

The Impact of the EU Internal Market on Social Health Care

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INTRODUCTION

In *Raymond Kohll v Union des Caisses de Maladie* and *Nicolas Decker v Caisse de Maladie de Employés Privés* the European Court of Justice of the European Communities (herein after the 'ECJ') used EC law on the free movement of goods and services to substantially increase a patient's options for receiving non-emergency health care in another Member State at the expense of his/her social health care system. However these decisions left many unresolved questions, such as their impact on national health systems, their effect on the distribution of health care between the rich and poor or the extent to which the EC can dictate the range of care provided by the social system. It also raised the more fundamental issue of the extent to which economic rules should be applied to special areas like social health care. Part One of this article introduces the judgements. Part two then advances a hypothesis indicating the limits of their application. This hypothesis is founded upon the principle of subsidiarity and balances national sovereignty with the EC rules on fair trade without 'persecuting' any particular model of social health care provision. It was advanced to the EC Commission as part of a report produced by the Association Internationale de le Mutualite (AIM)¹. Part three of this article deals with two very recent decisions of the ECJ called *Peerbooms/Smits* and *Van Braekel*. These decision have clarified some of the uncertainty stemming from *Kohll* and *Decker*. Part three also looks at how these two new cases integrate with existing models of patient mobility within Europe. Part three concludes with a flow diagram indicating when a patient may receive non-emergency social health care abroad. The final section of this article addresses the wider issues behind *Kohll* and *Decker* and what they mean for the balance between the economic and social domains of the European Union.

1. KOHLL AND DECKER: THE FACTS AND JUDGEMENTS

The *Kohll*² and *Decker*³ decisions send a clear message to all those in the social health care sector that just because something is connected to social security does not mean that it is beyond the grasp of the internal market⁴. The cases concerned the provision of medical goods and services in another Member State at the expense of the patient's social health care system. The EC Social Security Co-ordination Regulation 1408/71 clearly states that social health care can be provided in another Member State in several situations⁵. For example the social health care system will pay for emergency medical treatment needed during a visit to another EC state. Regulation 1408/71 EC also allows EU nationals to travel to another Member State for non-emergency medical goods and services at the expense of their own health care system provided that their social health insurer or social health care administrator gives express authorisation before hand. If this authorisation is provided the patient can travel to another Member State and receive treatment, the patient's health care system then has to pay the foreign health care provider according to the rate and rules applied in the state where the treatment is given. When a patient uses the authorisation procedure this means that, in principle, they do not have to pay the foreign health care provider directly.

¹ Palm, Nickless, Lewalle & Coheur *Implications of recent jurisprudence on the co-ordination of health care protection systems*, a report produced for the European Commission Directorate General for Employment and Social Affairs, May 2000, the report may be found on AIM's website (www.aim-mutual.org)

² (1998) ECR I-1931

³ (1998) ECR I-1831

⁴ For an excellent introduction to these cases see *Health Care without Frontiers within the European Union?* International Symposium (Luxembourg, November 18th 1998), available on request from Association Internationale de la Mutualité (Brussels)

⁵ article 22 Regulation 1408/71, OJ 1971 L149/2 (since amended)

Mr Kohll and Mr Decker were Luxembourg nationals covered by the Luxembourg social health care system. In Luxembourg people receive their health care coverage from social health insurers. The patients pay their health care provider directly and are then partially reimbursed by their insurer. Mr Kohll wanted to purchase some new spectacles and Mr Decker wanted orthodontic treatment for his daughter (a minor covered under his insurance). Both the purchasing of spectacles and treatment by an orthodontist are covered by the Luxembourg health insurance and their costs are partially refunded by social health insurers.

However, Mr Kohll and Mr Decker did not want to purchase these goods and services in Luxembourg, instead Mr Kohll went to Belgium in order to get his glasses and Mr Decker wished to take his daughter to an orthodontist in Germany. Neither Mr Kohll nor Mr Decker wanted to rely upon the authorisation procedure provided for in the EC Regulation. Instead, they wanted to go to another Member State, purchase their medical goods and services, then return to Luxembourg and receive a refund from their social health insurer as if the treatment or products had been obtained in Luxembourg. They were prepared to pay the foreign health care provider directly and then be refunded according to the fees and rules that operated in their state of insurance.

The Luxembourg social health insurers relied upon the national rules that implemented Regulation 1408/71 EC in order to refuse reimbursement. Mr Kohll and Mr Decker challenged these rules on the grounds that they violated the principles of the free movement of goods and services contained in articles 28 and 49-50 of the EC Treaty, respectively.

The first point that the ECJ addressed in its judgements was whether the EC rules on the free movement of goods and services could be applied to social security systems. This is because the Luxembourg government and several intervening governments insisted that these were economic rules and so did not apply to the social security field.

The European Court of Justice reviewed its case law in this area and concluded that Member States have a great deal of freedom in the organisation of their social security systems. In the absence of EC harmonising measures, they are free to decide who can become affiliated to a social security scheme, what conditions must be fulfilled in order to receive benefits and how much these benefits will be. The Member States thus have a wide degree of discretion in organising social security but the Court concluded that this discretion cannot be used to breach EC law. As the Advocate General explains in his opinion:

“[T]he Court’s consistent view that “Community law does not detract from the powers of the Member States to organise their social security systems” by no means implies that the social security sector constitutes an island beyond the reach of Community law and that, as a consequence, all national rules relating to social security fall outside its scope”⁶

This means that just because something is strongly connected with the social security system does not mean that it is exempt from the application of EC law. Calling something social security policy does not give Member States carte blanche. The Member States have some discretion but that discretion is confined.

The rules concerning the free movement of goods and the free provision of services can be divided into a two-stage test. The first stage determines whether there have been any restrictions on the free movement of goods and services across internal borders of the EU. If some restriction is identified then the second stage asks whether there is any reason that might justify this restriction.

⁶ AG Tesauero, para 17

According to the case law of the European Court of Justice it is very easy to prove a restriction on the free movement of goods or services, the slightest hindrance of free movement whether direct or indirect, actual or potential, is enough to breach articles 28 or 49-50 EC Treaty⁷. Mr Kohll and Mr Decker explained that the social health care insurers would reimburse goods and services obtained in Luxembourg without demanding any formal authorisation, whereas if the same goods or treatment were to be provided outside Luxembourg no reimbursement would be given without prior authorisation. This extra requirement for foreign goods and services was found to deter people from travelling to other states and this deterrent was sufficient to constitute a breach of article 28 and 49-50.

The Luxembourg government and the Luxembourg social health care insurers tried to justify the national rules in both *Kohll* and *Decker* by insisting; firstly that prior authorisation was necessary to ensure the financial balance of the social security system and secondly that it was needed in order to maintain a functioning health care system open to all and thereby protect the public health of human beings.

As regards the first justification, the ECJ had ruled in previous cases that economic rules on the liberalisation of trade should not be applied where they jeopardise the delicate balance between contributions and benefits in a social security system⁸. However, in *Kohll* and *Decker* it explained that the gentlemen only wanted to receive the same amount of money as if they had purchased their goods and services in Luxembourg. The social health care insurers would not have to pay out any more than they would have done had Mr Kohll and Mr Decker remained in Luxembourg. This meant that the health care budget would remain undisturbed.

