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Legal Protection for Telemedicine Patients Based on Pancasila Justice Values

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Abstract
The current development of telemedicine can be seen as an opportunity to open wider access for the public to health services. On the other hand, it provides new challenges to adapt various aspects of health services for people in Indonesia and all nations in the world. The aim of this research is to analyze and formulate legal protection for telemedicine patients that adheres to Pancasila justice. The research method used is normative juridical research. By using secondary data. The data analysis used is qualitative data analysis. The research results found that legal protection is weak and injustice for patients if harm occurs. The provisions regarding telemedicine as regulated in Article 25 of Law Number 17 of 2023 concerning Health, are very far from adequate, in fact the direction is not clear, whether it is only a legal umbrella for telemedicine which has been regulated in Minister of Health Regulation Number 20 of 2019 concerning the Implementation of Telemedicine between Health Service Facilities, or will regulate the Implementation of Telemedicine not only between Health Service Facilities but also between Health Service Facilities or doctors and patients. The reconstruction of regulations in Article 25 of Law Number 17 of 2023 concerning Health, which generally regulates the practice of medicine via telemedicine, requires reconstruction of values and reconstruction of norms in order to provide justice for the practice of medicine via telemedicine between Health Service Facilities, as well as between Health Service Facilities or doctors and patient.
Keywords: protection; patient; telemedicine; justice;
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A. INTRODUCTION

Long distance health services (telemedicine)[1] is one form of information technology development. Technological developments or what is called technological disruption that occurred in the 21st century, were driven by a drastic change from an industrial society to a technology and information industry. Telemedicine is the use of information and communication technology combined with medical expertise to provide health services, starting from consultations, diagnoses and medical procedures, without limited space or carried out remotely.

The aim of telemedicine is to achieve equitable health services across the country's population, improve the quality of service, especially for remote areas and save costs compared to conventional methods. Telemedicine is also aimed at reducing referrals to doctors or health services in big cities, medical education facilities and also for emergency cases.[2]

The risk of providing health services via telemedicine is greater than that of health services via face-to-face or in person, considering that not all areas (especially in remote areas) in Indonesia have good and quality internet access (difficult) like the quality of internet in urban areas, thus making communication is not smooth, the information obtained is incomplete or comprehensive.[3] There is still a lot that needs to be improved in the implementation of telemedicine in health services in Indonesia.[4] One of them is the legal umbrella for health services via telemedicine which is currently only intended for the provision of telemedicine services between health service facilities. Based on the description of the background to the problem, the problem raised is how legal protection for telemedicine patients is based on Pancasila justice values.

B. RESEARCH METHODS

The research method used is normative juridical research[5]. By obtaining data based on secondary data through statutory regulations, reviewing textbooks (literature reviews), dictionaries, encyclopaedias, materials from the

[1] Fauziyyah, 2021. Telemedicine Education During the Covid 19 Pandemic Obstacles in Adaptation Efforts. See too J. Field M, (Ed.), 1996. Telemedicine: A guide to assessing telecommunications in healthcare, Washington, D.C.: National Academies Press, page. 288
[2] El Muhtaz, Majda, 2017,Hak Asasi Manusia dalam Konstitusi Indonesia: Dari UUD 1945 sampai dengan Perubahan 1945 tahun 2002 (edisi ke 2), Jakarta, page. 87-88
[3] B.H. Sianipar, 2020. *Kebijakan Pengembangan Tele-Medisin di Indonesia. Kajian Kebijakan dan Hukum Kedirgantaraan*. Page.42-64
[4] Sri Kusumadewi, dkk, 2009, Informatika Kesehatan, Yogyakarta : Graha Ilmu dan Rumah Produksi Informatika, page.41.
[5] Anis Mashdurohatun, Gunarto & Adhi Budi Susilo, The Transfer Of Intellectual Property Rights As Object Of Fiduciary Guarantee, Jurnal Akta. Volume 9 No. 3, September 2022.

internet, and so on. [1]The data analysis used is qualitative data analysis, namely data that cannot be measured or assessed directly with numbers[2].

C. DISCUSSION

The current development of telemedicine can be seen as an opportunity to open wider access for the public to health services. On the other hand, it provides new challenges to adapt various aspects of health services for people in Indonesia and all nations in the world.

Utilization of telemedicine depends greatly on the type of telemedicine practice. Types or forms of Telemedicine practice can be teleconsultation, teleassistance, tele-education and telemonitoring as well as telesurgery. Supported by medical equipment that can convert video images into digital images, now the use of telemedicine in medical practice is widely used. Until now telemedicine has been applied in many countries in the world such as America, Greece, Israel, Japan, Italy, Denmark, the Netherlands, Norway, Jordan, India and Malaysia.

