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- draft version -

EUROPEANIZATION OF LONG-TERM CARE

AN ECONOMIC APPROACH TO EUROPEAN SOCIAL SECURITY LAW

Abstract

Great importance has always been ascribed to the matter of social security coverage for migrating individuals in the Single European market. The key to this concern is the coordination of national social security schemes by means of Community Law. The coordination regulations are based on four core principles which are discussed in this paper and applied to the provision of long-term care with cross-border elements. The need for coordination of these benefits has started out due to the fact that several Member States implemented statutory long-term care schemes. Unavoidable cross-border elements of these systems consequently called for European regulative measures which are outlined in the paper at hand. In two case-studies we test the effectiveness of the coordination of long-term care benefits by bringing together benefits of great structural variation. Accordingly, we select a social security system in the tradition of Bismarck as well as Beveridge respectively. The surprising results of the case-studies show that international mobility may have undesirable repercussions on the social security position of a dependent migrant.

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1. Introduction

The fact of European aging societies has been increasingly drawing public as well as political attention to long-term care schemes. Several Member States responded to the discussion with the implementation of public long-term care schemes - some organized statutory and insurance-based, others designed within the framework of social assistance. However, the question of cross-border access to public benefits of long-term care is hardly addressed although an increasing number of retirees are vividly mobile. A brief look at e.g. 128,000 Austrian or nearly 52,000 Finnish pension-recipients abroad in 2004 reveals that cross-border elements in long-term care may in the future gain considerable significance. In this regard, the paper at hand tries to assess the effects of cross-border elements in a individual's long-term care position which are caused by migration. In theory, internationally mobile individuals could totally or partly retain their claims from insurance or welfare-based systems when moving to another country, or even lose them altogether.

The paper is divided into six sections. After this brief topic outline, the following section takes a look at the European coordination regime of social security and outlines its principles. Section three summarizes the European coordination provisions for long-term care as well as their history. Section four introduces the different setups of long-term care systems in the United Kingdom (U.K.) and in Germany which are at the bottom of two case studies in section five. The case studies show the results of European coordination of long-term care benefits between the provision in the traditions of Bismarck and Beveridge. The conclusion draws the reader's attention to restraints of this paper and possible future development.

2. The Community Provisions on Social Security

Social Security is one of the most popular public programs and fundamentally a creation of national law. In turn, every national system is a result of long-standing traditions and reflects the culture of each Member State. Consistent with this territorial nature of social security systems, the amounts of benefits, conditions of entitlement and duration of payment within social security schemes are determined by each Member State. Thus, a European perspective of social security which comes along with the softening of the defined territorial scopes of national systems is fairly complex. The Community's mandate for adopting measures in the field of social security can be found in the provisions of the free movement of people (Art. 42 EC). In execution of this order, the European Council released regulations for coordinating the statutory social security systems of the Member States as a prerequisite for effective exercise of the free movements of persons. However, the coordinating instruments

neither change the substance of a national social security system, nor do they change the amount of benefit or the conditions of entitlement. The regulations merely apply in situations which entail cross-border elements since their central function is to ensure that migrants are treated fairly. This aim is pursued by exempting international social security law from Member States' competence. The 'Short guide to coordination of social security in the Council of Europe' brings this fact down to the point: "Where social security is a creation of national law, co-ordination is a creature of international law and relies heavily upon co-operation between states"[1].

In general, social security coordination instruments operate on four basic principles. These principles ought to guarantee migrant individuals' social protection as well as rectify the problems created by the territoriality and diversity of national systems. The first rule refers to **equal treatment** between nationals and non-nationals. Its aim is to prevent states from treating foreign nationals differently to their own nationals which means that a person residing in the territory of one Member State shall be subject to the same obligations and enjoy the same benefits as the nationals of that State without discrimination on grounds of nationality.[2] The second principle states the determination of the **applicable legislation** and the avoidance of collision of different national legislations. Generally, one and only one social security legislation should apply at any time and establish a rule to decide which law it should be. Thus, a migrating individual may enjoy proper social protection without being subject to the legislation of two Member States at the same time and having to pay double contributions, or none at all. The general rule of the European collision norms is tied up to the place of employment (lex loci laboris) since the regime was designed in the tradition of Bismarck. The third principle refers to the maintenance of acquired rights. It states that periods of insurance, residence or employment performed in one State should be taken into account in another. The totalising up of periods of insurance, residence or employment is called **aggregation**.[3] Finally, the fourth principle refers to the **export of benefits**. This means that if someone who is already entitled to or would be entitled of benefits covered by the coordinating instrument takes up residence in another state, his/her benefit shall still be paid by his state of origin. This principle predominantly applies to continuing benefits such as old age as well as invalidity pensions or to benefits of long-term care.[4]

