



Implementing Indonesia's Free Health Check National Priority Program: A Case Study of Saka Kajang Village, Pulang Pisau Regency

Suprayitno*, Mochammad Helmy Fikri, Trisni Salsa Ramadina, Peronika Simanjuntak, Cyntia Lupita Sari, Melia Sinta

Department of Public Administration, Faculty of Social and Political Sciences, Universitas Palangka Raya, Palangka Raya, Indonesia

* Correspondent Author: suprayitno@fisip.upr.ac.id

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Abstract

The Cek Kesehatan Gratis (CKG) program is one of Indonesia's national priority initiatives designed to improve equitable access to preventive healthcare services. This study aims to analyze the implementation of the CKG program in Saka Kajang Village, Pulang Pisau Regency, Central Kalimantan Province. A qualitative descriptive approach was employed to obtain an in-depth understanding of the program's implementation. Data were collected through in-depth interviews with key stakeholders, field observations, and a review of relevant documents and literature. The findings indicate that the program has generally been implemented effectively and has been positively received by the local community because it improves access to free health screening services. Despite these achievements, several challenges remain, including limited healthcare facilities, inadequate financial and human resources, and the need for stronger coordination among implementing agencies. These constraints may affect the consistency and sustainability of program implementation if not adequately addressed. The study concludes that strengthening institutional coordination, improving resource allocation, and maintaining government commitment are essential to enhance the effectiveness and long-term sustainability of the CKG program. These findings provide practical implications for local governments, policymakers, and researchers seeking to strengthen the implementation of preventive healthcare policies in Indonesia.

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1. Introduction

National development in Indonesia is currently entering a phase in which the quality of life of the people has become the primary benchmark for governmental success. The administration of President Prabowo Subianto, which began on 20 October 2024, brings a new direction to national development by placing public welfare as its main priority (Setkab, 2025). Within this broader vision, Indonesia's development is not only focused on economic growth but also on improving the quality of life, strengthening national sovereignty, and ensuring equitable distribution of development outcomes across regions.

As a manifestation of this commitment, President Prabowo Subianto launched several National Priority Programs that serve as the foundation of government policies for the 2024–2029 period. These programs include Free Nutritious Meals (MBG), the construction of 3 million houses through the Housing Financing Liquidity Facility (FLPP) scheme, Merah Putih Cooperatives, People's Schools, Garuda Superior Schools, School Rehabilitation, Free Health Check-ups (Cek Kesehatan Gratis), Tuberculosis Eradication, the Development of Quality Hospitals, Food Barns, and the Construction of Dams and Irrigation Systems. Collectively, these programs aim to reduce social inequality, strengthen human capital, and foster a healthier and more competitive population.

Central Kalimantan Province is among the regions that have begun to experience the implementation of several of these national priorities, particularly in the health and social sectors. Programs such as Free Nutritious Meals, Free Health Check-ups, Tuberculosis Eradication, School Rehabilitation, the Food Estate initiative, and Merah Putih Cooperatives have been rolled out to address persistent disparities in access to public services. With a territorial area of approximately 153,443 km², Central Kalimantan is the largest province in Indonesia (Badan Pusat Statistik Provinsi Kalimantan Tengah, 2024). Despite its vast size, the province continues to face uneven development, largely due to infrastructural limitations that constrain access to education, healthcare, and economic opportunities, especially in remote and rural areas.

Within this provincial context, Pulang Pisau Regency illustrates the challenges of health service delivery under conditions of spatial inequality. Although it borders Palangka Raya City, the provincial capital, Pulang Pisau continues to experience disparities in infrastructure development, particularly in the health sector. This indicates that geographical proximity alone does not guarantee service equity. Jabiren, a district within Pulang Pisau Regency, oversees eight villages and has a community health center (Puskesmas) responsible for 18 Posyandu/Pustu (integrated service posts/sub-health centers). Jabiren District is known as one of the areas with limited access to adequate healthcare services. Administrative records from Puskesmas Jabiren show that the cumulative achievement rate of the Free Health Check-up program reached only 14.93% of the regional target of 36% as of 21 October 2025. Based on administrative records and field interview findings, this low level of coverage underscores

the complexity of policy implementation in contexts characterized by limited facilities, constrained human resources, and accessibility barriers.

Table 1.1. Results of the Community Satisfaction Survey in the Pulang Pisau Regency Health Sector

No.	Name of Health Service Unit	Community Satisfaction Index (CSI) Score
1	Pulang Pisau Regional General Hospital	87.62
2	Maliku Community Health Center	86.31
3	Jabiren Community Health Center	80.57
4	Pulang Pisau Community Health Center	89.50
5	Bereng Community Health Center	88.88
6	Tahai Community Health Center	82.06
7	Pangkoh Community Health Center	85.00
8	Bukit Rawi Community Health Center	86.59
9	Bahaur Tengah Community Health Center	81.15
10	Bawan Community Health Center	80.72
11	Tangkahen Community Health Center	83.20
12	Sebangau Community Health Center	87.22
13	Bahaur Hilir Community Health Center	82.93
Overall Community Satisfaction Index (CSI)		84.75

Source: Authors' compilation based on Community Satisfaction Survey (CSS) data from the Pulang Pisau District Health Office (2025).

Based on the survey results presented in Table 1.1, the Community Satisfaction Survey conducted by the Pulang Pisau Regency Health Office in 2024 indicates that Puskesmas Jabiren recorded the lowest Community Satisfaction Index among all public health centers in the regency. Specifically, Puskesmas Jabiren obtained a satisfaction score of 80.57, which is below the overall regency-wide index of 84.75. This pattern suggests notable variation in how healthcare services are perceived across service units within the same administrative context (Dinas Kesehatan Kabupaten Pulang Pisau, 2024).