In its implementation, the types of telemedicine are implemented in two concepts, namely real time (synchronous) and store-and-forword (asynchronous). Real time telemedicine (synchronous telemedicine) can be as simple as using a telephone or more complex as using a surgical robot. Synchronous telemedicine requires the presence of both parties at the same time, for this reason a liaison media is needed between the two parties which can offer real time interaction so that one party can carry out health care. Another form of Synchronous telemedicine is the use of health equipment connected to a computer so that health inspections can be carried out interactively. An example of the use of this technology is a tele-otoscope which provides facilities for a doctor to look into a patient's hearing from a distance. Another example is a tele-stethoscope which allows a doctor to listen to a patient's heartbeat remotely. Store-and-forword telemedicine (asynchronous telemedicine) involves collecting medical data and sending this data to a doctor (specialist) at a convenient time for offline evaluation. This type of telemedicine does not require the presence of both parties at the same time. Dermatologists, radiologists and pathologists are specialists who usually use asynchronous telemedicine. Medical records in proper structure should be a component in this transfer.

The medical conditions in the United States before the era of using telemedicine were no different from the conditions in Malaysia and India before they were introduced to telemedicine. Despite the fact that the United States is one of the countries that allocates the largest health budget when compared to other countries in the world. Facts prove that the United States was also ranked as the country with the worst ranking in providing health services compared to other developed countries. Many indicators show that in America's rural and border areas, disparities in health care delivery are common. Several factors which according to Leonard R. Graziplene (President of The Center for Rural Resurgence, Inc.) were the background for America to develop an action plan by utilizing the latest technology so that people in rural and border areas could have their medical needs served are as follows:[3] **First**, high levels of poverty and low levels of health. Data shows that the per capita income of rural US residents is low, so poverty is widespread and health practices are affected. **The second** factor is the lack of health personnel. Geographically, the rural and border areas of the United States constitute the largest part of the total area of America.

There are approximately 60 million people living in sparsely populated areas and 9 million of them live in border areas. This number is quite large and is recognized as a population that is higher than the total population of several of the largest European countries, such as England, France and Italy. Meanwhile, it is also known that there is a shortage of health care professionals in rural areas**. Third,** a large area with a low population. In rural areas that are categorized as border areas, the population density is less than six people per square mile.

There are very few health services there, in fact it was discovered that as many as 78 districts have no health services at all. Twenty years ago, there were only 123 physicians still practicing in the country's rural borders."[4] As a result, rural areas are very likely to be served by foreign doctors who come to the country to work on special visas.[5]

The fourth factor is a decrease in the number of rural and frontier hospitals. Quite a lot of rural and border

[1]Irwansyah, Ahsan Yunus, Penelitian Hukum Pilihan Metode & Praktik Penulisan Artikel, Mirra Buana Media , Yogyakarta. 2020. Bimo Bayu Aji Kiswanto, Anis Mashdurohatun, The Legal Protection Against Children Through A Restorative Justice Approach, Law Development Journal, Volume 3 Issue 2, June 2021, pp. (223 – 231). Agus Irawan Yustisianto, Sri endah Wahyuningsih, & Anis mashdurohatun, Reconstruction of Legal Protection Regulations against Victims of Crime of Household Violence Based on Justice Value, Sch Int J Law Crime Justice, Dec, 2022; 5(12): 513-519

[2]Yeltriana, Ideal Reconstruction Of Protection For Layoff Victim At The Industrial Relations Court Based On Justice, International Journal of Law, Government and Communication, Volume: 4 Issues: 14 [March, 2019]. See too Anis Mashdurohatun, Danialsyah, Reconstruction of Mediation in Environmental Disputes Settlement Based on Pancasila Justice, Volume.24 Issue 3. Journal Of Law And Political Sciences, 2020.pp. 123-138.

[3] Arman Anwar. 2023 Hukum Kesehatan Praktik Kedokteran Telemedicine. Yogyakarta : Deepublish.page 101

[4] Quality Through Collaboration: The Future of Rural Health Care." The National Academies Press. http://www.nap.edu/openbook.php?record_id=11140&page=200

[5] Eric H. Larson & Thomas E. Norris. "Rural Demography and the Health Workforce: Interstate Comparisons," Chapter 4.

hospitals have closed, and even if they survive they are usually unable to provide up-to-date technology.[1] The situation is made worse when most rural hospitals suffer from a lack of funding and a high number of patients without health insurance. In order to respond to the health crisis in rural and border areas as described above, a method is needed that can overcome this problem effectively and efficiently. The strategy adopted by the United States Government is a model consisting of three main components which, when combined, will be able to more effectively provide health services to rural and border areas. One of these three components is telemedicine.[2]

