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Implementation of the Policy on Periodic Health Examinations Based on Equal Access for National Police Personnel at the Polda Metro Jaya

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Abstract: This study analyzes the implementation of the periodic health examination policy for Indonesian National Police personnel at the Polda Metro Jaya, examines the extent of equitable access, and identifies factors that prevent full equity. The study employed a qualitative approach with a case study design. Data were collected through in-depth interviews with eleven informants comprising three key and eight supporting informants, supplemented by a comprehensive document review. Data analysis involved data reduction, data presentation, conclusion drawing, and source and method triangulation. The analytical framework utilizes Grindle's policy implementation theory, Whitehead's health equity theory, and Rawls's theory of justice. Research findings indicate that the policy implementation mandated by the Regulation of the Chief of the Indonesian National Police Number 7 of 2013 has not proceeded optimally. Key obstacles include the absence of integrated personnel health history data, budget constraints limiting examination quotas, uneven distribution of healthcare personnel, limited healthcare facilities, the lack of a dedicated Hospital for the Polda Metro Jaya, and target-selection mechanisms that fail to provide equal opportunities for all members. From Whitehead's perspective, these conditions reflect avoidable and remediable inequities in access. Viewed through Rawls's lens, they demonstrate a failure to fully realize the principle of fair equality of opportunity. Based on Grindle's framework, the implementation process is shaped by the interplay between policy content and context. This study proposes an "Access-Equity-Based Model for Periodic Health Examination Policy Implementation," integrating policy implementation, equitable access, and justice principles to enhance evaluation effectiveness, contribute to public administration, and refine future police health policies.

Keywords: Policy Implementation, Periodic Health Check-Ups, Equitable Access, Health Equity.

INTRODUCTION

Policing is a profession characterized by high levels of physical, mental, and social stress. Members of the Indonesian National Police must operate in unpredictable environments, facing security risks, heavy operational burdens, intense psychological pressure, and a 24-hour readiness schedule, while contending with ever-increasing societal expectations. Under these conditions, personnel health is no longer merely a matter of individual well-being; it is a fundamental prerequisite for sustaining the police organization's capacity to maintain domestic security, uphold law enforcement, and provide protection, guidance, and service to the public. Various studies indicate that the policing profession carries a higher risk of health issues compared to other professions. Hartley et al. (2011) demonstrated that the prevalence of hypertension, obesity, and sleep disorders is significantly higher among police officers than in other professions.

In modern police organizations, personnel health can no longer be viewed merely as a matter of medical treatment or individual healthcare services. The health of members is an integral component of institutional governance that determines the organization's capacity to sustain operational continuity, the quality of public service, and long-term institutional stability. Police organizations facing high operational demands require human resources that are not only professional and skilled but also physically, mentally, and socially healthy. Within the realm of public policy, the Indonesian National Police Chief's Regulation serves as a broad, strategic internal health policy designed to safeguard the force's human resources. This policy aims not only to treat ailing members but also to establish systems for prevention, early detection, health maintenance, and ongoing protection for the personnel who serve as the primary agents of the state's domestic security functions; indeed, the health of police personnel cannot be treated solely as an individual medical issue, but rather as a vital element of the institution's internal public policy implementation.

This study focuses on Indonesian National Police officers, as they constitute the majority of the workforce—comprising over 80 percent of total personnel—compared to civilian staff. Empirical data from the Polda Metro Jaya indicates a total workforce of 28,684 in 2024; however, only 7,142 officers (approximately 24.9%) underwent periodic health check-ups, including those required for educational selection processes. This reveals that the implementation gap in Polri's health policy is not merely an administrative issue but has resulted in structural inequality regarding access. Furthermore, that same year saw 50 personnel suffering from chronic illnesses and 78 passing away before reaching retirement age. These figures demonstrate that the majority of officers—around 75%—lack access to preventive health services, despite such access being normatively guaranteed by organizational policy.

The situation highlights a disconnect between normative rights and actual access. While regulations designate periodic health check-ups as a right for all officers without exception, in practice, not everyone enjoys equal opportunity to access these services. Factors such as limited check-up quotas, the distribution of health facilities, medical personnel capacity, and operational constraints—including the need to attend to other community-related duties—result in unequal access, favoring certain groups or units over others. This inequality also manifests as disparities across different regions and organizational levels. Personnel stationed at the Regional Police level or near health facilities generally enjoy better access than those at the Resort Police or Sector Police levels, or in remote areas like the Thousand Islands Resort Police. Similarly, officers with heavy operational workloads often face time and opportunity constraints that prevent them from undergoing periodic health check-ups. Ultimately, this situation illustrates that formal equality of rights does not automatically translate into substantive equality of access.