Existing studies on health policy implementation in rural and peripheral regions have largely emphasized structural determinants such as infrastructure availability, fiscal capacity, and intergovernmental coordination as key drivers of service performance and policy outcomes (Abdoellah & Rusfiana, 2016; Nugroho, 2012). However, fewer studies have examined how these macro-level policy designs are interpreted, negotiated, and enacted at the micro level of village governance, particularly from the perspective of frontline implementers and community members who directly experience the program's delivery (Denzin & Lincoln, 2018; Sandelowski, 2000).

Within this context, Saka Kajang Village represents an analytically significant case. Located in Jabiren District, this village is characterized by limited health infrastructure and constrained access to comprehensive healthcare services, as reported by healthcare workers and village officials during field interviews conducted in October 2025. Although the presence of a Sub-Health Center (Pustu) provides basic health services, it remains insufficient to meet the broader healthcare needs of the community. Despite these structural constraints, interview findings and field observations indicate relatively high levels of community participation in the Free Health Check-up (Cek Kesehatan Gratis/CKG) program. As noted by one healthcare worker, *"In terms of participation, Saka Kajang Village is quite high—currently the highest percentage. Today, there are about 31 people present"* (Healthcare worker, interview, October 2025). This pattern suggests a divergence between limitations in local service capacity and the degree of community engagement, emphasizing the role of the Jabiren Community Health Center's routine implementation of the CKG program in mediating between national health policy objectives and the practical realities of service delivery at the local level.

Further insights from a key health sector informant indicate that the implementation of the CKG program continues to face fundamental policy-related challenges, particularly in relation to budgetary support. At the operational level, the program has not been supported by a dedicated budget allocation at either the national or provincial level and remains dependent on funding associated with the Non-Communicable Diseases (NCD) program. This fiscal arrangement directly affects service coverage, implementation intensity, and program sustainability, contributing to outcomes that remain below established targets.

Rather than treating limitations in infrastructure and funding merely as technical obstacles, this study positions them as a critical context to examining how national health policies are adapted, negotiated, and implemented at the village level. The CKG program in Saka Kajang Village not only provides access to standardized basic health examinations but also reveals the role of local governance capacity, coordination among health actors, and limitations in fiscal policy support in shaping policy outcomes at the grassroots level.

Accordingly, this study aims to conduct an in-depth analysis of the implementation of the CKG program in Saka Kajang Village, Jabiren District, Pulang Pisau Regency, Central Kalimantan Province. By focusing on a resource-constrained rural setting, this research seeks to enrich the literature on policy implementation and local governance by demonstrating how national priority programs operate at the village level under conditions of limited infrastructure. The findings are expected to provide empirical evidence that can inform policymakers in designing more context-sensitive health policies and in improving the quality of healthcare service delivery in remote and peripheral areas.

A review of previous literature provides the conceptual foundation in order to position this study within the field of policy implementation and local governance. This research does not merely describe concepts of public policy. Instead, it adopts a policy implementation

perspective to analyze how nationally designed health programs are translated into practice at the village level under conditions of limited resources.

Public policy is commonly defined as “*whatever governments choose to do or not to do*”, reflecting both governmental actions and inactions in responding to public problems (Dye in Purwabati et al, 2020). In this sense, public policy represents the government's strategic effort to understand social problems and formulate solutions through authoritative decisions (Kartasmita in Purwabawati et al., 2020). Anderson further emphasizes that public policy consists of a series of deliberate actions undertaken by government actors to achieve specific objectives (Anderson in Tahir, 2020). Within this framework, public administration functions as the mechanism through which policies are operationalized through coordination and collaboration among various stakeholders (Indradi, 2016).

To examine how public policies are implemented in practice, this study draws on the policy process framework proposed by Dunn, which conceptualizes policy as a sequence of interrelated stages, including agenda setting, policy evaluation (Dunn in Marwiyah, 2022). Among these stages, this study places analytical emphasis on the implementation stage, as it represents the critical point at which policy objectives are translated into concrete actions at the local level

Policy implementation is understood as the process through which policy objectives are realized through the actions of public officials and implementing organizations (Nugroho, 2012; Van Meter and Van Horn in Wahab, 2006). To systematically analyze the dynamics of implementation, this study adopts the policy implementation model developed by George C. Edwards III, which identifies four key factors influencing the success of policy implementation: communication, resources, disposition, and bureaucratic structure (Abdoellah & Rusfiana, 2016).

First is communication. In the context of a national health program, effective communication is a crucial prerequisite for ensuring that local-level implementers clearly understand policy objectives, operational procedures, and established performance targets. Second is resources. Resources include the availability of competent personnel, adequate budgetary support, supporting facilities, authority, and access to relevant information. This dimension is particularly important in analyzing health program implementation in rural areas, where fiscal and infrastructural constraints often limit service coverage. Third is disposition which refers to the attitudes, commitment, and motivation of policy implementers (Abdoellah & Rusfiana, 2016). The willingness of frontline health workers to support and adapt policy directives under conditions of limited resources plays a significant role in shaping implementation outcomes. Fourth, bureaucratic structure encompasses organizational arrangements, standard operating procedures (SOPs), and coordination mechanisms among implementing agencies (Abdoellah & Rusfiana, 2016). Institutional fragmentation and rigid procedures may hinder effective policy implementations, particularly within decentralized

governance systems.

By employing the Edwards III policy implementations framework, this study analyzes how resource constraints, communication processes, bureaucratic arrangements, and implementer dispositions shape the implementation of the Free Health Check-up Program in Saka Kajang Village. This theoretical framework enables the study to move beyond purely empirical description and provides an analytical lens for understanding why policy outcomes at the village level often diverge from nationally established targets.

2. Method

This study employed a qualitative descriptive approach to examine the implementation of Indonesia's Free Health Check (Cek Kesehatan Gratis/CKG) Program in Saka Kajang Village, Pulang Pisau Regency, Central Kalimantan Province. A qualitative approach was selected because it enables an in-depth understanding of policy implementation processes, stakeholder experiences, and contextual factors that influence the delivery of public health programs in natural settings (Creswell & Poth, 2018; Denzin & Lincoln, 2018). The study was conducted during October 2025 at Jabiren Community Health Center (Puskesmas Jabiren) and Saka Kajang Village, which were purposively selected because the village represents one of the service areas with active implementation of the CKG Program and receives institutional support from the village government. The research focused on examining the implementation process of the program, the factors supporting and constraining implementation, and community responses to the program.