The second justification focused on the protection of human health, which is an express exception to the rules on the free movement of goods and services and is contained in articles 30 and 46 of the Treaty respectively. It was argued that if prior authorisation were abandoned there would be no way to ensure the quality of the goods and services provided by orthodontists and opticians in other Member States. The ECJ dismissed this justification by referring to the mutual recognition of diplomas and the efforts made during the 1970's in order to harmonise the training requirements for most medical professions⁹. It claimed that on the basis of this mutual recognition and harmonisation, Member States could rest assured of a minimum level of skill and qualifications from health care providers right across Europe. The justification on the grounds of public health was thus dismissed. However, a closer inspection of the mutual recognition rules reveals that this was the wrong legal basis on which to base the assumption that there is a similar standard of health care right across Europe¹⁰.

It is important at this point to stress that the ECJ did not say that the justifications advanced by the parties could never be used to justify violations of articles 28 and 49-50 of the EC Treaty. The Court merely made it clear that those justifications could not be used in the present cases because of the specific facts of those cases.

The ECJ held that the national rules did violate articles 28 and 49-50 of the EC Treaty because they unjustifiably hindered the free provision of goods and services over the internal borders of the EU. However, the national rules were a very careful implementation of the authorisation procedure described in article 22 Regulation 1408/71. It may have seemed logical that if the national rules were in violation of the Treaty then so was the Regulation. Nonetheless, the ECJ held that

⁷ *Procureur du Roi v Dassonville* (1974) ECR 497

⁸ *Duphar v The Netherlands* (1984) ECR 523

⁹ see for example Directive 93/16/EC (OJ 1993 L165 p.1) which is a consolidation of all the mutual recognition legislation for doctors, specialised doctors and general practitioners.

¹⁰ Nickless, J *A guarantee of similar medical standards right across Europe: Were the European Court of Justice Decisions in Kohll and Decker right?* (2001) EURO-HEALTH, Spring edition, London School of Economics and World Health Organisation

Regulation 1408/71 did not violate the Treaty. The ECJ explained that the EC regulation only *suggested* one way of organising non-emergency social health care in another Member State, it was not an exhaustive list and did not prevent other methods of trans-border treatment. The national rules on the other hand had been interpreted as an exhaustive list and thus violated EC law.

By applying the rules on the free movement of goods and services in this way and at the same time reaffirming the legitimacy of the procedure contained in Regulation 1408/71, the ECJ has created an alternative method of obtaining non-emergency social health care in another Member State. This means that a person may either:

1) apply for authorisation, travel to another state and receive medical goods and services, which are then paid for by the patient's own health care system (this means that patients do not theoretically need to take any money with them)

OR

2) go straight to the foreigner provider and pay directly for the goods and services before returning home and being refunded as if the treatment or products had been purchased in his/her home state

However, this creativity of the ECJ left many unanswered questions. The most obvious of which was, what if the social health care system does not operate a reimbursement mechanism? What if it is an NHS system or one where social health insurers employ doctors directly and so the patients do not have to pay all their costs up front? The decisions did not say whether or not they only applied to states with a reimbursement mechanism. Did this mean that some states were obliged to create a reimbursement mechanism, which would divert money from health care provision into health care administration. If a person was covered by an NHS system does this mean they are entitled to a 100% reimbursement, otherwise domestic treatment would be "free" and foreign treatment would be more expensive and thus "hindered"?

Issues were also raised about waiting lists, did these decisions mean that trans-European waiting lists would emerge? Did patients have to apply in advance to the foreign health care institution or could they just turn up and receive treatment? Were states allowed to give their own nationals priority or would this be unfair discrimination? What about the principle of equal access for rich and poor? Richer people will find it easier to cover the travel costs and are more likely to have the liquid funds to pay foreign health care providers up front.

How were these decisions going to effect health costs? It could be said that waiting lists in some systems are a means of controlling the flow of expenditure and the uncontrolled movement of patients abroad would seriously interfere with budgeting plans.

There was also a degree of uncertainty about the precise scope of *Kohll* and *Decker*. In *Kohll* the ECJ made some reference to the fact that the service was provided outside any "hospital infrastructure". The Court did not explain precisely what it meant by this but it seemed to imply that this fact was somehow relevant to deciding whether or not treatment by an orthodontist in the context of social health care provision was really a service according to article 49 EC Treaty. The Advocate General also referred to the concept of a "hospital infrastructure". He thought that services provided in the context of a "hospital infrastructure" were distinguished because the location and number of hospitals is determined by forward planning and that the costs of one person's stay in a hospital can not be separated from the costs of running the hospital as a whole. He concluded that if people were to receive treatment in hospitals abroad the cost of maintaining an under utilised hospital at home may well throw off the balanced financing of the social security health care system. This could endanger the continued existence of hospital facilities for people who do not wish to travel. *Kohll* was not about hospital treatment and therefore the ECJ did not have to explain

its position in relation to hospitals any further. The result was considerable uncertainty about whether or not social health care provided in a hospital infrastructure was really a 'service' according to the EC Treaty.

The ECJ did not answer these unresolved questions because it did not have to. The ECJ is an adversarial court that argues only on the points that are raised by the parties and that are relevant to the specific case. These points were not raised during the proceedings and even if they were, it is arguable that they were not immediately relevant to the cases at hand. The ECJ is a judicial body that is not even indirectly democratically accountable. It is a judicial body that is placed under a tremendous amount of pressure, which means it cannot conduct really extensive research on the full implications of its decisions.

Of course, the ECJ is only doing its job, its ensuring a true and effective internal market and where there is no guiding secondary legislation the only tool available to the court is the EC Treaty itself.

The uncertainty created by the *Kohll* and *Decker* decisions led to a number of further references to the ECJ. Two of the most notable references were those in *Peerbooms/Smits* and *Van Braekel*. These two cases have now been decided by the ECJ and shall be discussed in Part Three below. However, before looking at these decisions I shall describe a hypothesis that was advanced to the EC Commission¹¹ before *Peerbooms/Smits* or *Van Braekel* were decided.

2. THE PARAMETERS OF KOHLL AND DECKER: A HYPOTHESIS

The *Kohll* and *Decker* cases created legal and administrative uncertainty. The political responses of the Member States were varied. Most actors simply advanced that "my country is different", implying that the effects of these two judgements were confined to social health care systems that rely upon reimbursement. As for those systems that operate a reimbursement mechanism they were uncertain about the range of treatments covered by the decisions, for example did they include hospital services or simply out patient care? It was clear that this uncertainty had to be resolved. This resolution had to take the form of a single model that respects EC law and national sovereignty without 'persecuting' any particular system. This model had to be seen to apply to all countries regardless of whether they operate a reimbursement mechanism, benefits in-kind system or national health service. Furthermore, it could not disturb the delicate financial balance of the national social security systems or unduly impact upon national provisions aimed at controlling accelerating health care costs.