Telemedicine is defined by the American Telemedicine Association as follows. “Telemedicine has the potential to play a central role in resolving this ongoing disparity. Defined as "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status".[3] Currently there are 187 more than 200 telemedicine networks involving more than 2,000 medical institutions throughout the United States. Also recently, the Federal Communications Commission was awarded a grant to substantially increase this number. Sixty-nine new networks coming soon. Established in 42 states and three United States territories under the Telemedicine Pilot Project to Improve the Health of Rural Communities.[4] The California Telehealth Network has been able to connect 319 health care sites across the country as part of a three-year pilot program to assist patients in the provision of services on health access in rural areas.[5]

The United States currently has thousands of installed telemedicine networks with varying sizes and capabilities. Nineteen of the fifty-five states in the United States have determined that they do not require a separate license for physicians who wish to practice telemedicine across state lines. The nineteen states in question include New York, California, Montana, Kansas, Alaska and Maine.[6]

The Chairman of the United States Senate in his letter to the President of the United States gave serious attention to the regulatory arrangements regarding telemedicine. According to him, considering the potential of telemedicine, Congress has directed the Department of Commerce to consult with the Minister of Health, and asked the Joint Working Group Telemedicine (JWGT) - an interfederal joint working group - which is federally funded to report on the telemedicine research activities and their implementation that they have carried out. This report provides information on the state of telemedicine across the country and discusses the many technical, legal, and political issues that must be resolved in order to make telemedicine the best option for a successful form of health care in the United States. For this reason there are many things that must be resolved, he further said that: "The main issues that must be resolved before telemedicine can develop rapidly include: licensing of telemedicine health professionals who work across countries or who provide services on a multi-country basis, the security of telemedicine and issues relating to standards relative lack of standards in this area; lack of insurance payment for telemedicine services, privacy and security issues unique to telemedicine, and costs of telecommunications infrastructure and accessibility for telemedicine use.[7]

Law in the United States stipulates that the state has two authorities, namely to regulate health workers who practice in its territory and jurisdiction over medical malpractice claims. Therefore, the United States has created a set of regulations related to telemedicine, such as Telehealth HR 6331. Sec 149. This law regulates Medicare improvements for patients and medical service providers, including hospital-based access for critical or emergency-based patients. central hospitals for kidney dialysis patients, skilled nursing facilities, and community mental health centers.[8]

On November 5, 2009, the Senate and Congress also enacted the Telemedicine Act for the Rural Telemedicine Enhancing Community Health (TECH) Act of 2009. The law aims to regulate the development of telehealth pilot projects, expanding access to telehealth Stroke services under the Medicare program , and improve access to 'store-and-forward'. In addition, this provision stipulates in this regulation the need to consider and prioritize the credential standards of the originating site in connection with receiving remote health services.

Apart from having regulations regarding telemedicine, in the United States there are also other regulations relating to telematics law such as the Electronic Signatures in Global and National Commerce Act, Uniform Electronic Transaction Act, Uniform Computer Information Transaction Act, Government Paperwork

[1] Improving Health Care for Rural Populations,” Agency for Healthcare Research and Quality. Dalam http://www.ahrq.gov/research/rural.htm. See too , Quality Through Collaboration: The Future of Rural Health Care . New York : The National Academies Press, 2005

[2] Arman Anwar Op.Cit page 102-103

[3] About Telemedicine, American Telemedicine Association, Http://Www. Americantelemed.Org/ 4a/Pages/Index.Cfm?Pageid=3331

[4] Connecting Rural America to Better Health.” U.S. Department of Health and Human Services. http://www.hhs.gov/news/facts/20080131f.html. See too, “Telemedicine 2010: Visions for a Personal Medical Network,” The Telemedicine Alliance (July 2004). “Increasing Access to Health Care in Rural America Through Broadband Telehealth.” Benton Foundation, February 21, 2008.

[5] Telemedicine Network at the Forefront of Schwarzenegger’s Agenda for Health IT.” May 15, 2007. http://www.californiahealthline.org/articles/2007/5/15/Telemedicine- Network-at-the-Fore front. See too, “Telehealth Network to Expand,” Federal Telemedicine News (June 29, 2008) and “States to Expand Communications,” Federal Telemedicine News, (October 8, 2008).