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[1] Nickles/Siedl, 2004, p. 11

[2] Cf. Judgment of the Court of 30 January 1997. Fritz Stöber (C-4/95) and José Manuel Piosa Pereira (C-5/95) v Bundesanstalt für Arbeit. Joined cases C-4/95 and C-5/95. European Court reports 1997 p. I-0511.

[3] Cf. Steinmeyer, 2002, p. 171ff.

[4] Cf. Pennings, 2003, p. 8-12; Nickles/Siedl, 2004, p. 12-14, COM(2002) 694 final, p. 10.

As one would expect, the European coordination regime takes account of all four principles in order to facilitate the execution of the freedoms provided by the European Treaty. Today's regime is based on Reg. 1408/71 which - after more than thirty years in force - was replaced by Reg. 883/2004 last year. However, the new regulation will come effectively into force not before the end of 2006, when its corresponding co-legislation will have been conducted. Reg. 883/2004 is supposed to simplify and clarify the Union's rules governing the coordination of social security systems. Furthermore, the new regulation should bring the European coordination regime in line with frequent changes in national level and case law of the European Court of Justice.[5] A major development during the thirty years of Reg. 1408/71 was the emerging discussion about aging societies, long-term care and the implementation of statutory long-term care schemes in several Member States. The complicated way of long-term care schemes into the coordination regulations – which generally apply to all statutory branches of social security referred to in its material scope - is outlined in the following section.

3. The Community's Special Provisions on Long-Term Care

Historically, the European coordination regime was set up covering mainly traditional Bismarckian social risks such as old age, invalidity, death, sickness and maternity, unemployment or accidents at work. Consequently, the fairly new risk of dependency did not explicitly fall under the material scope of Reg. 1408/71. Yet, as one would anticipate, the new coordination regime clearly takes account of long-term care.[6]

The development went underway with the implementation of statutory long-term care schemes in several Member States such as Germany and some beneficiaries causing cross-border elements. Similar to all other branches of social security, Member States are autonomous when it comes to the design of their long-term care schemes. The first milestone in the discussion on the European qualification of long-term care benefits can be found in the *Molenaar* judgement of 1996. The Court had to answer the question whether benefits of the German Care Insurance Code (*Pflegeversicherungsgesetz*) fell under the provisions concerning sickness or old-age. This question was of major importance to Mr and Mrs Molenaar given that it determined the applicable rules of exportability on this benefit; particularly since the insurance care benefits were to be paid only to insured persons residing in German territory before the judgement. Mr and Mrs Molenaar were employed in Germany but residing in France. Under the law, any person insured, either voluntarily or compulsory,

[5] Cf. e.g. Welti, 2001.
[6] Cf. Art. 34 Reg. 883/2004.

against sickness must contribute to the care insurance scheme. The couple was voluntarily insured against sickness in Germany. For the applicable rules it followed, as they were informed by the German benefits agency that as long as they resided in France they were not entitled to any care insurance benefits. By looking at the objectives of the German dependency insurance scheme, the European Court of Justice qualified such benefits as sickness benefits.[7] Since the *Molenaar*-judgement, long-term care benefits have been treated as social security benefits which are subject to the special coordination provisions of sickness. The Court emphasised its prevailing case law in the *Jauch* judgement in 2001.[8] The specific regulations for sickness benefits consequently set out the conditions under which individuals have access to health care or long-term care respectively when they move within the European Union. The rules are applicable for any social protection scheme, no matter whether the benefits originate from contribution-based/employment-oriented or tax-financed/residence-oriented system.

