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GOVERNING HEALTH IN HIGH-RISK BUREAUCRACIES: INSTITUTIONAL MISALIGNMENT AND REACTIVE POLICY IMPLEMENTATION IN THE INDONESIAN NATIONAL POLICE

Niken Manohara[1*], Triyuni Soemartono[1], T. Herry Rachmatsyah[1], Gatot Hery Djatmiko[1]
[1]Universitas Prof. Dr. Moestopo, Jalan Hang Lekir I No. 8, Jakarta 10270, Indonesia

[*]Correspondence E-Mail: nikenmanohara3@gmail.com
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ABSTRACT

This study examines the institutional governance of occupational health within high-risk law enforcement institutions through a case study of the Indonesian National Police (INP), focusing on the misalignment between formal policy design and reactive implementation practices. Despite regulatory mandates such as the Chief of Police Regulation No. 7/2013 requiring periodic health screenings, participation remains low (24–26%), while high-risk classifications have tripled within a year. Using a qualitative case study approach, institutional screening data and medical records from the Jakarta Metropolitan Police (Polda Metro Jaya) were analyzed through documentary and thematic content analysis guided by Matland's ambiguity–conflict model and policy implementation theory. The findings reveal that bureaucratic quota systems, weak digital infrastructure, and the absence of leadership accountability mechanisms undermine preventive health outcomes, leading to rising chronic diseases, preventable deaths, and declining institutional resilience. The study identifies systemic governance failures driven by compliance-oriented routines and proposes four reforms: risk-adaptive screening protocols, centralized digital health integration, leadership accountability metrics, and cross-sectoral preventive care partnerships. The novelty of this research lies in exposing institutional misalignment in police health governance, an underexplored area in Indonesian bureaucratic sociology, while extending the New Public Service paradigm to occupational health governance. Conceptually, it contributes to institutional sociology by linking policy rationality with frontline implementation behavior in high-risk public sectors.

Keywords: *Health Governance, Institutional Misalignment, Law Enforcement, New Public Service, Occupational Health Policy*

INTRODUCTION

The health and well-being of police personnel form the fundamental basis for operational readiness and institutional resilience within law enforcement organizations. Within the framework of modern public administration, human resources are no longer perceived merely as bureaucratic instruments but as strategic assets determining institutional effectiveness and the quality of public service outcomes (Ananthapavan et al., 2021; Rivera & Knox, 2023). In the context of policing, an occupation characterized by high-risk environments and constant psychological stress, health governance extends beyond welfare concerns to become a core administrative function directly linked to organizational sustainability and public trust (Cloeren

et al., 2025; Jansen et al., 2021). In Indonesia, this issue gains further relevance through national health policies such as the Jaminan Kesehatan Nasional (JKN) and internal police regulations, including Chief of Police Regulation No. 7 of 2013, which mandates regular health screenings for all personnel. However, implementation in practice, particularly within the Jakarta Metropolitan Police (Polda Metro Jaya), one of Southeast Asia's most operationally demanding institutions, has yielded suboptimal outcomes. Health screening coverage remains limited to 24–26% annually, while the prevalence of chronic diseases and preventable deaths continues to rise, as reflected in the 2024 Stakes classification and mortality data (Lissåker et al., 2021).

From a policy implementation perspective, this condition illustrates a persistent gap between policy design and operational achievement. Hassan et al. (2023) and Shishavan et al. (2023) argue that implementation success depends on the alignment between policy instruments, institutional structures, and frontline actors. In the case of the Indonesian National Police (Polri), the quota-based screening system, inadequate digital infrastructure, and weak data integration indicate administrative barriers and strategic misalignment (Carter et al., 2022; Lagoe et al., 2023). Health governance in high-risk bureaucracies should ideally integrate early prevention, risk detection, and data-driven decision-making. Hill and Hupe (2018) and Or et al. (2022) emphasize that workplace health promotion and routine screenings are among the most efficient interventions for reducing long-term morbidity and improving productivity. Nevertheless, their effectiveness depends heavily on institutional commitment, adequate resource allocation, and adherence to the principles of equity and public value management (Ndlela & Naidoo, 2023; Smith-MacDonald et al., 2021).

The limited coverage of health screening among Polri personnel thus represents not only a technical issue but also a symptom of systemic governance failure. Data from 2023–2024 show that only one-fourth of personnel underwent scheduled medical examinations, while the proportion of high-risk officers tripled. In the same period, 78 preventable deaths and 50 chronic illness cases were reported (Michele et al., 2023). This phenomenon aligns with what Kanol (2022) describes as an implementation gap, the disjunction between policy intent and actual outcomes. Within Polri, such gaps are driven by quota restrictions, funding constraints, and the absence of digital medical record systems (Lissåker et al., 2021; Wang et al., 2022). Consequently, preventive measures lose their effectiveness, and health governance becomes reactive rather than proactive, ultimately diminishing both individual well-being and long-term organizational resilience (Asadi-Lari et al., 2021).