Participants were selected using purposive sampling based on their direct involvement in the implementation of the CKG Program (Etikan et al., 2016). Eleven informants participated in the study, consisting of health administrators, healthcare workers responsible for implementing the program, and community members who had received CKG services. Data collection continued until information redundancy was achieved, indicating data saturation (Guest et al., 2006). Primary data were collected through semi-structured interviews using open-ended questions, allowing participants to describe their experiences and perceptions while maintaining consistency across interviews. Interviews were conducted face-to-face at the community health center and in the village, with follow-up clarification undertaken through WhatsApp when necessary. Field observations were also carried out to obtain a better understanding of service delivery practices and interactions between healthcare providers and community members.

Secondary data were obtained from official government documents, including the Technical Guidelines for the Free Health Check Program, Community Satisfaction Survey reports published by the Pulang Pisau Regency Health Office, organizational documents of Puskesmas Jabiren, the *Aplikasi Sehat IndonesiaKu* (ASIK), and relevant academic literature. These documents were used to complement and verify the interview findings through data triangulation.

All interview recordings were transcribed verbatim and analyzed using thematic analysis following Braun and Clarke (2006). The analytical process involved familiarization with the data, generation of initial codes, identification of themes, review and refinement of themes, and interpretation of findings. Documentary data were analyzed using qualitative content analysis to identify policy objectives, implementation mechanisms, and institutional arrangements relevant to the CKG Program. The interpretation of the findings was guided by the policy implementation framework adopted in this study, enabling empirical evidence to be examined systematically in relation to the dimensions of policy implementation. Triangulation of interview, observation, and documentary data was employed to enhance the credibility of the findings (Denzin & Lincoln, 2018).

The trustworthiness of the study was established using the criteria proposed by Lincoln and Guba (1985), namely credibility, transferability, dependability, and confirmability. Credibility was strengthened through triangulation of multiple data sources and participant categories, while transferability was supported by providing detailed descriptions of the research context and participants. Dependability was ensured by maintaining a systematic record of data collection and analysis procedures, and confirmability was achieved by grounding interpretations in empirical evidence derived from interviews, observations, and official documents. Ethical principles were observed throughout the research process. Participants were informed about the objectives of the study, the voluntary nature of their participation, and their right to withdraw at any stage. Verbal informed consent was obtained before each interview, participants' identities were anonymized using role-based identifiers, and all research data were stored securely and used solely for academic purposes (Creswell & Poth, 2018).

3. Results and Discussion

3.1 . Results

3.1.1. Communication

Communication is a fundamental determinant of successful policy implementation because it ensures that policy objectives, procedures, and responsibilities are clearly understood by implementing actors. Following Edward III's policy implementation framework (as cited in Abdoellah & Rusfiana, 2016), this study examines communication through three dimensions: transmission, clarity, and consistency.

The findings indicate that communication in implementing the Free Health Check (CKG) Program has generally functioned effectively. Jabiren Community Health Center (Puskesmas Jabiren) serves as the primary coordinating institution responsible for translating national policy directives into operational activities at the village level. Policy information is transmitted through a hierarchical communication system, beginning with the Ministry of

Health and district health authorities before reaching the community health center, village government, community health cadres, and local residents.

A healthcare worker explained that after receiving directives from higher authorities, the community health center organized internal coordination meetings and collaborated with village governments to mobilize community participation.

"The program comes from the national level. We conduct coordination meetings and ask village heads to help mobilize residents, including visiting houses to encourage participation." (Healthcare worker, interview, October 18, 2025)

This communication mechanism demonstrates a structured top-down implementation model while maintaining collaboration with local stakeholders. The involvement of village governments enables policy messages to reach residents more effectively, particularly in rural communities where interpersonal communication remains an important source of information. Similar findings have been reported by Suprayitno et al. (2026), who argue that coordination between implementing agencies and local governments strengthens policy implementation by reducing communication gaps between policymakers and beneficiaries.

The transmission process is also supported by clear coordination among healthcare workers. Operational schedules, staff assignments, and service locations are prepared by Puskesmas Jabiren and communicated through internal WhatsApp groups before being disseminated to village authorities. One healthcare worker explained:

"The health center prepares the monthly schedule, determines the assigned health workers, and informs us through the WhatsApp group before the activities begin." (Healthcare worker, interview, October 18, 2025)

The use of digital communication facilitates coordination among implementing staff and contributes to more efficient program management. At the same time, the centralized scheduling system ensures that healthcare personnel are distributed across villages according to service needs.

Communication was also characterized by a high degree of message clarity. The implementation of the CKG Program follows the Circular Letter of the Ministry of Home Affairs No. 400.5.2/290/SJ, which provides clear guidance regarding program objectives and implementation procedures. These policy directives are subsequently translated into operational activities by Puskesmas Jabiren through coordination meetings involving village governments and community health cadres. A healthcare worker explained:

"We coordinate with the village government, and they recruit local health cadres to assist us in providing services." (Healthcare worker, interview, October 18, 2025)

The participation of community health cadres enhances the clarity of policy communication

because information is delivered through trusted local actors who understand community characteristics and can explain the program using language familiar to residents. This finding supports Edward III's proposition that clear communication reduces ambiguity among policy implementers and beneficiaries, thereby increasing implementation effectiveness.

The third dimension, communication consistency, was reflected in the routine implementation of monthly health check activities. Although operational schedules occasionally changed because of village events or seasonal flooding, these adjustments were communicated systematically through established coordination channels. A key informant stated:

"Every month there is a schedule, although it may change if the village has another activity or when flooding occurs." (Key informant, interview, October 14, 2025)

Rather than weakening implementation, schedule adjustments illustrate administrative flexibility while maintaining policy consistency. Changes are communicated transparently to all implementing actors, allowing service delivery to continue despite local constraints. Such adaptive communication helps preserve community trust and minimizes confusion among program beneficiaries.