Consequently, the new Reg. 883/2004 paved the way for more transparency in coordinating benefits of long-term care. Thus, Art. 34 explicitly states that benefits of long-term care in cash have to be treated as sickness benefits and are therefore granted by the competent Member State for cash benefits. Furthermore, Art. 34 provides for a regulation that prevents unjustifiable accumulation of benefits in cash and in kind if both benefits are at the expense of only one Member State. Such a situation may arise if a person whose competent state is e.g. Germany lives in the U.K. and draws long-term care benefits in cash from Germany. At the same time the person claims for benefits in kind according to E 121 from the British National Health Service which may provide for certain long-term care benefits in kind at the expense of the competent institution in Germany.[9]

In order to guarantee that migrating persons are entitled to gain **access** to long-term or health care **at the expense of their competent (care) institution** in other Member States, two out of the four basic coordination principles have to be considered particularly.[10] The first refers to the rules on **the determination of the applicable legislation** that establish the state in which beneficiaries are insured. This competent state is basically - according to the lex loci laboris-principle - the state where beneficiaries are employed. In fact, it is the competent state

[7] Cf. Judgment of the Court of 5 March 1998. Manfred Molenaar and Barbara Fath-Molenaar v Allgemeine Ortskrankenkasse Baden-Württemberg. Case C-160/96. European Court reports 1998 p. I-00843; Pennings, 2001, p. 131 et seq.
[8] Cf. Judgment of the Court of 8 March 2001. Friedrich Jauch v Pensionsversicherungsanstalt der Arbeiter. Case C-215/99. European Court reports 2001 p. I-01901.
[9] Cf. Spiegel, 2005, p. 25.
[10] Cf. Mei van der , 2003, p.221-234.

that collects contributions or taxes and it is the legislation of this state that determines which persons are insured, and the conditions under which they are insured.

The second set of rules refers to the **principle of export**. There are special export provisions on health respectively long-term care for persons not living in the competent state which are laid down in Art. 19 of Reg. 1408/71. On the one hand, this article contains rules on the exportability of cash benefits. It provides that these benefits are provided and exported by the competent institution in accordance with the legislation which it administers. On the other hand, it provides that persons that fall under the personal scope of the regulation are entitled to benefits in kind from the competent institution in the place of residence. Simply put, anyone staying or residing in a Member State other than the one where they are insured against sickness or long-term care – their competent state – is entitled to receive long-term care benefits in kind according to the legislation of this Member State as if beneficiaries were insured there, but at the expense of the competent state. As a consequence, loopholes in a migrant's social security coverage may arise if statutory system provisions on long-term care in the providing state differ from those in the competent one. In fact, the benefits a dependent individual can assert his/her claim to may differ greatly, as will be outlined in the following section.

4. The Provision of Long-Term Care in the United Kingdom and in Germany

In the paper at hand we analyse the coverage of the social risk of long-term care with a perspective on country-specific features and cross-border elements. Particularly, the two countries at hand represent prototypes within the field of social security tradition, namely Germany and the U.K.[11] Historically, the roots of insurance-based social security date back to Bismarck (1815-1898) in Germany whereas the idea of public welfare was born by Beveridge (1879-1963) in England. However, the polarities between the two organizing frameworks have diminished to this day. We have chosen the two countries not only for their maximum structural variation but also because of similarities in central relevant statistical parameters. For instance, both countries showed the same old-age ratio of 24,1% in the year 2000 and almost the same expenses for 'services for the Elderly and disabled people' which differed only on 0,063% of GDP in 2000.[12]

[11] Cf. Schulte, 1998; Harris 1994.
[12] Cf. OECD: Society at a Glance, 2002.

In 1995, a statutory universal long-term care insurance (*Soziale Pflegeversicherung*) was introduced throughout Germany. The *Pflegeversicherungsgesetz* was designed to cover the costs entailed if insured persons become reliant on care. This means that if a permanent need were to arise for those insured e.g. assistance from other persons in the performance of their daily routine, care insurance will give entitlement to benefits in kind and cash designed to cover costs incurred for care provided in the home or in some care institution. Social long-term care insurance is not conceived as a full-coverage system, but as a scheme to assure minimum provision of personal assistance for long term care necessities. In fact, the statutory *Pflegeversicherung* is not supposed to cover the entire cost of long-term care provision. However, supplementary, means-tested benefits can be obtained from welfare schemes on state and local levels which are subordinate to social insurance benefits.