It is with these elements in mind that the following hypothesis was advanced to the EC Commission as a legal model by which to resolve the uncertainty that cloaked patient mobility for nearly two years.

2.1 A fundamental principle

The fundamental principle behind the *Kohll* and *Decker* decisions is that the patient should be able to go to another Member State and purchase goods and services there that are then refunded as *if they had been delivered in the patient's home state*. This principle is clear from the Court's response to claims that unchecked patient immigration would disrupt the financial balance of the health care system¹². The only way that the balance of the system can be protected is if the goods and services are refunded according to the boundaries of the social health care system in the patient's home state.

2.2 The boundaries of social health care systems

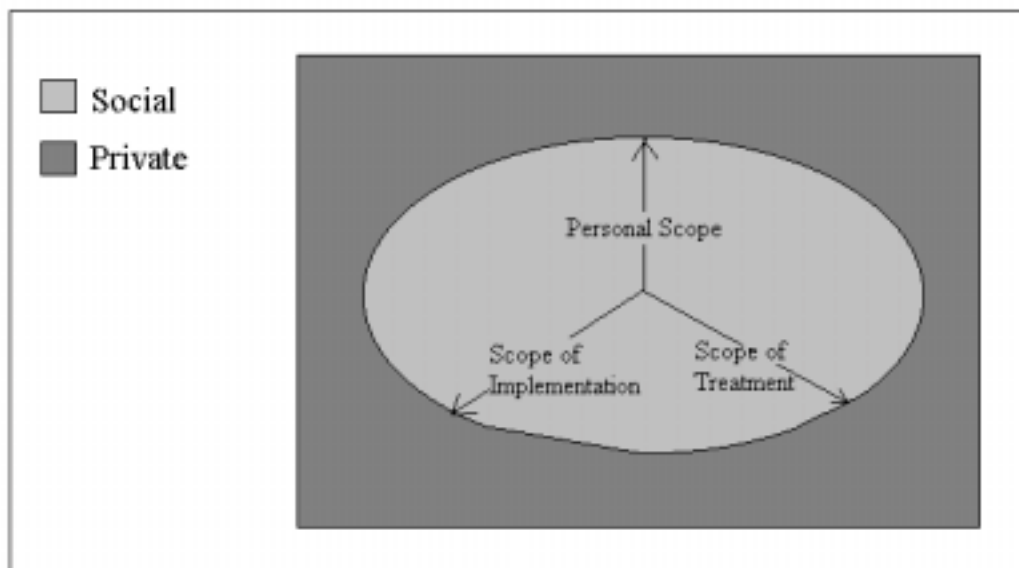
¹¹ see note 1 supra

¹² Paragraph 17 of *Kohll* and 21 of *Decker*

The boundaries of social health care are different in every Member State. These boundaries dictate which goods and services are covered by the social security system. When a patient steps outside these boundaries s/he ceases to be covered by the social system and becomes a 'private patient' who must cover his/her own costs. The boundaries of social care in every system are determined by three basic elements these elements are:

- **Personal scope:** this refers to the range of people covered by the social health care system. The general principle is that of universal coverage, which demands that all citizens are entitled to health services. However, some states have chosen to exclude the richer members of their population as these groups can afford private insurance, thereby alleviating pressure on the social system.
- **Scope of treatment:** every system lays down what treatment and drugs can or cannot be provided to its patients. A good example is the exclusion of cosmetic surgery in many countries or the creation of positive and/or negative lists of available pharmaceuticals.
- **Scope of implementation (authorised providers):** all health systems determine which health care professionals or institutions are entitled to give treatment that is financed by the social system. In some cases this may be civil servants employed by the social health administration (as in a 'pure' National Health Service). In other cases it might include all those with whom the health care system has a contract (this is common in benefits in-kind systems). It is also possible that a social system allows its patients to go to any health care professional in its territory (which is the case in most reimbursement mechanisms).

These three elements can be visualised in the diagram below:



If a patient steps outside the lighter coloured circle (because s/he is not included in the personal scope, s/he asks for treatment that is not covered by the system or s/he goes to a professional who is not authorised by the social system) s/he steps outside the social system and becomes a 'private' patient.

2.3 The limits of EC power

Fears have been raised that the EC may be able to interfere with these three essential elements and thus alter the boundaries of the national social health care systems. These fears focus on both the EC legislator and the European Court of Justice.

2.3.1 The EC Legislator

Passing legislation at an EC level is a two-stage process. Firstly the legislator must find a legal basis in the EC Treaty that authorises law making in the chosen field. Once a legal basis has been found the proposed act must comply with the principle of subsidiarity. The EC legislator has very few options through which to pass legislation in the social security field. None of these options expressly empower it to determine the scope of social health care packages¹³. However, the EC legislator might be able to pass laws in this area according to a broad interpretation of the new article 137(3) in the Social Chapter of the EC Treaty. This article allows the adoption of Directives on “*social security and social protection of workers*”, a competence that is shared with the Member States¹⁴.

The principle of subsidiarity applies whenever the Member States and the EC share the power to legislate. The basis of this principle is that decisions should be made as closely as possible to the people who are going to be effected by them. Its legal definition can be found in article 5 (ex article 3b) EC Treaty. This article explains that the EC is only allowed to use its shared powers if it can be demonstrated that the objective cannot be achieved sufficiently by the Member States *and* the EC can do a *better* job.

There has been a great deal of political and academic debate about the precise meaning of subsidiarity in the EC Treaty¹⁵ but there are some good arguments to indicate that the setting of national social health care parameters should be left to the Member States and therefore does not fall within the scope of EC law. Firstly, the Member States have been rationing scarce health care resources for many years. The financing of these resources usually comes from general taxation and/or social security contributions levied on a territorial basis. The EC has no power to directly influence the level or sources of social security financing or general taxation and the EC does not make any substantial financial contribution to the provision of social health care services. There are also strong arguments to indicate that the health needs of the people of Europe vary from one Member State to another. Some states have higher incidences of cardio-vascular disease, teenage pregnancy, alcohol abuse etc. Furthermore, at the moment there is no European body charged with the co-ordination and identification of epidemics and many states would argue that they are in the best position to identify and contain diseases in their countries because they can have more direct contact with health care providers and institutions. The moral attitudes of the people also vary from state to state and it is important that sensitive issues such as abortion, blood transfusions and organ donations are dealt with at a level close to the people. The Member States have been rationing health care and attempting to balance budgets for a long time and it would be difficult for the EC to claim that it can do a better job, especially given the already strained resources of the EC institutions.

Some guidelines for the application of the principle of subsidiarity were annexed to the EC Treaty in a Protocol after the ratification of the Amsterdam Treaty. These guidelines include examples of when EC action may be justified under the subsidiarity principle. One example refers to action at a Community level that would produce clear benefits by reason of its scale or effects compared with action at the level of the Member States. This statement closely relates to the economic theory of economies of scale which states that savings can be made when production takes place on a large

¹³ For example article 49 (ex article 51) EC Treaty is confined to the co-ordination of social security for migrant workers and may not be used to alter the substance of the national systems. The new provisions on public health (article 152(5) EC Treaty) expressly state that “*Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care*”.