[6] Alexander Soule, Telemedicine firm attracts interest at venture event, Rochester Business Journal, (Nov 14, 2003): page 15

[7] Senat-Presiden, see in http://www.ntia.doc.gov/legacy/reports/telemed/.htm,

[8] Arman Anwar Op.Cit page 104-105

Elimination Act, Electronic Communication Privacy Act, Privacy Protection Act, Fair Credit Reporting Act, Right to Financial Privacy Act. Computer Fraud and Abuse Act, Anti-cyber squatting consumer protection Act, Child online protection Act, Children's online privacy protection Act, Economic espionage Act, and "No Electronic Theft" Act.[1]

Article Meanwhile, laws related to regulating the provision of individual health services are enforced through state legislative decisions including by delegating authority to individual state Licensing Boards to grant permits to practice medicine.[2]

In the state of California, a law regarding Telemedicine has been created which is referred to as "The Telemedicine Development Act 1996". This law stipulates several requirements that regulate the provision of health services via telemedicine. This law also defines telemedicine as the transfer of electronic medical information in the form of graphic displays, video or sound, between remote locations. In addition to providing a link between patients and health professionals, the system is also used by specialists and institutions for consultation and educational purposes. A medical specialist or educator at the host site can communicate directly with patients, clients, or colleagues via the remote site."[3]

The Telemedicine Development Act of 1996 itself underwent several changes before becoming the Telehealth Advancement Act of 2011. The history of California law regarding telehealth begins with The Telemedicine Development Act (TDA) where this law formed the basis for state laws governing telehealth.[4]

Several telemedicine regulatory substances in California's Telemedicine Development Act from 1996 to 2011 include AB 415 which concerns the repeal of laws relating to telemedicine and replacing them with the Telehealth Advancement Act of 2011. Previously the Telemedicine Development Act of 1996, SB 1665 Chapter 864 , Statutes 193 of 1996 regulates telemedicine as follows:"

1. Defines "telemedicine" as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications;
2. Prohibits, as of Jan. 1, 1997, health plan contracts or health insurance policies from requiring face-to-face contact between providers and patients for services appropriately provided by telemedicine, subject to all terms and conditions of the contract or policy, except that health plans and insurers are not required to pay for consultations provided via telephone or fax;
3. Extends health plans and insurers prompt payment and claims processing requirements, and the related procedures health plans and insurers must have in place, to telemedicine;
4. Requires telemedicine services to be considered in determining compliance with the access to care standards imposed on health plans under the Knox-Keene Health Care Service Plan Act of 1975;
5. Prohibits until Jan. 1, 2001, for purposes of Medi-Cal, and subject to federal financial participation, a requirement of face-to-face contact for services otherwise covered by the Medi-Cal program, and appropriately provided through telemedicine, subject to billing and reimbursement policies developed by the California Department of Health Services (DHS);
6. Extends the face-to-face prohibition to Medi-Cal contracting health plans only to the extent that both of the following apply: a) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program ; and, b) Medi-Cal managed care plan contracts are amended to add coverage for telemedicine services and to make any appropriate capitation rate adjustments;
7. Requires the Medi-Cal program to pursue private or federal funding to conduct an evaluation of the cost-effectiveness and the quality of telemedicine services provided in Medi-Cal;
8. Requires health care providers, as defined, who have ultimate authority over the care or diagnosis of a patient, to obtain the written informed consent of patients prior to providing telemedicine services, except in an emergency where a patient cannot give consent, as specified . Specifies that information about risks and benefits of telemedicine must be provided verbally to patients, guarantees patients access to all medical information transmitted during a telemedicine consultation, and defines as unprofessional conduct the failure of a health care provider to obtain informed consent for telemedicine;
9. Exempts from California physician licensing laws physicians outside of California when in actual consultation within the state, or when consulting across state lines with a physician licensed in California. States that the Act shall not be construed as altering the scope of practice of any health care provider; and,
10. Makes legislative findings and declarations related to the potential for telemedicine to address major challenges in health care access, costs and quality.[5]

The essence of this regulation is that the Telemedicine Development Act of 1996 requires several requirements governing the provision of health services via telemedicine and also makes changes to several parts

[1] Ibid
[2] Ibid
[3] Senat-Presiden, Loc.Cit.
[4] Arman Anwar Op.Cit page 106
[5] Telehealth Law History, http://www.cchpca.org/policy-projects/telehealth-model- statute/ telehealth-law-history.

of the law in question, such as:

1. The practice of telemedicine as a legitimate means by which an individual can receive medical services from a health care provider without person-to-person contact through the provider.
2. That the enactment of this law shall not be construed to change the scope of practice of any health care provider or authorize the provision of health services or arrangements in other ways not authorized by law.
3. Exempts out-of-state practitioners, as defined by the Medical Practice Act when consulting, either within the relevant state or across state lines with practitioners licensed in California. Prohibits out-of-state practitioners from having ultimate authority over patient care or primary diagnosis in California.
4. Practitioners must obtain verbal and written informed consent from patients before providing health care via telemedicine, and also require that a signed written consent statement be made part of the patient's medical record. Patient medical records must be managed by a licensed health care provider.
5. Every Health care service must meet the requirements.[1]

Regarding insurance coverage, insurance companies in most countries do not reimburse doctors for telemedicine services. However, laws in California and Louisiana actually require insurance companies to cover doctors' costs for telemedicine services.[2] Likewise, many countries require doctors to first obtain an in-state medical license, and in recent years several countries have enacted laws that implement very strict licensing requirements for telemedicine. In California and two other states, such as Alabama and Oregon, the law actually provides reciprocal licensing, allowing doctors in any of the three states to practice via telemedicine freely. This is different where in other countries they have to apply for a special telemedicine permit.[3]

The purpose of licensing professional health services is to protect the public from incompetent practitioners. For this reason, a practitioner is required to have a license certificate from the country where he works or from the country where his patients are located. This provision applies to all practitioners who provide health services whether they work as doctors, nurses, pharmacists, therapists and other professionals.[4]

If a practitioner wants to provide telemedicine health services to patients abroad, the licensing requirements will certainly be more complicated because they must have a reciprocal license based on the laws in force in the country where the practice will be carried out. Therefore, before practicing medicine, doctors need to ensure that their activities are legally protected.[5]

Licenses themselves generally contain practical rules designed to protect the public relating to permitted procedures, actions and processes. The granting of licenses is legally limited to specifications according to the special education, experience and competence of the relevant practitioner.[6]

Each country has its own laws, licensing bodies and regulations that explain the requirements for medical practice along with determining the scope of that practice. Health care professions with scopes determined by law and practice regulations include nursing, midwifery, emergency medical services, pharmacists, social workers, physicians and surgeons, or chiropractors/orthopedists.[7]

In order to optimize the efficiency of the national telemedicine network in all fields, the limited licensing regulations in the United States must be eliminated. This seems to be getting quite a bit of attention as several states have introduced legislation that would allow doctors from across the United States to practice in their states via telemedicine networks.[8] On October 7 2011, based on the approval of the Governor of California, the Senate passed the Telehealth Advancement Act of 2011 to replace the Telemedicine Development Act of 1996. In the Telehealth Advancement Act of 2011, the term "telemedicine" was replaced with a broader and more precise term, namely " telehealth." The birth of this law was motivated by the potential that basic health care providers and their relationships with patients could not only be maintained, but could also be supplemented and improved, through the use of telehealth as a tool to be integrated into medical practice.

In an effort to keep up with technological advances, the Indonesian Ministry of Health launched the Telemedicine Indonesia (TEMENIN) application in 2017. This application is able to provide long-distance medical services, such as tele-radiology, tele-EKG, tele-ultrasound, and tele-consultation (Ministry of Health of the Republic Indonesia, 2020). During the COVID-19 pandemic, this application played an important role as a tool to prevent the spread of the virus in accordance with Circular Letter Number HK.02.01/MENKES/303/2020 concerning Providing Health Services Through the Utilization of Information and Communication Technology.

The use of technology in the health sector has had many positive impacts, especially in increasing the

[1] Arman Anwar Op.Cit page 108
[2] David Campbell, CEO and Jack L. Shaffer, Jr. Chief Information Officer, Transforming Health Care in West Virginia through Telehealth and Broadband Access, dalam www.chnwv.org
[3] Ibid
[4] Arman Anwar Op.Cit page 110
[5] Ibid
[6] Ruthe C. Ashley, "Telemedicine: Pertimbangan hukum, etika, dan tanggung jawab", Journal of American, Dietetic Association 2002,
[7] Dictionary McGraw-Hill, Concise Kedokteran Modern 2002
[8] Julian Matthews, "Telemedicine Network Operational.", dalam. http://www.openmed.com/.htm. 3.

efficiency of health service delivery. Technology makes it easier for doctors to provide medical services remotely, including the transfer of medical information, diagnosis, therapy and education via images, video, audio and medical records.[1]

The implementation of telemedicine is based on a strong legal foundation, which includes various laws and government regulations. However, there is still a need to improve regulations, especially in addressing issues that have legal implications to protect the interests of patients and healthcare providers.

