limitations; Inter-departmental resistance	RS Alpha, RS Gamma (stronger); RS Beta (partial)
3. Human Resource Dimensions of BPR	Staff competency gaps; Training programs; Incentive misalignment; Resistance patterns	All three (varied intensity)

4. Outcomes and Sustainability	Service quality improvements; Efficiency gains; Fragility of change; Institutionalization	RS Alpha, RS Gamma (sustained); RS Beta (partial)
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Source: Thematic analysis of field data (2026).

4.1 Enabling Conditions for BPR Adoption

Across all three hospitals, BPR initiatives were precipitated by a convergence of external pressures and internal leadership vision rather than by a single trigger. The most consistently cited external driver was the accreditation process, particularly the SNARS Ed. 1.1 Requirements for documented process standardization and continuous improvement evidence. As the Director of RS Alpha explained:

When we began the Paripurna journey, we realized that accreditation was not just about documents. The surveyors were asking us to show how we had fundamentally changed our processes, not just written new SOPs. That was the moment we understood we needed BPR, not just TQM. *(RS-A-DI, Hospital Director)*

The shift to INA-CBGs tariff payments under JKN was the second major external driver, creating financial pressure to reduce service delivery costs while maintaining quality. The Deputy Director of RS Gamma articulated this tension directly:

Under JKN, we receive a fixed tariff per diagnostic group. If our processes are inefficient, we absorb the loss. BPR was not optional for us. It was a financial survival strategy. *(RS-G-DDI, Deputy Director for Operations)*

Internal enabling conditions centred on the presence of a visionary and operationally engaged hospital director, the existence of a dedicated process improvement team, and prior organizational experience with quality management systems. RS Beta, which achieved the least comprehensive BPR outcomes, was the only site where the director had been in post for less than one year at the time of BPR initiation, limiting the accumulation of organizational trust and political capital necessary for radical change.

4.2 Process Redesign and IT Integration Challenges

All three hospitals undertook patient registration process redesign as their initial BPR focus, consistent with findings by [Nazaria et al. \(2024\)](#) that registration represents the most commonly reengineered hospital process in Indonesia. RS Alpha successfully reduced patient registration time from an average of 47 minutes to 12 minutes through a combination of online pre-registration, queue management system integration with SIMRS, and the elimination of three redundant verification steps. The Quality Manager at RS Alpha described the redesign process:

We mapped every step. We counted the handoffs. There were eleven handoffs in the old registration process, and only three of them added any value for the patient. We eliminated eight steps. The resistance was enormous at first. Staff felt their roles were being erased. *(RS-A-QMI, Quality and Accreditation Manager)*

IT integration emerged as both an enabler and a significant constraint across all sites. RS Alpha and RS Gamma, both operating fully integrated SIMRS, were able to automate data flows across registration, pharmacy, billing, and clinical documentation, substantially reducing manual transcription errors and inter-departmental communication

delays. RS Beta's partially integrated SIMRS, however, created persistent bottlenecks at the interface between clinical and administrative modules, limiting the scope of achievable process redesign. A department head at RS Beta noted:

The system cannot talk to the pharmacy module. Every prescription still requires a paper copy to accompany the electronic entry. We have digitized the work, but we have not yet eliminated the paper. That is not BPR. That is just expensive inefficiency. *(RS-B-CH2, Clinical Department Head, Internal Medicine)*

4.3 Human Resource Dimensions of BPR

Human resource factors emerged as the most decisive determinants of BPR success across all three sites, consistent with the theoretical arguments of Hammer and Stanton (1995) and the empirical findings of [Efawati et al. \(2025\)](#). Three sub-themes were prominent: staff competency gaps and training responses, incentive misalignment, and resistance patterns.

Staff competency gaps in digital literacy and process thinking were identified at all three hospitals, but responses varied markedly. RS Alpha and RS Gamma implemented structured competency development programs prior to BPR rollout, including process mapping training for department heads, IT literacy modules for administrative staff, and change champion programs embedding process improvement advocates within each clinical unit. RS Beta relied primarily on vendor-led system training without accompanying process redesign capacity building, resulting in superficial technology adoption without genuine workflow transformation.

Incentive misalignment was identified as a systemic barrier across all sites. Under the existing civil servant compensation structure (remunerasi PNS), productivity gains achieved through BPR did not generate commensurate financial benefits for frontline staff, undermining motivation for sustained process change. The HR Director of RS Gamma articulated this structural tension:

We redesigned the process. Efficiency improved. But the nurse who made the process more efficient received the same salary as before. We need to redesign the incentive system alongside the operational system. BPR without HR reform is incomplete. *(RS-G-HRD1, Human Resources Director)*

Resistance patterns were most pronounced among senior physicians and specialized clinical staff who perceived BPR as an administrative imposition threatening clinical autonomy. Successful cases (RS Alpha, RS Gamma) managed this resistance through early involvement of clinical opinion leaders in process redesign, explicit framing of BPR as patient safety and quality improvement rather than cost reduction, and visible endorsement from the medical committee.

4.4 Organizational Outcomes and Sustainability

Cross-case comparison revealed significant variation in both the nature and sustainability of BPR outcomes. Table 3 summarizes key documented outcomes across the three hospitals.

