



Strategic Governance of Health Services in Pekalongan Regency: a Socio-Legal Analysis of Social Security for The Underprivileged

Tata Kelola Strategis Layanan Kesehatan Di Kabupaten Pekalongan: Analisis Sosio-Legal Jaminan Sosial Bagi Masyarakat Prasejahtera

Wafa Alfida¹ Syarif Khasna²

^{1,2} Fakultas Syariah, Universitas Islam Negeri K.H. Abdurrahman Wahid Pekalongan, Indonesia

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Corresponding Author:

Penulis Korespondensi
✉ wafa.alfida3@gmail.com

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Abstract

Despite Indonesia's constitutional guarantees regarding the right to health, local governments frequently face structural obstacles when implementing universal healthcare mandates at the grassroots level. This study analyses the strategic efforts of the Pekalongan Regency Government in fulfilling the right to health for underprivileged communities under Regent Regulation (Perbup) No. 6 of 2020 and evaluates the socio-legal implications of administrative failures within the local health insurance distribution system. Adopting a socio-legal approach with qualitative methods, empirical data were gathered through interviews with the Pekalongan Regency Health Office, Social Affairs Office, and underprivileged families, complemented by an analysis of regional socio-economic indicators. The study reveals that whilst Pekalongan Regency achieved a nominal Universal Health Coverage (UHC) rate of 99.67%, a data disparity exists. Approximately 40% of health infrastructure in remote areas remains deficient, and thousands of impoverished beneficiaries experience unilateral, unnotified deactivation of their local government-funded health insurance (PBI APBD) due to poor inter-agency database synchronisation. The implementation of Regent Regulation No. 6 of 2020 satisfies formal legal certainty but fails to deliver substantive justice due to bureaucratic inertia and structural data paralysis. This study recommends a paradigm shift towards an Integrated Fiduciary Data System to prevent ongoing neglect of civil rights


Abstrak

Meskipun konstitusi Indonesia menjamin hak atas kesehatan, pemerintah daerah sering kali menghadapi hambatan struktural saat menerapkan mandat layanan kesehatan universal di tingkat akar rumput. Penelitian ini menganalisis upaya strategis Pemerintah Kabupaten Pekalongan dalam mewujudkan hak atas kesehatan bagi masyarakat kurang mampu berdasarkan Peraturan Bupati (Perbup) Nomor 6 Tahun 2020 serta mengevaluasi implikasi sosio-yuridis dari kegagalan administratif dalam sistem distribusi jaminan kesehatan daerah. Dengan mengadopsi pendekatan sosio-legal dan metode kualitatif, data empiris dikumpulkan melalui wawancara dengan Dinas Kesehatan Kabupaten Pekalongan, Dinas Sosial, dan keluarga kurang mampu, serta dilengkapi dengan analisis indikator sosio-ekonomi regional. Studi ini mengungkapkan bahwa meskipun Kabupaten



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Pekalongan mencapai tingkat Cakupan Kesehatan Semesta (UHC) nominal sebesar 99,67%, terdapat ketidaksesuaian data. Sekitar 40% infrastruktur kesehatan di daerah terpencil masih kurang memadai, dan ribuan penerima manfaat yang kurang mampu mengalami penonaktifan sepihak dan tanpa pemberitahuan atas asuransi kesehatan yang didanai pemerintah daerah (PBI APBD) akibat sinkronisasi basis data antarinstansi yang buruk. Penerapan Peraturan Bupati No. 6 Tahun 2020 memenuhi kepastian hukum formal namun gagal mewujudkan keadilan substantif akibat kelambanan birokrasi dan kelumpuhan data struktural. Studi ini merekomendasikan pergeseran paradigma menuju Sistem Data Fidusia Terintegrasi untuk mencegah pengabaian hak-hak sipil yang terus berlanjut.

INTRODUCTION

The constitutional architecture of the Republic of Indonesia explicitly positions the right to health as a non-derogable human right under any circumstances and imposes it absolutely as a fundamental *state obligation* that must be fulfilled progressively. Placing ecological and medical rights at this highest level imposes a heavy legal and moral duty on the state to actively ensure that no form of socio-economic vulnerability should prevent citizens from accessing emergency medical treatment to sustain their lives. Article 28H (1) of the 1945 Constitution of the Republic of Indonesia explicitly mandates that every person has the right to a prosperous life, both physically and mentally, to a place of residence, and to a good and healthy living environment, as well as the right to adequate health services. This fundamental norm is further reinforced imperatively by Article 34 (3) of the 1945 Constitution, which constitutionally states that the state bears full responsibility for providing adequate health care facilities and public service facilities for all segments of the population without exception. Within the context of the modern welfare state (*welfare state/verzorgingsstaat*), this constitutional guarantee gives rise to a *fiduciary duty* whereby local governments are obliged to position themselves as the primary guardians of their citizens' welfare at the local level.¹⁰⁷ This highly noble constitutional mandate requires local executives to design, budget for, and explore inclusive social security policies to embrace underprivileged communities living in the grip of extreme poverty.¹⁰⁸ Consequently, the failure of local authorities to provide a secure and sustainable health security system constitutes a clear breach of constitutional duty and a violation of the social contract of humanity.