Benefits of the *Pflegeversicherung* are universal since services are provided for everybody by everybody.[13] The insurance provides for care clients regardless of age, financial need or cause of dependency. Furthermore it covers dependency on care resulting from disability, physical or mental illness.[14] Benefits in kind are intended to be the dominant way of care provision, however, care clients can opt for cost reimbursements, as well.[15] Long-term care benefits are not subject to financial assessment. They are graded flat rate benefits, depending on the individual's need of care.

Since *Pflegeversicherung* ties up to salaried employment status and earned income, it is mandatory for a significant part of the population. Wage- as well as salary-earners and their families with an income below the social security contribution ceiling are obliged to make contributions and are entitled to get coverage by care funds.

In the U.K. provision of social security is not based on an insurance model in the technical meaning of the term. Instead, an elaborate system of public welfare is responsible for social protection. Characteristically, public welfare is characterized by funding out of the public purse. The tax financed system has always been based on means-tested and non-contributory benefits and focuses on a minimum protection of each resident. Generally, the system has a strong territorial scope. Every individual living in the U.K. is covered by public welfare if s/he meets the necessary requirements of residence and/ or presence. This means that the provision of benefits usually ceases to exist, as soon as an individual leaves the national

[13] Cf. Titmus 1976, p. 129, quoted from Pratt 2001, p. 258
[14] Cf. Schneider, 1999; Evams-Cuellar/Wiener, 1999; Schaaf/Vogel, 1995.
[15] Cf. Udschnig, 2000, p. 147 mn. 2.

solidarity community to join another system with different socio-cultural minimum requirements.[16]

In principle, the public delivery of care is based on services in kind. Apart from private for- and nonprofits, there are two main sources of long-term care provision in the U.K. On the one hand, local authorities and the National Health Service (NHS) are the main sources for benefits in kind. Under the *Health and Social Care Act 2001*, nursing care services are universal and provided free of charge but personal care services are selective (in England only) which means potential beneficiaries need to satisfy a double criterion for free benefits. Thus, the individual must actually be in need of care and s/he must have low income as well as little assets. Generally speaking, all with sufficient low income are eligible for services provided by local authorities whereas NHS services are usually free of charge, regardless of the individual's income or assets.[17] Similar to that, a central cash benefit for persons in need of care which we refer to in this paper, *Attendance Allowance*, is disbursed universally by the government without prior means-test.

Generally speaking, public provision of long-term care in Germany and in the U.K. differs considerably. To identify the problems faced by the European coordination of the two systems, we conduct two case studies in the following section.

5. Coordination of Long-Term Care Benefits between Germany and England

The coordination of the English and German provisional systems for long-term care seems to be a complex issue. For simplification we start by distinguishing two cases concerning migration and export-rules. The first case concerns the complete integration in another Member State's social protection scheme as a result of migration. Here, no requirement of direct coordination of long-term care benefits emerges. The second case is typical for cross-border commuters or for retirees and involves some cross-border elements. This situation can be illustrated by an individual that moves to the U.K. after having ceased to work in Germany. In fact, this individual will remain a beneficiary of a German care fund and will not integrate in the British system.[18] If this individual wants to claim a benefit, the above mentioned exportability rules will apply. In fact, our case studies are based on the latter situation. The benefits which are of particular interest here and their exportability rules are illustrated in Table 1.

[16] Cf. Schulte 1991, p. 739; Baldock, 2003.
[17] Cf. Robinson 2002, p. 37; Alaszewski/Billings/Coxon, 2004.
[18] Cf. Judgment of the Court of 12 June 1986. A. A. Ten Holder v Direction de la Nieuwe Algemene Bedrijfsvereniging. Case 302/84. European Court reports 1986 p. 01821.