¹⁴ The Social Chapter of the EC Treaty refers to a sharing of power between the EC and the Member States, this is clear from statements such as “... *the Community shall support and compliment the activities of the Member States ...*”¹⁴ and “(t)he provisions adopted pursuant to this article shall not prevent any Member State from maintaining or introducing more stringent protective measures compatible with this Treaty” (article 137(5) EC Treaty)

¹⁵ see Toth, A.G. and Steiner, J. in O’Keefe, D. and Twommey, P. (eds) *Legal Issues of the Maastricht Treaty* 1994 John Wiley & Sons and N. Emiliou *Subsidiarity: An Effective Barrier Against the “Enterprises of Ambition”?* (1992) ELRev 383

scale, it also relates to the theory of specialisation that claims that efficiency is increased if people concentrate on the tasks they are good at and avoid unnecessary duplication. There is no doubt that economies of scale and specialisation both have a real role to play in improving the application of social health care, the measures currently in operation in the border regions are testimony to this. It is therefore advanced that the subsidiarity principle does not exclude all Community action in the field of health care but merely that, at the present time, the EC does not have the experience, resources and contact with the citizens (and health care providers) to better ration health care resources by setting the parameters of national social health packages.

2.3.2 The European Court of Justice

In *Kohll* and *Decker* it was made absolutely clear that the EC principles concerning free trade can and will be applied to the social security sector. The question is then whether these principles could be used to attack the boundaries of social health care in the Member States¹⁶. In the past the European Court of Justice has tolerated restrictions of trade if these are necessary in order to maintain the financial balance of the social security system. Such restrictions will not be removed provided that they do not arbitrarily discriminate against goods and services from other Member States. For example in *Duphar v The Netherlands*¹⁷ that Court decided the exclusion of some pharmaceutical products from social security reimbursement could constitute a restriction of trade. However, this was justifiable “*in order to promote the financial stability of health insurance schemes*” provided that the criteria used to determine the range of drugs covered were fair and objective. In *Kohll* and *Decker* the European Court of Justice accepted that this justification could be used but not on the specific facts of those cases.

Every state has its own criteria to determine who is covered by the social health care system, what treatments patients are entitled to and which providers are authorised to provide these treatments. If a social health care system were forced to accept a patient who is not normally covered, fund a treatment that is not usually available or pay a provider who would not otherwise be authorised then this will increase costs. These increases could then disrupt the balanced financing that is based upon the established criteria. It is consequently unlikely that the free movement of goods and services could be used by the European Court of Justice in order to alter the boundaries of social health care systems.

2.4 The limits of *Kohll* and *Decker*

The fundamental principle of *Kohll* and *Decker* is that the goods and services received by the patient are treated as if they were delivered in the patient's state of residence. Thus, if patients step outside the social boundaries of their own system they will not be entitled to reimbursement. The system in Luxembourg states that the patient can receive treatment from any orthodontist registered in the territory of the Grand Duchy. In the ‘Euro-speak’ of the internal market this is translated as any provider in the territory of the EU. However, had orthodontic treatment been excluded from the Luxembourg social health care package (i.e. from the scope of treatment) Mr Kohll could have been refused a refund. If this were not the case then the Luxembourg health care system would be thrown off-balance. It therefore makes sense that if patients step outside the system in their home state they cannot be refunded if they step outside this system in another state. So, in the context of a national health service, if a patient goes to a professional in another Member State who is not contracted to the national health service in that patient's home state then s/he has stepped out of the social and into the private sector. This means that no refund should be given. By this hypothesis the Court and legislator must respect the sovereignty of the Member States to determine the parameters of their social health care packages.

¹⁶ This issue was already raised in a case pending before the European Court of Justice, *Peerbooms*.

¹⁷ (1984) ECR 523

This is a favourable hypothesis for those systems that limit their scope of implementation to a limited number of contracted providers. However, it does not mean that *Kohll* and *Decker* have absolutely no impact upon them. The Court has made it clear that the balanced financing justification will only be accepted if the criteria used to control spending are fair, objective and free from arbitrary discrimination. This means that *Kohll* and *Decker* will have a two-fold impact upon systems that limit the range of authorised providers (mainly benefits in-kind systems and national health systems):

- Sometimes mechanisms exist whereby patients are pulled back from the private sector and into the social one. For example, in Spain if a patient is injured in front of a private hospital, and therefore closer the private institution than one contracted by the NHS, and his condition is life threatening, he will be taken to the private institution and the costs of his treatment will be refunded in full by the National Health Service. The principle of non-discrimination dictates that if a Spanish resident sustains life threatening injuries in another Member State then s/he will be entitled to a full refund even though the foreign hospital is not part of the Spanish social security system. Thus, any mechanism that allows the exceptional use of unauthorised providers or the special provision of otherwise excluded treatments should be made available for goods and services emanating from other Member States.
- As the selection criteria have to be fair, objective and free from discrimination this means that it should be just as easy for a provider in State A to be contracted in State B as it is for providers in State B. In other words there should be no discrimination on the basis of nationality or territorial location. This means that direct discrimination will not be tolerated e.g. confining authorisation to those established in one country. However, indirect discrimination, where criteria appear at first glance to be neutral but in fact place a harsher burden on foreign goods and service, could be justified. For example, a restriction on the contracting of non-emergency in-patient care where all institutions must guarantee that at least four hundred insured persons will be treated every year, otherwise they are not fully using resources and forcing the health care system to operate inefficiently.

This hypothesis respects national sovereignty and the principle of subsidiarity on the one hand whilst ensuring the EC principles of non-discrimination and free trade on the other. It applies to every system and therefore does not single out or 'persecute' any particular countries, allowing a uniform application right across the EC.

3. PEERBOOMS/SMITS AND VAN BRAEKEL: THE ECJ ATTEMPTS TO DEFINE THE LIMITS OF KOHLL AND DECKER

On the 12th July 2001 the ECJ delivered two decisions which resolved some of the unresolved issues raised by the *Kohll* and *Decker* cases. These two clarifying decisions were ***Geraets-Smits v Stichting Ziekenfonds VGZ*** and ***Peerbooms v Stichting CZ Groep Zorgverzekeringen*** (joined cases C-157/99) on the one hand and ***Abdon Van Braekel and Others v Alliance nationale des mutualités chretiennes (ANMC)*** (case C-368/98) on the other. This section shall look at the facts, decisions and impact of each of these cases in turn, beginning with *Peerbooms/Smits*, it shall then look at what these two decisions mean for patient mobility within the European Union.

3.1 Peerbooms/Smits

3.1.1 The facts

Mrs Smits and Mr Peerbooms were both insured under the benefits in-kind system of social health care in the Netherlands. In the Netherlands social health care is provided by social health insurers who enter into contracts with care providers (such as doctors and hospitals). Insured persons are then entitled to treatment from health care providers who have a contract with the insured person's health insurer. When an insured person goes to a contracted doctor s/he receives their treatment

and the health insurer then pays the doctor on their behalf. Insured persons in the Netherlands therefore do not have to pay their health care providers directly for the full price of the treatment, although they may be asked to make a small contribution as a co-payment or 'visit fee'. The scope of implementation is thus confined to contracted providers.

