Available online at: http://journal.uinsgd.ac.id/index.php/ks
Khazanah Sosial, Vol. 8 No. 1: 111-130

DOI: 10.15575/ks.v8i1.34229

Implementing Internal Public Service through a Risk-Based Employee Medical Check-Up (MCU) Program

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Abstract

This study analyzes the implementation of an employee Medical Check-Up (MCU) program as an internal public service in a regional public hospital in South Sumatra, given the rising risk of non-communicable diseases among the working-age population and the limited use of MCU outputs for evidence-based occupational health policy. The study applies a qualitative document analysis approach using official MCU implementation records for the 2025 cycle, including the service flow, the schedule of 664 participants across more than 130 work units, a risk-based examination matrix, an aggregation of 124 health findings, and employee attendance records. Data were analyzed through thematic content analysis based on a policy implementation lens.. The MCU is implemented through standardized procedures, a rotating cross-unit scheduling system, risk-based differentiation of examination packages, and an aggregate reporting mechanism integrated into the hospital's occupational health and safety database (K3RS). The aggregated findings indicate a predominance of metabolic disorders and cardiovascular risk factors, notably dyslipidemia, hyperuricemia, elevated fasting glucose, and hypertension. The program demonstrates how internal health services can strengthen administrative coordination and support data-informed decision-making for preventive and promotive interventions, thereby sustaining workforce capacity that underpins external public service delivery. This study contributes by explicitly mapping documentary evidence of MCU implementation to Edwards' dimensions while linking risk-based screening to organizational health data governance, an analytical combination that remains limited in empirical studies of MCU implementation in Indonesian government hospitals.

Keywords: Evidence-Based Governance; Internal Public Service; Medical Check-Up (MCU); Occupational Health; Public Hospital.

Abstrak

Penelitian ini menganalisis implementasi program *Medical Check-Up* (MCU) karyawan sebagai pelayanan publik internal di rumah sakit pemerintah daerah di Sumatera Selatan, sebagai respons atas meningkatnya risiko penyakit tidak menular pada usia kerja serta belum optimalnya pemanfaatan hasil MCU untuk kebijakan kesehatan kerja berbasis bukti. Penelitian menggunakan analisis dokumen kualitatif dengan sumber data dokumen resmi pelaksanaan MCU siklus 2025, meliputi alur layanan, jadwal 664 peserta dari lebih 130 unit kerja, matriks pemeriksaan berbasis risiko pekerjaan, rekapitulasi 124 temuan kesehatan agregat, serta data kehadiran pegawai. Data dianalisis melalui analisis isi tematik menggunakan lensa implementasi kebijakan. Pelaksanaan MCU berlangsung terstruktur melalui prosedur terstandar, penjadwalan bergilir lintas unit, diferensiasi paket pemeriksaan berbasis risiko kerja, serta sistem pelaporan agregat yang terintegrasi ke database K3RS. Profil temuan agregat didominasi gangguan metabolik dan faktor risiko kardiovaskular, seperti dislipidemia, hiperurisemia, hiperglikemia puasa, dan hipertensi. Temuan menunjukkan bahwa layanan kesehatan internal dapat memperkuat koordinasi administratif dan pengambilan keputusan berbasis data untuk intervensi promotif–preventif, sekaligus menjaga kapasitas SDM yang menopang keberlanjutan layanan publik eksternal. Studi ini menempatkan implementasi MCU bukan hanya sebagai skrining klinis, tetapi juga sebagai mekanisme tata kelola pelayanan publik internal yang mengintegrasikan prosedur layanan, diferensiasi risiko kerja, dan manajemen data kesehatan organisasi untuk mendukung keputusan kelembagaan.

Received: March 27, 2024; Revised: March 2, 2026; Accepted: March 5, 2026

Kata Kunci: Tata Kelola Berbasis Bukti; Pelayanan Publik Internal; Pemeriksaan Kesehatan; Kesehatan Kerja; Rumah Sakit Publik

INTRODUCTION

Over the past decade, the Indonesian government has placed the occupational health of civil servants at the center of bureaucratic reform and public service governance strengthening (Simandjorang et al., 2022; Zulhakim & Yogopriyatno, 2025). The epidemiological transition from communicable diseases to non-communicable diseases (NCDs) has created a major challenge for the productive-age population. The Ministry of Health of the Republic of Indonesia reported in 2023 that NCDs accounted for more than 70% of national mortality, with hypertension prevalence reaching 34.11%, diabetes mellitus 8.5%, and various forms of dyslipidemia exceeding 24% among adults (Kementerian Kesehatan RI, 2025). Data from the Basic Health Research Survey show that 95.5% of the population consumes insufficient fruits and vegetables, 33.5% engages in inadequate physical activity, and 29.3% of the productive-age population smokes daily, thereby increasing NCD risks among working-age groups (Kementerian Kesehatan RI, 2020). These trends indicate that occupational health no longer constitutes a residual issue but has become a structural concern that affects workforce productivity, including civil servants.

NCD implications for the public sector are significant because civil servants perform administrative and service functions that require consistent attendance and work performance. The National Civil Service Agency reported that, as of November 2025, Indonesia employed 5.58 million civil servants, meaning that their health carries systemic consequences for the quality of government services (Badan Kepegawaian Negara, 2025). Research demonstrates that worker health status correlates with productivity, absenteeism, and organizational performance (Restiatun et al., 2024; Taresh et al., 2025). Other studies confirm that chronic diseases and mental health disorders reduce work capacity and increase organizational burdens (Parwati et al., 2025; Suwarsi et al., 2024). In government hospitals, this issue becomes more complex because institutions not only provide health services to the public but also bear responsibility for protecting employee health through occupational health and safety (OHS) systems (Dewi & Wardani, 2022).