Table 1 –National long-term care benefits and the principle of exportability

	England	**Germany**
cash benefits	**(-)** *Attendance Allowance* ➢ special non-contributory benefit ➢ exception to the principle of the exportability (Art. 10a (1) and Annex IIa Reg. 1408/71)	**(+)** *Pflegegeld* ➢ treated as sickness benefit ➢ subject to the principle of the exportability (Art. 19 (1a) Reg. 1408/71) ➢ cash-benefits from other Member-States can possibly be deducted[1]
Benefits in kind	**(+)** ➢ subject to the principle of the exportability (Art. 19 (1a) Reg. 1408/71) ➢ from a perspective of the Member State, the provision of benefits in kind is some sort of social welfare ➢ Community Law (Reg.1408/71) is applicable (*social security benefit*)	**(+)** ➢ subject to the principle of the exportability (Art. 19 (1a) Reg. 1408/71) ➢ services provided on behalf of the competent institution by the institution of the country of residence ➢ Community Law is not applicable for combined benefits of cash and in kind components (*Kombinationsleistungen*, para. 38 SGB XI)[1]

[1] Cf. Spitzenverbände der Pflegekassen, 2002, p. 34.
Source: Author

Germany. According to the *Molenaar* judgement, German cash benefits are subject to social security coordination. Table 1 shows that cash benefits are disbursed to the insured with German care funds even if s/he lives abroad. Benefits in kind are restricted to the design of long-term care provided on behalf of the competent institution by the institution of the receiving country. In the reverse case of migration, an individual is granted full access to the German provisions for long-term care as long as it is covered by the health care system of another Member State.

England. In contrast to the general rule of exportability which states that social security benefits must be paid in whichever country the beneficiary resides, a particular category of benefits linked to the social environment of the Member State, called 'special non-contributory benefits' are an exception to this rule. These benefits which fall between the traditional categories of social assistance and social security are listed in Annex IIa of Reg. 1408/71. Indeed, they are subject to all coordination provisions; still, they may not be exported and are consequently only payable in the providing country. Until recently, many benefits for disabled people fell under this criterion, which has been considered to be a major threat to migrating beneficiaries. Meanwhile, almost all Member States have subjected their dependency benefits to the coordination regulations. Still, the long-term care benefit at hand, *Attendance Allowance*, can be found in Annex IIa. [19] In fact, the European Court of Justice

[19] Still, the U.K. currently refuses compliance and may consequently expect treaty violation proceedings.

approved on this practise in its *Snares* judgment.[20] However, individuals moving to England qualify for the residence-oriented universal benefit *Attendance Allowance*, as well.

Even though British benefits in kind are means-tested and resemble welfare benefits, they are bound to the principle of exportability as they are treated as sickness benefits in European legal terms. In case of reverse migration, an individual that falls under the coordination regulations is fully entitled to benefits in kind according to English law. Consequently, potential care clients have to undergo financial assessment although their competent institution would grant benefits without financial assessment. The outlined coordination rules between German and British long-term care benefits will be the subject of two case studies in the following section.

6. Case Studies

The object of investigation is an individual eligible for statutory long-term care benefits. In a first step, the case-studies outline a cross national perspective by analysing similar situations in England in Germany. In a second step, the interactions of Member States' policies and Community Law in case of a mobile beneficiary are briefly outlined and the resulting microeconomic effects on the financial budget of the mobile care client are presented. The approach is applied to two scenarios which centre on benefits in kind and in cash. The case-studies are subject to the following assumptions. The individuals investigated have ceased to work and have reached the age of 65[21]. Naturally enough, they are in need of long-term care and subject to the personal scope of Reg. 1408/71. The object of investigation is solely the legal provision of long-term care. Other subsidiary systems remain out of consideration. The provisions of national law in 2004 are applied. Neither financing, quality, nor take-up of benefits is considered. The care needed can be provided through legal amounts. Further private out-of-pocket payment is frequently required but not subject of the present case studies.

Case Study 1: Cash Benefits

Cash benefits are generally provided and exported by the competent institution in accordance with the legislation which it administers. Table 2 shows the two different sets of provisions of allotments in England and in Germany.