Overall, the communication dimension demonstrates that the implementation of the CKG Program in Saka Kajang Village is supported by effective coordination among government institutions, healthcare workers, village authorities, and community health cadres. Communication is characterized by structured policy transmission, clear operational guidance, and consistent information dissemination despite contextual challenges. These findings confirm Edward III's argument that effective communication constitutes a critical prerequisite for successful policy implementation and reinforce previous studies highlighting the importance of interorganizational coordination in improving public service delivery at the local level.

3.1.2 Resources

Resources constitute one of the most critical determinants of successful policy implementation. According to Edward III (as cited in Abdoellah & Rusfiana, 2016), even well-designed public policies are unlikely to achieve their intended objectives without adequate resources. These resources include human resources, information, authority, and facilities, all of which influence the capacity of implementing agencies to translate policy into practice. The implementation of the Free Health Check (CKG) Program in Saka Kajang Village demonstrates that the availability and management of these resources significantly affect both service quality and program sustainability.

The first resource dimension concerns human resources. The implementation of the CKG Program relies primarily on the healthcare personnel of Jabiren Community Health Center,

consisting of physicians, nurses, midwives, laboratory analysts, nutritionists, and administrative staff. Each professional performs specific responsibilities according to their competencies. Physicians supervise clinical services, nurses conduct basic health examinations and health education, midwives focus on maternal and reproductive health, laboratory analysts perform diagnostic tests, while nutritionists provide nutritional assessments and counselling. Administrative personnel support participant registration, documentation, and reporting through the national digital health information system.

In addition to healthcare professionals, village health cadres play an important role in supporting service delivery. Their responsibilities include participant mobilization, registration assistance, crowd management, and health promotion activities. This collaborative arrangement reflects the integration of formal healthcare providers and community-based volunteers in delivering preventive healthcare services.

Despite this multidisciplinary workforce, interview findings reveal that the number of healthcare personnel remains insufficient to meet operational demands. A key informant explained that each integrated health post is generally served by only two healthcare workers, while financial incentives are limited to transportation reimbursement.

"Two health workers are assigned to each integrated health post. They conduct the examinations, while the data are entered into the ASIK application. We only provide transportation reimbursement of around IDR 50,000 to IDR 60,000 from the Community Health Center budget." (Key informant, interview, October 14, 2025)

Healthcare workers also acknowledged that staff shortages frequently affect field operations.

"Usually there are three of us, but today I am working alone because the others are unavailable and no replacement is available." (Healthcare worker, interview, October 18, 2025)

These findings indicate that although qualified personnel are available, the quantity of implementing staff remains inadequate, particularly during outreach activities involving multiple service stations. Human resource shortages increase individual workloads and may reduce service efficiency if participant attendance continues to increase. Similar findings have been reported by Ferriyanto (2026), who argues that policy implementation capacity depends not only on institutional commitment but also on the adequacy of frontline personnel responsible for delivering public services.

To compensate for these limitations, Puskesmas Jabiren actively involves village health cadres in service delivery. A healthcare worker explained:

"Our core team consists of only three health workers, but five cadres assist us during the examinations. Their support allows us to maintain service quality despite staff shortages." (Healthcare worker, interview, October 18, 2025)

The involvement of community health cadres represents an adaptive implementation strategy that expands service capacity without substantially increasing operational costs. Beyond assisting healthcare workers, cadres also strengthen communication between service providers and local residents because they possess extensive knowledge of community characteristics and enjoy a high level of public trust. Their participation therefore enhances both operational efficiency and community acceptance of the program.

The second resource dimension concerns information, which is essential for coordinating implementation activities and ensuring that policy objectives are understood by both implementers and beneficiaries. The findings indicate that the CKG Program has adopted a digital information management system through the Aplikasi Sehat IndonesiaKu (ASIK). Healthcare workers use this platform to record participant data, upload examination results, and submit reports to the district health office.

Nevertheless, implementation challenges remain, particularly during participant registration. Healthcare workers explained that although digital registration is officially available through the Satu Sehat application and WhatsApp, many participants, particularly older adults, are unable to complete the process independently.

"Participants can register through the Satu Sehat application or WhatsApp, but most of the time we help them because many elderly participants do not have mobile phones or are unfamiliar with the technology." (Healthcare worker, interview, October 14, 2025)

Consequently, healthcare workers frequently perform manual registration before entering participant information into the digital system.

"We usually register participants manually first, and then we input the data into the online application ourselves." (Healthcare worker, interview, October 14, 2025)

These findings reveal that digitalization has improved reporting efficiency but has not fully eliminated administrative burdens. Limited digital literacy among elderly participants shifts additional responsibilities to healthcare workers, thereby increasing their workload during service delivery. Similar challenges have been identified in studies of digital public services, which emphasize that technological innovation alone cannot improve policy implementation unless accompanied by adequate user capacity and digital inclusion initiatives.

Information dissemination to the community is primarily conducted through village governments, health cadres, and integrated health posts. Community members generally reported that they learned about CKG activities through local health volunteers.

"We receive information from the health cadres because the activities are held every month." (Community member, interview, October 18, 2025)

This finding indicates that interpersonal communication remains more effective than digital communication in rural communities, particularly among older populations. Therefore, although digital platforms have strengthened administrative reporting, community-based communication continues to play a central role in ensuring program participation.

The third resource dimension relates to authority. Edward III emphasizes that effective policy implementation requires clear institutional authority and well-defined responsibilities among implementing organizations. The findings demonstrate that the organizational structure of the CKG Program clearly allocates authority among the Ministry of Health, the Pulang Pisau District Health Office, Puskesmas Jabiren, village governments, healthcare workers, and community health cadres.