Telemedicine has grown rapidly in recent years, influenced by various factors such as organizational regulations, financial factors, technological infrastructure, and the COVID-19 pandemic.[2]

All of these factors are driving the increasing use of telemedicine, but there are still several challenges that need to be overcome in its implementation, such as technological capabilities, privacy and security of patient data, regulations and laws, usage guidelines, and individual patient problems.[3]

Law and justice are two sides of a coin. If justice is described as material and law as "form", then the value of justice is the material that must fill the legal form. Meanwhile, law is a form that must protect the value of justice. Thus, justice has both normative and constitutive characteristics for law. Justice is normative for law because it functions as a transcendental prerequisite that underlies every dignified law. Justice is the moral foundation of law and at the same time the benchmark for a positive legal system. In other words, justice is always the basis of law. Without justice, a rule does not deserve to be called a law.[4]

Equating justice and legal regulations is the easiest way to understand justice. Legal regulations are used to promote justice in 2 (two) ways: **first**, legal regulations introduce a number of moral norms as legal norms and establish norms in the legal system as a system of justice. **Second**, the justice system is formed through a number of institutions established by legal regulations to:

1) Implement and enforce legal regulations to obtain justice.
2) sorting and presenting to decision makers the existence of other forms of legal violations;
3) Decide when a legal violation has occurred and what the sanctions are;
4) Implement the contents of existing decisions.[5]

Apart from that, substantive justice must refer to a measure of equality and freedom. **First**, is the principle of greatest equal liberty. Through this principle, each person has equal rights to the entire system which is composed of freedoms and which is compatible with these freedoms.

Second, fair equality of opportunity (the principle of fair equality of opportunity). The essence of the principle of fair equality of opportunity refers to those who have the least opportunities to achieve prospects of prosperity, income and authority.

Rawls's procedural justice is of three kinds. Apart from perfect procedural justice, there are also two other types, namely: imperfect procedural justice and pure procedural justice. Perfect procedural justice refers to the availability of procedures that have previously been well designed, but the final results may be different from the original design. Pure procedural justice departs from the absence of independent criteria that precede a procedure, and what is needed is a process of formulating a correct and fair concept of justice to guarantee a correct and fair final result.

Thus, the value of fairness in providing health services via telemedicine is as follows:

1. The Pancasila principle of justice is based on the belief in the Almighty God in wiretapping regulations, namely that telemedicine regulations do not conflict with the religious values and beliefs held by each individual citizen.
2. The Pancasila principle of justice prioritizes human rights and humanizes humans as social creatures who must be protected in telemedicine regulations.
3. The Pancasila principle of justice upholds the value of unity and oneness in telemedicine regulations in order to create a conducive atmosphere in the nation and state.
4. The Pancasila principle of justice adheres to the principle of democracy in telemedicine regulations, namely the accommodation of the opinions of community members or people's representatives based on deliberation to reach consensus.
5. The Pancasila principle of justice provides justice for all citizens in telemedicine regulations, namely clear, complete regulations and the existence of an objection mechanism for telemedicine medical practices that are suspected of violating procedures that are detrimental to patients.

The need to adjust regulations regarding the implementation of electronic medical records in hospitals or

[1] Wootton, R. (2012). Telemedicine. British Medical Bulletin, 101(1), 1-17.
[2] Weinstein, RS, Lopez, AM, Joseph, BA, Erps, KA, Holcomb, M., Barker, GP, & Krupinski, EA (2014). Telemedicine, telehealth, and mobile health applications that work: Opportunities and barriers. American Journal of Medicine, 127(3), 183–187.
[3] Scott Kruse, C., Karem, P., Shifflett, K., Vegi, L., Ravi, K., & Brooks, M. (2018). Evaluating barriers to adopting telemedicine worldwide: A systematic review. Journal of Telemedicine and Telecare, 24(1), 4–12.
[4] Bernard L. Tanya, Yoan N. Simanjuntak, dan Markus Y. Hage, 2006, Teori Hukum: Strategi Tertib Manusia Lintas Ruang dan Generasi, Jakarta : CV. Kita, page. 106.
[5] Richard A. Myren. 1988. Law and Justice An Introduction. Brooks/Cole Publishing, Pasific Groove. page 31

level I health facilities in accordance with Article 16 of the ITE Law shows the importance of electronic signature certification. In facing the COVID-19 pandemic, the Indonesian government is encouraging the public and medical personnel to use telemedicine services. However, clear policies and ongoing cooperation between the government, hospitals and medical personnel are needed to overcome the various challenges that arise.[1]

The use of digital telemedicine platforms is increasingly important in providing equal access to health services, especially in geographically challenged areas such as North Sumatra Province. The province's topography varies, from lowlands to mountains, which makes it difficult to provide equitable health services. Therefore, telemedicine is an ideal solution to overcome these challenges (Indonesian Medical Council, 2020). There are three regulatory and policy instruments related to the provision of telemedicine services that are currently being used as references. First, Minister of Health Regulation Number 20 of 2019 concerning the Implementation of Telemedicine Services between Health Service Facilities (Permenkes 20/2019).