To operationalise this noble constitutional mandate, the state has formulated a multi-layered social regulatory framework designed to integrate national budgetary potential with dynamic local autonomy policies. The integration of these legal provisions is absolutely essential to ensure that local governments have a legal basis and fiscal certainty in reaching marginalised groups excluded from the national social security assistance schemes. At the national level, Law No. 40 of 2004 on the National Social Security System (SJSN) and Law No. 24 of 2011 on the Social Security Administration Agency (BPJS) establish health insurance mechanisms through the Premium Assistance Recipient (PBI APBN) scheme. Meanwhile, at the sub-national level, the Pekalongan

¹⁰⁷ Nurnaeni and Syamsul Bachri, "Kesehatan Masyarakat Dan Tanggung Jawab Hukum Negara," *Jurnal Berita Kesehatan* 18, no. 2 (2025): 265–80.

¹⁰⁸ Arief Budiono et al., "National Health Security Policy in Indonesia: A Narrative Review from Law Perspective," *Journal of Medical Sciences* 10, no. 03 (2022): 183–87.

Regency Government has formulated Regent Regulation (Perbup) No. 6 of 2020 on the Implementation of Health Insurance Premium Assistance Funded by the Regional Revenue and Expenditure Budget (APBD). This Regent Regulation is philosophically designed as a local-level social safety net to cover the poor population of Pekalongan Regency whose data is scattered and not accommodated in the national integrated database. Through this local regulation, the local government has consciously allocated a portion of local tax revenue to cover the monthly BPJS premiums for residents categorised as underprivileged.¹⁰⁹ Thus, Regent Regulation No. 6 of 2020 plays a strategic role as the most crucial local legal instrument in efforts to bring health equity closer at the regency level.

However, a stark sociological tension emerges when Pekalongan Regency's administrative statistical achievements are confronted with the empirical reality at the grassroots level. This tension arises because the high figures in quantitative reports released by the local bureaucracy often overlook various administrative pathologies that tangibly undermine the civil rights of the underprivileged. In 2024, the Pekalongan District Government proudly announced the region's success in achieving a nominal Universal Health Coverage (UHC) rate of 99.67%, covering 553,625 national beneficiaries (PBI APBN) and 223,229 regional beneficiaries (PBI APBD). On the other hand, official data from the Central Statistics Agency (BPS) indicates that the macro-level poverty rate in Pekalongan Regency remains at 8.95%, representing approximately 81,720 poor residents living in economically precarious and vulnerable conditions.¹¹⁰ The author notes a sociological anomaly whereby, despite the high number of claims for coverage, underprivileged residents in various villages consistently face the unilateral deactivation of their BPJS cards without prior notice. This wide disparity demonstrates that success on paper bears no linear correlation with substantive health rights protection that treats the poor with dignity.¹¹¹ In conclusion, this failure of data synchronisation demands a critical examination of the effectiveness of local regulatory enforcement to ensure the law does not lose its protective function on the ground.

Although the discourse on national and regional health security has attracted considerable academic attention, most previous research remains trapped in sterile normative-descriptive analysis. This theoretical weakness arises because previous researchers tended merely to map citizens' administrative rights textually without evaluating the power relations and bureaucratic pathologies entangled within the regional poverty data system. Research by Daniel Ginting et.al analysed the governance of BPJS Kesehatan from a general administrative perspective but did not address the specific legal vulnerabilities of regent regulations at the local level.¹¹² Other regional

¹⁰⁹ Siti Aulia Baedarus, Vivi Della Atika, and Bernika Salsa Nabila, "Kebijakan Penerima Bantuan Iuran (PBI) Yang Tidak Tepat Sasaran: Telaah Berdasarkan Undang-Undang No 24 Tahun 2011 Tentang Sistem Jaminan Sosial Nasional," *Journal of Industrial Relations Studies (JIRS)* 2, no. 1 (2026): 60–75.

¹¹⁰ <https://pekalongankab.bps.go.id/id/publication/2025/11/28/825c4b1c31ecd8f719c6b7/statistik-kesejahteraan-rakyat-kabupaten-pekalongan-2025.html>

¹¹¹ Friedrich Max Rumintjap, Merry Fridha, and Tri Palupi, "Advocating BPJS Salary Justice: A Local Income-Based Perspective Mengadvokasi Keadilan Iuran BPJS: Sebuah Perspektif Berdasarkan Pendapatan Lokal," *Asian Journal of Healthcare Analytics (AJHA)* 2, no. 2 (2023): 301–24.

¹¹² Daniel Ginting, Suharto, and Nina Fentiana, "Analysis of Health Disparities Among Different Socioeconomic Groups in Indonesia: Implications for Health Policy," *Gema Lingkungan Kesehatan* 22, no. 2 (2024): 108–13.

analyses of local health policies also frequently overlook critiques of cross-agency technological integration linking social services, health departments, and primary healthcare facilities. The author addresses this academic *gap* by offering a comprehensive socio-legal analysis to dissect the dialectic between licensing law, poverty data, and the health rights of the underprivileged population in Pekalongan Regency. This research specifically employs the analytical tools of legal sociology to unpack how state law is undermined by bureaucratic inertia and data paralysis, which undermine the right to life of the underprivileged. In conclusion, the theoretical novelty offered in this article is a conceptual framework regarding a model of local administrative legal accountability for the failure to fulfil citizens' social security rights.