Puskesmas Jabiren functions as the primary implementing institution responsible for planning operational schedules, assigning healthcare personnel, coordinating with village governments, and monitoring program implementation across eight villages within its service area. A key informant explained:

"Puskesmas Jabiren is responsible for eight villages, and we prepare the monthly implementation schedule for each service location." (Head of Administration, interview, October 14, 2025)

Healthcare workers confirmed that operational decisions are made centrally by the community health center.

"The health center prepares the schedule; we simply carry out the assigned activities." (Healthcare worker, interview, October 18, 2025)

This centralized authority ensures consistency in service delivery while allowing operational flexibility at the field level. Healthcare workers retain sufficient discretion to respond to unexpected technical problems without disrupting service delivery. Community members acknowledged that occasional equipment failures or logistical constraints were generally resolved immediately by the implementing team.

Overall, these findings demonstrate that institutional authority within the CKG Program is clearly defined and functions effectively through coordination among multiple administrative levels. Such clarity minimizes role ambiguity and facilitates efficient decision-making during implementation.

The fourth resource dimension concerns facilities and infrastructure. Interview findings consistently identify limited equipment and financial resources as the primary constraints affecting program implementation. Although the CKG Program offers comprehensive health examinations in principle, healthcare workers acknowledged that service delivery is restricted by insufficient diagnostic equipment and operational budgets.

"The application includes many examination features, but in practice we cannot perform all of them because equipment and budgets are limited." (Healthcare worker, interview, October 14, 2025)

Another healthcare worker similarly observed:

"The quality of services is constrained by limited examination equipment because the program does not have a dedicated operational budget." (Healthcare worker, interview, October 18, 2025)

Despite these limitations, the Saka Kajang Village Government provides complementary logistical support by purchasing diagnostic test strips for blood glucose, cholesterol, and uric acid examinations, as well as providing refreshments for participants attending monthly activities.

"The village government purchases examination strips every month and provides snacks for community members who participate." (Healthcare worker, interview, October 18, 2025)

Community members also recognized that although equipment occasionally became unavailable, the overall quality of services remained satisfactory.

"The services are good, although sometimes the examination equipment runs out." (Community member, interview, October 18, 2025)

These findings suggest that local government support partially compensates for the limited financial resources allocated to the national program. The active contribution of the village government illustrates how local institutional commitment can enhance policy implementation even when central funding remains insufficient. Nevertheless, dependence on village-level initiatives also raises concerns regarding long-term sustainability because service quality may vary across villages with different fiscal capacities.

Overall, the resource dimension demonstrates that the implementation of the CKG Program benefits from committed healthcare personnel, effective organizational authority, community participation, and local government support. However, shortages of healthcare workers, limited digital literacy among participants, inadequate medical equipment, and insufficient operational funding continue to constrain implementation. Consistent with Edward III's policy implementation framework, these findings indicate that the availability of resources remains a decisive factor influencing implementation effectiveness. Strengthening human resource capacity, expanding digital literacy initiatives, improving medical infrastructure, and ensuring more sustainable financial support are therefore essential to enhance the quality and continuity of preventive healthcare services under the CKG Program.

3.1.3. Disposition

Disposition refers to the attitudes, commitment, and willingness of policy implementers to carry out government programs in accordance with their intended objectives. According to Edward III (as cited in Abdoellah & Rusfiana, 2016), policy implementation is more likely to succeed when implementers possess a positive attitude toward the policy and demonstrate commitment despite operational constraints. In the context of the Free Health Check (CKG) Program, the findings indicate that healthcare workers exhibit a strong sense of responsibility and commitment, which has contributed significantly to the continuity of service delivery despite limitations in financial incentives and medical resources.

Field observations and interview data reveal that the implementation of the CKG Program is supported by constructive collaboration between Jabiren Community Health Center and the Saka Kajang Village Government. The village government provides logistical assistance, including examination venues, refreshments for participants, and supplementary medical supplies, while healthcare workers are responsible for conducting health examinations, delivering health education, and providing basic treatment when appropriate. This collaborative arrangement reflects a shared commitment among local stakeholders to improve community access to preventive healthcare services.

The attitudes of healthcare workers emerged as one of the strongest enabling factors in program implementation. Although operational conditions remain challenging, healthcare personnel consistently demonstrated professionalism and a strong service orientation. Interviews with community members revealed high levels of satisfaction with the behaviour and communication of healthcare workers during service delivery. Participants emphasized that healthcare workers were approachable, respectful, and willing to explain examination results in language that was easy to understand.

"They are all friendly and provide good services." (Community member, interview, October 18, 2025)

Another participant similarly stated:

"The healthcare workers are friendly, and they explain our health conditions clearly even though they cannot always provide medicines." (Community member, interview, October 18, 2025)

These findings suggest that interpersonal communication and positive attitudes among frontline healthcare workers strengthen public trust in the CKG Program. In preventive healthcare programs, community acceptance often depends not only on the availability of medical services but also on the quality of interactions between service providers and beneficiaries. Friendly and respectful communication encourages community participation and supports the long-term sustainability of public health interventions.

Despite this positive disposition, interviews also indicate that healthcare workers receive relatively limited financial compensation. Rather than performance-based incentives, implementing staff receive transportation reimbursement for each outreach activity conducted in the villages. One healthcare worker explained:

"We receive around IDR 50,000 as transportation reimbursement each time we conduct health services in the village." (Healthcare worker, interview, October 18, 2025)

Another informant clarified that the reimbursement is financed directly from the operational budget of Puskesmas Jabiren and varies according to travel conditions.

"Transportation costs are covered by the health center. In remote villages, expenses are sometimes much higher because we need river transportation and motorcycles, especially during the rainy season." (Healthcare worker, interview, October 14, 2025)

These findings demonstrate that financial incentives remain modest relative to the operational demands of outreach services. Healthcare workers frequently travel long distances, transport medical equipment, and provide services under difficult geographical conditions. Nevertheless, limited financial rewards have not diminished their willingness to implement the program. Instead, professional responsibility and commitment to public service appear to be stronger motivational factors than monetary incentives.