Previous studies have shown that the effectiveness of occupational health policies depends on the integration of policy design, administrative capacity, and organizational behavior. Asriyanti et al. (2020) and Rose et al. (2021) found that sustainable workplace health programs significantly reduce absenteeism and extend personnel retention in high-risk public institutions. In contrast, Teddy et al. (2019) and Yakubu and Chaudhuri (2022) observed that policy failures often result from institutional fragmentation and unclear command chains. In the Indonesian context, studies by Alika et al. (2024) and Ramli et al. (2025) on civil service health policies

revealed that low participation in screening and weak digital monitoring systems are the primary causes of undetected chronic diseases. Similarly, Mess et al. (2024) and Yun et al. (2023) noted that the absence of integrated health data systems hampers the ability of public institutions to conduct longitudinal monitoring of employee health conditions.

International research further highlights the significance of occupational health governance in high-risk public sectors. Carter et al. (2022) found that police officers in Canada face a threefold higher risk of metabolic syndrome compared to the general population due to shift work and chronic stress. Shishavan et al. (2023) reported that the use of biometric monitoring devices in high-risk workplaces significantly reduces blood pressure and enhances early detection of hypertension. Studies from South Korea by Lambin and Nyyssölä (2024) and Lipsky (2018) reinforce these findings, showing that employees who do not undergo regular screenings have a 57.5% higher mortality risk. Furthermore, Lambin and Nyyssölä (2024) proposed the precision prevention paradigm, emphasizing adaptive, data-driven approaches to health risk management.

Within the public administration literature, Denhardt and Denhardt (2018) through the New Public Service (NPS) paradigm argue that the legitimacy of public institutions is no longer measured solely by efficiency but also by their commitment to employee well-being. NPS situates employee health and safety as integral to public value creation, asserting that internal well-being determines the quality of external service delivery. This aligns with the findings of Ghotbi (2022) and Martin et al. (2023), which show that reactive health policies weaken institutional trust, whereas proactive approaches strengthen organizational integrity. Conceptually, this perspective expands the understanding of modern bureaucracy as not merely a productivity-oriented structure but also a moral system accountable for the welfare of its human resources.

Policy implementation theory also provides a critical lens for understanding this phenomenon. Goetzel and Ozminkowski (2018) view implementation as a complex process involving multiple actors and coordination levels. In large, decentralized institutions such as Polri, discrepancies between central policy and regional execution are inevitable. Subramony et al. (2022) and Tuzovic and Kabadayi (2021) demonstrate that administrative capacity and cross-unit coordination are crucial for successful social policy implementation, while Kervezee et al. (2021) highlight how street-level bureaucrats face normative dilemmas in executing health mandates amid limited resources. In Polda Metro Jaya, high operational pressure and limited time often cause health examinations to be deprioritized despite being mandatory.

When integrated, the three theoretical frameworks, New Public Service, policy implementation theory, and occupational health governance, offer a comprehensive perspective on how health policies are executed in high-risk law enforcement agencies. The NPS paradigm reveals the tension between operational output and employee welfare; policy implementation theory explains structural and behavioral constraints; and occupational health governance underscores the lack of technological adaptation and risk-based prevention. Together, they emphasize that the success of health policy depends not only on regulatory content but also on

institutional capacity to translate policy into consistent, equitable, and value-oriented action.

Despite growing global attention to occupational health governance in high-risk sectors, empirical studies on health policy implementation within the Indonesian police remain scarce. Most existing research focuses on general public health policies without addressing how bureaucratic structures and policy instruments shape health outcomes among law enforcement personnel. Given the administrative complexity and operational pressures characteristic of metropolitan police institutions such as Polda Metro Jaya, health governance requires a more adaptive and integrated institutional approach.

This study addresses that gap by offering a comprehensive analysis linking public administration theory, policy implementation, and occupational health governance within a unified framework. By examining the case of Polda Metro Jaya, the study identifies the underlying causes of implementation failure and formulates a policy model oriented toward workforce sustainability and institutional legitimacy. Theoretically, this research contributes to institutional sociology by demonstrating how employee health can serve as an indicator of bureaucratic integrity. Practically, the findings are expected to inform health governance reforms in other high-risk institutions in Indonesia, where employee well-being should be recognized not merely as an administrative goal but as a strategic foundation for building sustainable public value.