The implementation of Medical Check-Up (MCU) programs for civil servants and healthcare personnel represents an internal public service mechanism oriented toward early detection and occupational risk management. Indonesia regulates MCU services through Ministry of Health standards that ensure examinations follow established medical protocols (Lelyana & Sarjito, 2024). The Ministry of Manpower Regulation No. 02/MEN/1980 governs worker health examinations, while Ministry of Health Regulation No. 14 of 2021 and Law No. 1 of 1970 on Occupational Safety regulate service standards and workplace safety (Kementerian Kesehatan RI, 2021). Technological innovations such as telemedicine and remote monitoring systems have expanded access to and improved the efficiency of health examinations across regions (Hidayatullah et al., 2024; Mehta & Chaudhary, 2022). However, although many institutions routinely conduct MCU programs, scholars have rarely examined MCU as a data-driven internal public service policy implementation system.

In this study, internal public service refers to employee-facing services delivered by public organizations such as occupational health programs, HR welfare services, and internal safety systems, that are institutionally mandated and managed within public governance structures. Although the MCU is provided to civil servants and contract employees rather than to external citizens, it remains a component of public service governance because it protects and sustains the workforce capacity that directly determines the continuity, responsiveness, and quality of services delivered to the public. Therefore,

 ISSN 2715-8071 (online)

analyzing the MCU as an internal public service allows this study to link occupational health screening to bureaucratic coordination and evidence-based decision-making in the public sector."

The Regional Public Hospital *(Rumah Sakit Umum Daerah*-RSUD*)* Siti Fatimah, South Sumatra Province, implements the MCU program as an institutional practice that integrates service procedures, cross-unit scheduling, risk-based examination differentiation, and reporting mechanisms to strengthen the employee health database (RSUD Siti Fatimah, 2025f). Government hospitals conduct MCU programs annually, yet limited research has examined MCU as an internal public service policy implementation system. This gap has limited the optimal use of MCU data as a foundation for evidence-based occupational health policies, even though MCU findings can guide sustainable promotive and preventive strategies and health risk management for employees.

Previous research on Medical Check-Ups, occupational health, and organizational productivity in Indonesia has developed along three main trends. First, several studies treat MCU as an early detection instrument for NCDs and focus on individual clinical outcomes. These studies assess MCU effectiveness through medical indicators such as blood pressure, glucose levels, lipid profiles, and other metabolic risk factors (Hastuti & Pratama, 2022; Lestari, 2023; Putri et al., 2021). In regulatory contexts, scholars have examined MCU practices from procedural compliance and legal perspectives, particularly regarding service standards and informed consent (Anindyajati et al., 2022). Other research highlights individual behavior toward periodic health examinations and psychosocial factors influencing MCU participation, such as perceived benefits and preventive orientation (Maulana & Pradana, 2018). While this literature enriches understanding of MCU's medical and legal dimensions, it rarely addresses MCU as an organizational governance system integrated with institutional data management and decision-making processes.

Second, research on occupational health and productivity in Indonesia emphasizes the relationship between worker health status, workplace safety, work environment, and organizational performance. Empirical studies demonstrate that worker health significantly influences productivity and economic growth (Restiatun et al., 2024; Taresh et al., 2025). Behavioral health interventions and workplace health promotion programs improve employee health status and reduce NCD risks (Abdul Aziz & Ong, 2025; Siswati et al., 2022). Other research shows that effective OHS practices enhance project performance and workforce productivity (Rauzana & Dharma, 2023; Siregar et al., 2020). Work environment factors, ergonomics, and safety climate contribute to organizational performance (Basaria, 2023). Additionally, mental health issues such as work stress, burnout, and workplace bullying reduce productivity and increase organizational dysfunction risks (Ankhofiya et al., 2023; Kadir et al., 2025; Widodo & Saptadi, 2020; Yolanda & Hendijani, 2025). Despite demonstrating strong health–productivity relationships, most studies treat occupational health as an independent variable affecting organizational outputs and rarely examine how health screening programs such as MCU operate administratively as structured and documented internal public service systems within government institutions.

Third, public policy implementation literature asserts that program success depends on policy communication, resource availability, implementer disposition, and bureaucratic structure (Edwards, 1980). Scholars have widely applied this framework to evaluate health policies and other public programs. Meanwhile, research on health system innovation in Indonesia highlights how technology integration, telemedicine, and health information systems improve service access and efficiency (Hidayatullah et al., 2024; Jatmiko et al., 2023; Sumiati et al., 2025). Studies on health promotion financing emphasize the importance of regulatory support and institutional capacity in strengthening disease prevention efforts (Fuady et al., 2024; Gamalliel & Fuady, 2024). However, scholars have rarely linked MCU implementation

explicitly to policy implementation frameworks and evidence-based governance through systematic employee health database management.

These three research streams reveal a gap in integrating medical, administrative, and policy dimensions in MCU implementation within public institutions. Previous studies separate MCU as a clinical activity, a health promotion intervention, or a component of occupational safety systems without examining MCU as an internal public service policy implementation system that integrates service flows, cross-unit scheduling, risk-based examination differentiation, and institutional data management for decision-making. Therefore, research must combine policy implementation analysis with risk-based occupational health practices and organizational data utilization as a foundation for evidence-based governance in the public sector (Edwards, 1980).

This study aims to analyze the implementation of public service through the Medical Check-Up program at the Regional Public Hospital Siti Fatimah, South Sumatra Province. The study examines service flow mechanisms, scheduling systems and participant coverage, variations in risk-based examinations, and the management and implications of health findings for civil servant occupational health policy.

This study uses Edwards' (Edwards, 1980) policy implementation framework to explain how communication, resources, implementer disposition, and bureaucratic structure shape MCU effectiveness. The study argues that the MCU represents not merely a routine medical activity but an internal public service policy instrument that reflects organizational governance capacity. A structured, documented, and risk-based MCU implementation expands Edwards' (Edwards, 1980) framework by incorporating health data management as a strategic dimension of evidence-based governance. Therefore, the effectiveness of MCU implementation at the Regional Public Hospital Siti Fatimah can serve as an indicator of a regional hospital's capacity to build adaptive, transparent, and human-resource-oriented public service governance.