This finding supports Edward III's argument that the disposition of implementers extends beyond formal organizational arrangements and includes individual commitment to policy objectives. Similar observations have been reported in previous studies of public service implementation, which found that intrinsic motivation and professional ethics among frontline workers often compensate for limited organizational resources and financial support (Ferriyanto, 2026). However, sustained reliance on intrinsic motivation alone may not be sufficient to maintain program effectiveness over the long term.

Healthcare workers also expressed expectations for greater institutional support to improve program implementation. Several informants emphasized the need for increased operational budgets, additional medical supplies, and more adequate transportation support, particularly for outreach activities conducted in geographically isolated villages. These expectations should not be interpreted as dissatisfaction with the program itself but rather as constructive feedback aimed at improving service quality and ensuring program sustainability.

Overall, the disposition dimension indicates that the implementation of the CKG Program is supported by highly committed healthcare workers who continue to deliver services professionally despite limited incentives and operational challenges. Positive attitudes toward the program, effective communication with community members, and a strong sense of public service have strengthened community trust and participation. Nevertheless, sustaining this positive disposition requires greater institutional recognition through adequate financial

support, improved working conditions, and continuous professional development. Strengthening these aspects would not only enhance staff motivation but also contribute to the long-term effectiveness and sustainability of the CKG Program within rural communities.

3.1.4. Bureaucratic Structure

Bureaucratic structure constitutes the fourth dimension of Edward III's policy implementation framework and refers to the organizational arrangements, standard operating procedures (SOPs), and division of responsibilities that guide policy execution (Edward III, as cited in Abdoellah & Rusfiana, 2016). A well-structured bureaucracy facilitates coordination among implementing agencies, minimizes administrative ambiguity, and promotes consistency in service delivery. The findings of this study indicate that the implementation of the Free Health Check (CKG) Program in Saka Kajang Village is supported by a relatively well-defined bureaucratic structure characterized by standardized procedures and effective collaboration among government institutions, healthcare workers, and community health cadres.

The implementation of the CKG Program follows operational procedures established by the Ministry of Health and implemented through the Pulang Pisau District Health Office and Puskesmas Jabiren. These procedures regulate participant registration, health examinations, data recording, and reporting using the national digital health information system. Interview findings suggest that the procedures are simple and accessible, allowing community members to participate without experiencing significant administrative barriers. A healthcare worker explained:

"The procedure is very simple. New participants only need to bring their identity card and complete the registration form, while returning participants present their visit card before undergoing the examination." (Healthcare worker, interview, October 18, 2025)

The simplicity of these procedures contributes to efficient service delivery by reducing administrative complexity while maintaining accurate participant records. First-time participants complete basic registration, whereas returning participants continue their health monitoring through existing medical records. Attendance is subsequently documented and reported through the ASIK digital information system, ensuring that program implementation complies with national reporting requirements.

The findings indicate that standardized operational procedures also contribute to service consistency across different villages within the jurisdiction of Puskesmas Jabiren. Although outreach activities are conducted in geographically dispersed communities, healthcare workers apply the same registration process, examination sequence, and reporting mechanism at every service location. Such procedural consistency supports equal access to healthcare services while maintaining uniform service standards throughout the

implementation area.

Beyond administrative procedures, the effectiveness of the bureaucratic structure is also reflected in the clear distribution of responsibilities among implementing actors. Puskesmas Jabiren functions as the principal implementing institution responsible for operational planning, scheduling outreach activities, assigning healthcare personnel, supervising service delivery, and submitting program reports to the district health office. Healthcare workers conduct medical examinations, provide health education, record participant information, and upload service data through the ASIK application. Village governments facilitate implementation by providing venues, logistical support, and community mobilization, while village health cadres assist healthcare workers with participant registration, health promotion, and service coordination at the community level.

A key informant described the organizational arrangement as follows:

"Two healthcare workers are assigned to each integrated health post to conduct the examinations, while all service data are recorded through the ASIK application." (Key informant, interview, October 14, 2025)

This division of responsibilities demonstrates a complementary implementation model in which each stakeholder performs specific tasks according to institutional authority and professional competence. Rather than creating overlapping responsibilities, the organizational structure encourages collaboration among different actors while maintaining clear lines of accountability.

The role of village health cadres represents an important component of this bureaucratic arrangement. Healthcare workers explained that village governments recruit local cadres who receive guidance from the community health center before participating in outreach activities.

"The village government recruits local health cadres to assist us during the implementation of the program." (Healthcare worker, interview, October 18, 2025)

The participation of community health cadres strengthens the implementation process because they possess detailed knowledge of local communities and maintain close relationships with residents. Their involvement facilitates participant mobilization, improves communication between healthcare providers and beneficiaries, and enables healthcare workers to concentrate on clinical examinations. This collaborative approach illustrates the integration of formal bureaucratic structures with community-based participation, thereby increasing both implementation efficiency and public acceptance of the program.

The findings also indicate that the bureaucratic structure remains sufficiently flexible to respond to operational challenges encountered during implementation. Healthcare workers reported that technical problems, such as temporary shortages of medical supplies or

equipment malfunction, were generally addressed immediately without disrupting service delivery. Community members similarly acknowledged that although equipment occasionally became unavailable, healthcare workers adapted quickly to ensure that examinations continued whenever possible.

Such operational flexibility demonstrates that standardized procedures do not prevent local adaptation. Instead, implementing personnel exercise limited administrative discretion to respond to unforeseen field conditions while remaining within the overall policy framework. This balance between procedural standardization and operational flexibility is particularly important in rural settings, where geographical conditions and infrastructure limitations frequently require practical adjustments during service delivery.