RESEARCH METHOD

This research employs a descriptive qualitative approach with a case study design, as its primary aim is not to quantify phenomena but to gain a deep understanding of how health policies are implemented within high-risk police institutions. A qualitative approach is appropriate because public policy, particularly health policy for public officials, operates within complex social and bureaucratic contexts. Bryda and Costa (2023) and Doyle et al. (2020) assert that qualitative inquiry enables researchers to capture contextual dynamics, power relations, and subjective meanings that cannot be reduced to numerical indicators. In this regard, the case study design allows for an in-depth exploration of processes, actors, and institutional interactions within a holistic system (Khoa et al., 2023; Taquette & Souza, 2022).

The research site, Polda Metro Jaya, was chosen for its status as Indonesia's largest police institution with the highest operational workload. With more than 28,000 personnel distributed across the Jakarta metropolitan area, it represents an extreme case of the challenges in implementing health policies under high-risk and high-pressure conditions. This setting enables analysis of the interrelationship between organizational scale, operational stress, and policy effectiveness. Moreover, Polda Metro Jaya has implemented annual health screening programs under Chief of Police Regulation No. 7 of 2013, yet with consistently low coverage, making it a critical case for examining the gap between policy design and practical execution.

Research participants were selected purposively based on their positions and relevance to health policy implementation. The sample consisted of 12 informants: three officials from the

Medical and Health Division (Biddokkes) responsible for coordination and reporting of health screenings; four officers from the Human Resources Bureau (Biro SDM) in charge of quota allocation and personnel administration; two field officers performing the examinations; and three police members receiving health services. This selection followed the principle of functional representation rather than numerical proportionality to ensure a comprehensive understanding of implementation processes and challenges (Stanley, 2023).

Data were collected through three primary techniques: in-depth interviews, document review, and limited observation. Semi-structured interviews facilitated open exploration of participants' experiences and perceptions, allowing for a deeper understanding of the internal logic and rationale underlying policy implementation. Document review included health screening reports from 2023–2024, Stakes classifications, mortality reports, and internal regulations such as Chief of Police Regulation No. 7 of 2013. These documents provided factual verification and served as triangulation references. Limited field observations were also conducted in Polri health clinics to observe screening practices and administrative procedures. The combination of these three techniques ensured a holistic understanding of normative, empirical, and behavioral dimensions of implementation (Sardana et al., 2023).

Data analysis followed a thematic approach, identifying patterns of meaning, barriers, and adaptive strategies emerging from interviews and documents. The analysis followed the standard procedures of data reduction, display, and conclusion drawing as outlined by Aspers and Corte (2019). A gap analysis framework was employed to map the distance between policy objectives and actual implementation, linking findings to policy implementation theory and occupational health governance.

To ensure data validity and reliability, the study employed both source and method triangulation. Source triangulation was achieved by comparing responses from policy-level and operational-level informants, while method triangulation was conducted by cross-checking interview findings with document analysis and field observations. Validity was further reinforced through member checking with key informants to confirm interpretive accuracy. The principles of credibility, transferability, and dependability were maintained to ensure that the research findings are scientifically sound and practically relevant for similar institutions facing comparable challenges.

RESULTS AND DISCUSSION

Overview of Health Policy Implementation in the Indonesian National Police

The implementation of health policy within the Indonesian National Police (Polri) reflects the inherent complexity of modern bureaucratic systems in managing occupational health challenges within high-risk institutions. The Regional Police of Metro Jaya (Polda Metro Jaya) provides a representative case for examining this dynamic, particularly regarding the execution of health screening policies designed to detect early disease risks and sustain institutional

resilience. Based on screening data from 2023–2024, there was a notable decline in participation rates, from 26% in 2023 to 24% in 2024. Out of 29,263 personnel in 2023, only 7,602 underwent screening, while in 2024, participation further decreased to 6,774 out of 28,684 personnel. This decline, despite a relatively stable number of total personnel, underscores a significant gap between policy formulation and practical implementation.

Table 1 Health Screening Coverage (2023–2024), Polda Metro Jaya

Year	Total Personnel	Screened	Coverage (%)
2023	29,263	7,602	26
2024	28,684	6,774	24

Source: Medical and Health Section Report (2024)

The low screening coverage highlights the weakness of preventive health strategies within an environment where occupational health should be a central concern. In a high-risk institution such as the police, where exposure to work-related stress, extended duty hours, and physical hazards are part of routine operations, insufficient screening participation signals a serious challenge to institutional resilience. Field observations at the Medical and Health Division (Biddokkes) of Polda Metro Jaya revealed empty waiting areas despite early scheduling announcements. Administrative officers noted that many personnel delayed their check-ups due to heavy operational workloads, particularly in traffic and criminal investigation units. This situation suggests that participation issues stem not only from individual motivation but also from organizational structure and workload distribution.