The low coverage of periodic health check-ups, alongside the continued prevalence of chronic illnesses and personnel deaths prior to retirement age, underscores the importance of

strengthening promotive, preventive, and early detection functions within the National Police personnel health protection system. In this study, these data serve as indicators of policy urgency rather than proof that low participation in periodic check-ups is the direct cause of chronic disease or death; establishing a causal link between periodic check-ups and health outcomes requires a different research design—such as a longitudinal or cohort study—that connects individual examination histories with risk factors, diagnoses, lifestyle, age, duty type, comorbidities, and health outcomes over a specific period.

The low rates of periodic health check-ups and the high incidence of chronic illness and pre-retirement mortality must be viewed through the lens of policy implementation, as the core issue lies not in a lack of regulations but in the gap between policy design and implementation capacity. Grindle (1980) posits that successful policy implementation hinges on two primary aspects: policy content and implementation context. In the case of the Polda Metro Jaya, the low coverage of periodic check-ups reflects suboptimal implementation capacity regarding Polri health policies—a situation driven by resource constraints, bureaucratic coordination issues, facility distribution, and organizational complexity. However, this implementation gap cannot be viewed merely as an administrative issue. When a policy nominally applicable to all members is accessible to only a subset of personnel, questions of equitable access arise. From Whitehead's (1992) perspective, health disparities become issues of justice when the differences are systematic, preventable, unnecessary, and disadvantageous to specific groups. Thus, limited access to periodic health check-ups represents more than just a disparity in service delivery; it potentially constitutes a form of inequity in health protection for Polri personnel.

The health of National Police personnel is a fundamental aspect of ensuring the effective execution of institutional duties, particularly in regions characterized by high levels of activity and operational risk, such as the Polda Metro Jaya. However, in practice, various issues persist, indicating that the implementation of the National Police's health policies has not yet reached optimal levels. There are still officers who suffer from serious health problems or even pass away before reaching retirement age. These conditions demonstrate that the personnel health protection system—specifically regarding prevention and early detection—is not yet functioning to its full potential or with consistent effectiveness.

Data from the Polda Metro Jaya Medical and Health Division (Biddokkes Polda Metro Jaya) for 2024 indicates that only 7,142 out of a total of 28,684 personnel—approximately 24.9%—underwent periodic health examinations. This situation reveals a significant gap in the implementation of the periodic health examination policy. Furthermore, records from 2024 show that 50 personnel suffered from chronic illnesses, while 78 passed away before reaching retirement age. These facts highlight weaknesses in early detection capabilities and indicate that the system for preventive and continuous health protection for personnel is not yet optimal (Helen, M., Evilianti, M., & Juita, R. (2021).

Research by Anders et al. (2024) indicates that policing is a high-risk profession regarding health, driven by work-related stress, psychological trauma, and continuous operational demands. The study underscores the importance of organizational support, health protection systems, trauma counseling, and periodic psychological health evaluations for police personnel. Anders et al. (2024) further conclude that high-pressure working conditions not only impact the physical and mental health of personnel but also affect professional commitment and the quality of service interactions with the public. Schroter et al. (2023) characterize police organizations as the "canary in the coal mine"—public institutions that are among the first to sense and be affected by social, economic, political, technological, and environmental changes. The study emphasizes that the quality of human resources and personnel protection systems are crucial factors in maintaining the resilience of police organizations amidst an increasingly complex strategic environment.

Research on healthcare access for vulnerable groups was also conducted by Lauralie et al. (2016) in Australia. The study demonstrated that improving primary healthcare access for vulnerable groups is a key challenge in achieving equitable health outcomes. Lauralie emphasized that equitable access is determined not merely by the availability of services, but also by the ability of vulnerable groups to effectively benefit from them. Meanwhile, in a study on health system reform in Nigeria, Uneke et al. (2016) concluded that the low effectiveness of healthcare services is closely linked to weak policy implementation, limited health resource capacity, and a lack of optimal understanding among policymakers regarding actual healthcare needs. The study underscored the importance of adopting needs-based and evidence-based health policy approaches.

Research by Aidoo et al. (2012) on occupational health risks in Ghana also revealed that workers often lack awareness of the health risks they face. The study recommended the implementation of health education, risk mapping, and more robust preventive health systems within workplace organizations. In the context of the Indonesian National Police, several studies and internal assessments have been conducted regarding healthcare services for personnel. A 2023 study by the Polri Research and Development Division on the Polri Health Development Index measured personnel health status and its determinants, including the distribution of health facilities and access to internal Polri healthcare services.

The study identified disparities in health facilities across work units and recommended strengthening Polri's internal health management. Rebeca, et al, (2021), examined healthcare services and facilities for civil servants within the Polri organization. Their research indicated that the majority of Polri's primary healthcare facilities (FKTP) still face various limitations, such as non-strategic locations, limited clinic accreditation, a shortage of healthcare personnel, and restricted service hours. These conditions have resulted in suboptimal healthcare quality for Polri members.

