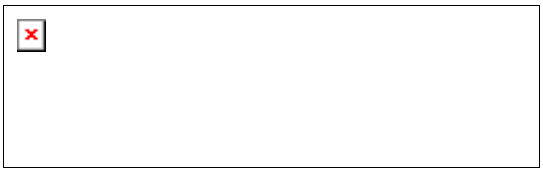
ABSTRACT



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The Finnish Health System and CT Law: The Difficulty of Caring for Santa's Bairns

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The dare of the care - managing with the elderly

The contemplation here is based on the pressure to develop the health care system as has often been emphasised in the media lately. This seems to be particularly true in Finland where, at the moment, 15 % of the population is over 65 year-olds and year 2030 the same figure is estimated to arise up to 26 %.[1] To make the matters worse, the burden of aging population is not equally geographically shared but the several smaller communes and rural areas are aging more rapidly and severally than the towns where the working population is concentrated. According to the estimates of the Central Statistical Office of Finland, in almost 50 municipalities the percentage of over 65 year-olds will arise above 40 %.[2] Although, the burden of aging population in the European Union hits first and worst in Finland, there is no doubt similar problems have to be tackled also elsewhere in Europe.[3]

The above-described development will and has already created pressure especially on the social and health care sector in providing the necessity services. At the moment, the worst stories tell that one has had to wait over a fortnight to be submitted to the health clinic. Thus, there clearly is request for regional co-operation in providing the services and combining different service sectors to make them more efficient. One important characteristics of the development is that new technology is employed to facilitate the distant health care services. This has attracted also businesses with new technical innovations to penetrate into the markets. In order to ensure that the requirements of the fundamental rights to social and health care and that other rights of individuals are respected in the course of this rapid technical development, the legal aspects of the telemedicine infrastructure should be contemplated concurrently.

The objective of this paper is not to try to solve the looming social problem of public sector but to look at the legal implications and possible bogeys that this development might and has already brought about especially with regard to the person's privacy. In order to do that we will contemplate some ongoing both research and practical projects, like the virtual health centres taking place mainly in Finland. This is done in reflection to the legal regulation of Information Society Services (ISSs) in the EU and Finland.

General impressions on the meaning of telemedicine

The use of ICT is an important aspect in the health sector and the term telemedicine is referred to in this paper in ongoing basis. However, it does not always become clear to public what that term

actually encompasses. Thus, some definitions are at place to start with. In general the telemedicine refers to telematics (automatic systems for distribution of distant information), which are used in health care and enable diagnosis or seeking medical assistance from a distant.[4]

This is carried out through telecommunication technology or services, which enable the transfer of biomedical information. Another straightforward definition of telemedicine is "use of telecommunications to provide medical information and services".[5] A definition of telemedicine by V*an Goor and Christensen* (Advantages in medical informatics, 1992), also employed by the European Union maintains "medical integration, monitoring, acceptance and education of patients and personnel by exploiting systems that enable fast connection to the professional skills of the doctors and the patient data, where-ever they reside physically." Thus, in its widest the telemedicine encompasses all the telecommunications enabling the distant health care services from telephone consultations to teleradiology (sending x-rays, CT scans or other so-called store-and-forward images), telepathology and telesurgery applications.[6]

As can be concluded already from the wide definition above, it is impossible to describe all the possible legal issues involved in telemedicine already where in fact it can comprise a whole variety of services and medias from professional consultations on the phone to directly transferring patient data or conducting examinations online. Thus, the legal challenges of telemedicine - as listed by *Hodge, Gostin* and *Jacobson*: privacy, quality of health data and tort-based liability - will be discussed here in fairly general level.[7]

The state of art of the health regulation

Until recently the advancements have concentrated more on the technical innovations than constructing general infrastructure for effectively enforcing the application in practice. As has become imminent, more comprehensive and system-oriented approach has to be adopted. Also, more aggregation of legal aspects of e-health will be produced in order to remove the legal uncertainties of the businesses.[8] There is not yet much legislation in European level concerning specifically the health care and social sectors, the reasons being the dissimilar requirements of national regulations, and due to the public nature services they appear fairly difficult to harmonise. Thus, the exploitation of telemedicine is also usually restricted by these national regulations. Due to the impairment of the Community to pass new legislation, there have been both legislative and non-binding initiatives e.g. in Finland recently.[9]