These findings support Edward III's argument that bureaucratic effectiveness depends not only on formal organizational structures but also on the ability of implementing agencies to coordinate responsibilities efficiently and adapt to contextual challenges. Similar conclusions have been reported by Suprayitno et al. (2026), who found that clearly defined organizational roles and effective interinstitutional coordination improve the implementation of public service programs at the local level. Likewise, Ferriyanto (2026) argues that institutional coordination and administrative clarity strengthen governance by reducing implementation uncertainty and enhancing organizational accountability.

Overall, the bureaucratic structure supporting the implementation of the CKG Program in Saka Kajang Village demonstrates several institutional strengths. Standard operating procedures are clear and easily understood by both implementers and participants, organizational responsibilities are distributed systematically among relevant stakeholders, and coordination mechanisms facilitate efficient service delivery across multiple administrative levels. The integration of community health cadres into the implementation process further enhances bureaucratic capacity by expanding outreach while maintaining community engagement. Although operational challenges remain, particularly concerning resource limitations, the existing bureaucratic structure provides a stable institutional foundation for implementing preventive healthcare services. These findings indicate that clear organizational arrangements, standardized procedures, and collaborative governance constitute essential institutional conditions for sustaining the effectiveness of the CKG Program in rural communities.

3.2 Discussion

The findings of this study demonstrate that the implementation of Indonesia's Free Health Check (CKG) Program in Saka Kajang Village has generally been effective despite several operational constraints. Using Edward III's policy implementation framework, this study shows that communication, resources, disposition, and bureaucratic structure collectively influence the effectiveness of program implementation. Rather than operating independently,

these four dimensions interact dynamically, creating both opportunities and constraints that shape policy outcomes at the local level. The findings therefore reinforce Edward III's proposition that successful policy implementation depends on the simultaneous functioning of multiple institutional factors rather than the strength of a single implementation variable.

Communication emerged as one of the strongest determinants of implementation success. The hierarchical transmission of policy from the Ministry of Health to the district government, community health center, village government, and community health cadres ensured that policy objectives were consistently understood by implementing actors. The use of regular coordination meetings, village outreach, and community-based communication contributed to relatively high community participation in the program. These findings support Edward III's argument that clear and consistent communication minimizes implementation ambiguity and strengthens policy compliance. Similar conclusions have been reported by Suprayitno et al. (2026), who found that effective communication among implementing institutions improves policy coordination and enhances public participation in government programs. The present study extends these findings by demonstrating that interpersonal communication through village governments and community health cadres remains more influential than digital communication in rural communities where face-to-face interaction continues to be the dominant channel for information exchange.

Although communication functioned effectively, the implementation process remained constrained by resource limitations. Human resources, financial support, medical equipment, and digital infrastructure were insufficient to fully support the increasing demand for preventive healthcare services. Healthcare workers frequently experienced staff shortages during outreach activities, while the availability of diagnostic equipment was limited because the program did not receive a dedicated operational budget. Furthermore, although the ASIK digital reporting system improved administrative efficiency, limited digital literacy among elderly participants required healthcare workers to manually register participants before entering data into the system. These findings indicate that digital transformation alone cannot improve policy implementation unless accompanied by adequate human capacity and technological accessibility. Similar observations have been reported in studies of digital public administration, which emphasize that technological innovation should be supported by institutional readiness and user capability to generate meaningful improvements in public service delivery.

The findings also reveal that resource constraints have been partially compensated through collaborative governance involving multiple stakeholders. Village governments provide logistical support by purchasing examination materials, preparing service locations, and encouraging community participation. Community health cadres assist healthcare workers during outreach activities, allowing limited medical personnel to serve larger numbers of participants. This collaborative arrangement demonstrates that local institutional capacity

can compensate for limitations in central government funding. From the perspective of collaborative governance, the implementation of the CKG Program illustrates how local governments, healthcare institutions, and community organizations jointly contribute to policy implementation. Consequently, the effectiveness of the program depends not only on government resources but also on the ability to mobilize community participation and local institutional support.

Another important finding concerns the disposition of policy implementers. Healthcare workers consistently demonstrated positive attitudes, professional commitment, and strong motivation despite receiving relatively limited financial incentives. Community members repeatedly described healthcare workers as friendly, responsive, and willing to explain health conditions clearly, indicating that interpersonal trust has become an important component of program effectiveness. These findings support Edward III's proposition that implementers' commitment significantly influences policy outcomes because positive attitudes encourage greater responsiveness to community needs. At the same time, the findings suggest that intrinsic motivation currently plays a greater role than financial incentives in sustaining service delivery. While this reflects the professionalism of healthcare workers, long-term dependence on intrinsic motivation alone may not be sustainable if operational workloads continue to increase without corresponding institutional support. Increasing transportation allowances, improving working conditions, and providing opportunities for continuous professional development would therefore strengthen both employee motivation and program sustainability.

The bureaucratic structure supporting the CKG Program also contributes positively to implementation effectiveness. Standard operating procedures are clearly defined, participant registration is relatively simple, and responsibilities are distributed systematically among the Ministry of Health, district health authorities, community health centers, village governments, healthcare workers, and community health cadres. This organizational arrangement reduces role ambiguity and facilitates coordination across multiple administrative levels. The findings therefore confirm Edward III's argument that clearly defined bureaucratic structures improve implementation consistency by establishing transparent organizational responsibilities and operational procedures. However, the study also demonstrates that bureaucratic effectiveness depends not only on procedural standardization but also on institutional flexibility. Healthcare workers frequently adjusted service delivery schedules in response to flooding, village activities, and temporary shortages of medical supplies without disrupting overall program implementation. This adaptive capacity suggests that flexible implementation mechanisms are particularly important for public health programs operating in geographically dispersed rural areas.