Minister of Health Decree 4829 is the second decision related to telemedicine services, which revokes the Minister of Health Decree and establishes guidelines for health services via telemedicine during the COVID-19 pandemic. Perkonsil 74/2020 is the third decision related to medical practice via telemedicine during the COVID-19 pandemic in Indonesia.

Minister of Health Regulation 20/2019 aims to improve specialist health services and service quality, especially in remote areas. This regulation allows telemedicine services between Health Facilities such as teleradiology, tele-electrocardiography, tele-ultrasonography, teleconsultation clinics, as well as other telemedicine services in accordance with developments in science and technology.

The regulation also limits that only hospitals can provide consultations via telemedicine services. Meanwhile, other health facilities such as first level health facilities and others can request consultations via telemedicine services.

However, this regulation only applies to the needs of Health Facilities, and does not yet regulate telemedicine services for doctors or health facilities with patients. The COVID-19 pandemic which requires social distancing has forced the use of telemedicine services in public health services. In response, the Ministry of Health has issued guidelines governing telemedicine services that can be utilized by the public or patients. During the pandemic, the Ministry of Health has issued two instructions regarding telemedicine, namely Minister of Health SE and Minister of Health Decree 4829. However, Minister of Health SE has now been replaced and revoked with Minister of Health Decree 4829.

Telemedicine regulations were issued with the aim of facilitating remote health services in an effort to prevent the spread of COVID-19. Minister of Health Decree 4829 and Perkonsil 74/2020 provide a definition that telemedicine is a health service that uses information and communication technology for various medical functions, including handling and monitoring COVID-19 patients. However, this service is only valid during the pandemic. Health facilities that can provide telemedicine services include hospitals, health centers, clinics, independent doctor's practices, and pharmacies[2]

Minister of Health Decree 4829 and Perkonsil 74/2020 provide legal certainty for doctors practicing during the pandemic. However, these three instruments have limitations as guidelines for implementing telemedicine which are currently still in the development stage.

Therefore, the government needs to formulate more comprehensive regulations, including adjustments to several laws related to public health services.

Telemedicine arrangements must take into account the interests of patients and the protection of medical personnel. Telemedicine has been implemented in Indonesia to overcome the problem of inequality in health workers, especially doctors and specialist doctors. However, the Health Law has not yet designated telemedicine as a health service facility, so protection for medical personnel and patients must be regulated in statutory regulations. Telemedicine can be an effective means of equalizing access to health, therefore regulations for its use need to be drafted in the form of law.

Even though it has weaknesses, one of which is that physical examinations cannot be carried out directly, telemedicine is considered to facilitate public access to health services. Health consultations can be done without visiting a health facility, thereby saving time and costs. Distance and time are no longer the main obstacles in this case

The development of telemedicine will bring the world of health into a new phase with adaptation to information and communication technology. This new phase must be followed by adjustments to related regulations so that telemedicine practices can run optimally and also provide legal certainty for the parties involved such as medical personnel, health workers and patients.

There are four regulatory and policy instruments related to the implementation of telemedicine services that are currently being referred to. First, Minister of Health Regulation no. 20 of 2019 concerning the

[1] Scott Kruse, C., Karem, P., Shifflett, K., Vegi, L., Ravi, K., & Brooks, M. (2018). Op.Cit, 4–12.
[2] Wrede, R. Von, Moskau-hartmann, S., Baumgartner, T., Helmstaedter, C., & Surges, R. (2020). Counseling of people with epilepsy via telemedicine: Experiences at a German tertiary epilepsy center during the COVID-19 pandemic. Epilepsy & Behavior : E&B, January.

Implementation of Telemedicine Services between Health Service Facilities (Permenkes 20/2019). Second, Decree of the Minister of Health Number HK.01.07/MENKES/4829/2021 concerning Guidelines for Health Services Via Telemedicine During the Covid-19 Pandemic (Kepmenkes 4829). This decision revokes the Circular Letter of the Minister of Health Number HK.02.01/MENKES/303/2020 concerning the Implementation of Health Services through the Use of Information and Communication Technology in the Context of Preventing the Spread of Covid-19 (SE Minister of Health). Third, Indonesian Medical Council Regulation no. 74 of 2020 concerning Clinical Authority and Medical Practice Through Telemedicine During the Covid-19 Pandemic in Indonesia (Perkonsil 74/2020). Fourth, Law Number 17 of 2023 concerning Health, which in article 25 regulates medical practice via telemedicine.