METHODS

This research employs an empirical legal research design, situated within the framework of the socio-legal approach, to evaluate the effectiveness and enforcement of local social security policies. This methodological choice is based on the academic imperative to view law not merely as a rigid set of written rules (*law in books*), but as an active social force that directly impacts the welfare of vulnerable populations (*law in action*). The socio-legal approach¹¹³ enables researchers to integrate normative legal analysis with sociological and public administration perspectives to uncover systemic failures in local regulations. Esmi Warassih asserts that empirical studies in legal research are highly effective for revealing the functional and administrative gaps in state regulations when applied to marginalised groups.¹¹⁴ The author uses this framework to critically evaluate how the local health bureaucracy negotiates regulations with the sociological realities of the underprivileged under the umbrella of Pekalongan Regency Regulation No. 6 of 2020. This perspective is crucial because the true value of any administrative regulation can only be measured through its concrete impact on the lives of the poorest citizens. Thus, this methodological approach ensures that the research remains grounded in the real-life experiences of the social groups that the law is intended to protect.

This empirical field research was conducted in several sub-districts in Pekalongan Regency, focusing on areas with high concentrations of poverty and distinctive geographical challenges, such as Petung, Lebakbarang, Limbangan and Kandangserang. The selection of these specific sub-districts was based on the socio-demographic vulnerability of the area, where isolated mountainous terrain and limited infrastructure access exacerbate the economic precariousness of the local community.¹¹⁵ The unit of analysis in this study is the actual implementation of Regent Regulation No. 6 of 2020 concerning the registration and maintenance of participation in the health insurance

¹¹³ Reza Banakar, "On Socio-Legal Design," 2019.

¹¹⁴ Esmi warassih, "Pemberdayaan Masyarakat Dalam Mewujudkan Tujuan Hukum (Proses Penegakan Hukum Dan Persoalan Keadilan); Pidato Pengukuhan Disajikan Pada Upacara Penerimaan Jabatan Guru Besar Madya Dalam Ilmu Hukum Pada Fakultas Hukum Universitas Diponegoro" (Semarang: Fakultas Hukum Universitas Diponegoro, 2001), http://eprints.undip.ac.id/282/1/Esmi_Warassih.pdf.

¹¹⁵ Sulistyowati Irianto et al., *Kajian Sosio-Legal. Terj. Tristam Moelyono*, ed. Adriaan W Bedner et al., 1th ed. (Denpasar: Pustaka Larasan, 2012).

premium assistance (PBI) scheme funded by the local budget (APBD). A sociological analysis of these remote sub-districts is crucial to uncovering the operational dynamics of local health services, which are often concealed behind the government's seemingly flawless quantitative reports. The author notes that the distribution of poverty in this mountainous region creates unique administrative barriers for data update officers in the villages. These geographical challenges directly test the capacity of the local bureaucratic machinery to deliver social justice to residents in peripheral areas. Consequently, this local case-study approach is vital for illustrating how spatial inequalities and bureaucratic performance are intertwined in limiting or facilitating residents' access to healthcare.

To achieve empirical depth and academic credibility, this research utilises primary and secondary data sources, ensuring rigorous data triangulation. This dual data collection strategy is essential to prevent subjective field bias and to ensure that research conclusions are robustly supported by formal legal documents as well as direct narratives from the grassroots level.¹¹⁶ Primary data was obtained through semi-structured in-depth interviews with key actors, both from the bureaucracy and from underprivileged communities who are in direct contact with the local health insurance system. Meanwhile, secondary data was obtained from official statistical reports by the Central Statistics Agency (BPS), membership data from the Pekalongan Branch of the National Health Insurance Agency (BPJS Kesehatan), and documents detailing complaints from underprivileged communities submitted to local legal aid institutions.¹¹⁷ Primary and secondary legal materials were selected based on strict relevance to local budget allocation and the updating of poverty data in Pekalongan Regency. By juxtaposing formal legal texts with the sociological narratives of affected residents, this research is able to construct an objective and balanced analytical perspective.¹¹⁸ The richness of this empirical and normative data ensures the scientific rigour of the draft manuscript, distancing it from speculative analysis and aligning it with the academic standards of the AJLH.

Data collection was carried out systematically through three coordinated techniques: in-depth interviews, direct field observation, and analysis of legal documentation. This methodological combination is designed to capture the full spectrum of policy implementation, ranging from high-level bureaucratic design to the physical realities in remote Community Health Centres (Puskesmas). In-depth interviews were conducted with key informants selected through purposive sampling and classified into three groups: (1) agency bureaucrats, including representatives from the Health Department, the Social Affairs Department, and the Pekalongan Branch of the Health Social Security Agency (BPJS Kesehatan); (2) data operators, comprising village officials responsible for updating the Integrated Social Welfare Data (DTKS); and (3) beneficiaries, namely low-income families both registered and those excluded from the PBI APBD scheme. Direct observation focused on the physical accessibility and readiness of medical

¹¹⁶ Sheyla Nichlatus Sovia et al., *Ragam Metode Penelitian Hukum*, ed. Moch Choirul Rizal (Kediri: Lembaga Studi Hukum Pidana, 2022).