The classification of health risks (stakes) offers further insights into personnel health conditions. In 2023, most screening participants fell into Stakes 3 (4,544 personnel) and Stakes 4 (1,004 personnel), indicating moderate to high-risk profiles. However, in 2024, Stakes 4 surged dramatically to 3,744 personnel, more than a threefold increase, signifying a rising prevalence of high-risk individuals that may threaten institutional performance if not addressed systematically.

Table 2 Health Risk Classification (Stakes Categories), Polda Metro Jaya

Year	Stakes 1	Stakes 2	Stakes 3	Stakes 4	Total Screened
2023	1,496	397	4,544	1,004	7,441
2024	934	490	1,974	3,744	7,142

Source: Medical and Health Section Report (2024)

Informal interviews with Biddokkes officers suggested that the increase in Stakes 4 cases is strongly linked to chronic work stress and delayed detection of non-communicable diseases such as hypertension and diabetes. One informant (Bripka R.) stated that most personnel “only come for screening when symptoms are already severe,” as routine check-ups are often perceived as mere administrative formalities rather than components of a sustainable health system. This finding reinforces what Zhang and Zhang (2021) describe as a manifestation of street-level bureaucracy, where state policies are mediated by the interpretations and

discretionary practices of frontline actors operating under limited time and resources.

The discrepancy between policy design and field implementation is evident within Polri's health governance framework as regulated by the Chief of Police Regulation No. 7 of 2013 on Health Service Administration within the Indonesian National Police. The regulation assigns Biddokkes as the main health service provider, in coordination with the Human Resources Bureau (Biro SDM), which allocates screening quotas, and operational units, which ensure personnel participation. However, field observations indicated overlapping coordination between units, especially concerning scheduling and reporting. In several cases, discrepancies between data from operational units and Biddokkes reports led to delays in medical follow-up for high-risk personnel.

This condition illustrates institutional misalignment, where formal governance mechanisms fail to ensure adaptive implementation responsive to operational realities. As Cartwright and Roach (2021) argue, public policy failures often stem not from flawed design but from "interpretive gaps" between strategic and operational levels. In the case of Polri, such misalignment manifests as a disconnect between preventive health objectives and operational priorities emphasizing security performance.

Furthermore, screening results revealed concerning health outcomes. In 2024, there were 50 chronic disease cases and 78 deaths, most related to cardiovascular diseases and hypertension, conditions largely preventable through early detection.

Table 3 Health Outcomes at Polda Metro Jaya (2024)

Health Outcome	Number of Cases
Chronic Diseases	50
Deaths	78

Source: Medical and Health Section Report (2024)

The relatively high number of deaths indicates the persistence of preventable mortality due to delayed diagnoses and weak post-screening follow-up mechanisms. Interviews with a Polri physician (Dr. M.) revealed that many personnel were reluctant to undergo further examination after receiving their screening results, citing time constraints and administrative burden. This aligns with findings by Bentancur et al. (2023), who demonstrated that workers who skip routine health check-ups face significantly higher mortality risks.

This phenomenon highlights the limitations of top-down policy approaches that fail to consider organizational social contexts. According to Gorgenyi-Hegyes et al. (2021), successful policy implementation depends not only on clarity of objectives but also on institutional capacity and grassroots-level support. In Polri's case, despite the existence of a legal framework and formal structure, implementation remains hampered by weak institutional commitment, inadequate monitoring, and ineffective communication strategies.

From direct observation, the dense workload and limited time available to officers at Polda Metro Jaya were the primary obstacles. Screening rooms at Biddokkes were only open

during regular working hours, while most field officers could only attend after duty hours, resulting in postponed or canceled appointments. Health facilities also remain insufficient to accommodate the large number of personnel.

Theoretically, this situation can be analyzed through the precision prevention framework, which emphasizes data-driven and personalized interventions. Within Polri's context, such an approach implies that screening and preventive programs should be tailored to the specific risk profiles of each unit, for example, traffic units exposed to high physical stress and pollution may require more frequent screening than administrative divisions.