[20] Cf. Judgment of the Court of 4 November 1997. Kelvin Albert Snares v Adjudication Officer. Case C-20/96. European Court reports 1997 p. I-06057.
[21] Attendance Allowance requires an age-minimum of 65 years.

Table 2 - Eligibility requirements for cash benefits

	Germany	**England**
Benefit	*Pflegegeld* (para. 37 SGB XI) (monthly payment)	*Attendance Allowance* (weekly payment)
Financing	1,7 per cent contribution rate from earned income, paid at par by employer and employee	tax financed
Financial assessment	no	no
age qualification	no	yes, persons aged 65 or over
qualifying conditions	- provision is dependent on the membership in a care fund - since 1.1.2000: the applicant must have a minimum record of five year insurance with a care fund within the last ten years - disability	- the three primary qualifying conditions which apply to AA are 1. age (>65), and 2. residence and presence, and 3. disability. - the applicant must have been in need for help for at least six months
definition of dependency	*in need for long term* care within the meaning of para. 14 and 15 SGB XI (Pflegebedürftigkeit): limited in - activities of daily living (ADL) and - instrumental activity of daily living for at least 6 months	no legal definition AA is a benefit designed to help severely disabled people who need from other persons 1. attention, or 2. supervision, or 3. watching over.
help needed	- minimum help with two ADL and with one IADL - subject to dependency level: minimum help with ADL once a day and minimum help with IADL once a week.	help with - activities of daily living („main meal test“) - bodily functions and personal hygiene - ingestion
guidelines for screening	screening is carried out through the medical service of the health funds according to care survey guidelines (*Begutachtungsrichtlinien*)	generally no, however there can be screenings in individual cases
designation for a specific use	no	no

Source: Author, according to SGB XI and Decision Makers Guide Vol. 10.

When it comes to benefit-design, *Pflegegeld* and *Attendance Allowance* are comparable in some categories, e.g. both cash benefits correlate positively with the level of dependency of the individual in need. Whereas German law distinguishes three dependency levels, British regulations specify only two. Fortunately, we are able to subsume the British categories under the German terminologies. Table 3 epitomizes the two cash benefits. Supposed that the purchasing power[22] in both countries is about the same, a German individual in need of care is worse off at disability level 'low' than his/her English counterpart. At all other disability levels this assessment is diametrically converse.

[22] Cf. HICP – Health – Index (1996=100) of EUROSTAT: Germany HICP 129.5 and United Kingdom HICP 126.2 (5/2004) (Source: http://europa.eu.int/comm/eurostat/newcronos/queen/display.do?screen=detail&language=en&product=EUROIND&root=EUROIND/shorties/euro_cp/cp060).

Table 3 – Comparable disability levels and monthly benefits[23]

Germany		England	
disability level	*benefit*	*disability level*	*Benefit*
low (*Pflegestufe 1*)	205 EUR (136.67 GBP)	day or night	225.90 EUR (150.60 GBP)
medium (*Pflegestufe 2*)	410 EUR (273.33 GBP)	day or night	225.90 EUR (150.60 GBP)
severe (*Pflegestufe 3*)	665 EUR (443.33 GBP)	day and night	337.50EUR (225.00 GBP)

Source: Author

In the following, we assume that an individual in need for long-term care moves either from Germany to Britain or vice versa and dependency becomes a cross-border issue. Table 4 outlines the relevant characteristics of the situation.

Table 4 – Pflegegeld and Attendance Allowance as cross-border benefits

Disability level	*expected cash benefit the immigrant will receive in England*	*difference to the situation in Germany*	*difference to regular cash benefit in England (Attendance Allowance)*
Low (*Pflegestufe 1*)	225.90 EUR (150.60 GBP)	+20.90 EUR (13.93 GBP)	nil
medium (*Pflegestufe 2*)	410 EUR (273.33 GBP)	nil	+184.10 EUR (122.73 GBP)
severe (*Pflegestufe 3*)	665 EUR (443.33 GBP)	nil	+327.50 EUR (218.33 GBP)