This study employs Rawls's theory of justice (1971) due to its philosophical and normative nature in explaining how the basic structure of society and public institutions ought to be organized equitably. Within the context of this research, the Indonesian National Police—as a public institution—is viewed as part of the state's basic structure, bearing the obligation to ensure equitable access to healthcare services for all its members.

In the context of the National Police's health policy, Rawlsian theory provides a normative foundation establishing that access to healthcare services for police personnel must not depend on the chance of one's duty station, proximity to medical facilities, or specific privileges within the organizational structure. Periodic health check-ups, as an institutional right, must be equitably accessible to all police personnel, free from discrimination based on region, position, or rank.

METHODS

This study employs an interpretive constructivist paradigm, which views social reality as plural, dynamic, and contextual—shaped by the experiences, values, and interactions of individuals. This paradigm is rooted in the perspective that knowledge is not discovered but socially constructed by individuals within a specific context (Creswell, 2013). It was selected because it aligns with the study's focus: examining how health policies within the Indonesian National Police are implemented and interpreted by the actors involved, and how equitable access to healthcare services is perceived by the personnel—the policy recipients—across various work units and operational areas. A qualitative method is employed in this study, utilizing data collection techniques comprising in-depth interviews, participant observation, and policy document analysis.

This study took as subjects members of the Indonesian National Police with the rank of Non-Commissioned Officer and Officer who served in various work units in the Polda Metro

Jaya area, in this case in Biddokkes, SDM and in the South Jakarta Police, Bekasi Police, and Seribu Islands Police. Informants in this research were selected taking into account their involvement and understanding of the topic under study.

The number of informants was 11 people, consisting of:

1. Head of the National Police Medical and Health Center, Head of the National Police Health and Medical Center, the official who makes policy, along with two Bureau Heads at the National Police Health and Medical Center, Head of the Police Health Bureau, Karo Kespil, and Head of the Police Medical Bureau, Karo Dokpil, as key informants.
2. Head of Medicine and Health, Head of Health and Medical Sciences, Polda Metro Jaya. Officials from the Medical and Health Sector (Dokkes) Polda Metro Jaya who act as health policy implementers in police institutions, as supporting informants.
3. Head of the Human Resources Bureau of Polda Metro Jaya. Officials from the Human Resources (HR) Bureau of Polda Metro Jaya who are involved in planning, supervising and controlling policies related to personnel health, are policy implementers as supporting informants.
4. Head of the Bekasi Metro Resort Police, Bekasi Metro Police Chief. The head of the work unit affected by the policy and has a role in facilitating the implementation of the policy at the operational level. Kasatker, apart from being a policy implementer, is also a party affected by the policy, as a supporting informant.
5. National Police members with the rank of Non-Commissioned Officer from work units in the Regional Police and Regional Police who are the main targets of the periodic health examination policy and represent groups affected by the policy.

The data analysis technique employed in this study is a thematic analysis approach—a process of systematically categorizing and interpreting qualitative data to identify meaningful themes relevant to the research focus. This method was selected because it enables the researcher to identify patterns, experiences, and informant perceptions regarding the implementation of the National Police's health policy, specifically within the context of equitable access.

Thematic analysis was chosen because the study aims not only to describe the administrative execution of the policy but also to understand the dynamics of its implementation, barriers to healthcare access, the experiences of National Police personnel, and the relationship between organizational structure and the equitable distribution of healthcare services.

RESULTS AND DISCUSSION

In-depth interviews with informants revealed that, normatively, periodic health check-ups are intended for all members of the Indonesian National Police. Informants generally viewed that every member has an equal opportunity to undergo these health check-ups. However, this equality of opportunity is not always matched by equal access during implementation.

Informants B, D, E, G, H, and J explained that while the opportunity to participate in periodic health check-ups is, in principle, extended to all members, the actual implementation remains constrained by budget availability and examination quotas. Consequently, the number of members able to undergo the check-up in any given period falls short of covering all personnel who should ideally receive the service.

These findings were corroborated by Informants F and I, who stated that limited quotas are a factor influencing members' opportunities to participate in periodic health check-ups. Meanwhile, Informant C highlighted access barriers faced by members stationed in areas with specific geographical characteristics. Informant K also revealed that, in practice, member

participation is linked to appointment mechanisms via official orders and arrangements within specific work units.

The interview results indicate a disparity between the normative right to equal treatment and the actual opportunity to access the service. While policy establishes an equal basis for Polri members to receive periodic health check-ups, the realization of access is influenced by factors such as budget, quotas, participant selection mechanisms, and the characteristics of the duty area.

Other findings indicate that, under certain conditions, specific groups of members receive special attention or priority. Informants A, B, C, and D cited, among others, members with specific health risk factors, those undergoing education or career development, and those with operational duty profiles. Conversely, several other informants did not specifically observe the existence of priority groups in the implementation of periodic health check-ups. Thus, the interview results indicate that the issue of access to periodic health check-ups is not solely a matter of policy existence; it also hinges on the system's ability to translate a right—formally applicable to all members—into a tangible opportunity that every member can actually access. Variations in the informants' experiences also reveal that the policy's implementation has not yet been experienced uniformly across the various work units and regions within the Jakarta Metro Police.