Bureaucratic Rationality and the Logic of Quota-Based Screening

The implementation of health policy in Polri reveals a distinctive pattern of bureaucratic rationality, a rationality of compliance in which administrative adherence is prioritized over substantive policy outcomes. In Polda Metro Jaya, the annual quota-based screening system exemplifies how bureaucratic logic emphasizing order, reporting, and numeric targets often displaces the core preventive and welfare-oriented essence of health policy. As Becker et al. (2022) note, modern bureaucracy operates on instrumental rationality (Zweckrationalität), where individual actions are directed toward formally defined goals through procedures and hierarchy. In this context, annual quotas function as instruments of performance measurement that enforce structural compliance rather than substantive effectiveness.

Empirical observations at Biddokkes confirmed this logic. Screenings took place in an atmosphere of rigid administrative procedure, with personnel attending according to schedules set by the HR division, completing forms, undergoing brief examinations, and returning to duty. Medical staff followed a daily target list with little time for in-depth consultations. One officer (Aiptu H.) remarked, "What matters is that the data are entered, because the central office will audit it later," underscoring the dominance of administrative compliance over meaningful medical engagement.

This logic produces paradoxical effects. While quotas are designed to ensure equitable access, they often foster symbolic compliance, screenings performed merely to fulfill administrative obligations without ensuring substantive early detection. This aligns with Lipsky's (2018) street-level bureaucracy theory, wherein frontline implementers make daily decisions under resource constraints and performance pressure, exercising discretion to "make the system work."

Field observations found cases where personnel signed attendance sheets without completing full examinations, or requested to have their names recorded to avoid being marked absent. As one informant (Bripka R.) noted, "Health checks are often just formality, field duties are more important." Such behavior exemplifies bureaucratic discretion, where both staff and participants treat policy implementation as an administrative burden rather than a welfare mechanism.

The limited resources further reinforce this pattern. Biddokkes faces medical staff shortages and inadequate facilities while facing administrative pressure from the central police headquarters to maintain high annual coverage rates. Consequently, screenings are often rushed, prioritizing data collection over clinical accuracy, an example of what McLaughlan and Lodge (2019) describe as reactive bureaucracy, where institutions respond retrospectively rather than proactively to health risks.

Between 2023 and 2024, Polda Metro Jaya recorded a decline in screening participation from 26% to 24%, alongside a threefold increase in Stakes 4 classification (from 1,004 to 3,744 personnel) and a 40% decline in Stakes 1. These trends indicate that the quota-based approach fails to capture the evolving health dynamics of personnel, consistent with Michele et al. (2023), who found that irregular screening correlates with higher morbidity and mortality risks.

Further investigation revealed that policy implementation is more influenced by reporting logic than by preventive urgency. Several HR officials (Kompol S.) stated that annual targets "must be achieved so that the report is accepted by headquarters," even if the achievement does not reflect comprehensive medical evaluation. This represents a classic manifestation of Weberian bureaucratic rationality, where organizational behavior is driven by adherence to formal rules and hierarchical authority rather than substantive public health outcomes.

The administrative setting at Biddokkes vividly illustrates this rationality: piles of report forms, personnel lists, and quota graphs fill the workspace. Weekly data compilation and submission cycles dominate staff activities, leaving no room for reflection on whether the screenings reduce chronic disease rates or enhance health awareness. The policy, in effect, becomes a bureaucratic ritual that perpetuates its own system rather than serving as a transformative instrument for personnel welfare.

This practice can also be interpreted through the ambiguity–conflict model, which situates policy implementation along a continuum between ambiguity and conflict. In Polri's case, health policy is highly ambiguous, its objectives are not concretely measurable, and low in conflict, there is little debate about reporting importance, resulting in symbolic compliance rather than substantive outcomes.

This analysis underscores that Polri's bureaucratic rationality remains within an industrial-modern paradigm rather than evolving toward the New Public Service model proposed by Denhardt and Denhardt (2018), which emphasizes creating public value through responsive, human-centered services. In practice, Polri's health policy remains dominated by performance reporting and reactive administrative control.

Resource limitations exacerbate the situation. Health program budgets are allocated based on output targets (number of personnel screened) rather than outcomes (reductions in chronic illness). Consequently, preventive interventions such as healthy lifestyle promotion, psychological support, or stress management remain marginal. Field data indicate minimal facilities for mental health assessment and no integration between physical and psychological screening records, despite global evidence showing that law enforcement officers face a 3.2

times higher risk of metabolic syndrome due to chronic occupational stress and sleep disorders (World Health Organization, 2024).

This reactive tendency also characterizes institutional responses to personnel mortality. In 2024, 78 deaths were recorded, mostly from preventable chronic diseases, yet institutional responses remain confined to administrative evaluations rather than systemic reform. Tuzovic and Kabadayi (2021) describe this pattern as a reactive governance trap, where public organizations remain caught in cycles of short-term crisis response rather than building long-term anticipatory capacity.