Source: Author

If an individual moves from Germany to England, the second column shows the expected cash benefits in the receiving country. Each of these amounts consists of two components: First of all, the person in need of long-term care is eligible for cash benefits from the German care fund, and secondly, its new place of residence grants *Attendance Allowance*. Since legislation administered by the English institution does not make arrangements for reductions or retirement provisions, the *Attendance Allowance* is fully deducted from the German *Pflegegeld.*[24] As a result, a dependent individual at disability level 'low' receives more than its immobile German equivalent. At disability level 'medium' or 'severe' its position remains the same, but the benefit is partly drawn from both countries. The third column shows the differences to typical cash benefits in Germany. The last column illustrates the differences in regular cash benefits provided in England as well as the actually paid benefit from German care funds. Taking a closer look at the immigrant to England (column 2) and its English counterpart (column 4) with disability level 'medium' or 'severe' shows that the principle of horizontal equity is not accomplished. The emigrant is better off than the comparable persons in need of care in the receiving country.

[23] Currency calculations are based on an exchange rate of 1.5 EUR/GBP, approached to the June 2004 22-day-average of 1.50499 EUR and the July 2004 7-day-average of 1.49681 EUR.
[24] See: Spitzenverbände der Pflegekassen, 2002, p. 34.

If our model care-client moves from England to Germany, the individual will abandon its claim on *Attendance Allowance*. Still, the immigrant is eligible for German cash benefits. At disability level 'medium' or 'severe' the immigrant in need of long-term care is far better off in Germany than in England. The individual financial improvement is displayed in the last column of Table 4. Thus, we arrive at the conclusion that a dependent individual can, ceteris paribus, improve or worsen its financial situation through moving in another Member State. Depending on the disability level and the destination country, the individual long-term care budget can change for the better or the worse.

Case Study 2: Benefits in kind

Benefits in kind for home care services are the object of investigation of the second case study. Following an overview in Table 5 comparing the country-specific eligibility requirements for home care services, an analytic framework is presented and effects of migration are evaluated.

Table 5 - Eligibility requirements for benefits in kind

	Germany	**England**
Benefit	benefits in kind for home care services (*Pflegesachleistung bei häuslicher Pflege*, para. 36 SGB XI)	community-based *social home care services* for older people
age qualification	no	no
Financing	1.7 per cent contribution rate from earned income, paid par by employer and employee	- tax financed - following a financial assessment care clients are charged for services
Financial assessment	no	- yes - the first six weeks home care services are free of charge (financial assessment period)
qualifying conditions	- provision is dependent on the membership in a care fund - since 1.1.2000: the applicant must have a minimum record of five year insurance with a care fund within the last ten years - disability	- residence or presence in England
definition of dependency	*in need for long term* care within the meaning of para. 14 and 15 SGB XI (Pflegebedürftigkeit): limited in - activities of daily living (ADL) and - instrumental activity of daily living for at least 6 months	Home care is for people age 16 and over including: - older people (over 65); - older people who are mentally frail (over 65); - people with mental health problems (16 -65); - people with learning disabilities (16 - 65); - people with physical disabilities (16 - 65); - people with visual impairments (16 and over); and - people with hearing impairments (16 and over).
guidelines for screening	screening is carried out by the medical service of the health funds according to care survey guidelines (*Begutachtungsrichtlinien*)	a social worker screens the potential care client

Source: Author

The analytic framework can be based on the German *Dependency Insurance Act* which characterises a care client with a *substantial* functional dependency. The fact of substantial dependency implies daily help with at least two activities, including dressing, moving or personal hygiene and help with additional support, such as housekeeping on a weekly basis. The *Dependency Insurance Act* sets a minimum time input at 10.5 hours per week for care, at least half of which has to be disposed for basic care needs. Conversely, English rules and regulations do not include a comparable precise circumscription for care needs. However, the weekly time input can be used as an indicator for drawing a comparison between the different systems.