Grounded in the principle of fairness—whereby everyone holds equal rights—Informant A stated that all members are entitled to the same healthcare services, though the actual provision is tailored to specific needs, vulnerabilities, risk factors, and age groups. Informant A did not view service disparities based on rank as a formal policy, but rather as a reflection of medical necessity; fairness is understood as the provision of care aligned with risk and need, rather than the delivery of identical services to everyone.

Applying the difference principle, Informant A identified members stationed in border areas and remote regions as the group facing the greatest difficulty in accessing services. Attention toward members with chronic illnesses is managed through periodic check-ups, home visits, and health education. The policy is considered geared toward protecting vulnerable groups, although its implementation requires further strengthening.

Regarding equality of opportunity, all members are deemed to have equal access, albeit within budgetary constraints. Time-related barriers to service are considered manageable, given that Bhayangkara Hospitals operate on a 24-hour basis. The guarantee of healthcare rights is realized through the expansion of National Police health facilities across various provinces and regencies, including ongoing efforts to construct Bhayangkara Hospitals in newly established Regional Police jurisdictions. Thus, according to Informant A, fairness constitutes an equality of rights accompanied by adjustments based on objective needs.

Informant A assesses that healthcare services are generally accessible, though personnel stationed far from health facilities face limited access; the primary obstacle is their duty location. Referrals to National Police health facilities are considered straightforward and should not be unnecessarily complicated. Service locations and scheduling are still being refined, particularly for remote areas.

Service utilization is considered fairly even, although not all members make use of it. Some members hold other insurance or access alternative health facilities, feel healthy, are indifferent, or worry that examination results might impact their careers. Service quality is deemed comparable when assessed based on needs and age; while facilities and healthcare personnel have improved, they remain insufficient.

Informant A acknowledges that disparities due to distance persist. These disparities could be mitigated through collaboration with the Ministry of Health, utilization of the BPJS (national health insurance) system, the expansion of facilities in remote areas, increased budgets, and the

recruitment of more healthcare personnel. This perspective indicates that geographic disparity is viewed as an issue that can be remedied through policy interventions.

Informant C distinguishes between equal rights and unequal access. According to the informant, all members possess equal rights, yet officials or decision-makers may receive faster attention due to the demands of their duties. Fairness is understood in terms of urgency and priority, accompanied by effective communication to ensure that differences in service delivery are understood. Members stationed far from facilities face the greatest difficulty in accessing services. Members with chronic illnesses receive care through the Prolanis program and home visits. While the policy is considered protective of vulnerable groups, its implementation is not yet optimal. Opportunities for medical examinations are equal in principle but remain contingent upon budget availability. Administrative hurdles must not impede service delivery. Informant C's perspective demonstrates that formal equality does not automatically result in equal substantive access.

Access is considered easy for members located near facilities, yet distance remains a primary constraint. Referrals from primary care facilities (FKTP) to National Police hospitals are viewed as straightforward. Service locations and operating hours are still being adjusted. Utilization is uneven due to factors such as duty locations, awareness levels, possession of other insurance, a culture of prioritizing duty, and career-related concerns. Service quality varies because facilities and healthcare personnel differ across regions, even though efforts are made to meet basic standards. Informant C acknowledged the existence of disparities resulting from the distribution of duty stations and facilities. These disparities could be mitigated by bringing services closer to members, increasing the number of facilities and healthcare personnel, raising budgets, and strengthening Bhayangkara hospitals in every province.

Informant F emphasized that all members are entitled to equal service regardless of rank; however, in practice, he observed that higher-ranking members often receive better care. Fairness is understood in terms of standards, conditions, rank, and age, even though he also desires the absence of status-based distinctions. Members stationed far from facilities constitute a group with limited access. Members with chronic illnesses require special attention, continuity of data, and adjustments to their duty assignments. Protection for vulnerable groups is considered in need of improvement. While formal opportunities for medical check-ups are equal, quotas prevent all members from undergoing annual examinations. Time constraints and the absence of a dedicated Polda Metro Jaya hospital also pose obstacles. Informant F advocates for the establishment of a Polda Metro Jaya hospital as a means to expand genuine access to care.

Access to services is considered easy for members located near facilities but difficult for those further away. Barriers include service hours, distance, and hospital limitations. The referral process is viewed as relatively easy and fast. Service utilization is uneven, particularly among personnel at remote sector police stations. Some members feel healthy, rely on herbal remedies, fear hospitals, or have had traumatic experiences. Quality of care is perceived as relatively consistent but remains influenced by rank, position, and location. Personal satisfaction among informants is low due to traumatic experiences with National Police hospital services.