¹¹⁷ Depri Liber Sonata, "Metode Penelitian Hukum Normatif Dan Empiris: Karakteristik Khas Dari Metode Penelitian Hukum," *FIAT JUSTISIA*, 2017, <https://doi.org/10.25041/fiatjustisia.v8no1.283>.

¹¹⁸ Soetandyo Wignjosobroto, "Ragam-Ragam Penelitian Hukum," in *Metode Penelitian Hukum; Konstelasi Dan Refleksi*, ed. Sulistyowati Irianto dan Shidarta, 1st ed. (Jakarta: Yayasan Pustaka Obor Indonesia, 2017).

facilities at auxiliary Puskesmas in isolated highland areas. Documentary analysis was used to test the consistency of Regulation No. 6 of 2020 with the overarching national social legislation. To ensure data accuracy, all interview processes were recorded, transcribed verbatim, and systematically coded under strict confidentiality protocols. This multi-layered data collection ensures that every finding is based on cross-validation from various validated sources.

The qualitative data collected was analysed using an interactive analysis model, which includes data reduction, thematic data presentation, and verification to draw structured socio-legal conclusions. This rigorous analytical framework is essential for transforming broad, descriptive field data into an academic narrative focused on answering the research questions. This analytical method, as is common in empirical legal research methodology (Salam, 2019), assists researchers in filtering raw information into systematic academic themes. The reduced data is then critically examined against the concepts of *Good Financial Governance* and the constitutional right to health. This analysis aims to uncover whether the inaccuracies in PBI data in the field are caused solely by technological limitations or constitute a form of institutional negligence on the part of local bureaucracy. This critical examination is vital to ensure the research does not merely become a standard descriptive report, but is instead capable of offering a transformative reconstruction of the social security governance model. Ultimately, this data analysis technique serves as the primary instrument for producing accountable conclusions and policy recommendations that are applicable to local governments, thereby making this draft worthy of passing the peer review process of an international journal.

RESULT AND DISCUSION

RESULT

Empirical Mapping of Local Health Security, Budget Allocation, and Data Inaccuracies

An empirical mapping of access to health insurance in Pekalongan Regency reveals a sharp contradiction between claims of formal administrative achievements and the sociological reality of underprivileged communities on the ground. This structural contradiction is caused by a wide gap between the official statistical reports released by the relevant agencies and the daily realities faced by poor residents when seeking medical treatment. Quantitative data from the Central Statistics Agency (BPS) indicates that the poverty rate in Pekalongan Regency stands at 8.95 per cent, representing approximately 81,720 underprivileged residents living below the poverty line.¹¹⁹ Under the mandate of Regent Regulation No. 6 of 2020, it is this group of people living below the poverty line that is legally designated as the primary target recipients of regional health insurance premium assistance. However, in its operational implementation, this social protection policy frequently suffers from distribution failures, meaning that thousands of poor residents remain effectively excluded from active health insurance coverage. Local

¹¹⁹ Satria S. Pamungkas, "Jumlah Penduduk Miskin Tahun 2024 Di Kabupaten Pekalongan," n.d., <https://www.panturapost.com/ekonomi/2074937992/jumlah-penduduk-miskin-tahun-2024-di-kabupaten-pekalongan-berkurang-62-ribu-jiwa#:~:text=Berdasarkan data dari buku Kabupaten,Pekalongan sebanyak 1.007.384 jiwa.>

positive law has successfully created the normative category of 'beneficiaries', but the administrative machinery of the social services department has failed to deliver these rights consistently and fairly. Consequently, the local regulatory framework, so beautifully articulated in the Regent Regulation, loses its sociological foundation at the level of low-income families.

This operational gap becomes increasingly evident when we compare the local government's claims of success regarding Universal Health Coverage (UHC) with empirical findings at local community health centres. The discrepancy between nominal registration data and on-the-ground realities demonstrates that high participation rates on paper do not guarantee the sustainability of legal protection for the poor. In 2024, the Pekalongan Regency Government announced the achievement of a very high nominal Universal Health Coverage (UHC) rate, standing at 99.67%.¹²⁰ According to local administrative records, this coverage comprises 553,625 beneficiaries of national premium assistance (PBI APBN) and 223,229 beneficiaries of regional premium assistance (PBI APBD) funded directly by the Pekalongan Regency APBD. On paper, these fantastic figures suggest that almost all low-income residents are protected by safe, free healthcare. However, this near-perfect nominal percentage actually obscures the fact that the on-the-ground distribution system for coverage is highly fragile and prone to malfunction for the poorest residents. Thus, the quantitative success celebrated by the local bureaucracy operates as a statistical illusion that masks the real exclusion from health coverage at the grassroots level.