RESEARCH METHODS

This study designates the Regional Public Hospital Siti Fatimah, South Sumatra Province, as the unit of analysis at the institutional level. The study focuses on the implementation of the Medical Check-Up (MCU) program for civil servants and hospital contract employees as a form of internal public service. The study does not examine individual MCU participants as behavioral subjects; instead, it analyzes institutional mechanisms, including service flow, scheduling patterns, variations in risk-based examinations, and the reporting system for examination results. The study selects the institutional level as the unit of analysis because public policy implementation occurs within organizational contexts and is shaped by bureaucratic structure, administrative communication, and resource coordination (Edwards, 1980; Van Meter & Van Horn, 1975).

This study adopts a qualitative document analysis (QDA) design. QDA is appropriate because the unit of analysis is an institutional policy implementation mechanism that is materially expressed in official organizational records (e.g., service flow, schedules, risk matrices, reporting formats) rather than in individual perceptions or behaviors. Accordingly, the study systematically examines how the MCU program is organized, implemented, and recorded through formal documents, enabling an analytically grounded interpretation of administrative coordination and governance processes (Bowen, 2009).

This study uses secondary data derived from official MCU implementation documents issued by the hospital for 2025. The analyzed documents include: (1) Appendix I on the MCU examination flow; (2) Appendix II on the employee MCU schedule; (3) Appendix III on the list of examinations based on occupational risk; (4) Appendix IV on the list of diseases identified from MCU results; and (5) Appendix V

 ISSN 2715-8071 (online)

on employee attendance records. These documents represent administrative artifacts that reflect formal policies and operational practices within the organization (Bowen, 2009). The study selects official documents as the primary data source because organizational documents provide stable, authentic, and context-rich information regarding policy implementation processes.

Document inclusion criteria were as follows: (1) issued for the 2025 MCU implementation cycle; (2) classified as official hospital documents (e.g., formal appendices/SOP attachments) used in operational implementation; (3) containing identifiable administrative markers (e.g., document title, issuing unit/committee, date/period, and internal validation/endorsement by the responsible unit). Exclusion criteria included draft materials, informal communications (e.g., unissued memos), documents outside the 2025 cycle, and records not directly related to MCU implementation mechanisms (e.g., general promotional materials without procedural content)

The study collects data through a systematic document review technique. The researcher thoroughly examines each document, selects relevant sections, and codes the document content based on predetermined thematic categories. The researcher develops a coding sheet as an analytical instrument by referring to Edwards' (Edwards, 1980) policy implementation dimensions, namely communication, resources, implementer disposition, and bureaucratic structure. The researcher verifies the alignment between document content and the research focus to ensure consistency and credibility in the data collection process (Bowen, 2009; Corbin & Strauss, 2015).

The study analyzes the data using content analysis and thematic reduction. The researcher reads the documents repeatedly to identify patterns of implementation, administrative categories, and relevant health findings. The researcher conducts the analysis through three stages: data condensation, data display, and conclusion drawing/verification, as proposed by Miles and Huberman (Matthew B. Miles & Huberman, 2013). During the condensation stage, the researcher reduces the data according to categories of service implementation, scheduling systems, examination variations, and result reporting. During the display stage, the researcher constructs thematic matrices to map relationships among procedures and organizational structures. During the verification stage, the researcher interprets the findings from an implementation perspective to assess the extent to which MCU execution reflects effective, coordinated, and data-driven public service principles.

RESULTS AND DISCUSSION

Structure and Mechanisms of MCU Program Implementation at the Regional Public Hospital Siti Fatimah

This study finds that the Regional Public Hospital Siti Fatimah implements the Medical Check-Up (MCU) program for civil servants and contract employees through a structured, coordinated, and documented organizational system. The study shows that MCU implementation operates as an institutional administrative mechanism that integrates service flow, role distribution across units, reporting systems, and employee health database management. The study demonstrates that the MCU program does not operate as a sporadic activity but functions as an internal public service practice embedded within the hospital's bureaucratic structure.

First, the administrative structure of MCU implementation. MCU implementation documents show that hospital management designates the Hospital Occupational Health and Safety Committee (*Keselamatan dan Kesehatan Kerja Rumah Sakit*—K3RS) as the unit responsible for processing and integrating examination results (RSUD Siti Fatimah, 2025a). Hospital management coordinates MCU

implementation through an internal committee that collaborates with unit heads based on documented scheduling structures and service flow procedures (RSUD Siti Fatimah, 2025b, 2025a). The MCU committee prepares examination schedules on a rotating basis by unit or department to maintain service order and ensure operational continuity (RSUD Siti Fatimah, 2025b).

Each work unit receives an MCU schedule according to a calendar established by the committee and documented in Appendix II on the employee MCU schedule (RSUD Siti Fatimah, 2025b). Unit heads inform employees of the schedule and ensure participation according to the designated time listed in attendance records (RSUD Siti Fatimah, 2025e). This mechanism reflects vertical coordination between management and work units as well as horizontal coordination across units within the hospital's bureaucratic structure, as documented administratively (RSUD Siti Fatimah, 2025b, 2025e).

Documents on risk-based examination lists show that management differentiates examination types according to each unit's risk characteristics (RSUD Siti Fatimah, 2025c). Units with high medical exposure risk, such as laboratory installations and patient service units, receive more comprehensive examination packages based on the occupational risk examination list (RSUD Siti Fatimah, 2025c). Non-clinical units receive general examination packages and basic laboratory tests according to their occupational exposure level as specified in the same document (RSUD Siti Fatimah, 2025c). This differentiation pattern indicates that the MCU administrative structure formally adopts a risk-based approach in service implementation (RSUD Siti Fatimah, 2025c).