Table 3. Summary of BPR Outcomes Across Case Sites

Outcome Indicator	RS Alpha	RS Beta	RS Gamma
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Patient registration time	47 min to 12 min	51 min to 38 min	43 min to 15 min
Bed occupancy rate (BOR)	72% to 81%	68% to 71%	75% to 84%
JKN claim rejection rate	8.2% to 2.1%	7.6% to 5.8%	9.1% to 1.9%
Drug procurement cycle time	14 days to 7 days	16 days to 13 days	15 days to 6 days
Patient satisfaction score (IKM)	76.4 to 88.2	74.1 to 79.6	77.3 to 90.1
Staff training hours (annual)	12 to 48 hours	12 to 22 hours	16 to 56 hours
Process sustainability (self-assessment)	High	Moderate-Low	High

Source: Hospital administrative records and interview data (2026)

RS Alpha and RS Gamma demonstrated substantially more robust outcomes across all indicators, with particularly striking reductions in JKN claim rejection rates reflecting the redesign of clinical documentation and coding processes. RS Beta's more modest improvements are consistent with its fragmented IT integration and less systematic change management approach.

Sustainability of reengineered processes was the most pressing concern articulated by informants across all sites. Institutionalization of new processes required not only updated SOPs but ongoing monitoring through process performance dashboards, integration of process compliance into performance appraisal systems, and periodic process review cycles. The Quality Manager at RS Gamma described their sustainability mechanism:

We built a BPR maintenance committee that meets monthly. Every quarter, we review the process metrics dashboard. If a process indicator falls below the target, we trigger a rapid review. BPR is not a project with an end date. It is a permanent organizational discipline. *(RS-G-QM1, Quality and Accreditation Manager)*

5. Discussion

The findings of this study illuminate several dimensions of BPR implementation in Indonesian public hospitals, extending and nuancing existing theoretical frameworks. Four key discussions emerge from the cross-case analysis.

First, the primacy of external institutional pressures as triggers for BPR adoption is a distinctive feature of the Indonesian public hospital context. Unlike private sector organizations, where BPR is often driven by competitive market dynamics, public hospitals in this study were propelled principally by regulatory and accreditation imperatives. This finding resonates with institutional theory ([DiMaggio & Powell, 1983](#)), which distinguishes coercive, mimetic, and normative isomorphism as mechanisms of organizational change. The JKN and SNARS frameworks constitute powerful coercive isomorphic pressures that create an institutional mandate for process reengineering, a dynamic not adequately captured in most BPR frameworks developed in market economy contexts.

Second, the findings strongly confirm the centrality of human resource factors in BPR success, consistent with [Hammer and Stanton \(1995\)](#), [Locock \(2003\)](#), and Efawati et al.

(2025). However, this study contributes a more granular understanding of how HR dimensions operate differently across professional groups. The contrast between the successful physician engagement strategies at RS Alpha and RS Gamma and the unresolved clinical resistance at RS Beta suggests that profession-specific change management strategies, rather than uniform organizational approaches, are required in hospital BPR. The framing of BPR as a patient safety initiative rather than an efficiency program was particularly effective in engaging clinical staff whose professional identity centres on patient welfare rather than organizational productivity.

Third, IT infrastructure readiness emerged as a necessary but insufficient condition for BPR. RS Beta's experience demonstrates that the presence of a SIMRS does not automatically enable process reengineering; it is the integration, interoperability, and user competency dimensions of IT deployment that determine BPR enablement. This finding aligns with [Teng et al. \(2020\)](#) and extends it by showing that partial IT integration can create additional complexity and resistance rather than enabling simplification.

Fourth, the sustainability challenge identified across all three sites points to a critical gap in the BPR literature: most frameworks focus on implementation processes and immediate outcomes but provide limited guidance on institutionalization and long-term maintenance of reengineered processes. The BPR maintenance committee model employed by RS Gamma, combining structured performance monitoring with responsive review cycles, represents an indigenous organizational innovation worthy of further investigation and potential diffusion across the Indonesian hospital sector.

5. Conclusion

This multiple case study has generated an empirically grounded understanding of BPR implementation dynamics in Indonesian public hospitals. The findings establish that BPR in this context is shaped by a distinctive constellation of institutional pressures, human resource dynamics, IT infrastructure conditions, and leadership factors. Cross-case comparison reveals that leadership commitment, systematic change management, IT integration quality, and competency development investment are the primary determinants of BPR depth and sustainability.

For hospital administrators, this study underscores the necessity of treating BPR as an integrated organizational transformation program rather than a discrete technical project. The alignment of process redesign with HR reform, including incentive restructuring, competency development, and professional engagement strategies, is essential for achieving sustainable outcomes. For health policy makers, the findings suggest that BPR capacity development should be incorporated into hospital accreditation standards, JKN provider capacity requirements, and hospital leadership development programs.

This study has several limitations. The purposive selection of three hospitals limits geographic and contextual diversity, and the reliance on self-reported data from hospital personnel may introduce social desirability bias. Future research should extend the multiple case design to hospitals in Eastern Indonesia and private hospital settings, and employ longitudinal designs to track BPR sustainability over extended time horizons. A cross-sectoral comparative study examining BPR dynamics across hospitals, primary health centers (Puskesmas), and specialist clinics would further enrich the contextual evidence base.

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