Institutional Misalignment: Disconnect between Policy Design and Operational Practice

This study reveals a significant institutional misalignment between the design of the Indonesian National Police (Polri)'s health policy and its operational implementation. Within the context of Polda Metro Jaya, this misalignment is not merely administrative but reflects deeper structural issues embedded in the institutional governance of Polri. Field observations show that the annual health screening, formally regulated through the Chief of Police Regulation No. 7 of 2013, lacks internal institutional coordination that should serve as the backbone of health governance. The Human Resources Bureau (Biro SDM) controls administrative planning and quotas, whereas the Medical and Health Division (Biddokkes) is responsible for technical execution and medical follow-up. In practice, however, these roles operate in isolation, creating a "grey area" that weakens accountability and blurs lines of responsibility.

According to Matland (2018), policy implementation outcomes are contingent upon two dimensions: the level of conflict and the degree of ambiguity in policy interpretation. When both are high, as evident in Polri's health policy, implementation tends to be shaped by local political power and contextual contingencies rather than policy design. A field officer (identified as Bripka T.) noted, "We often do not know who is actually responsible for ensuring members participate in screenings, whether HR should summon them or the medical unit should visit." This statement reflects the uncertainty surrounding administrative authority, where a policy intended as preventive health care becomes trapped in bureaucratic coordination mechanisms.

Such ambiguity fosters a condition where administrative rationality overrides the logic of public health service. Observations at a precinct in East Jakarta revealed that the annual screening was conducted in a ceremonial fashion. Medical officers operated a temporary post for only two days in a police hall with minimal equipment, serving hundreds of personnel, many of whom were not examined by the program's end. An HR officer on-site admitted that quota targets still had to be reported as fulfilled, with missing participants' names filled in for the next period. This indicates that implementation priorities have shifted from health outcomes toward administrative formalism.

This phenomenon exemplifies institutional decoupling, as defined by Hill and Hupe (2018), a separation between formal norms and actual practices. While the normative framework emphasizes prevention and early detection, the implementation has been reduced to symbolic

compliance aimed at producing performance reports. As one mid-level officer (Kompol R.) stated, "The screening report is part of the unit evaluation indicator, but there is no follow-up for those identified at high risk." This reflects a system focused on input compliance rather than outcome management, thereby diminishing the policy's public value.

The absence of a centralized digital infrastructure further exacerbates this institutional misalignment. As of 2024, no integrated electronic system connects Biddokkes' medical data with Biro SDM's personnel records. Data remain stored in separate spreadsheets across regional commands, hindering longitudinal analysis and real-time monitoring. Each unit submits screening data via email for manual consolidation at the provincial level, resulting in delays and inconsistencies. When asked about potential digital integration, a Biddokkes officer (Ipda M.) remarked, "We proposed an integrated system, but there is no central budget or policy yet." This technological gap weakens both organizational efficiency and institutional learning.

A comparative overview of the misalignment is presented in Table 4, highlighting discrepancies between the normative design and empirical practice of Polri's health governance.

Table 4 Comparison between Policy Design and Implementation Practice in Polri's Health Program at Polda Metro Jaya

Institutional Aspect	Policy Design (Normative)	Implementation Practice (Empirical)	Type of Misalignment
Responsibility Structure	Integrated coordination between HR and Medical Divisions	Weak coordination; fragmented implementation	Role and accountability ambiguity
Screening Mechanism	Annual, prevention-based health screening	Quota-driven, report-oriented implementation	Shift from preventive to administrative logic
Data System	Centralized digital database	Fragmented manual data by unit	Inconsistency and data inaccuracy
Performance Evaluation	Outcome-based (health results)	Output-based (number of screenings)	Reduction of performance meaning
Follow-up Procedures	Mandatory for high-risk personnel	No systematic medical follow-up	

Source: Author's analysis (2025)

The findings indicate that misalignment is systemic, affecting nearly all dimensions of policy execution, from organizational structure to evaluation mechanisms. When institutional responsibilities are poorly defined, each unit interprets its authority according to sectoral rationalities. This supports Matland's (2018) argument that policy ambiguity generates negotiation spaces at the implementation level, producing inconsistent and uneven outcomes across organizational units.

Within this context, a conflict of rationalities emerges. The Biro SDM operates under an administrative rationality, prioritizing compliance and reporting, while Biddokkes follows a professional medical rationality focused on care quality. The absence of an integrative mechanism causes these two rationalities to function in parallel, fragmenting the policy's

purpose. Even progressive initiatives such as digitalization become stalled due to the absence of a single coordinating authority. Consequently, institutional misalignment results not only in administrative inefficiency but also in a failure to generate public value for police personnel, the intended beneficiaries.