The scope of treatment includes that provided by a general practitioner or a specialist "*the [extent of which] shall be determined in accordance with what is normal in the professional circles concerned*". If an insured person in the Netherlands wishes to obtain treatment from a doctor or institution which is not contracted with her or her health insurer (whether this institution is established in the Netherlands or not), the s/he must obtain permission. Permission will only be granted for treatment abroad if the said treatment falls within the scope of treatment described above and is not available in time in the Netherlands.

Mrs Smits suffered from Parkinson's disease and went to a specialised clinic in Germany to receive a multi-disciplinary treatment. This treatment sought to create an integrated programme of physiotherapy, medical treatment, ergotherapy and socio-psychological support that dealt with all of Mrs Smits symptoms at the same time. Mrs Smits paid the German clinic directly and tried to obtain reimbursement from her Dutch health insurer according to the procedure created by *Kohll*. The reimbursement was refused because the treatment obtained was not considered as 'normal treatment' and treatment for her individual symptoms was available in contracted clinics in the Netherlands.

Mr Peerbooms was a 36 year old man suffering from a coma. He was transferred from a hospital in the Netherlands in order to receive neuro-stimulation in a clinic in Austria. Neuro-stimulation was practiced in the Netherlands at that time but it was only provided in two institutions, it was only available to people under 25 years of age and it was still considered 'experimental' by the social health care system. Whereas in Austria it was an accepted treatment covered by the social health care system's scope of treatment. This treatment would not have been available to Mr Peerbooms in the Netherlands. Fortunately Mr Peerbooms did recover from his coma but when he tried to use the principles established in *Kohll* in order to recover the costs of his treatment in Austria, he was turned down by his Dutch health insurer.

Mrs Smits and Mr Peerbooms both initiated court action, claiming that they were entitled to a refund of the costs of their treatment under the EC rules on the free movement of services.

The ECJ had to decide if the Treaty provisions on the free movement of services applied to social health care provided in hospitals. It then had to decide if the requirement of prior authorisation for hospital treatment in another Member State violated these Treaty provisions and if so, whether the Dutch system of authorisation could be justified.

3.1.2 The decisions

DO THE TREATY PROVISIONS ON THE FREE MOVEMENT OF SERVICES APPLY TO HOSPITAL TREATMENT?

The ECJ reaffirmed what it had said in *Kohll* about each Member State retaining a wide margin of discretion in the personal scope, conditions of entitlement and range of benefits. It also repeated that this discretion was subject to the rules contained within the EC Treaty, including the free movement of services.

The concept of 'service' is defined in both the EC Treaty (article 50) and EC case law¹⁸ as an **economic activity** that is **provided for remuneration**. A number of governments insisted that in this context the patient does not pay for the treatment himself and that the person providing the service does not do so with the aim of making a profit.

The ECJ dismissed these arguments. It looked at previous case law that said that medical treatment was a service in the context of article 50 EC Treaty and that it did not matter whether that treatment was provided in hospital or not¹⁹. Furthermore the special nature of service did not exclude them from the Treaty's scope, as was decided in *Webb*²⁰ which concerned the provision of labour mediation for unemployed persons. Furthermore, the hospitals attended by Mrs Smits and Mr Peerbooms in Germany and Austria were paid directly and so were remunerated. It was also noted that a service does not have to be paid for by the person who receives it in order for it to be classified as a service²¹. Finally it was also noted that contracted hospitals receive consideration for the treatment they provide which amounts to both remuneration and economic activity.

It was therefore decided that social health care treatment in a contracted hospital or foreign hospital was a service in the sense of the free movement of services in the EC Treaty.

DID THE AUTHORISATION PROCEDURE IN THE NETHERLANDS RESTRICT TRADE BETWEEN MEMBER STATES?

A person insured under the benefit in-kind system in operation in the Netherlands can only obtain health care abroad under his or her social insurance if s/he obtains authorisation before hand. The ECJ concluded that prior authorisation was not required for treatment in contracted hospitals in the Netherlands, which is the main way of obtaining social hospital treatment. Therefore the need to apply for authorisation for treatment abroad was an actual hindrance to the free movement of services over the internal borders of the European Union. The next issue was whether this hindrance could be justified.

CAN THE OBLIGATION TO OBTAIN PRIOR AUTHORISATION BE JUSTIFIED?

The ECJ accepted that "*seriously undermining a social security system's financial balance*"²² and "*maintaining a balanced medical and hospital service to all*"²³ could both justify the hindrance caused by a prior authorisation procedure provided that they were fair and that they were proportionate to their aims.

¹⁸ see *Humbel* [1989] ECR 5365 and *Society for the Protection of Unborn Children Ireland* [1991] ECR I-4685

¹⁹ see *Luisi and Carbone* [1984] ECR 377 and *Society for the Protection of Unborn Children Ireland* *ibid*

²⁰ [1981] ECR 3305

²¹ see *Bond van Adverteerders and Others* [1989] ECR 2085

²² see *Kohll* paragraph 41

²³ see Article 56 EC Treaty and *Kohll* para 56

The ECJ accepted that:

“it is well known that the number of hospitals, their geographical distribution, the mode of their operation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible.”²⁴

It went on to explain that this system of planning and contracting was necessary not just to provide regular hospital services but also to avoid wastage and control costs. The system was therefore justified both on the grounds of maintaining a balanced medical service for all and on the grounds of protecting the financial structure of a social security system. The ECJ stated:

“Looking at the system set up by the ZFW (the law on sickness funds), it is clear that, if insured persons were at liberty, regardless of the circumstances, to use the services of hospitals with which their sickness insurance fund had no contractual arrangements, whether they were situated in the Netherlands or in another Member State, all the planning which goes into a contractual system in an effort to rationalise, stable, balanced and accessible supply of hospital services would be jeopardised at a stroke”²⁵

The ECJ then took a closer look at the authorisation procedure in order to ensure that it was fair and proportional. It did this by looking at the two tests used to decide whether authorisation should be given or not; firstly whether the treatment was regarded as normal in the professional circles concerned and secondly whether or not the treatment was available in sufficient time from a contracted provider in the Netherlands.