The importance of telemedicine to the national economy has been acknowledged also by the European Union.[10] The Information Society Directorate-General has launched an initiative called *eEurope* where there is a specific action plan for ehealth - *Health Online*: the *Health Online* action recognizes five target actions in the exploitation of information technologies in the health sector, the first of which is to implement a infrastructure which will provide user-friendly, validated and interoperable systems for medical care, disease prevention, and health education through national and regional networks which connect citizens, practitioners and authorities on-line.[11] In order to achieve that, the *Health Online* has set further actions, namely to draft guidelines for *quality criteria for Health Related Websites*.[12]However, it must be highlighted that those will only be the guidelines and all issues of implementation of the criteria will be conducted at the national or local level. In order to further the applicability of the innovations in practice, the Directorate has also introduced *Best Practices* action, whereupon several ongoing telemedicine projects have taken place [13].The next step in the *Health Online* action would be to establish a series of data networks to assist the Member States' health care organizers in planning the service[14].

Finally, there is the question of reviewing the health regulations that has been raised. With regard to establishing health related Web Sites and other Web based services, the existing general regulations on information society services combined with the voluntary guidelines drafted specially for the health online provide a good starting point with regard to e-commerce.[15] It remains to be seen

what legislative initiatives - if any - the Commission's Communication on "Legal Aspects of eHealth in 2001" will suggest. The preparatory document should be drafted for comments by February 2002, but was not available for the author at the time of writing this article.

General characteristics and loopholes of the current regimes

In the imminent lack of resources to provide sufficient health care and social services sector, the public authorities are forced to recline on privatisation and out-sourcing of parts of services.[16] Also, the employment of telematic innovations has increased the presence of commercial businesses. Taking into account the particular nature of health services as necessity services guaranteed as fundamental rights and thus, the specific requirement of the accessibility and quality of the health services, it is at place to emphasise the pronounced duty of care and liabilities of the service providers and that special regard should be had to the quality of this transition. Those specific requirements set by the health care regulation and delicate nature of information involved should also be taken into account, when allocating the liabilities in contracting between the service provider and the authority that has the duty to produce the services within the limits of the resources: in other words, despite of the out-sourcing or privatisation, the authorities remain liable for providing the inhabitants sufficiently efficient and quality services at the threat of neglecting the obligation to provide for the statutory health service.[17]

Also, a special non-discrimination duty arises from the necessity nature of the health and social services.[18] Thus, the needs of elderly and disabled people should play an important role in arranging the services or providing information, should the telemedicine provide for primary source of service or substantially supplement the traditional health services and social. Thefefore, it might be necessary to employ parallel technical solutions considering the impairments of individual users, which again raises the costs of implementing the service.[19]. This is also of importance in planning the data security measures: certain authorisation systems may refrain the disabled persons from using the system, e.g. the physically impaired persons from using the fingerprint identification system. This obligation of equality in providing the health services arises in Finland explicitly from the Constitution.[20] An example of a step taken towards right direction is the Web Accessibility Initial of the World Wide Web Consortium, which seeks to insure that the Web is accessible to everyone regardless of the disabilities.[21]

As the complete breakthrough of telemedicine as the primary form of service is unattainable at the moment, the exploitation of the benefits and cost-savings of telemedicine takes place as supplementary service. Maintaining many parallel systems in the name of providing better information for the public and more efficient service has clear benefits and cost-savings may take place also through individual actions. However, as will be shown there are also many disadvantages in the existence of unconsolidated systems. Similar to the privatisation of railways in Britain, in the lack of clear roles and regulations, there will be problems to decide who is responsible for calling the `fire brigade' should something go wrong. In other words, in the case of malpractice, it might be difficult to pin point which party, for example, has neglected its duties. Due to the amount of detailed provisions concerning duties of health and social service providers, changes in service concepts might entail confusion on the legal state. Thus, the threat of such disputes is imminent as long as the regulatory aspects remain uncertain.

Another metaphor could be made to the illusion of paperless offices in the area of electronic communications. Although, it is undeniable fact that the digital processing of health information has the requisites to enable more correct diagnosis and better treatment especially in the case of emergency, where manual records might not be available at all. For example, storing patient information in electronic form should make it more easily transferable and thus, decrease the need to maintain many different registrars. However, it might well be that the relative easiness to establish patient data registers actually increases the amount of delicate personal information and is disposed to breaches of data security. The `health information flow' might appear to be as difficult to control

as the breach of copyright of digital works.