Minister of Health Regulation 20/2019 is intended to improve specialist health services and service quality, especially for remote areas. Telemedicine services that can be provided based on this regulation are health services between health facilities. Telemedicine services between health facilities include teleradiology, tele-electrocardiography, tele-ultrasonography, clinical teleconsultation, and other telemedicine services in accordance with developments in science and technology. Meanwhile, telemedicine regulations based on article 25 of Law Number 17 of 2023 concerning Health will be further regulated by Government Regulation.

Health service activities via telemedicine regulated in the Minister of Health Decree include: (a). communication, information and education consultation (KIE), (b). clinical consultation which includes anamnesis, certain examinations via audio-visual, providing recommendations/advice needed based on the results of supporting examinations and/or the results of certain physical examinations, establishing a diagnosis, management and treatment of patients, writing prescriptions for drugs and/or medical devices, given to patients according to the diagnosis, (c). supporting examinations, and (d). tele-pharmacy services.

Health service facilities providing telemedicine services include hospitals, health centers, clinics, independent practices of doctors/dentists and specialist doctors/specialist dentists, laboratories and pharmacies. Health services provided by health facilities can use applications that have been developed themselves by the health facilities concerned or collaborate with government or private applications.

The four instruments described previously have limitations as guidelines for implementing currently developing telemedicine services. Minister of Health Regulation 20/2019 only regulates the implementation of telemedicine between health facilities. Meanwhile, Minister of Health Decree 4829 and Perkonsil 74/2020 limit the implementation of telemedicine in pandemic situations. When the government lifts the Covid-19 pandemic situation, there will be a vacuum in the instruments that guide the implementation of telemedicine.

The implementation of telemedicine seems inevitable. The government needs to take quick steps to formulate more comprehensive regulations. A number of laws related to public health services need to be adapted to current needs. Among them is Law no. 29 of 2004 concerning Medical Practice, Law no. 36 of 2009 concerning Health and Law no. 44 of 2009 concerning Hospitals.

The need for adjustments to at least these three laws shows the need for telemedicine regulation in a law. Apart from that, we also remember that the scope of the regulation is to meet the basic needs of the community related to health services. Telemedicine arrangements need to pay attention to the interests and safety of patients as well as the protection of medical and health personnel. It is hoped that this arrangement will not only make it easier for patients to access health services, but will also provide legal certainty and clear guidelines for medical and health personnel while maintaining service quality.

Some of the material contained in the previous instrument is still relevant and will be rearranged in the instrument that needs to be formed later. Other materials that need to be regulated include telemedicine providers, the rights and obligations of the parties in telemedicine services, the scope of telemedicine services, quality assurance aspects, service responsibilities, service management, protection and development of medical and health personnel, medical record management, supervision and public education.

D. CONCLUSION

Use of health applications or conversation applications, where health services are carried out privately between the doctor and the patient. This is also not regulated in the Circular Letter of the Minister of Health concerning the Implementation of Health Services Through the Use of Information and Communication Technology in the Context of Preventing the Spread of COVID-19. Several existing regulations related to the implementation of Telemedicine, include: Minister of Health Regulation no. 90 of 2015 is still limited to only regulating telemedicine between health service facilities and the use of telemedicine in relationships between doctors and doctors, while the specific use of telemedicine in relationships between doctors and patients has not been regulated. UU no. 29 of 2004 concerning Medical Practice only regulates the relationship between doctors and patients which is carried out conventionally or face to face without the role of third parties as found in the telemedicine concept. The fact that telemedicine practice has not been regulated in a separate regulation that covers it has the potential to give rise to legal problems. One of them is related to medical permits. Considering that there are no telemedicine regulations, especially in the practice of telemedicine between doctors and patients,

reconstruction must be carried out regarding weak legal protection regulations and injustice for patients if they cause harm. The provisions regarding telemedicine as regulated in Article 25 of Law Number 17 of 2023 concerning Health, are very far from adequate, in fact the direction is not clear, whether it is only a legal umbrella for telemedicine which has been regulated in Minister of Health Regulation Number 20 of 2019 concerning the Implementation of Telemedicine between Health Service Facilities, or will regulate the Implementation of Telemedicine not only between Health Service Facilities but also between Health Service Facilities or doctors and patients. Reconstructing the regulations of Article 25 of Law Number 17 of 2023 concerning Health, which generally regulates the practice of medicine via telemedicine, requires reconstruction of norms in order to provide justice for the practice of medicine via telemedicine between Health Service Facilities, as well as between Health Service Facilities or doctors and patients.

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