These findings show that the MCU administrative structure positions K3RS as the data integration hub based on examination flow and reporting mechanisms described in Appendix I and Appendix IV (RSUD Siti Fatimah, 2025d, 2025a). The MCU committee performs operational functions according to the structured schedule in Appendix II (RSUD Siti Fatimah, 2025b). Unit heads coordinate employee participation as reflected in attendance records in Appendix V (RSUD Siti Fatimah, 2025e). This structure demonstrates clearly defined, documented, and formalized role distribution within the MCU implementation mechanism at the Regional Public Hospital Siti Fatimah.

Second, the MCU service flow. The MCU examination flow document shows that the hospital implements sequential and standardized service stages (RSUD Siti Fatimah, 2025a). The service process begins with a registration stage lasting approximately five minutes, as stated in Appendix I (RSUD Siti Fatimah, 2025a). Participants verify their identity, sign informed consent forms, and complete examination forms according to documented procedures (RSUD Siti Fatimah, 2025a).

Medical staff then conduct physical examinations for approximately fifteen minutes according to the service sequence (RSUD Siti Fatimah, 2025a). Laboratory personnel collect blood and urine samples for approximately ten minutes following the physical examination, in accordance with the established examination list (RSUD Siti Fatimah, 2025c, 2025a). Medical personnel subsequently conduct electrocardiogram (ECG) examinations for approximately five minutes as part of the supporting examinations specified in the flow document and risk-based examination list (RSUD Siti Fatimah, 2025a, 2025c).

Laboratory and diagnostic units process examination results within five to seven working days according to the completion timeline stated in Appendix I (RSUD Siti Fatimah, 2025a). Administrative staff deliver examination results to participants after completing the validation process, following documented service mechanisms (RSUD Siti Fatimah, 2025a). The MCU committee then reports aggregated examination results to K3RS for employee health data processing as described in Appendix IV on MCU disease findings (RSUD Siti Fatimah, 2025d).

 ISSN 2715-8071 (online)

Table 1. MCU Examination Flow for Employees at the Regional Public Hospital Siti Fatimah

Service Stage	Main Activities	Estimated Time
Stage 1: Registration	Identity verification, informed consent, form completion	±5 minutes
Stage 2: Sample Collection	Blood and urine collection	±10 minutes
Stage 3: Examination	Physical examination and electrocardiogram (ECG)	±20 minutes
Stage 4: Result Processing	Laboratory and diagnostic analysis	5–7 working days
Stage 5: Reporting	Aggregation and integration into the K3RS database	After results are completed

Source: RSUD Siti Fatimah (2025a)

Data in Table 1 show that the hospital structures service stages systematically and sequentially. Each stage has a clearly documented time estimate. The estimated direct service time totals approximately thirty-five minutes, excluding laboratory processing time. This pattern reflects the presence of operational standards that regulate service rhythm consistently.

Third, the documentation and reporting system. The MCU disease findings document shows that the hospital recapitulates examination results in aggregate form based on disease type and case numbers (RSUD Siti Fatimah, 2025d). Administrative staff collect health findings from all units and categorize data according to health condition classifications as stated in Appendix IV (RSUD Siti Fatimah, 2025d). K3RS receives these reports to evaluate overall employee health conditions in accordance with documented reporting mechanisms in the examination flow (RSUD Siti Fatimah, 2025a, 2025d).

The MCU committee enters examination results into the hospital's internal documentation system after completing all service stages in accordance with the MCU implementation flow (RSUD Siti Fatimah, 2025a). K3RS uses these data to update the employee health database periodically based on aggregated findings (RSUD Siti Fatimah, 2025d). This mechanism shows that the hospital not only provides results to individual participants but also integrates data as institutional records within the hospital occupational health and safety system (RSUD Siti Fatimah, 2025a, 2025d).

Reporting documents show that staff input data only after relevant units validate all examination results according to the MCU processing stages (RSUD Siti Fatimah, 2025a). Staff prepare aggregated reports based on the MCU disease findings list to avoid individual bias and protect personal data confidentiality (RSUD Siti Fatimah, 2025d). This reporting pattern reflects a data-oriented administrative approach that supports collective employee health monitoring through the hospital's internal documentation system (RSUD Siti Fatimah, 2025d).

The recapitulation of health findings shows variations ranging from healthy status to specific health conditions requiring medical follow-up, as recorded in the MCU disease findings list. These variations indicate that the MCU produces outcome-based outputs that function as aggregate indicators of civil servant health conditions within the hospital's internal health data management framework (RSUD Siti Fatimah, 2025d).

Fourth, procedural consistency and standardization. The examination flow and MCU schedule documents show that the hospital applies uniform procedures across all units while adjusting examination types according to occupational risk levels (RSUD Siti Fatimah, 2025a, 2025b, 2025c). The MCU committee develops rotating schedules to ensure that each unit receives examination opportunities without

disrupting primary hospital services, as documented in Appendix II (RSUD Siti Fatimah, 2025b). This pattern reflects consistent implementation across units because each unit follows the same service framework with risk-based differentiation.

MCU implementation documents show that each service stage appears in written appendices that include examination flow, scheduling, and risk-based examination lists. These documents function as operational guidelines for implementers to carry out each service stage according to established standards (RSUD Siti Fatimah, 2025a). The existence of written documentation demonstrates that the hospital maintains formally documented procedural standards for each MCU implementation period.

Standardized service flow and time estimation show that the hospital organizes service processes in a replicable pattern for each implementation cycle as described in Appendix I (RSUD Siti Fatimah, 2025a). Risk-based examination differentiation operates within the same procedural framework as specified in the occupational risk examination list (RSUD Siti Fatimah, 2025c). This mechanism demonstrates a balance between general service standards and contextual adjustments based on unit characteristics.