Although, the singular conducts appear completely acceptable and comply with the particular requirements of data processing, summing up may prove differently. Take for example, the fairly simple Finnish service of Net Nurse Service recently established in Rovaniemi, where people from that hospital district can send health-related questions over e-mail. In accordance with the *Degree 99/2001 on the formulation and preserving of patient documents and other related material related to the treatment* and *the Act 1992/785 on the status and rights of a patient,* those emails might be interpreted to amount to patient documents and are therefore, rightly saved as such for ten years after the consultation.[22]

Also, in accordance with the applicable law, the information on that registrar is used merely by appointed Net Nurses and not as basis of diagnosis. This caution on the transfer of patient information at the threat of breaching person's privacy might actually lead to situation where individual authorities maintain several parallel registers containing same delicate information in different forms, which again is likely to increase the risk of breaching the data protection principles. In this context, the importance of the quality and correctness of the stored data as part of the good data protection practices should be emphasised. Such bogeys may take place at least in the transition phase, where there are numerous pilot projects and several different actors involved. Suddenly, we have a situation at hand were delicate health information and communications to the health authorities are stored in various locus and forms. Thus, in conclusion it could be said that the assessment of the quality of data processing should be done more comprehensive level.

The endeavours for one-stop health shops in Finland

The concern over the discontinuity of the different health and social services in Finland has recently spawned an interesting information technology initiative called *Satakunnan Makropilotti*, where the purpose is to consolidate the services of different actors, which requires creation of regional electronic data systems.[23] At the moment, the operations of the organisations are governed by individual Acts and thus, in order to enable that regional and trans-organisational cooperation of the six participating municipal hospital districts the adoption of a temporary Act was recommended by the Working Group of the Ministry of Social Affairs and Health on data protection and data security. [24]

In the course of the *Satakunnan Makropilotti* project, the assistance of new and existing telematic and teleinformatic innovations are employed. The idea is to accumulate the dispersed results of previous individual projects. However, exploitation of the state of art of the electronic data systems is conducted fairly cautiously and thus, are not exploited to their fullest: for example, unlike some other smart card experiments, the multi sphere smart card is used here merely as a key and identification tool needed to access the local data bases containing the actual delicate information. This is due to the data security risks that the gathering of sensitive personal information on one electronic data system might bring about.

One dimension of the project is to create one-stop shop -systems, where the assistance of a personal consultant can be exploited when accessing different social or health services. Based on explicit written consent of the client, there is no general objection in the current Finnish law to the transfer of patient data between different registrars and authorities.[25] The clients also have the possibility to opt-out from the personal consultant system. In a longer course of time, however, this type of data processing might become dubious, if the clients are not offered genuine alternative care regimes. This is especially the concern of certain Nordic legal experts on data protection: monitoring of the information given to the data subject and the genuineness of the consent becomes more important after the necessity requirement of processing of delicate personal data is abolished by the Directive 95/46/EC, like in the Danish legal system.[26]

Although, the present requirements of the privacy enhancing legislation is taken into account, one cannot refrain from suspecting that the consolidated services might in practice be achieved on the cost of data subjects sovereignty. Having one-stop shop systems entail temptations to disregard the requirement of genuine consent to data transfer. Also, compilation of delicate personal information is very attractive target for commercial and terrorist interest groups.

The globalisation strive and free movement of patients

The e-commerce phenomenon and the globalisation in general have put pressures on the legislators to harmonise also the regulations in health and social sectors.[27] Thrusts for harmonisation may in practice arise even from the difficulty to maintain the restrictions in practice. One good example such ineffectiveness is the commercial communications of pharmaceuticals: unlike in European Union, the marketing of prescription medicine to the patients is allowed for example in the USA and New Zealand. Partly due to this imbalance of the markets, the European Commission has recently introduced proposals to review the EU pharmaceutical legislation, which includes the idea of opening up the marketing of prescription medicine directly to consumers.[28] At the pilot phase of the reform, the liberalisation would concern AIDS, diabetes and asthma drugs. The release of prescription pharmaceuticals has thus raised concerns among the health professionals on the impacts to the consumer behaviour and doubt that the thrust for the liberalization is rather economic-driven than concern over the patients' access to information.[29]