The primary systemic issue driving this failure in health coverage is severe data inaccuracy (*database mismatch*) between different government agencies. This systemic pathology persists due to the absence of a directly synchronised digital communication system between local poverty databases and national social security administrators. Field findings confirm the absence of real-time technological and administrative coordination between the Integrated Social Welfare Database (DTKS) managed by the Social Affairs Department and the active membership data held by BPJS Kesehatan.¹²¹ As a result of this synchronisation failure, the membership status of low-income residents becomes highly fluctuating and unstable from month to month. Poor residents are often recorded as active in the regional DTKS system but, for some unknown reason, appear as inactive or have been removed from the card-reading system on the BPJS Kesehatan server. This breakdown in data integration means that neither the village authorities nor the relevant departments have the tools to verify the validity of residents' cards before they fall ill. Consequently, this administrative separation of databases directly undermines legal certainty and the guarantee of protection for low-income residents.

This administrative data paralysis is not merely an abstract digital technical problem, but a real humanitarian threat to the safety of poor residents at Community Health Centre (Puskesmas) service units. This is because the deactivation of KIS cards without prior notice immediately cuts off low-income residents' access to free emergency medical treatment. The real-life case experienced by Mrs Mila, a low-income resident in

¹²⁰ Sri Mugirahayu, "Capaian Uihc Kabupatein Peikalongan 99,67%," n.d., <https://peikalongankab.go.id/Weibsitei/Beirita/3006-Capaian-Uihc-Kabupatein-Peikalongan-99-67>.

¹²¹ <https://kemensos.go.id/pemerintah-tingkatkan-kualitas-data-pbi-jk>

Pekalongan Regency, serves as a stark illustration of this administrative negligence.¹²² Although she was legally registered as a recipient of the PBI APBD scheme based on the poverty criteria set out in Regent Regulation No. 6 of 2020, her health insurance card was suddenly deactivated unilaterally by the system without any notification to her family. She only discovered this deactivated status when she was ill and attempted to seek treatment at the local community health centre, which resulted in the refusal of free services and forced her family to bear medical debts that placed a severe financial burden on the household. The rejection of the health insurance card during this medical crisis highlights the failure of the state's protective functions, transforming social security into a deadly administrative trap for the poor. Consequently, the lack of transparent data updates directly exposes vulnerable residents to the risk of deeper poverty resulting from the health crisis.

In-depth interviews with village-level data operators (*village operators*) confirmed that this administrative instability constitutes a widespread structural pathology in Pekalongan District. This bureaucratic vulnerability persists because village-level officials are burdened by a manual data update system that is extremely slow and fails to adapt to sociological changes among residents. Village operators complain about the complexity of the poverty data verification process and the convoluted schedule for periodic data submissions dictated by the district social services bureaucracy. Due to the lack of a synchronised Application Programming Interface (API)-based system integration, village operators cannot monitor whether the data on poor residents they have submitted is suddenly and automatically deleted during the central government's seasonal data cleansing process. This lengthy manual data input process is highly prone to *human error*, which often results in the exclusion of the most vulnerable residents from the PBI list. This situation demonstrates that although local governments allocate billions of rupiah in the Regional Budget (APBD), the local bureaucratic machinery lacks the administrative precision to distribute these funds securely. Consequently, this data inaccuracy indicates that the local social security digital infrastructure remains too weak to support a reliable social safety net.

Spatial Disparities, Deficits in Health Infrastructure, and Socio-Cultural Barriers Facing Remote Communities

Physical access to medical services for underprivileged communities in Pekalongan Regency is severely hampered by a combination of geographical isolation and a deficit in healthcare infrastructure. This spatial isolation is exacerbated by a highly uneven pattern of regional healthcare resource allocation, where high-quality medical facilities are concentrated in urban centres whilst leaving mountainous areas in a state of medical neglect. Official data from the Pekalongan Regency Health Office reveals a serious gap in medical facilities, with only around 60% of the infrastructure standards for Community Health Centres (Puskesmas) and essential medical equipment having been met across the

¹²² Interview with Mrs Mila: Low-income residents in Pekajangan village, Kedungwuni sub-district, 16 June 2025.

regency.¹²³ This figure confirms a structural deficit of 40% in the provision of basic health facilities for the community. Field findings demonstrate that this 40% deficit is not felt equally; rather, it accumulates as a burden of geographical injustice borne by underprivileged residents in the peripheral mountainous areas. Whilst residents in the district capital (Kajen) have easy access to a fully-equipped general hospital, the poor in remote villages must make do with auxiliary Puskesmas that are severely under-resourced. Consequently, this spatial inequality acts as a tangible physical barrier, preventing low-income residents from accessing the right to adequate healthcare services guaranteed by the constitution.

This spatial injustice in healthcare is particularly acute in the highland sub-districts of Pekalongan Regency, which feature hilly terrain and are geographically isolated. This is due to the mountainous geography and the substandard quality of the road network, which makes medical journeys to referral healthcare facilities extremely costly and hazardous to patient safety. Low-income residents living in remote areas such as Petung, Lebakbarang, Limbangan, and Kandangserang must traverse severely damaged, rocky roads and spend hours just to reach the nearest community health centre. In contrast to urban areas, clinics in these remote mountainous regions are generally non-inpatient facilities with very limited operating hours and no on-call ambulances. For a poor family in Lebakbarang, when a medical emergency occurs at night, they must hire a local resident's private car at a cost of hundreds of thousands of rupiah just to cross the mountains to the District General Hospital in Kajen—a transport cost that often far exceeds their financial means. These spatial barriers ensure that even holding a valid health insurance card loses its value when residents lack the physical means to reach the Community Health Centre (Puskesmas) quickly. Consequently, the poor spatial planning of local healthcare facilities directly diminishes the value of the right to health for the inland population.