The study concludes that MCU implementation at the Regional Public Hospital Siti Fatimah operates as a structured and documented organizational system based on examination flow, scheduling, risk-based examination lists, and aggregated examination results. The hospital integrates administrative structure, standardized service flow, aggregate reporting systems, and employee health database development into a formally documented bureaucratic mechanism (RSUD Siti Fatimah, 2025d). The MCU implementation reflects characteristics of internal public service that emphasize procedural compliance, occupational risk differentiation, and institutional data management through the K3RS system (RSUD Siti Fatimah, 2025a, 2025d).

Participant Coverage and Cross-Unit Scheduling Patterns

Participant coverage and cross-unit scheduling patterns in the implementation of the MCU program at the Regional Public Hospital Siti Fatimah include participant distribution, a rotating scheduling model, organizational efficiency, and employee attendance rates as indicators of administrative capacity and internal coordination.

First, total participants and unit distribution. The employee MCU schedule document shows that the MCU program covers a large number of participants across organizational functions (RSUD Siti Fatimah, 2025b). Document analysis indicates that the MCU committee recorded 664 valid participants scheduled for examination (RSUD Siti Fatimah, 2025b). The schedule document further shows that MCU participants come from more than 130 different work units or installations (RSUD Siti Fatimah, 2025b). These data indicate that the hospital involves medical service units, medical support units, administrative units, and operational support units within a comprehensive occupational health examination system.

The MCU schedule document shows that several units have a high number of participants due to service characteristics and larger staff numbers. The document shows that the group of doctors under 35 years old includes 52 scheduled participants. The nursing unit includes 51 scheduled participants. The group of doctors over 35 years old includes 39 scheduled participants. The ICU nursing unit includes 35 scheduled participants. The pharmacy unit includes 30 scheduled participants (RSUD Siti Fatimah, 2025b)..

The schedule document also shows that several units have smaller participant numbers due to limited staff size and specific work characteristics. The IPSRS unit includes 11 scheduled participants, and the housekeeping unit also includes 11 scheduled participants. This distribution indicates that the MCU

 ISSN 2715-8071 (online)

committee schedules examinations for clinical and non-clinical units within the same implementation period (RSUD Siti Fatimah, 2025b)..

Table 2. MCU Participant Distribution by Unit/Installation (Summary of Largest Units)

No.	Unit/Installation	Scheduled Participants
1	Doctors (< 35 years)	52
2	Nurses	51
3	Doctors (> 35 years)	39
4	ICU Nurses	35
5	Pharmacy Staff	30
6	Hospital Security Unit	28
7	Perinatology	27
8	Medical Records	22
9	Treasury & Fund Mobilization	19
10	Operating Room Nurses (IBS)	17
11	Emergency Room Nurses (IGD)	17
12	Midwives (IKB)	16
13	PONEK Unit	15
14	IPSRS	11
15	Housekeeping	11
	Others (±130 units/installations)	274
	Total	664

Source: Processed data from Appendix II, Employee Medical Check-Up (MCU) Schedule, RSUD Siti Fatimah (RSUD Siti Fatimah, 2025b).

Table 2 shows that the MCU program reaches clinical, support, administrative, and operational elements of the organization . Clinical units contribute a large number of participants because the hospital concentrates human resources in medical and nursing services . Non-clinical units also participate in the MCU program because the committee schedules examinations across functions as part of the hospital's internal occupational health service (RSUD Siti Fatimah, 2025b).

Second, the cross-unit rotating scheduling model. The MCU schedule document shows that the committee applies a rotating scheduling model based on work units or installations. The committee divides participants according to work units and assigns different examination dates for each unit. This mechanism indicates that the committee organizes examinations gradually to ensure an even and controlled distribution of participants (RSUD Siti Fatimah, 2025b).

The MCU examination flow document shows that the hospital integrates rotating scheduling with standardized service procedures for each session. The hospital applies the same service sequence for every participant, so differences in examination dates do not alter procedural structure. This scheduling model combines scheduling equity with process uniformity (RSUD Siti Fatimah, 2025a).

The risk-based examination list document shows that the hospital combines rotating scheduling with differentiated examination types based on occupational risk (RSUD Siti Fatimah, 2025c). Certain units receive more comprehensive examination packages due to higher exposure risk. This mechanism demonstrates that the hospital applies adaptive scheduling based on examination needs without changing the standardized service structure.

Third, organizational efficiency and operational management. The MCU schedule document shows that the hospital distributes schedules to ensure that primary services continue without disruption). The committee schedule examinations by unit so that the hospital does not withdraw all personnel simultaneously. This pattern shows that the hospital applies time management strategies to maintain service continuity while implementing the MCU program.

The examination flow document shows that the hospital sets direct service time at approximately 35 minutes per participant, enabling the committee to manage daily examination capacity. Laboratory and diagnostic units process results within five to seven working days, allowing the hospital to manage examination data processing in stages. This mechanism indicates that the hospital divides service workload into two phases: direct examination and result processing.

The schedule document shows that coordination between the MCU committee and unit heads ensures effective distribution because each unit receives a clear schedule. Attendance records show that the hospital monitors participant attendance as an indicator of schedule implementation. This pattern demonstrates that the hospital uses administrative instruments to maintain operational order and measurable implementation.

Fourth, employee attendance and participation. Attendance records show that the hospital documents participant attendance as part of implementation control and evaluation. The MCU committee records attendance and absence status for each scheduled examination. This mechanism shows that the hospital treats employee participation as a measurable indicator of scheduling effectiveness.

The MCU schedule document shows that 664 participants were scheduled, enabling calculation of participation rates by comparing schedule and attendance data. Attendance records allow researchers to identify units with high and low participation by comparing actual attendance with scheduled numbers. These data enable assessment of unit compliance with established schedules.