Also, the licensing schemes are national based and thus, might refrain the service provider from fully exploiting the possibilities of telemedicine. In relation to licensing, the regulation concerning patient insurance systems may have to be revised, regardless whether compulsory or voluntary in nature. Also, the impact of internal market goal on the national health care regulations is an interesting question. There is a ECJ case *Nicolas Decker v Caisse de maladie des employés privés*[30] on the conflict of national security rules and the free movement of goods, where the ECJ ruled that the Articles 28 (ex 30) and 30 (ex 36) of the EC Treaty overstrip the refusal of reimbursement of optician services of another Member State under national security rules, on the ground that prior authorisation is required for the purchase of any medical product abroad. A similar preliminary ruling on case *Raymond Kohll v Union des caisses de maladie*[31] took place in the European Court of First Instance a few years later with the same outcome, although in that case the question was on the breach of freedom of services Articles 49 (ex 59) and 50 (ex 60) of the EC Treaty. According to a Study Report commenting on the above-mentioned cases, it remains to be seen whether the aspects of free movement of patients expressed in those cases will extend to accessing cross-border health services by telecommunication means.[32] At least, in relation to the requirements of national licensing practice of health care workers and its relation to the reimbursement of malpractice might be more difficult to walk over on the basis of the exception of protection of health granted in Article 30 (ex 36) in the EC Treaty. On the other hand, there is already European harmonisation on the mutual recognition of the qualifications in medicine and coordination of provisions in respect of the activities of the doctors.[33]

Any turn on the issue of free movement of patient and health services might be expected soon, since the developing cooperation between different EU health systems as parts of *Program of Community Action in the Field of Public Health* was considered to be one of the key priorities for the Spanish presidency during the ministerial meeting in Malaga in February 2002.[34] According to Commissioner Byrne, "there is a need to develop a coherent and co-ordinated approach across these different policy areas to enable health systems to function effectively and address citizens expectations that they can seek treatment abroad".[35]

Estimates on the level of further development of framework in social and health sector

Despite the recent national and European initials to accommodate legal framework for the cooperation in the health and social sector, the governance of legal infrastructures in the

telemedicine lies still mainly on the basis contractual networks and voluntary codes of conducts adopted with objectives to facilitate confidence in the service. In order to elucidate the uncertainty of the validity of the basis of the cooperation, the contemplation on legal aspects on eHealth is welcomed. The systematic exploitation of telematic innovations is also restricted by the ineffectiveness of the public service providers: the relative smallness of the hospital district units and the economical difficulties of many of the communes do not provide financial wherewithals for facilitating large organisational reconstructions. In order to insure the best practices in telemedicine the evaluations should nevertheless be done comprehensively, as the *Satakunnan Makropilotti* project aims for. However, the necessity of reducing health and social costs should not distract the decision makers from constructing a service system that respects the data security and thus, right to privacy of the data subject.

Harmonising the health care regulation in Europe appears to be an excessive task considering the different starting points and strong public interests. Thus, the emphasis is put more on seeking solutions in the national level, as the follow-up Communication to the *e*Europe initiative proposes: "Member States would insure by the end of 2002 that primary and secondary healthcare providers have health telematics infrastructure in place including regional networks".[36] Some restrictions are laid down, however, in the community level with regard to the free movement of patients and health services and coordination concerns in preparing policies and programmes in the health sector.

It is foreseeable that, in the course of the development and increase in use of distant communication means, also the traditional concept of doctor-patient relationship will take new forms. What are the impacts on the allocation of liabilities between different actors involved in providing the service would be of interest, for example, to the insurance companies. Also, the convergence of different services might give rise to accommodate the detailed and inflexible provisions to fit the new service concepts. Nevertheless, the confidence in the general regulation on information society services providing the basis of the regulatory framework prevails.

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[1] Helsingin Sanomat p. A6 on March 3,2002 in Article Väestön ikääntymisestä tulossa kunnille iso taakka by *Olli Pohjanpalo*.

[2] Helsingin Sanomat p. A6 on March 3,2002 in Article Väestön ikääntymisestä tulossa kunnille iso taakka by *Olli Pohjanpalo*.

[3] See *Parkkinen, P.,* Report on the structure of population up until year 2050 in Finland and other European Union Member States (Suomen ja muiden unionimaiden väestön ikärakenne vuoteen 2050). Published on February 8, 2002.

[4] The definition of telemedicine in the INCLUDE-project of STAKES, the Finnish National Research and Development Centre for Welfare and Health on page http://www.stakes.fi/includef/telelääk.html. The abbreviation INCLUDE stands for Inclusion of Disabled and Elderly people in telematics project

[5] *Perednia, D.A. - Allen, A.,* Telemedicine technology and clinical applications, JAMA 1995, v. 273(6): 483-488.