These physical limitations are further exacerbated by the chronic shortage of medical staff and basic medical equipment at auxiliary health centres in the highlands. This shortage of healthcare facilities in mountainous areas persists due to the difficulty local bureaucracies face in attracting specialist doctors or residents to settle in remote, sparsely populated peripheral areas. Interviews with village midwives and hamlet heads in Kandangserang revealed a scarcity of first-aid equipment, a lack of consistent oxygen cylinder supplies, and the absence of on-call doctors available at night. When faced with patients suffering from pregnancy complications or severe accident-related trauma, these under-resourced auxiliary health centres can only issue referral letters to urban hospitals without being able to provide initial life-saving treatment. However, the high cost of transport for referrals across the mountains means that many low-income families choose not to follow up on these referrals, taking the patient home instead and resigning themselves to fate. These medical limitations have transformed the role of auxiliary health centres in the highlands into little more than administrative transit points for issuing referral letters, rather than places providing actual medical care. Consequently, this

¹²³ Dinkes Kabupaten Pekalongan, "Desk Profil Kesehatan 2025: Dinkes Hadirkan Data Lengkap Dari 26 Puskesmas Hingga RS," n.d., <https://dinkes.pekalongankab.go.id/articles/desk-profilkes-2025-dinkes-hadirkan-data-lengkap-dari-26-puskesmas-hingga-rs>.

deficit in village clinic facilities directly erodes the quality of life and increases the risk of unnecessary deaths among mountain residents.

These physical and healthcare facility barriers are further exacerbated by socio-cultural conflicts and communication barriers that isolate low-income communities from utilising their entitlement rights. These sociological barriers persist due to the local government's failure to conduct public education on the mechanisms of the Regent Regulation health insurance scheme in a persuasive and culturally sensitive manner. Due to the lack of outreach from the health department, the vast majority of underprivileged residents in remote areas have absolutely no understanding of their legal rights or the registration procedures for the PBI APBD scheme. Rather than attempting to navigate the complexities of a health insurance bureaucracy perceived as using confusing and intimidating urban administrative language, the poor choose to avoid it. When struck by illness, they tend to retreat into traditional medicine or rely on mutual aid loans from close relatives, which are of very limited value and do not address the root cause of the illness. Rigid bureaucratic language acts as a communication barrier, isolating illiterate poor people from access to state services. In conclusion, the accumulation of spatial barriers, a shortage of healthcare facilities, and cultural isolation conspire to ensure that Regent Regulation No. 6 of 2020 remains a dead letter for the underprivileged residents of Pekalongan Regency.

DISCUSSION

Theoretical Anatomy of the Legality Deficit: Evaluating Regulatory Efficacy and Violations of the Constitutional Right to Health

An evaluation of the implementation of Pekalongan Regency Regulation No. 6 of 2020, using Soerjono Soekanto's five-factor analysis of legal effectiveness,¹²⁴ reveals a severe deficit of legality on the ground. This structural deficit arises because the regional health insurance system merely fulfils the aspect of regulatory perfection on paper (*law in books*), whilst systematically neglecting the other four pillars of legal enforcement effectiveness (*law in action*). Soekanto posits that the effectiveness of law in society is determined cumulatively by five factors: the law itself, the law enforcement officials, the supporting facilities, the target community, and the prevailing legal culture. Applying this framework to the Pekalongan case, although the text of the Regent's Regulation had been designed progressively, its enforcement was paralysed because the law enforcement apparatus (social services data officers and village operators) lacked the technical capacity and legal training to manage health insurance data with due diligence. The deeply rooted bureaucratic culture is a model of 'ritualistic compliance', in which officials prioritise achieving a nominal UHC rate of 99.67% as a political achievement report to the central government over ensuring that the social security cards of the underprivileged remain active and usable when seeking medical treatment. Consequently, the combination of incompetent law enforcement officials and the absence of reliable data synchronisation technology has thwarted the humanitarian objectives of the regulation.

¹²⁴ Soerjono Soekanto, *Pokok-Pokok Sosiologi Hukum* (Jakarta: Rajawali, 1983).

Soekanto's theoretical analysis scientifically demonstrates that a local legal instrument will never achieve its welfare objectives when implemented by a dysfunctional bureaucratic apparatus and administrative infrastructure.