The Regional Public Hospital Siti Fatimah applies broad participant coverage and planned cross-unit scheduling through a rolling unit-based system. The hospital manages employee participation through gradual scheduling that preserves primary service continuity. The hospital enhances organizational efficiency through time estimation, workload regulation for diagnostic units, and administrative control through attendance monitoring. The rotating scheduling model, cross-functional distribution, and attendance monitoring system reflect organizational coordination capacity in implementing MCU as an internal public service. The combination of rotating schedules and risk-based examination differentiation demonstrates management's ability to balance service equity, occupational risk needs, and operational stability.

The study shows that the 664 participants scheduled for the MCU program consist of civil servants and contract employees working in more than 130 units or installations within the hospital (RSUD Siti Fatimah, 2025b). These data indicate that the MCU program reaches the entire organizational structure supporting public service delivery. This cross-unit coverage shows that hospital management positions civil servant health as an integrated component of internal public service governance.

The rotating scheduling model demonstrates that the hospital manages civil servant health examinations collectively without disrupting public service stability. This mechanism shows that MCU implementation focuses not only on individual examinations but also on managing the work capacity of civil servants as key public service resources. The attendance monitoring system shows that the hospital exercises administrative control over employee participation in the MCU program (RSUD Siti Fatimah, 2025e). This mechanism demonstrates that the hospital treats civil servant health as a measurable and manageable component within its organizational governance framework.

 ISSN 2715-8071 (online)

Risk-Based Examination Differentiation and Employee Health Findings Profile

The Risk-Based MCU Examination List document shows that the hospital classifies work units according to exposure characteristics and potential occupational risks. The document indicates that the hospital differentiates units with low, moderate, and high exposure risks through variations in the number and type of examination components provided.

The examination matrix document shows that units with direct medical exposure, such as the ICU and Radiology, receive more comprehensive examination coverage than non-clinical units such as IPSRS and Laundry. The document indicates that high-risk units receive additional supporting examinations, including spirometry, audiometry, and more comprehensive organ function tests. The document also shows that lower-risk units receive more basic examination packages consisting of routine laboratory tests and general physical examinations (RSUD Siti Fatimah, 2025c).

These findings indicate that the hospital uses job characteristics and exposure potential as the basis for determining examination depth for civil servants and contract employees in each unit. This pattern demonstrates that hospital management applies a risk-based examination adjustment principle within the internal occupational health service system.

Appendix III shows that the hospital groups examination types into three main categories: initial or general examinations, laboratory examinations, and supporting examinations (RSUD Siti Fatimah, 2025c). The document indicates that all civil servants and contract employees undergo initial examinations that include medical history taking and basic physical examinations.

The document shows that laboratory examinations include complete blood count, liver function, kidney function, lipid profile, and urinalysis as routine components for most units. The hospital adds supporting examinations such as chest X-ray, electrocardiogram (ECG), spirometry, and audiometry for units with higher exposure risks.

Table 3. Matrix of MCU Examination Types by Unit/Installation (Example of 5 Units)

Type of Examination	ICU	Radiology	IPSRS	Laundry	CSSD
Medical history & physical exam	√	√	√	√	√
Complete blood count	√	√	√	√	√
Urinalysis	√	√	√	√	√
Liver function	√	√	√	√	√
Kidney function	√	√		√	
Lipid profile	√	√	√	√	√
Chest X-ray	√	√	√	√	√
Electrocardiogram (ECG)	√	√	√	√	√
Spirometry	√			√	
Audiometry			√		
Work-related mental examination	√	√	√	√	√
Total components	10	9	8	9	8

Source: Processed data from Appendix III – Risk-Based MCU Examination List (RSUD Siti Fatimah, 2025c).

Table 3 shows that high-exposure units such as the ICU receive more examination components than non-clinical units such as IPSRS. The table indicates that the hospital maintains universal examination components for all civil servants, including medical history, physical examination, complete blood count, and urinalysis, while adding specific examinations for selected units (RSUD Siti Fatimah, 2025c). This

pattern demonstrates a balance between general examination standards and occupational risk-based differentiation.

The MCU Disease Findings List document shows that the hospital recapitulates health findings of civil servants and contract employees in aggregate form. The document reports a total of 124 health findings distributed across several categories of metabolic disorders, hematological conditions, and organ function abnormalities (RSUD Siti Fatimah, 2025d).

The document shows that the five most dominant findings include dyslipidemia with 40 cases, elevated uric acid with 16 cases, elevated eosinophils with 8 cases, elevated fasting glucose with 8 cases, and Grade I hypertension with 6 cases. The distribution appears as follows:

Table 4. Distribution of MCU Disease Findings (Top 5 + Others)

Type of Disease/Finding	Number of Cases	Percentage (%)
Dyslipidemia	40	32.3
Elevated uric acid	16	12.9
Elevated eosinophils	8	6.5
Elevated fasting glucose	8	6.5
Grade I hypertension	6	4.8
Others	46	37.1
Total	124	100.0

Source: Processed data from Appendix IV – MCU Disease Findings List (RSUD Siti Fatimah, 2025d).

Table 4 shows that dyslipidemia represents the most dominant finding, accounting for 32.3% of total cases. Elevated uric acid ranks second at 12.9% of cases. Elevated fasting glucose and Grade I hypertension indicate the presence of metabolic and cardiovascular risk factors among civil servants and contract employees.

This distribution shows that most MCU findings relate to metabolic disorders and cardiovascular risk factors commonly observed in working-age populations. The pattern indicates that the MCU functions as an instrument for collectively mapping health risks among civil servants within the organizational context of public service delivery.

The examination flow document shows that the hospital delivers examination results to participants and reports aggregated findings to K3RS for further processing. The document indicates that the hospital stores MCU results within its internal documentation system as part of the employee health database.

The document shows that aggregated MCU results can serve as the basis for identifying follow-up medical needs and strengthening promotive and preventive programs for civil servants and contract employees. This mechanism indicates that the hospital does not treat examinations merely as routine activities but develops a sustainable, data-based health monitoring system (RSUD Siti Fatimah, 2025a, 2025d).