An important contribution of this study lies in demonstrating the interdependence of the four implementation dimensions. Communication supports the effective utilization of resources by

improving coordination among implementing actors. Adequate resources strengthen the motivation of healthcare workers by reducing operational constraints. Positive disposition encourages implementers to maximize available resources despite financial limitations. Meanwhile, an effective bureaucratic structure provides institutional mechanisms through which communication, resources, and implementer commitment can operate efficiently. This interaction suggests that weaknesses in one implementation dimension may be compensated temporarily by strengths in another dimension. For example, limited financial resources in Saka Kajang Village have been partially offset through strong collaboration between healthcare workers, village governments, and community health cadres. Nevertheless, such compensatory mechanisms should not replace systematic government investment because they rely heavily on local institutional commitment that may vary across regions.

Compared with previous studies, the present research contributes new empirical evidence regarding the implementation of Indonesia's Free Health Check Program at the village level. Existing studies have primarily focused on national policy objectives, program coverage, or preventive healthcare outcomes, while providing limited analysis of implementation processes within local administrative settings. By examining the interaction between communication, resources, disposition, and bureaucratic structure, this study offers a more comprehensive understanding of how national health policies are translated into local practice. The findings therefore extend Edward III's implementation framework by illustrating how community participation and village-level institutional support enhance policy implementation within decentralized public health systems.

The practical implications of this study are equally important. First, strengthening human resources through additional healthcare personnel and continuous professional training would improve service quality and reduce workload pressures. Second, increasing operational funding and expanding the availability of medical equipment would enhance the comprehensiveness of health examinations. Third, improving digital literacy among community members, particularly older adults, would maximize the benefits of the ASIK and Satu Sehat applications while reducing administrative burdens on healthcare workers. Finally, institutionalizing collaboration between community health centers, village governments, and community health cadres would strengthen local implementation capacity and improve the sustainability of preventive healthcare programs.

Overall, this study demonstrates that the successful implementation of the CKG Program cannot be explained by a single implementation factor. Instead, policy effectiveness emerges from the interaction of communication, resources, disposition, and bureaucratic structure within specific local contexts. Although significant challenges remain, particularly regarding human resources, operational funding, and medical infrastructure, the commitment of healthcare workers, strong community participation, and collaborative local governance have enabled the program to function effectively in Saka Kajang Village. These findings contribute

to the growing literature on policy implementation by providing empirical evidence from rural Indonesia and offer practical recommendations for strengthening the implementation of preventive public health policies in decentralized governance systems.

4. Conclusion

This study examined the implementation of Indonesia's Free Health Check (CKG) Program in Saka Kajang Village using Edward III's policy implementation framework. The findings indicate that the program has been implemented effectively, supported by clear communication, strong interorganizational coordination, committed healthcare workers, and well-defined bureaucratic arrangements. These factors have contributed to increasing community participation and improving access to preventive healthcare services. Nevertheless, the implementation process continues to face important challenges, including shortages of healthcare personnel, limited medical equipment, inadequate operational funding, and constraints related to digital literacy among participants. These limitations reduce the capacity of frontline implementers and may affect the long-term sustainability of the program if they are not systematically addressed.

This study also demonstrates that the four dimensions of Edward III's implementation framework are closely interconnected. Effective communication strengthens coordination among implementing actors, adequate resources support service delivery, positive implementer disposition enhances community trust, and a clear bureaucratic structure facilitates policy consistency. The interaction among these dimensions explains why the program has remained operational despite resource limitations, highlighting the importance of collaborative governance involving community health centers, village governments, and community health cadres. These findings extend the application of Edward III's framework by illustrating how local institutional support and community participation contribute to the implementation of preventive health policies in rural settings.

From a policy perspective, strengthening the sustainability of the CKG Program requires greater investment in human resources, medical infrastructure, operational funding, and digital capacity. Continuous professional development for healthcare workers, improved availability of diagnostic equipment, and expanded digital literacy initiatives would enhance both service quality and administrative efficiency. Institutionalizing collaboration among healthcare providers, village governments, and community organizations is equally important for maintaining community participation and strengthening local implementation capacity.

This study contributes empirical evidence on the implementation of a national preventive health policy at the village level, an area that remains underexplored in the literature on public policy implementation in Indonesia. Although the findings provide valuable insights, the research was conducted in a single village within one community health center service area. Consequently, the findings should not be generalized to all implementation contexts without

considering variations in institutional capacity, geographical conditions, and local governance arrangements. Future studies should employ comparative case studies across multiple regions or mixed-method approaches to generate a broader understanding of the factors influencing the implementation and sustainability of the CKG Program in different local contexts.

5. Ethics Approval

Ethical principles were observed throughout the research process. All participants were informed about the objectives of the study, the voluntary nature of their participation, and their right to withdraw at any stage without any consequences. Verbal informed consent was obtained from all participants prior to data collection. Participants' identities were anonymized to protect confidentiality, and all data were used solely for academic purposes. Because this study involved minimal risk and did not include clinical interventions or the collection of sensitive medical information, formal ethical approval was not required under the applicable institutional guidelines.

6. Author Contributions

Conceptualization: Suprayitno and Mochammad Helmy Fikri; Methodology: Suprayitno, Mochammad Helmy Fikri, and Trisni Salsa Ramadina; Data Collection: Suprayitno, Peronika Simanjuntak, Cyntia Lupita Sari, and Melia Sinta; Data Analysis: Suprayitno and Mochammad Helmy Fikri; Writing—Original Draft Preparation: Suprayitno; Writing—Review and Editing: Mochammad Helmy Fikri, Trisni Salsa Ramadina, Peronika Simanjuntak, Cyntia Lupita Sari, and Melia Sinta. All authors have read and approved the final version of the manuscript.

7. Declaration on the Use of AI and AI-Assisted Technologies in Writing

The authors used artificial intelligence (AI)-assisted technology solely to improve language quality, grammar, and readability during the preparation of this manuscript. The authors carefully reviewed and edited all AI-assisted outputs and take full responsibility for the accuracy, integrity, and originality of the manuscript. AI was not used to generate, analyze, or interpret research data, nor to formulate the study's scientific conclusions.

8. Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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11. Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request. The data are not publicly available because they contain information that could compromise the privacy and confidentiality of the research participants.

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