Furthermore, this systemic failure in the synchronisation of health insurance data constitutes a clear violation of the socio-economic human rights of the underprivileged, as guaranteed by the constitution. This constitutional violation occurs because the state, through local governments, has failed to fulfil its constitutional duty (*fiduciary duty*) to protect its citizens' right to a healthy life from the risk of administrative paralysis. Under Article 28H and Article 34 of the 1945 Constitution, the state bears absolute responsibility for providing adequate healthcare facilities and social security for the poor. When the local administrative system allows the unilateral deactivation of PBI cards without notice for vulnerable citizens such as Mrs Mila, the state has, in sociological terms, committed an act of '*civil rights negligence*'. This unilateral action violates the human rights of citizens as it instantly strips poor families of their sole economic defence against the threat of medical debt when a health crisis strikes. Under international human rights law,¹²⁵ the fulfilment of the right to health is categorised as a right that cannot be deferred in terms of meeting minimum standards of living. Therefore, the inaccuracies in social security data, which the Pekalongan Regency government has allowed to persist, constitute a breach of the state's constitutional contract regarding its citizens' right to a healthy life.

This administrative injustice is further exacerbated by a clear spatial disparity, which can be sharply analysed using the international standards of the right to health: AAAQ (*Availability, Accessibility, Acceptability, Quality*). This geographical disparity arises because the local government has failed to distribute healthcare facilities fairly, preferring to concentrate modern facilities in urban areas whilst neglecting the rights of residents in the highlands. The 40% deficit in healthcare facilities in mountainous areas such as Petung, Lebakbarang, Limbangan, and Kandangserang constitutes a direct violation of the standards of *Availability* and *Accessibility* of healthcare facilities. By concentrating advanced medical equipment and specialist doctors solely in Kajen, the local government is indirectly criminalising poor residents in the mountains based on the geographical location of their homes. This spatial inequality forces underprivileged residents in remote areas to bear a higher risk of death due to delays in emergency medical treatment whilst traversing dangerous mountainous terrain. This geographical discrimination demonstrates that the fulfilment of the right to health in Pekalongan Regency remains exclusive and dependent on residents' socio-economic class and place of residence. Thus, the AAAQ analysis proves that without a fair redistribution of healthcare infrastructure, Regent Regulation No. 6 of 2020 on the Implementation of the Health Insurance Scheme will never be able to achieve equitable health security.

Reconstructing Health Security Policy: Towards an Integrated Fiduciary Data System and an Adaptive Local Social Contract

To put an end to the recurring bureaucratic malpractice and administrative injustice, this study proposes a comprehensive reconstruction of the regional social security policy model. This systemic reconstruction is urgently needed to establish a

¹²⁵ United Nations, "Universal Declaration of Human Rights 1948" (n.d.), <https://www.supremecourt.ge/files/upload-file/pdf/act3.pdf>.

framework for *state administrative liability* for any negligence regarding social security data that causes harm to citizens. The Pekalongan Regency Government is obliged to amend Regency Regulation No. 6 of 2020 to include a clause on the legal liability of agencies for the unilateral deactivation of social security cards. Currently, when a social security card malfunctions due to clerical errors by data officers, there is no mechanism for compensation or legal accountability available to impoverished citizens who have been harmed.¹²⁶ The author proposes the establishment of an *'emergency override protocol'* at every local Community Health Centre (Puskesmas), which would legally oblige healthcare facilities to provide immediate free treatment to holders of inactive PBI cards, whilst the data correction process is resolved internally between departments. This policy is vital to ensure that no more poor citizens are denied treatment or fall into extreme poverty due to data entry errors by local bureaucrats. Consequently, establishing this administrative legal accountability is the cornerstone for restoring public confidence in the state's commitment to social security.

Technically and procedurally, this transformation must be realised by moving away from a manual, periodic data update system towards a modern technology-based **Integrated Fiduciary Data System**. This dynamic new system is essential to replace the slow and fragmented data synchronisation model with a *real-time synchronisation* model. This model utilises Application Programming Interface (API) technology to directly link the DTKS database of the Social Affairs Department, the population data of the Population and Civil Registration Office (Disdukcapil), and the active membership server of the Pekalongan Branch of the Health Social Security Agency (BPJS Kesehatan).¹²⁷ Through this integrated system, whenever a village operator updates a resident's poverty status at the village level, the data changes will instantly and automatically update the active status of the resident's BPJS card.¹²⁸ The implementation of this API technology will eliminate the risk of database mismatches and close the loophole whereby cards are deactivated without notification for 81,720 low-income residents. Making the poverty database a transparent shared fiduciary asset is an absolute prerequisite for upholding the principles of good *financial governance* at the local level. Therefore, the development of this integrated digital infrastructure is an absolute requirement for the creation of a reliable and humane social safety net system.

Finally, to break down the socio-cultural barriers that have long excluded remote low-income communities from formal services, local health policies must utilise the tools of legal anthropology. This transformative cultural approach is vital to replace the rigid, class-biased bureaucratic announcement model with a persuasive, community-based legal socialisation model. Rather than relying on confusing administrative leaflets for residents in remote areas, local health departments and KUA offices must embrace the local wisdom of mutual aid and the strong kinship systems of the Pekalongan

¹²⁶ Syifa Roudhotul Aulia, Desti Shintia Putri, and Amanda Kalila Azizah, "Pertanggungjawaban Pejabat Publik Dalam Keputusan Administratif Yang Merugikan Masyarakat : Antara Unsur Maladministrasi Dan Perdata," *Constitutio: Jurnal Riset Hukum Kenegaraan & Politik* 4, no. 1 (2025): 54–67.