The study shows that risk-based examination differentiation and aggregated health findings establish an administrative foundation for managing internal occupational health. These findings indicate that the MCU at the Regional Public Hospital Siti Fatimah functions both as an early detection instrument and as a health risk mapping system for civil servants within the hospital's public service structure.

DISCUSSION

 ISSN 2715-8071 (online)

This study shows that the Medical Check-Up (MCU) implementation at the Regional Public Hospital Siti Fatimah operates as a structured, documented, and coordinated internal public service system. The study finds that hospital management integrates the administrative structure, standardized service flow, occupational risk–based examination differentiation, cross-unit scheduling, and employee health database management into a systematic bureaucratic mechanism. The study shows that 664 civil servants and contract employees from more than 130 work units completed the MCU through a rolling scheduling model without disrupting continuity of services to the public. The study also shows that the hospital applies an occupational risk classification when it designs examination packages and compiles 124 aggregated health findings dominated by metabolic disorders and cardiovascular risk factors. These findings show that the MCU functions not only as an individual clinical examination but also as an instrument for managing civil servant health within an organizational governance framework.

This study argues that the MCU represents not merely a routine medical activity but an internal public service policy instrument that reflects organizational governance capacity. A clear administrative structure, a documented service flow, and a centralized reporting system indicate that MCU implementation fulfills the dimensions of communication, resources, implementer disposition, and bureaucratic structure described by Edwards (Edwards, 1980). Hospital management communicates the MCU policy through written schedules and cross-unit role allocation. The MCU committee and K3RS provide adequate administrative and technical resources to conduct examinations. Implementers demonstrate supportive dispositions through compliance with procedures and documentation. The hospital's bureaucratic structure facilitates integration of MCU results into the employee health database system.

A structured and occupational risk–based MCU implementation extends Edwards' (Edwards, 1980) framework by adding health data management as a strategic element of evidence-based governance. Edwards (Edwards, 1980) emphasizes communication, resources, disposition, and structure as determinants of successful policy implementation. This study shows that civil servant health database management functions as an additional mechanism that strengthens implementation capacity by integrating aggregated data into the organizational system. Therefore, the MCU at the Regional Public Hospital Siti Fatimah shows that the implementation of internal health policy depends not only on procedural compliance but also on organizational capacity to manage information as the basis for administrative decision-making.

Previous MCU research in Indonesia generally treats MCU as an early detection instrument for non-communicable diseases and focuses on individual clinical outcomes such as blood pressure, glucose levels, and lipid profiles (Hastuti & Pratama, 2022; Lestari, 2023; Putri et al., 2021). That literature deepens understanding of MCU's medical function, but it rarely examines MCU as an organizational governance system integrated with institutional data management. Regulatory studies emphasize procedural compliance and legal aspects such as informed consent (Anindyajati et al., 2022; Restiatun et al., 2024), while behavioral studies highlight psychosocial factors that shape individual participation in periodic health examinations, including perceived benefits and preventive orientation (Maulana & Pradana, 2018).

Research on occupational health and productivity shows that worker health status significantly affects organizational performance and economic growth (Restiatun et al., 2024; Taresh et al., 2025). Other studies show that health promotion interventions and effective occupational health and safety practices improve productivity and reduce disease risks (Abdul Aziz & Ong, 2025; Basaria, 2023; Rauzana & Dharma, 2023; Siregar et al., 2020; Siswati et al., 2022). However, most of this research treats occupational

health as an independent variable that influences organizational outputs and does not analyze how health screening programs operate administratively as documented systems inside government organizations.

Public policy implementation literature asserts that program success depends on communication, resources, implementer disposition, and bureaucratic structure (Edwards, 1980). Health system innovation literature adds that technology integration and information systems improve service efficiency (Hidayatullah et al., 2024; Jatmiko et al., 2023; Sumiati et al., 2025). However, studies that link MCU implementation to policy implementation frameworks and to civil servant health database management as a foundation for evidence-based governance remain limited. This study addresses that gap by integrating medical, administrative, and policy dimensions within a single analytical frame.

Historically, MCU implementation at the Regional Public Hospital Siti Fatimah indicates a shift from reactive occupational health approaches to more preventive and systematic approaches within a preventive occupational health governance framework. Public organizations in Indonesia have previously faced fragmented institutional coordination, resource constraints, and weak integration of occupational health and safety management systems (Lamba et al., 2019; Ramadhan & Indriani, 2025). Multiple sectors, including informal and construction sectors, show high occupational accident risks due to limited safety standard implementation and minimal structured preventive approaches (Arumsari et al., 2023; Widowati et al., 2024). Although Indonesia has established an occupational safety regulatory framework through Law No. 1 of 1970 and a national OHS management system, many institutions still experience gaps between regulation and practice (Buranatrevedh, 2015). In this context, the structured, documented, and risk-based MCU implementation at the Regional Public Hospital Siti Fatimah demonstrates institutionalization of prevention as part of modern bureaucratic practice, in which hospital management does not wait for declines in civil servant performance but systematically integrates early detection and health data management into organizational governance to strengthen public service capacity.

Socially, the dominance of metabolic disorders and cardiovascular risk factors indicates that civil servants as a productive-age group face health challenges associated with lifestyle patterns and workload within ongoing public service transformation. MCU implementation shows that public organizations carry a social responsibility to maintain civil servant work capacity as service providers to the public through structured occupational health mechanisms. This responsibility aligns with the Indonesian public sector's role in delivering basic occupational health services through government institutions and primary health centers, including the development of community-based occupational health services such as *Pos UKK* (Adi et al., 2024). The national regulatory framework through Law No. 1 of 1970 and oversight by the Ministry of Manpower and the Ministry of Health indicates that the state positions occupational health as an institutional mandate, although implementation across sectors still faces coordination challenges and uneven human resource quality (Hiraoka et al., 2017; Ramadhan & Indriani, 2025). Stakeholder analyses in the public sector also document coordination challenges and limited understanding of OHS management systems at the institutional level (Lamba et al., 2019), so an MCU program that covers 664 civil servants across units demonstrates a concrete institutional effort to internalize that responsibility. Cross-unit coverage and the rolling scheduling system show that the hospital treats civil servant health as a collective organizational concern rather than a purely individual matter, and this approach reflects a shift from partial responses toward more integrated occupational health governance in Indonesia's public sector.