[6] *Brown, N.,* What is Telemedicine Telemedicine Coming of Age, September 28, 1996, updated February, 2000 an Article by the Telemedicine Research Centre (TRC) http://trc.telemed.org/telemedicine/primer.asp.

[7] *Hodge, J.G. – Gostin, L.O. – Jacobson, P.D.,* Legal issues concerning electronic health: privacy, quality and liability, JAMA 282(15): 1466-71,Oct 20 1999 (Source: Abstract of the article in

Telemedicine Information Exchange (TIE) Bibliographic Database, http://tie2.telemed.org/Citations.asp?ID=7944)

[8] *Supra* footnote 12.

[9] See further above on Satakunnan Makropilotti project, which aims to employ the achieved results in order to construct consolidated social and health services.

[10] In the EU the issues of telemedicine are dealt under the Health and Consumer Protection Directorate-General or the Information Society Directorate-General. Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of the European Community (COM/2000/0285 final) http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=en&numdoc=52000DC0285&model=guichett .

[11] See See http://www.europa.eu.int/information_society/eeurope/ehealth/index_en.htm.

[12] See the Draft Guidelines for Health Related Websites in http://www.europa.eu.int/information_society/eeurope/ehealth/quality/draft_guidelines/index_en.htm However, it should be noted that these are only the draft guidelines, the final statement of the 'Criteria for Basic Good Conduct in the Development &Maintenance of Health Related Websites' will be included in the Communications from the Commission to the Council, European Parliament, Economic & Social Committee, and Committee of Regions, due to be published in the June 2002. See http://www.europa.eu.int/information_society/eeurope/ehealth/quality/draft_guidelines/index_en.htm for more on the state of art of the guidelines. Compare also the code of conduct of the first considerable international organisation concerning telemedicine issues, HON (Health On the Net Foundation) http://www.hon.ch/HONcode/Conduct.html. The provisions of the latter are more relax and functions as guarantee that a service provided by medically trained professionals, whereas the Draft Guidelines of the European Union comply with the more general requirements of information society services and there is no requirement of medical professionalism. However, they both lie on the principles of transparency.

[13] 'Best Practices and Trials in eHealth in Action Lines 1.1.4 in 2000 and 1.1.3 in 2001' in the IST Work Programme of the 5th Framework Programme. See http://www.europa.eu.int/information_society/eeurope/ehealth/best_practices/index_en.htm. See short introductions of the ongoing projects funded by the above-mentioned Action Line Programmes http://www.europa.eu.int/information_society/eeurope/ehealth/best_practices/ongoing_projects/index

[14] http://www.europa.eu.int/information_society/eeurope/ehealth/index_en.htm

[15] The draft guidelines for health on-line services referred for example to following Directives: Data Protection Directive 95/46/EC completed by e.g. the Recommendations 2/2001 on Minimum requirements for the Collection of Data On-line and the Directive 97/66/EC on Privacy in Telecommunications, Distance Selling Directive 97/7/EC and the E-commerce Directive 2000/31/EC and the Framework Directive 93/1999/EC on Electronic Signatures. See

[16] In Finland Terveydenhuolto 2000-luvulle -programme has as one of the objectives to contemplate the privatisation of health services. The report of working group shall be submitted during this spring. See Article by *Päivi Repo* on Terveyskeskusten palvelut kangertelevat jo Etelä-Suomessakin on p. A11 of Helsingin Sanomat February 28, 2002.

[17] The obligation of public authorities to provide sufficient health and social services to all citizens as set by the law is specifically mentioned in Article 19 of the Finnish Constitution 11.06.1999/731.

Section 2 of the Act 785/1992 on the Patient's status and rights defines the rights of permanent and temporary citizens to health and social services.

[18] In the Finnish Constitution 1999/731 this obligation can be drawn from Articles 6 and 19.

[19] See for example the CATCH I and II projects (Citizens Advisory System Based on Telematics for Communication and Health), which has adopted multimedia multilingual advisory system in order to be effective and efficient in any time and any place and accessible for many groups, including elderly and handicapped http://www.ehto.org/ht_projects/html/dynamic/20.html and http://www.ehto.org/ht_projects/html/dynamic/21.html. The CATCH I and II projects ran in the ETHOS project (The European Telematics Horizontal Observatory Service) during years 1996-97 and 1998-99. See for more health related ETHOS projects Web Page http://www.ethoseurope.org/ethos/tap.nsf/Healthcare+-+Interest+in+Other+Sectors?OpenView.