The ‘regarded as normal’ test is the rule that determines the scope of all social treatment, whether it is provided by a contracted hospital or not. The ECJ reaffirmed that Member States are free to set down the conditions of entitlement to social security benefits and decide the amount of that benefit. It also confirmed that States may develop limitative lists excluding certain products from social health care coverage²⁶ and went on to say:

“It follows that Community law cannot in principle have the effect of requiring a Member State to extend the list of medical services paid for by its social insurance system: the fact that a particular type of medical treatment is covered or is not covered by the sickness insurance scheme of other Member States is irrelevant in this regard”²⁷

However, the ECJ also reminded us that this discretion had to be exercised in accordance with EC law and gave a clear indication of what this means for a prior authorisation procedure:

“Therefore in order for a prior authorisation scheme to be justified even though it derogates from such a fundamental freedom, it must, in any event, be based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities’ discretion, so that it is not used arbitrarily”²⁸

The “regarded as normal in the professional circles concerned” test could be interpreted in a number of ways, it could mean regarded as normal in the Netherlands or regarded as normal on an international level. The ECJ concluded that if the test were confined to professional opinion in the Netherlands this would effectively restrict treatment to that habitually provided in the Netherlands making it harder to obtain treatments readily accepted as normal in other Member States. If this were the case the system upon which prior authorisation is based would not be fair and objective. This objectivity can only be assured by interpreting “normal in professional circles” to include

²⁴ paragraph 76

²⁵ paragraph 81

²⁶ paragraph 86 and *Duphar and Others* [1984] ECR 523

²⁷ paragraph 87

²⁸ paragraph 90

international professional circles. This is another example of translating national legislation into “Euro-speak”. The same approach was used in *Kohll* where the Luxembourg system allowed its socially insured patients to visit any orthodontist in Luxembourg and the ECJ effectively interpreted this as any orthodontist in the EU.

The ECJ then went on to investigate the second aspect of the authorisation test, i.e. whether equally effective treatment could be obtained in time from a contracted hospital. It was accepted that by using contracted providers whenever possible will ensure the continuation of a stable health care system and save costs thereby protecting its delicate financial balance. However, it was made clear that the Dutch health insurers could not favour non-contracted hospitals in the Netherlands over non-contracted hospitals in other Member States. Essentially a non-contracted hospital is outside the boundaries of the social system and this is so whether that hospital is based in Maastricht, Brussels, London or Barcelona.

3.1.3 Impact

The case of *Peerbooms/Smits* affirmed that the economic rules for the creation of an internal market can and will be applied to social security systems. The ECJ further confirmed that hospital services provided as part of the social protection system still represent a service in the context of the EC Treaty.

The ECJ also confirmed that it would respect the boundaries developed by Member States when defining the scope of their social health care. The Member States thus remain free to determine what treatment is provided to which patients by which service providers. However, these boundaries have to be fair, objective, transparent and capable of challenge. This means that the systems of contracting service providers should be open to doctors and institutions in other Member States. This means that express exclusion of providers from other Member States will only be tolerated on extremely limited grounds and that any rules that are apparently neutral but in fact make it harder for providers from other countries to join the social system will have to be justified. This justification could be based on the need to provide a sustainable health care service for all or the protection of the delicate financial balance of the health care system. This interpretation is very much in line with the hypothesis delivered above.

Finally a word must be said about the translation of national legislation into ‘Euro-speak’. The ECJ accepted that Member States could draw up “limitative lists” defining the boundaries of their systems²⁹. However, these limited lists will be interpreted wherever possible as referring not just to one state but the entire EU. Thus, entitling socially insured patients to attend any doctor in the country will be translated as any doctor in the EU. Offering to fully reimburse emergency treatment provided by non-contracted hospitals in Member State A provided that the patient’s condition prevents him being taken in due time to a contracted hospital will also apply to non-contracted hospitals in Member State B. Therefore if a person is socially insured in Member State A and goes on holiday to Member State B where he is hit by a car, his condition will dictate that he could not be taken to a contracted hospital in Member State A and so is entitled to treatment in a non-contracted hospital in Member State B³⁰. Legislatures and social administrators are thus going to have to take great care in how they phrase their legislation and policies in the future.

3.2 Vanbraekel

²⁹ paragraphs 86 and 87

³⁰ It is true that emergency treatment is provided by the E111 procedure but under that procedure the patient is treated as if he were insured with the state of treatment, this means that he will be taken to a social hospital and will have to meet any co-payments that nationals of the state of treatment might be expected to make. In the scenario above the patient would be entitled to treatment in any hospital in Member State, even an expensive private one. Furthermore if his home state guarantees 100% reimbursement this may oblige it to pay any co-payments charged in Member State B as well (however, see case note on *Van Braekel* below).

3.2.1 The Facts

This case concerned Ms Jeanne Descamps who suffered from bilateral gonarthrosis. Ms Descamps was a Belgian national, living in Belgium and insured by a Belgian social health insurer. In 1990 she applied for authorisation from her health insurer to undergo orthopaedic surgery in France. The Belgian government had implemented article 22(2) of Regulation 1408/71 that states that authorisation for treatment in another EC state must be given if the treatment is provided for under the legislation of the Member State of insurance and that treatment can not be provided in time in that state. Belgian law added that authorisation cannot be refused where better medical conditions are available abroad and a medical expert from a national university hospital declares that such treatment is essential.

Ms Descamps application was refused because she had not obtained the opinion of doctor practicing in a national university hospital. Despite the refusal of authorisation Ms Descamps went to France and paid for the service herself. When she returned she appealed against the refusal of authorisation and was successful. A Belgian court concluded that she should have been given authorisation. The problem then facing the court was whether she should be reimbursed according to the rules in France or according to the rules in Belgium. According to the procedure laid down in articles 22 and 36 of Regulation 1408/71 when a patient is treated in another Member State that patient is treated as if s/he is part of the social security system of the state of treatment and all costs are reimbursed according to the rules in operation in the state of treatment. However, according to *Kohll* a patient is entitled to travel to another Member State for medical care and then be reimbursed by his/her social health care system as if the treatment had been provided in the state of insurance. According to the French system Ms Descamps should have received FRF 38,608.99 whereas according to the Belgian system she should have recovered FRF 49,935.44. The Belgian national court wanted to know which amount had to be paid.

3.2.2 The Decision

INTERPRETATION OF REGULATION 1408/71

The ECJ explained that Regulation 1408/71 does not limit the circumstances in which authorisation for treatment in another Member State must be granted, this Regulation only suggests situations where such authorisation must be granted³¹. Thus, when the Belgian state grants authorisation or *should grant authorisation* under its own rules then this authorisation is effectively classified as authorisation under Regulation 1408/71.

The ECJ also confirmed that Regulation 1408/71 does not *prevent* reimbursement of medical costs incurred abroad if the state of insurance operates a reimbursement mechanism and the extent of reimbursement in that state happens to be higher than in the state of treatment. However, it goes on to say that Regulation 1408/71 does not oblige Member States to reimburse this higher amount. According to articles 22 and 36 of the Regulation the costs of treatment are determined by the rules of the state of treatment, in this case France.

³¹ paragraph 31

The ECJ followed its reasoning in *Peerbooms* and concluded that the EC Treaty rules on the free movement of services do apply to social hospital treatment³². It then decided that if a Member State pays lower rates of reimbursement for treatment delivered abroad it discourages people from applying for authorisation and thereby receiving medical treatment abroad. This amounts to a hindrance to trade and a violation of the principle of the free movement of services.