Disparities are evident, particularly regarding location, rank, facilities, and budget. These inequalities could be mitigated by increasing budgets and facilities in remote areas, eliminating rank-based distinctions, implementing annual check-ups for all members, integrating data, ensuring services are free from favoritism or "insider" influence, and potentially extending medical check-ups to members' spouses.

Informant K views rights and services as not yet fully equitable, as they remain influenced by position, rank, and official assignment orders. Fairness is perceived in terms of rank and position, reflecting an internalized hierarchy within the service experience. Members

stationed in remote areas face the greatest difficulty in accessing services. While all members are considered to require attention, vulnerable groups need stronger protections. Informant K has not personally experienced opportunities for medical check-ups, having never received an assignment order. Duty schedules and clinic operating hours affect access. Although, in principle, everyone should have equal opportunities, Informant K's experience reveals a gap between formal rights and the actualization of those opportunities.

Informant K considers access to basic services relatively easy due to the presence of the Resort Police clinic, though service hours are limited. Referrals to the Bhayangkara Hospital are viewed as easy. Service locations and schedules are still being adjusted to meet needs. Utilization is uneven, particularly among personnel stationed far away; some members feel healthy and are less concerned about the services. While the quality of care is considered consistent, it remains influenced by rank, position, and prevailing circumstances. Facilities and healthcare personnel are deemed insufficient. Disparities are primarily experienced by personnel located far from facilities, a situation caused by remote locations. Such disparities could be mitigated by extending services to the Sector Police level, increasing the number of doctors and nurses, implementing 24-hour service, raising the budget, and establishing a Bhayangkara Hospital for the Jakarta Metro Regional Police.

1. Implementation of the Periodic Health Check-up Policy

In general, informants A through K stated that periodic health check-ups serve as a vital instrument for maintaining the health and fitness of personnel, enabling early disease detection, and ensuring the smooth execution of duties. The policy explicitly targets National Police members; however, implementation does not yet reach every member annually, as the budget covers only a portion of the personnel. Execution proceeds through a tiered system and is heavily influenced by official orders, quotas, decisions made by unit heads, the availability of medical staff and facilities, and operational conditions. Within Grindle's framework, the interests of the target group and the policy's benefits are clearly identified, yet the desired degree of change has not been fully realized. Decision-making tends to be centralized, whereas flexibility is primarily found in the technical aspects of implementation. Resource limitations, a hierarchical culture, workload demands, and varying regional characteristics serve as contextual factors that determine implementation outcomes.

2. Extent of Equitable Access

The majority of informants acknowledge that, in principle, all members possess equal rights. However, this equality of rights is not always matched by equality of opportunity or quality of service experience. Disparities arise due to factors such as quotas, rank or position, proximity to health facilities, service hours, official orders, workload, and the capabilities of facilities in specific regions. From a Rawlsian perspective, while the principle of equal basic liberties or rights is recognized, "fair equality of opportunity" has not been fully realized. Prioritizing vulnerable groups—such as members with chronic illnesses, older personnel, those in high-intensity operational roles, or those stationed in remote areas—can be justified under the "difference principle," provided the aim is genuinely to improve the standing of the least advantaged, rather than simply reinforcing rank-based hierarchies. From Whitehead's perspective, access to, utilization of, and the quality of services are not yet fully equitable. Inequities are primarily experienced by personnel at local police stations, those stationed in remote or archipelagic areas, officers with long operational duty hours, and those who do not receive official inspection orders. These inequities are preventable and remediable, as they relate to resource distribution, budget design, quota mechanisms, service hours, and governance.

3. Reasons for the Lack of Equitable Access

Research findings indicate that there are still members of the National Police who have never undergone periodic health check-ups. Several key factors contribute to this situation. First, the budget for periodic health check-ups covers only a portion of the personnel, necessitating a rotational system for access. Second, the number of medical personnel is disproportionate to the number of facilities and activities. Third, facilities are unevenly distributed, including the absence of a dedicated Bhayangkara Hospital for the Polda Metro Jaya. Fourth, services at the Resort Police or Regional Police levels are generally limited to standard working hours, whereas operational duties continue around the clock. Fifth, the culture of hierarchy and adherence to official orders means that access relies heavily on the decisions of leadership and unit heads. Sixth, factors such as member awareness, career concerns, a culture of prioritizing duty, and unhealthy lifestyles reduce the utilization of these services.