¹²⁷ Endang Sulistyarningsih and Is Haryanto, "Transformation of the Social Insurance Management Agency on Health," *Medico-Legal Update* 21, no. 1 (2021): 223–27.

¹²⁸ Lusi Ariyani and Achmad Sarwandianto, "Penerapan Platform Informasi Pelayanan Data Terpadu Kesejahteraan Sosial (DTKS)," *Jurnal Kabar Masyarakat*, 2025, <https://api.semanticscholar.org/CorpusID:276311557>.

community.¹²⁹ Local governments can initiate the formation of a cadre of “Health Rights Navigators” (*health rights guides*) by recruiting youth leaders, PKK cadres, and RT/RW heads in remote mountainous areas to be trained in understanding health insurance procedures. These local cadres are tasked with providing personalised support to underprivileged residents, translating complex legal regulations into easily understandable local language, and assisting with the processing of residents’ health insurance data through proactive outreach. This legal anthropology approach ensures that underprivileged residents no longer turn to unsafe alternative medicine systems simply because they fear the administrative complexities of healthcare facilities. In conclusion, the combination of the ease of information technology and the involvement of culturally sensitive local communities is the key to achieving substantive, inclusive health equity that treats residents in Pekalongan Regency with dignity.

CONCLUSION

Based on a socio-legal analysis of the implementation of Pekalongan Regency Regulation No. 6 of 2020 regarding health insurance for low-income communities, this study concludes three fundamental points:

1. The Paradox of Quantitative Inclusion and Substantive Exclusion: There is a wide gap between the reported nominal quantitative achievement of Universal Health Coverage (UHC) in Pekalongan Regency, at 99.67%, and the sociological reality at the grassroots level. Behind these near-perfect statistics, thousands of underprivileged residents remain effectively excluded from active health insurance coverage due to poor governance of local social security data.
2. Structural Data Paralysis (*Database Mismatch*): The failure of PBI APBD health insurance protection is triggered by the lack of *real-time* API-based technological integration between the Social Affairs Department’s DTKS database and the active membership server of BPJS Kesehatan. This administrative pathology results in the unilateral deactivation of health insurance cards without notice to the poor, transforming social protection instruments into an economic trap that endangers the lives of the underprivileged when a medical crisis strikes.
3. Spatial Inequality and Geographical Isolation: The right to health for low-income communities in the peripheral mountainous regions (Petung, Lebakbarang, Limbangan, Kandangserang) is severely curtailed by a 40% deficit in local medical infrastructure and poor road access to referral healthcare facilities. These physical limitations are exacerbated by bureaucratic and socio-cultural communication barriers at the grassroots level, which force low-income residents to bypass formal medical channels and resort to inadequate traditional treatments.

To address administrative failures and uphold health equity for low-income communities in Pekalongan Regency, this study formulates the following strategic recommendations:

1. Legislation on Administrative Liability (*State Liability*): The Pekalongan Regency Government and the Regional People’s Representative Council (DPRD) must

¹²⁹ Akhlish dzikrullah Ahmad, Margaretha Hanita, and Renny Nurhasana, “Hambatan Sosial Budaya Dalam Pelayanan Kesehatan Pada Komunitas Tradisional: Studi Literatur,” *ETNOREFLIKA: Jurnal Sosial Dan Budaya*, 2025, <https://api.semanticscholar.org/CorpusID:283493392>.

- immediately revise Regency Regulation No. 6 of 2020 to include a clause on civil liability for compensation arising from administrative errors in health insurance data by officials. Furthermore, an “emergency override protocol” must be enacted, prohibiting Community Health Centres (Puskesmas) from refusing to provide free treatment to holders of inactive PBI cards during the data clarification process.
2. Implementation of an API-based Integrated Fiduciary Data System: The Social Affairs Department, Health Department, Population and Civil Registration Office, and BPJS Health Pekalongan must cease the model of periodic manual data cleansing and transition to the development of integrated digital infrastructure using Application Programming Interface (API) technology for real-time synchronisation of poverty data. This step is crucial to ensure the accuracy of the membership status of 81,720 underprivileged residents at the grassroots level and to eliminate incidents of cards being deactivated for no apparent reason.
 3. Redistribution of the Local Fiscal Budget for Mountainous Healthcare Facilities: The Pekalongan District Health Office must prioritise the allocation of capital expenditure from the Local Budget to address the 40% deficit in medical facilities in highland areas, particularly at the Lebakbarang and Petung Community Health Centres. The provision of mountain-ready ambulances, the regular deployment of specialist doctors, and the upgrading of first-aid equipment must be positioned as key performance targets for the health department to meet international standards for the availability and accessibility of the right to health.
 4. Establishment of Community-Based ‘Health Rights Navigator’ Cadres: Local governments must move away from rigid formal-administrative outreach and replace it with a culturally sensitive legal-anthropological approach. Through the establishment and funding of local cadres (Health Rights Navigators) who recruit local youth leaders and PKK cadres, the KUA and community health centres can provide proactive legal and medical support to underprivileged residents in remote areas, demystify the complexities of the social security bureaucracy, and organically strengthen public health literacy.

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