Having found a hindrance to trade the ECJ went on to determine whether that hindrance could be justified as ensuring a system of health care available to all or protecting the delicate financial balance of the social security system. It decided that as the patient would have received treatment in the state of insurance anyway this would not interfere with the delicate balance of the financing of social health care. Furthermore the patient in question is given authorisation to leave the state in order to receive treatment outside, inter alia, because treatment is not available in the home state, this does not jeopardise the sustainability of national health resources and in fact promotes the protection of human health.

The hindrance to trade could not be justified and the Belgian state is obliged by the economic rules on the free movement of trade to reimburse the higher amount of compensation.

3.2.3 *The Impact*

The ECJ in *Van Braekel* declared that where a patient travels abroad for medical treatment with the consent of his or her social health care system, Regulation 1408/71 should be used to calculate the amount of reimbursement according to the tariffs in operation in the state of treatment. However, Regulation 1408/71 does not prevent Member States from paying higher levels of reimbursement. In fact, if the state of insurance would have provided a higher level of reimbursement than that offered in the state of treatment then the economic rules on the free movement of services dictate that the higher amount should be paid. Nothing about this is mentioned in Regulation 1408/71 and therefore *Van Braekel* joins *Kohll* and *Decker* as an example where the social system is extended beyond a Member State's legitimate expectations. No matter how carefully the social legislation in this area (Regulation 1408/71) was implemented there was no way to predict the effects of the free movement of goods and services. Allowing the ECJ to continue to describe the rigid and structured system established by Regulation 1408/71 as merely suggestive or non-exhaustive will only serve to perpetuate legal uncertainty.

Van Braekel now leave us with more unresolved questions. It is clearly set in the context of a reimbursement mechanism but how will it effect benefit in-kind systems or national health systems. According to Regulation 1408/71 when a patient travels to another Member State for treatment s/he is treated as if s/he were part of the system in the state of treatment. This means that the patient should be subject to the same co-payments etc as are applied in the state of treatment. If the patient comes from an NHS system where treatment is free or a benefits in-kind system where the co-payments are lower will the state of insurance have to make up the difference? This difference in costs represents a hindrance to free movement and, according to the reasoning in *Van Braekel*, reimbursement of this higher cost will not effect the balanced financing of the social security system. The court did not explain what would happen in this situation because it did not have to and now there is no way of knowing with any certainty how *Van Braekel* will evolve in the future.

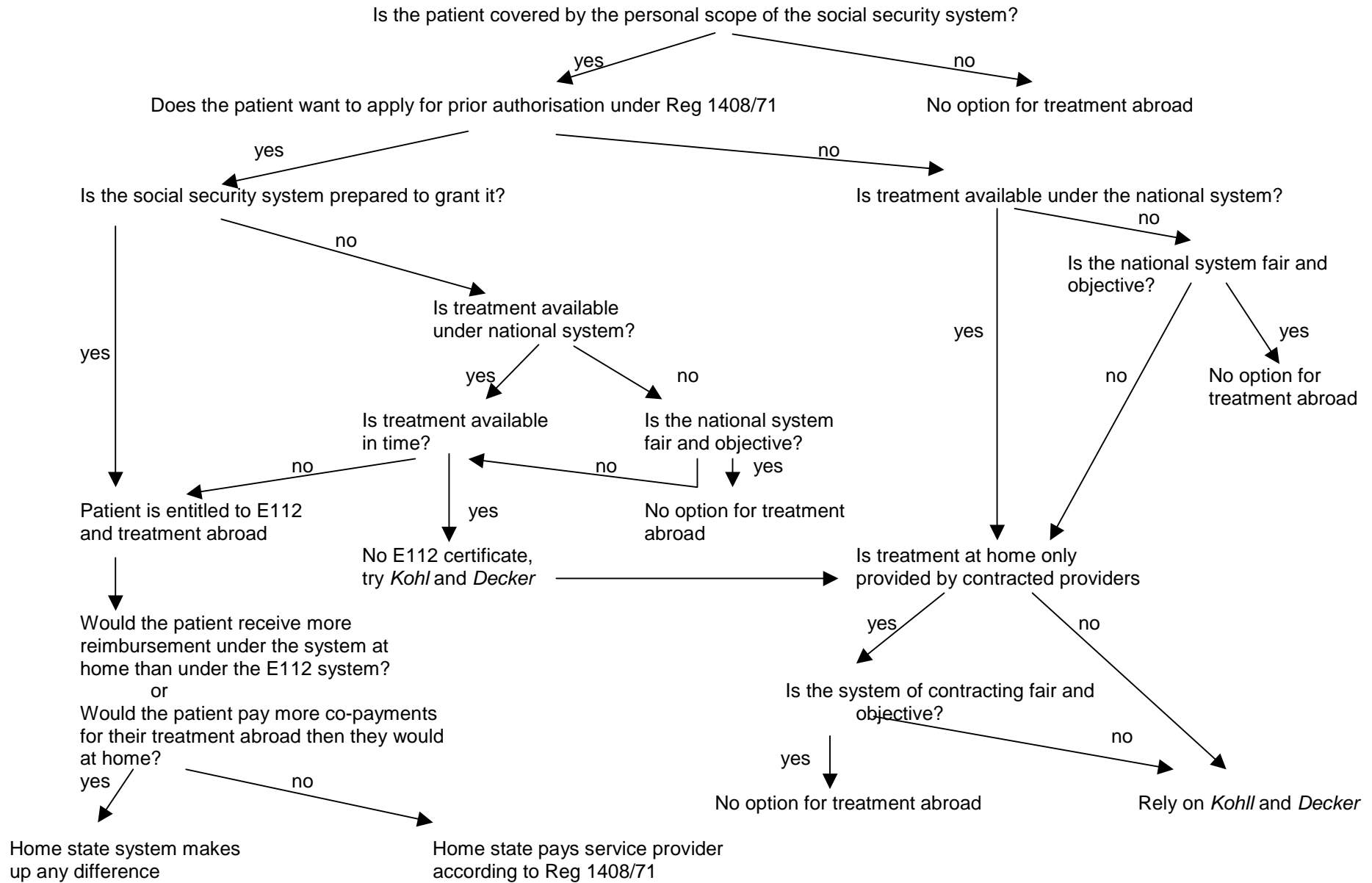
³² paragraphs 38-43

3.3 The combined impact of *Peerbooms/Smits* and *Van Braekel*

Peerbooms/Smits has resolved some of the outstanding uncertainty that surrounded the *Kohll* and *Decker* decisions. It has confirmed the role that shall be played by economic rules in the social security sector and it has demonstrated a respect for the boundaries of social health care established in each Member State. It has shown that *Kohll* and *Decker* shall effect all types of social health care systems by declaring that the boundaries of these systems must be fair, objective, transparent and, wherever possible, translated into 'Euro-speak'. *Van Braekel* on the other hand has created a degree of uncertainty and constitutes the first judicial step and just like *Kohll* and *Decker*, we are going to have to wait for more cases before we see how far this legal path will go, or where it will wind.

The diagram below called 'Entitlement to non-emergency social health care in another Member State' is a flow chart that can be used to determine when and under what system patients are able to travel to another Member State in order to receive medical treatment covered by their social health care system.