Ideologically, the MCU implementation reflects an evidence-based public governance orientation in Indonesia's public sector, in which the organization integrates examination results into a health database as a rational basis for administrative decision-making. Integration of MCU data into the internal K3RS

 ISSN 2715-8071 (online)

system indicates that the hospital adopts a data-driven management paradigm that aligns with national agendas such as the *Satu Data Indonesia* policy, which emphasizes coordinated and standardized data management in public governance (Wibowo et al., 2023). This paradigm also connects to efforts to strengthen meta-governance and cross-sector collaboration through digital instruments that enhance bureaucratic transparency and accountability (Nurdiansyah & Harakan, 2025). Evidence-based governance challenges in Indonesia, including limited institutional capacity and coordination across levels of government (Lewis, 2010), show that integrating a civil servant health database through MCU represents a concrete practice of institutional capacity strengthening at the organizational level. In addition, scholars have recommended evidence-based approaches to health priority setting as a foundation for more equitable and effective public policy reform (Alfaqeeh et al., 2025), so the documented and digitized MCU implementation indicates an ideological commitment to positioning data as an instrument for legitimizing internal occupational health policy within modern public administration.

The MCU primarily functions as an early detection and health risk mapping instrument for civil servants. The implementation strengthens organizational capacity to manage human resources preventively and in measurable ways. The implementation also strengthens administrative transparency through documentation and aggregated reporting.

However, MCU implementation can generate dysfunction if the hospital does not conduct follow-up on health findings systematically and integrate them into sustainable occupational health policy. Aggregated data that the hospital does not link to long-term promotive and preventive programs can reduce MCU effectiveness, particularly in Indonesia's context of fragmented institutional coordination and overlapping authority between health and labor agencies (Ramadhan & Indriani, 2025). Although Indonesia has an extensive occupational health regulatory framework, several regulations lack detailed operational guidelines, which complicates institutional compliance and consistency (Hiraoka et al., 2017). Decentralization also produces variation in implementation capacity across regions and public organizations (Sudarwanto & Kharisma, 2022), while limited human resources and unequal distribution of occupational health personnel remain structural challenges (Kurniati et al., 2015). Across sectors, including construction and small and medium enterprises, weak safety culture and variable compliance levels also hinder the effectiveness of occupational health policies (Febrina Maharani et al., 2025; Rauzana & Dharma, 2023). These conditions indicate that risk-based examination differentiation in the MCU can face constraints if budget capacity, technical resources, and cross-unit coordination do not support consistent follow-up examinations and sustainable interventions, which reinforces the need to integrate follow-up as part of the occupational health policy implementation cycle in the public sector.

To address this dysfunction, the hospital needs to strengthen integration of MCU follow-up into a structured and sustainable occupational health policy. Hospital management needs to develop internal operational guidelines that specify follow-up mechanisms for medical management, referrals, and promotive and preventive interventions based on metabolic and cardiovascular findings among civil servants. K3RS needs to integrate the MCU database with the annual occupational health program planning system so that aggregated data do not stop at administrative documentation but continue into measurable and scheduled intervention planning. The hospital needs to strengthen cross-unit coordination and clarify internal authority allocation to prevent fragmented follow-up implementation, especially given the coordination challenges that often arise in the public sector. Management also needs to allocate human resources support and budget proportionally for high-risk units so that risk-based examination differentiation receives consistent follow-up interventions. In addition, the hospital needs to develop a continuous monitoring and evaluation system to assess compliance with follow-up

recommendations and to measure intervention effectiveness. Through these steps, the MCU implementation can shift from periodic screening to a complete, integrated, and sustainable occupational health policy cycle within an evidence-based public service governance framework.

CONCLUSION

This study concludes that the Medical Check-Up (MCU) implementation at the Regional Public Hospital Siti Fatimah functions as a structured, documented, and integrated internal public service system within organizational governance. The study shows that hospital management operates the MCU through a clear administrative structure, a standardized service flow, a rotating cross-unit scheduling system, occupational risk–based examination differentiation, and an aggregate reporting system connected to the health database of civil servants and contract employees. The study also shows that the recapitulation of 124 health findings, dominated by metabolic disorders and cardiovascular risk factors, provides an empirical foundation for collectively mapping employee health risks. These findings confirm that the MCU functions not only as a periodic clinical screening but also as a policy implementation instrument for occupational health that supports human resource management within a public service organization.

This study contributes to the literature by positioning the MCU as an internal public service policy implementation system that integrates medical, administrative, and data-based governance dimensions. The study extends the policy implementation framework by demonstrating that program success depends not only on communication, resources, implementer disposition, and bureaucratic structure, but also on organizational capacity to manage and utilize health databases as a basis for decision-making. The study also provides empirical contributions by presenting institutional data on implementation structure, coverage of 664 civil servants across more than 130 work units, occupational risk–based examination differentiation, and aggregated health findings within a government hospital context. Therefore, this study offers an integrative approach that combines occupational health analysis and organizational governance in the public sector.

This study has limitations because it relies on document analysis without conducting in-depth interviews or participatory observation of implementers and MCU participants. The study also does not quantitatively measure the effectiveness of MCU follow-up interventions on long-term changes in civil servant health status. The study does not evaluate the direct impact of the MCU on work productivity or measurable public service quality. Therefore, future research should develop a mixed-method design that combines document analysis, longitudinal health surveys, and organizational performance evaluation to provide a more comprehensive assessment of the effectiveness of MCU-based occupational health policy in the public sector.

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