[20] Article 6 of the Finnish Constitution 11.06.1999/731.

[21] See http://www.w3.org/WAI/ where some practical aspects of constructing web-based services for disabled are considered. European Union has taken part in that initial.

[22] [1][1] The Net Nurse service of municipal of Rovaniemi and the Rural district of Rovaniemi can be found in http://www.terve.com/

[23] The "Satakunnan Makropilotti" project started in 2000 and is bound to last until the end of year 2003.

[24] See the Bill HE 33/2000 on the experiment on consolidated chain of social and health services and the social security card. The temporary Act 811/2000 (*Laki 811/2000 sosiaali- ja terveydenhuollon saumattoman palveluketjun ja sosiaaliturvakortin kokeilusta*) came in force on 1 October, 2000.

[25] See in general on the transfer of delicate personal information Sections 11-13 of *Act 1999/523 on personal information* and the specific provision on transfer of patient information in Section 13 of the *Act 1992/785 on the status and rights of a patient*.

[26] See *Peter Blume*, The Citizens' Data Protection, The Journal of Information, Law and Technology (JILT) http://elj.warwick.ac.uk/jilt/infosoc/98_1blum/default.htm

[27] In Decision 1400/97/EC of the European Parliament and of the Council adopting a program of Community action on health monitoring within the framework for action in the field of public health (1997 to 2001) one of the objectives was to enable the establishment of an effective and reliable system for the transfer and sharing of health data and indicators using telematic interchange of the data as the principal means

[28] Commission proposes comprehensive reform of EU Pharmaceutical Legislation, Press release Brussels 18 July, 2001 http://pharmacos.eudra.org/F2/review/index.htm. The three Proposals of the reforms are (1) the Proposal for a Regulation of the European Parliament and of the Council laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Agency for the Evaluation of Medicinal Products; (2) the Proposal for a Directive of the European Parliament and of the Council amending Directive 2001/83/EC on the Community code relating to medicinal products for human use
and (3) the Proposal for a Directive of the European Parliament and of the Council amending Directive 2001/82/EC on the Community code relating to veterinary medicinal products

[29] See page 7 of the Publication Vol 19, nr. 4, September 2001 of the Association for Physicians

for Social Responsibility – Finland (PSRF) (LSV-tiedote, Lääkärin Sosiaalinen vastuu ry) http://www.kaapeli.fi/~lsv/tied401.pdf. See also the statement January 21, 2002 of the PSRF on the proposal for reform of the pharmaceutical legislation in http://www.kaapeli.fi/~lsv/

[30] *Nicolas Decker v Caisse de maladie des employés privés,* Case C-120/95.

[31] *Raymond Kohll v Union des caisses de maladie,* Case T-158/96.

[32] Study on the use of advanced telecommunications services by health care establishments and possible implications for telecommunications regulatory policy of the European Union (SATS); Final Report, Bonn/Dublin, October 2000.

[33] Already in the 70's the so-called Recognition and coordination Directives had been passed. See Directives 75/362/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in medicine, including measures to facilitate effective exercise of the right of establishment and freedom to provide services and Directive 75/363/EEC concerning the coordination of provisions laid down by law, regulation or administrative action in respect of activities of doctors. Those Directives have now been replaced by the Directive 93/16/EEC to facilitate the free movement of the doctors and the mutual recognition of their diplomas and the other evidence of formal qualifications and the amendments of the Directive 98/21/EC. See also on recent case law on the mutual recognition of medical diplomas by the Member States: *Hugo Fernando Hocsman v Ministre de l´Emploi et de la Solidarité* C-238/98 and *Jeff Erpelding v Ministre de la Santé,* C-16/99. The present authorisation for the harmonisation of health sector can be found in Article 152 (ex 129) of the EC Treaty. In Joint Decision 645/96/EC of European Parliament and the Council adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996-2000).

[34] See Address by the Minister of Health and Consumer Affairs, Celia Villalobos, in the European Parliament, Strasbourg, 4 February 2002 in http://www.ue2002.es/principal.asp?idioma=ingles.

[35] See the summary on the 'free movement of patients' -debate in Malaga, Consumer Voice, February 2002, Edition 2/02 in http://europa.eu.int/comm/dgs/health_consumer/newsletter/200202/05_en.htm.

[36] *COM(1999) 687 final.*