When performance is measured by compliance rather than health impact, institutional legitimacy erodes. The number of personnel classified as high-risk (Stakes 3 and 4) tripled in 2024, indicating a systemic failure in preventive health functions. Field observations at Biddokkes examination rooms further reveal inadequate capacity relative to workload, where limited staff and equipment serve large numbers of personnel without risk-based prioritization. This condition exemplifies a bureaucratic culture where policy ideals are decoupled from operational realities, resulting in a reactive bureaucracy that focuses on retrospective reporting instead of proactive prevention.

Leadership Accountability and the Culture of Reactive Governance

The study further identifies weak leadership accountability and the prevalence of reactive governance culture as root causes of ineffective health policy implementation in Polri. In practice, leadership rarely internalizes personnel health as part of institutional performance, treating it instead as an individual responsibility. Despite rising cases of chronic illness and premature mortality, health has not been embedded in Polri's governance system.

A mid-level officer (Kompol H.) confirmed that follow-up for high-risk personnel (Stakes 4 classification) is rarely conducted systematically: "Usually, we only know when someone is already seriously ill or hospitalized; there's no routine reporting." Data from 2024 show that only 18% of 1,024 high-risk personnel received formal medical referrals. This aligns with Ebinger et al. (2022), who describe reactive bureaucracy as a governance pattern that responds to crises post-factum rather than developing anticipatory systems.

The absence of health indicators in leadership performance evaluations reinforces this issue. A review of Polri's 2023–2024 performance documents reveals that evaluation systems prioritize operational productivity (outputs) rather than personnel welfare (outcomes). As one officer (Ipda L.) remarked, "As long as targets are achieved, health is a personal matter, not a leadership concern." Such perspectives reflect a bureaucratic culture that separates performance from well-being, contradicting modern governance principles emphasizing strategic performance management.

Hassan et al. (2023), through their Public Service Motivation (PSM) 2.0 framework, argue that moral legitimacy in public leadership derives from integrating human well-being into institutional goals. Effective public leaders are measured not only by output achievement but also by their capacity to support employee welfare and ethical sustainability. In the Polri context, the absence of this orientation demonstrates that health policy remains a bureaucratic ritual rather than an ethical dimension of public service.

Field observations at Polres Jakarta Selatan clinics corroborate this. Medical staff reported that many officers seek treatment only after severe symptoms appear, as no routine check-up system exists. There is no hierarchical reporting from clinics to supervisors, leaving leaders uninformed about their members' health conditions. The dominance of command rationality, emphasizing discipline and rapid results, continues to overshadow empathy and reflective governance. As an HR officer (AKBP F.) noted, "Health is a personal responsibility; if you're sick, you take leave. It's not the leader's problem."

This paradigm signifies a moral deficit in leadership, where the institution's ethical foundation weakens as health is excluded from performance legitimacy. Consistent with PSM 2.0, the neglect of personnel welfare undermines the moral authority to demand professionalism and commitment. Thus, Polri's reactive approach to health management reveals not only administrative inefficiency but also a broader ethical failure in institutional governance.

Toward Preventive and Data-Driven Health Governance

The emerging direction of health governance within public institutions, particularly in the context of the Indonesian National Police (Polri), necessitates a paradigmatic shift from a reactive and administrative model toward a preventive and data-driven system. This transformation is not merely a technocratic innovation but an epistemological reorientation in understanding health as an integral component of bureaucratic performance and public legitimacy. In alignment with the New Public Service (NPS) paradigm, personnel health should not be treated as a private concern but as a collective organizational responsibility to "serve those who serve." Within this framework, employee health becomes a form of public value, requiring participatory, evidence-based, and risk-responsive governance.

Field findings indicate that Polri's current health system still operates under a fragmented administrative logic. A mid-level officer in the Human Resources Bureau explained that "health examinations are usually conducted only during recruitment or promotion," while follow-up actions for high-risk personnel are rarely taken unless serious symptoms appear. This reflects a reactive rather than preventive approach. Observations from a Bhayangkara hospital in eastern Indonesia revealed that medical examinations remain largely manual and mass-based, with health data stored on paper forms later archived by administrative units. The absence of an integrated digital system prevents the transformation of health data into actionable knowledge for policy decisions.

According to Sulaiman et al. (2024), in the digital era, public bureaucracies must optimize digital analytics and predictive modeling to anticipate issues before they escalate into crises. When personnel health data are collected, analyzed, and integrated across units, organizations can establish early warning systems for physical and mental health risks. Thus, digitalization is not merely a tool for efficiency but a mechanism for institutional learning that enhances evidence-based decision-making.