Table 1. Research results based on Merilee Grindle's Theory

No	Dimension	Research Findings	Informant	Conclusion
1	Affected interests	All members are targets, yet not all undergo the health check	A-K	There is a gap between normative targets and actual recipients.
2	Type of benefits	Health checks facilitate early detection and operational readiness	A-K	The benefits of the policy are strongly acknowledged.
3	Degree of change	Awareness has improved somewhat, but compliance still relies on official orders	A-K	Behavioral change has not yet been optimal.
4	Decision-making	Standards and budgets are centralized, while technical aspects allow for limited flexibility	A-K	Access is heavily influenced by structural decisions.
5	Program implementers	Coordination is effective, though capacities vary	A-K	Understanding does not always translate into uniform implementation.
6	Resources	Budgets, facilities, medical personnel, and quotas are limited	A-K	Resources constitute a major obstacle.
7	Actor power	Leadership and unit heads influence the opportunities available to members	A-K	Leadership commitment determines success.
8	Institutional characteristics	Hierarchy fosters compliance but can stifle initiative	A-K	Organizational culture has a dual impact.
9	Compliance and response	Compliance is high when official orders are issued, though personnel response remains inconsistent	A-K	Administrative compliance is stronger than personal conscience

Source: Researcher, 2026

Table 2. Research results based on John Rawls's Theory

No	Rawls's Principles	Research Findings	The Meaning of Justice
1	Equal rights	While the right to health is recognized equally, perceptions regarding privilege persist.	Formal rights do not always translate into equal treatment.
2	Support for disadvantaged groups	Groups with limited access have not yet truly gained tangible opportunities.	Policies do not yet sufficiently favor the most disadvantaged groups.
3	Equal opportunities	Opportunities are constrained by quotas, administrative directives, distance, and time.	Formal opportunities have not yet become actual opportunities.

Source: Researcher, 2026

Table 3. Research results based on Margaret Whitehead's Theory

No	Dimension	Form of Inequality	Nature of Inequality
1	Equity in Access	Distance, service hours, quotas, facilities, bureaucracy	Can be reduced through organizational interventions
2	Equity in Utilization	Awareness, being on duty, fear of career repercussions, negative experiences	Influenced by organizational and individual factors
3	Equity in Quality of Care	Disparities in facilities, personnel, location, and status	Lack of uniform actual quality
4	Avoidable Inequity	Police sector personnel, remote locations, low rank, chronic illness increasing vulnerability.	Largely preventable; potentially inequitable

Source: Researcher, 2026

Table 4. Research results matrix

No.	Name	Grindle	Rawls	Whitehead	Conclusion
1.	Informant A Head of the Medical and Health Center (Kapusdokkes) Indonesian National Police	All members have opportunities based on need, though there are limitations regarding budget, quotas, and resources.	Service differences are based on medical needs; fairness is determined by risk and necessity.	Personnel stationed far away struggle to access services; disparities arise due to the long distances involved.	Limited budgets and quotas mean not everyone can secure an opportunity.
2.	Informant B Head of the Police Health Bureau (Karo Kespel) Medical and Health Center Indonesian National Police	Health facilities are expanding rapidly, yet the budget for periodic health check-ups is insufficient.	All members have equal rights, though there are privileges regarding workload and time constraints.	There is no formal inequality, though gaps exist due to remote locations and limited facilities.	There is a distinction between normative equal rights and the reality of limited opportunities.
3.	Informant C Head of the Police Medical Services Bureau (Karo Dokpol) Medical and Health Center Indonesian National Police	Policy impact is assessed objectively, supported by additional budget allocations; the command structure plays a crucial role.	Fairness is based on urgency and operational demands.	Disparities arise from the distribution of duty stations.	Disparities arise from varying levels of urgency, workload, geographical distance, and insufficient budgetary support.
4.	Informant D Head of the Medical and Health Division (Kabid Dokkes) Jakarta Metro Regional Police	Opportunities are equal but rotated according to the budget; digitization and integration of personnel data are needed.	Service is uniform; there is no distinction based on rank. Priority is given to high-risk cases, those over 40, and those preparing for further training.	Services are easily accessible, but there are limitations regarding the types and quantities of medication available.	Budget constraints necessitate a rotational schedule for health check-ups; integration of personnel data is required.