ENTITLEMENT TO NON-EMERGENCY SOCIAL HEALTH CARE IN ANOTHER MEMBER STATE



4. THE INTERNAL MARKET AND SOCIAL HEALTH CARE

Over the past three decades the ECJ has been particularly active in realising the EU dream of a genuine internal market. In more recent years there has been some debate about the extent to which the rules governing the internal market can be applied to the social security/health care field. Several academics have noted that the wide interpretations created by the ECJ mean that the economic rules governing the internal market could be applied to the providers, insurers and administrations that are responsible for statutory health care³³. There are fears that the independence and sovereignty that the Member States have tried so hard to preserve in the social field shall be eaten away by the gradual penetration of internal market regulations. Hospitals, doctors and health insurers could be treated the same as hi-fi distributors and banana importers. There are strong arguments that the application of economic, market-oriented rules in these fields is not always appropriate and that the altruistic goals of social health care provision could be unnecessarily impeded.

This gradual infiltration of traditionally social fields by economic rules has been described as a process of “Euro-creep”³⁴ through which sovereign states see EC (economic) law creeping into areas they previously considered beyond the reach of EU “interference”. Euro-creep is the product of the application of economic rules by the ECJ and thus impervious to the limited legal bases and Member State vetoes that have become indicative of direct legislative action by the EU in the social field. The result is ironic, the restriction of legal bases for social action in the EC Treaty combined with the use of unanimous voting has prevented and complicated EC measures that are arguably necessary, whilst at the same time they have done nothing to stop the penetration of EC rules into national sovereign areas. The unanimous voting procedure has clearly failed to fulfil its role, it prevents binding law where it is necessary and fails to prevent EU interference where it maybe unnecessary and inappropriate.

The inappropriateness of applying internal market rules to the health care sector stems from the unique features of this sector. The internal market rules aim to create a fair and free market place where low prices and high quality are maintained by the threat of competition and the fear of bankruptcy. The producers in this ideal market are faced by consumers who know what they want and are (generally) capable of assessing (and comparing) the quality of the goods and services they receive. The primary objective of all the parties involved are selfish, consumers aim to maximise utility (low price with high quality) and producers aim to maximise profit (low costs and high prices). Failure means the prompt reallocation of resources and the production of a better good or service. The social health care “market” is not as simple as this. Going to the doctor is very different from getting a haircut or having your house painted. Many of the distinctive features of the health care market are related to the asymmetries of information that exist between a provider and his/her patient. The patient does not know what kind of treatment s/he may need and is completely reliant upon the advice of his/her doctor. Having received treatment there is often no way of assessing the real quality of that treatment. The result is that health care is a market where suppliers determine demand rather than well-informed consumers. Our reliance upon doctors transforms us from “consumers” into “patients”. As Rudolf Klein explains:

“A patient is someone who is undergoing treatment or to whom things are being done. It is essentially a passive concept, implying the acceptance of direction from others. A consumer

³³ see for example Pieters, D. and Van den Bogaert, S. *The Consequences of European Competition Law for National Health Policies* 1997 MAKLU Publishing (Antwerpen)

³⁴ I first heard this term used by Berman, P. in his speech *The effects of Euro-creep on health care: “Ostrich Policies or Anticipation”* delivered at the Fifth Workshop on European Legislation and National Health Policies at Oostende, 19 and 20 February 1998, organised by the Dutch Ministry of Health, Welfare and Sport.

*by contrast, is someone who uses a service or buys a commodity. It is essentially an active concept...*³⁵

Furthermore, social health care patients rarely pay the full price of their health care directly. The final costs of health care are typically covered by taxation and/or social security contributions. Thus, there is no appreciation of the true costs of treatment and no incentive to reduce unnecessary consumption. The people's lack of appreciation of the costs of treatment, combined with the popular philosophy that you can never get enough "health", is a prominent distinguishing feature of social health care. Medical goods and services are something to which many people, as economically active individuals, feel they have a right.

Indeed many national constitutions oblige the state to provide health care to everyone³⁶. The principle of "universal coverage" can also be found in international law as a fundamental human right³⁷. This means that even those in remote rural areas must be given access to hospitals, doctors etc, even if this is excessively expensive and not particularly cost effective. Universal coverage also means that medical treatment should be available to those who have not contributed towards its financing and who are unable to pay their share.

The threat of failure is not the same for a hospital as it is for an advocate's office or hairdresser. The political connotations of closing down health services are taken very seriously, as the closure of hospitals often generates protests and social disruption in the local community.

Therefore, the health market is a long way from the perfect market where egocentric consumers and producers ensure allocative and productive efficiency. Some states have tried to implement market forces into their social health care systems in order to encourage administrative efficiency and cost savings. These elements of competition have always been carefully introduced to confined areas, hence the term "quasi-market". Indeed, it is the absence of pure market forces that distinguishes private health care from social health care. That is social health care should be available to everyone and is typically financed from taxes or social security contributions whereas private health care is provided on the open market and is available to all those who can afford it. It is thus arguable whether the economic rules designed to create the internal market should be fully applied in the social health care sector.

³⁵ *Britain's National Health Service and the Consumer in Health Systems in Europe: Towards New Contracts Between Providers, Payers and Governments*, published by the ENSP (1996)

³⁶ see inter alia the Constitutions of Belgium (article 23.3.1), Italy (article 32), Finland (article 15a), Greece (article 21§3), Luxembourg (article 11.4) and Portugal (article 64)

³⁷ see inter alia International Covenant on Economic, Social and Cultural Rights (article 12) and the Social Charter of the Council of Europe (article 11)

However, the social health care sectors in the EU employ and contract millions of doctors, consultants, surgeons, nurses, physiotherapists, institutions etc and every year they purchase billions of Euro's worth of drugs and equipment. If the Member States were allowed to discriminate against foreign providers and institutions or foreign pharmaceuticals, this will reduce efficiency. It is not that the internal market has no role to play within the social health care sector but where it is introduced there must be no unanswered questions. The right balance of "Europe" in the health care sector could lead to improved treatment at lower costs. One of the most important differences between the social health care market and any other market is that saving money saves lives. What is needed is a balance and this balance cannot be achieved through Euro-creep. There is a great danger in sitting back and forcing the ECJ to fill in gaps. The governments, health care insurers, associations of professionals and other interested parties have to face facts; there is no resisting the relentless tide of Europe. It is better to let the internal market in through the front door than close one's eyes and let it creep through the back one.

Special internal market rules have been created for sectors such as transport³⁸, agriculture³⁹, sport⁴⁰ and military procurement⁴¹. These rules balance the interests of the internal market with the special features of those sectors; similar rules are needed for social health care. Social health care is an area that is too important, too specialised, too complicated and too diverse to leave entirely in the hands of an adversarial judicial body.

³⁸ Title V EC Treaty

³⁹ Title II EC Treaty

⁴⁰ see Declaration on Sport of the Amsterdam Treaty

⁴¹ see Treaty article 223