This study proposes four systemic reform strategies. First, transitioning to adaptive, risk-based screening protocols is essential. Health examinations should not be uniform but differentiated according to risk profiles derived from medical and performance data. A medical officer from Biddokkes noted that "every member is treated the same in examinations, even though workloads and occupational risks differ." Adaptive screening aligns with the global literature on digital occupational health, emphasizing the use of predictive health analytics to detect stress-related or environmental health risks.

Second, integrating centralized digital medical records is an institutional prerequisite for effective health governance. Field observations show that each Bhayangkara hospital maintains separate administrative systems with no inter-unit connectivity. In some cases, test results are physically delivered to the Human Resources Bureau, leading to data loss and delayed responses. A centralized system would enable authorized access to real-time health information, allowing longitudinal analysis of both individual and collective health conditions. At the managerial level, this would facilitate the development of health performance dashboards, linking health risks with attendance, productivity, and work stress trends.

Third, establishing health accountability indicators for leadership performance is critical. Interviews revealed that health outcomes are rarely considered in evaluating unit leaders. As one officer reflected, "as long as no one falls seriously ill or dies, everything is considered fine." This illustrates that health has not yet been internalized as a managerial responsibility. Hieng and Prabawati (2024) emphasize that ideal public leadership is not limited to managing resources but also cultivating human-centered service values. Making personnel health an accountability indicator symbolically reaffirms employee well-being as a moral foundation of public leadership.

Fourth, strengthening cross-sectoral partnerships is integral to modern health governance. Polri can collaborate with the Ministry of Health, BPJS Kesehatan, or universities to develop comprehensive health databases. Such collaborations enhance technical capacity and build public credibility through open data and independent evaluation. Field observations revealed early initiatives, such as limited partnerships between Bhayangkara hospitals and medical schools for hypertension screening programs, but these efforts remain fragmented and dependent on individual initiatives or project-based funding rather than institutionalized national policy.

Through these four strategies, Polri's health reform aligns with the spirit of the New Public Service, emphasizing the need to listen to and engage personnel as organizational citizens rather than policy objects. Within the NPS framework, a good bureaucracy is not only efficient but also responsive to the human needs of its members. Hence, data-driven health reform is not merely a technological endeavor but a moral and institutional effort to build an empathetic, participatory, and value-oriented work ecosystem.

The transformation toward preventive and data-driven health governance also carries profound sociological implications. On one hand, digitalization fosters a reflective culture in which every decision is grounded in empirical evidence. On the other hand, it demands a shift in

organizational values, from a reactive, hierarchical culture to one of transparency and learning. Field observations revealed that some medical staff are still “afraid of making mistakes” when reporting data, as reporting systems are often associated with administrative sanctions. This finding underscores that successful data-based governance requires not only technological modernization but also cultural reform, moving from a “problem-concealing” to a “data-learning” organizational culture.

CONCLUSION

This study concludes that the root cause of ineffective health policy implementation in high-risk institutions such as Polri lies in institutional misalignment between normative policy design and reactive implementation practices. When health regulations are treated merely as administrative obligations rather than as instruments of value-based and preventive governance, the system loses its adaptive capacity to respond to evolving occupational risks. Findings indicate that the ambiguity of roles between the Human Resources Bureau and Biddokkes, weak digital infrastructure, and the absence of health accountability indicators in leadership evaluations create institutional gaps that undermine oversight and organizational learning. Within this context, the New Public Service paradigm provides a renewed conceptual framework, emphasizing that health governance is not merely about bureaucratic efficiency but about upholding human values and public legitimacy within state institutions. Therefore, reforms toward preventive and data-driven health systems should not be perceived solely as technocratic solutions but as moral and institutional imperatives to restore balance between policy rationality and implementation realities, ultimately strengthening the resilience of public bureaucracies in managing long-term structural risks.

ETHICAL STATEMENT AND DISCLOSURE

This study was conducted in accordance with established ethical principles, including informed consent, protection of informants’ confidentiality, and respect for local cultural values. Special consideration was given to participants from vulnerable groups to ensure their safety, comfort, and equal rights to participate. No external funding was received, and the authors declare no conflict of interest. All data and information presented were collected through valid research methods and have been verified to ensure their accuracy and reliability. The use of artificial intelligence (AI) was limited to technical assistance for writing and language editing, without influencing the scientific substance of the work. The authors express their gratitude to the informants for their valuable insights, and to the anonymous reviewers for their constructive feedback on an earlier version of this manuscript. The authors take full responsibility for the content and conclusions of this article.

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