No.	Name	Grindle	Rawls	Whitehead	Conclusion
5.	Informant E Head of the Human Resources Bureau (Karo SDM) Jakarta Metro Regional Police	Health services are uniform for all, but the number of participants for health check-ups depends on allocations and requests from the Medical and Health Division (Biddokkes); the budget needs to be increased.	Service adjustments may occur due to rank and position; service time may need to be extended.	Facilities and medical personnel are unevenly distributed; personnel in remote areas face the greatest difficulty in accessing care.	Challenges include bureaucratic hurdles, high demand, limited quotas, and a shortage of medical personnel.
6.	Informant F Chief of Bekasi Metro Resort Police	Opportunities are not yet equal due to limited quotas and the high volume of National Police activities; members with heavy workloads should be prioritized.	All members should be treated equally, yet higher-ranking members receive better service. Fairness is based on standards, conditions, rank, and age.	Significant disparities exist, primarily due to duty location, rank, facilities, and budget allocation.	Comprehensive health check-ups are essential, yet quotas remain limited; the program is still evolving to better align with actual needs.
7.	Informant G Member of the Medical and Health Division Jakarta Metro Regional Police	Opportunities are equal with no specific prioritization; obstacles include member awareness and an inadequate budget for periodic health check-ups.	Service entitlements are not always identical, as examinations depend on age. Opportunities are equal, though access depends on activities and duty schedules.	Utilization is equitable, but regulations, facility availability, and budget support need to be addressed.	Member awareness and concern regarding personal health need to be improved.
8.	Informant H Member of the Human Resources Bureau Jakarta Metro Regional Police	Opportunities are equal based on need, though not everyone receives an examination; coverage and monitoring of sick members need to be improved, with a minimum frequency of once every two years.	Higher-ranking members receive faster service; members at the Sector Police (Polsek) level face the most difficulty in accessing services.	Service locations and hours do not yet meet needs; utilization is uneven, and there is a shortage of health facilities and personnel.	Inequities exist, particularly affecting personnel at the Sector Police (Polsek) level and those of lower rank; there is a need for more medical staff and the development of a dedicated Jakarta Metro Police hospital.
9.	Informant I	Opportunities are equal based on	Service is uniform	Disparities at Sector Police	Fairness is interpreted

No.	Name	Grindle	Rawls	Whitehead	Conclusion
	Member of South Jakarta Metro Resort Police	need, but not everyone receives an examination; coverage and monitoring of sick members need to be improved, with a minimum frequency of once every two years.	regarding age and risk, though differences based on rank exist and are understandable given varying workloads; however, insufficient attention is paid to members with chronic illnesses.	(Polsek) stations stem from a lack of health awareness and education, as well as limited health personnel.	based on individual roles, though all members should ideally have the opportunity for a check-up at least once every two years; a Jakarta Metro Police hospital needs to be built.
10.	Informant J Member of Bekasi Metro Resort Police	Periodic health check-ups are intended for early detection, but participation is not always possible as it depends on official assignment orders; service quality and health motivation need improvement.	Rights are equal, yet there are slight differences in treatment; low-ranking members face the most difficulty.	Access is relatively easy, despite bureaucratic hurdles.	Inequities persist due to lingering old paradigms, and satisfaction levels remain moderate, fluctuating over time.
11.	Informant K Member of Thousand Islands Resort Police	Has never undergone a periodic health check-up due to never receiving an assignment order and feeling healthy; opportunities are unequal.	Rights and services are not yet equal, as they are influenced by position, rank, and official orders. All members require attention, and equal opportunities have not yet been realized.	Utilization is uneven for personnel stationed far away; disparities could be mitigated if services were extended to the Sector Police level.	There is a gap between formal entitlements and the actual realization of opportunities.

Source: Researcher, 2026

CONCLUSION AND RECOMMENDATIONS

Conclusion

Based on the research findings and discussion regarding the "implementation of the periodic health examination policy for national police personnel based on equitable access at the Polda Metro Jaya" the conclusions are as follows:

1. Implementation of the Periodic Health Examination Policy for National Police Personnel at Polda Metro Jaya

The implementation of the periodic health examination policy for National Police personnel at Polda Metro Jaya is supported by a clear regulatory basis, objectives, an implementation structure, and service mechanisms. The policy yields significant benefits, including early disease detection, the identification of health risk factors, the maintenance of personnel health, and support for operational readiness. However, when analyzed

through the lens of Merilee S. Grindle's theory, the policy implementation is not yet fully optimal, despite being supported by clear benefits, the involvement of implementing institutions, hierarchical coordination, and leadership support. Regarding the policy content dimension, while the target group normatively encompasses all National Police personnel, in practice, not all members receive routine examinations. Regarding the implementation context dimension, the command structure and leadership support significantly influence the program's success. The command structure can enhance personnel compliance through official orders and the granting of authorization. However, a heavy reliance on superiors' decisions can also restrict access if examinations are deemed to interfere with duty performance or if personnel are omitted from the participant list.

The National Police's organizational culture—characterized by hierarchy, discipline, and a task-oriented mindset—also exerts a dual influence. While this culture fosters compliance, it simultaneously leads some personnel to prioritize their duties over their personal health.

Consequently, although the periodic health examination policy is functioning administratively and organizationally, its implementation is not yet fully effective in terms of coverage, equitable access, continuity, and service follow-up.

2. Realization of the Principle of Equitable Access in Periodic Health Examinations

The principle of equitable access has been realized at the normative level through the recognition that all Indonesian National Police members possess equal rights to healthcare services and periodic health examinations. However, this equity has not yet been fully realized at the substantive level.

Viewed through the lens of John Rawls's theory, while the principle of equal rights is acknowledged, equality of opportunity has not yet been fully achieved. Members' opportunities to undergo examinations remain influenced by factors such as the absence of integrated health history data (including records of annual periodic examinations), quotas, budget constraints, official orders, work unit submissions, duty locations, duty schedules, and supervisory approval. Furthermore, preferential treatment for the least advantaged groups has not been consistently implemented. Groups facing greater obstacles—such as members stationed at Sector Police offices, in archipelagic regions, or in remote locations, as well as those with heavy operational workloads, chronic illnesses, or a history of infrequent examinations—have not always received clear and measurable priority. Viewed through Margaret Whitehead's concept, equitable access remains incomplete due to persisting disparities in access, utilization, and service quality.

Disparities in access are evident in variations regarding distance, service hours, facility availability, the number of healthcare personnel, and quota limitations. Disparities in utilization stem from differences in member awareness, work culture, concerns regarding the impact of examination results on career progression, and prior service experiences. Disparities in quality are reflected in differences in facilities, waiting times, medical personnel availability, ease of referral, and perceptions of preferential, faster service for specific ranks or positions.

Consequently, equitable access to periodic health examinations has not been fully realized. Formal equality of rights has not been matched by actual equality of opportunity, equal capacity to utilize services, or equal quality of service.

3. Reasons Why Policy Implementation Has Not Fully Achieved Equitable Access

In general, this study concludes that while the policy of periodic health check-ups for National Police members at the Polda Metro Jaya has been implemented, it is not yet fully grounded in equitable access. Although the policy formally establishes rights and services, not all members possess an equal actual opportunity to undergo regular examinations. Equitable access cannot be achieved merely through uniform treatment; rather, it requires

services that are proportional to needs, health risks, geographical barriers, operational workloads, and the members' positions within the organizational structure.

Implementing a policy based on equitable access requires integrating implementation capacity, equal rights, a commitment to supporting disadvantaged groups, and the elimination of preventable inequalities.

Consequently, the periodic health check-up policy needs to shift from an administrative approach to equity toward a substantive one—providing universal service for all members while offering priority and special protection to those groups facing the greatest barriers to access.

The theoretical contribution of this study lies in advancing the perspective on policy implementation within public sector health organizations. It demonstrates that implementation success should not be measured solely by regulatory compliance, program execution, or administrative outputs; it must also be evaluated based on the distribution of actual opportunities and the policy's capacity to reduce preventable inequalities. Thus, the dimension of equitable access is positioned as a core metric of implementation success, rather than merely an incidental outcome following policy execution.

In the context of policing, this study also contributes by showing how the organization's hierarchical nature shapes the mechanisms for accessing internal services. The chain of command can serve as both a driver of implementation and a source of inequality if not accompanied by guaranteed rights and corrective mechanisms. Therefore, the proposed Polri Health Access Equity Model advocates a shift from administrative equity to substantive equity—delivering universal services alongside measurable prioritization for the groups with the greatest needs and the most significant barriers to access. The findings of this study indicate the following:

- a. The better the implementation of the health check-up policy—based on Grindle's dimensions—the greater the likelihood of achieving access to healthcare services for National Police members.
- b. Effective policy implementation does not automatically result in equitable access unless it upholds the principles of equal opportunity and consideration for vulnerable groups, as proposed by Rawls.
- c. Equitable access to health check-ups for National Police members can only be achieved if policy implementation addresses avoidable health inequalities, as highlighted by Whitehead.
- d. Implementing health policies within a hierarchical police organization characterized by high operational demands requires an approach grounded in equitable access—specifically, an integration of implementation effectiveness (Grindle), equitable access (Rawls), and health equity (Whitehead).

Recommendations

Research findings highlight the importance of distinguishing between services treated merely as organizational amenities and those positioned as institutional rights. Periodic health examinations should be understood as a personnel right, the implementation of which constitutes an organizational obligation. Consequently, every member requires a traceable examination schedule; work units must allocate time for members to undergo these checks; and any postponement due to operational exigencies must be followed by a firm rescheduling plan. Under this approach, access no longer relies entirely on leadership discretion but is instead guaranteed through the organizational system.

Based on the overall research findings, the priority recommendations for transforming the periodic health examination policy—shifting it from a mere annual check-up program into

a fair, sustainable, and needs-based health protection system for National Police members—are as follows:

1. Establish an integrated health database for all personnel—tracking histories of annual periodic examinations (whether routine, non-routine, or never performed)—to identify the specific health risks faced by each member.
2. Gradually expand the coverage of periodic health examinations until all members receive routine check-ups.
3. Shift the participant selection mechanism from a quota-based system to one based on health needs and risks.
4. Expand access through mobile services, adjusted service hours, and the strengthening of health facilities.
5. Implement specific policies for members in the most vulnerable positions who face the greatest difficulty in accessing services.
6. Revise the Chief of National Police Regulation Number 7 of 2013 concerning Periodic Health Examinations to incorporate provisions regarding coverage, priorities, the mandatory annual examination requirement for all Polri personnel, and the obligation for follow-up care for all personnel requiring it.

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