Before granting home care services free of charge, English law administers financial assessment for a potential care client. Using the 'County of Cumbria' for reference, the means-test for home care services would be administered as follows: The first six weeks of home care are provided free of charge. During this period, a social welfare officer will gather information about the care client's financial circumstances in order to assess if s/he has to pay a contribution after these first six weeks. Three things are considered when calculating the care client's contribution to the cost of home care: income, capital assets and allowances. Income includes all money the individual in need receives on a regular basis or payment which relates to a particular period of time. A weekly mandatory allowance of 191.45 EUR (127.63 GBP) is being allocated in all cases. There are several other allowances which are not considered in the paper at hand. Assets include savings, stocks, shares and any property (apart from the care client's home). If the total of financial assets is more than 29,250 EUR (19,500 GBP), the care client will be held to pay the full charge up to a weekly maximum of 225 EUR (150 GBP). Accordingly, the dependent individual has to pay up to 15 hours weekly by him-/herself, given that the hourly rate for care amounts to some 15 EUR (10 GBP). If capital assets total between 18,000 EUR (12,000 GBP) and 29,250 EUR (19,000 GBP), the care client is expected to make a contribution to his/ her charge from his/ her capital. This is called a "tariff". It is calculated from the amount of the individual's assets and included as income. If the financial assets total less than 18,000 EUR (12,000 GBP) they will have no effect on the assessment.[25] In order to carry out a financial assessment in the case study at hand, the care client is endowed with income and capital. Precisely, the dependent person's monthly income is assumed to be 1,154.10 EUR (770 GBP)[26] and its capital assets are variable. In Table 6 the

[25] Cf. Cumbria County Council Social Services (edt.) 2003, p. 7 et seqq.

[26] The amount represents the average of the income of a standardized German pensioner (*Eckrentner*) with a monthly pension of 1,175.85 EUR (2004) and the mean income over all English pensioners of the census „The average incomes of pensioner units 2003/04" of a weekly 189 GBP (1,134.00 EUR monthly). (Balchin/Shah (eds.): The pensioner's Income Series 2002/03, p. 13).

financial assessment procedure is applied to the model care client with a fixed income and a weekly care need of 10 hours (weekly charge of 150 EUR or 100 GBP). The variable parameter is shown by the individual's capital assets.

Table 6 – Monthly income of an English care client in weekly need of 10 hours of care

capital assets	*total assessable monthly income*	*total allowances deducted*	*maximum monthly charge payable*	*remaining monthly income after care charge (excluding the mandatory allowance of 510,52 GBP per month)*
0-18,000 EUR (0 – 12,000 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP)	389.22 EUR (259.48 GBP)	Nil
18,000-29,250 EUR (12,000-19,500 GBP) e.g. 27,000 EUR (18,000 GBP)	1,299 EUR (866 GBP)	765.78 EUR (510.52 GBP)	533.22 EUR (355.48 GBP)	Nil
more than 29,250 EUR (more than 19,500 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP)	600 EUR (400 GBP)	-210.78 EUR (-140.52 GBP)

Source: Author

Table 6 shows that after financial assessment and charge for care services, clients with little capital assets have to live on their mandatory allowance which applies to people with medium resources, as well. However, a monthly surcharge (tariff) to their income is apportioned from their capital assets (144 EUR or 96 GBP at assets of 27,000 EUR resp. 18,000 GBP). Care clients with substantial capital assets have to eat up their savings at an amount of 210.78 EUR (140.52 GBP) per month.

Taking a look at direct costs for the provision of home care, the dependent individual is charged between 389.22 EUR (259.48 GBP) and 600 EUR (400 GBP) for his/ her care needs. Within the first two capital intervals, the capital assets are not subject to financial assessment and the individual's income is not sufficient to compensate for all care costs. Therefore local authorities bear the remaining sum. In contrast, the German care client with a *substantial* functional dependency (*Pflegestufe I*) receives monthly benefits in kind to the value of 384 EUR (256 GBP). Assuming that the benefit in kind covers all individual care needs, neither income nor capital assets are decisive.

Despite comparable financial endowments of the model care clients in England and in Germany, each of them features different individual monetary positions. Table 7 draws a direct comparison between the incomes of the model care client in England and in Germany, depending on his/ her individual capital assets. Assuming that the individual tries to cover for charges on capital assets by its income first, the German one is substantially better off in any case.

Table 7 –Comparison of the individual financial positions in England and in Germany after charges for home care services

capital assets	*England: remaining monthly income including mandatory allowance*	*Germany: remaining monthly income*
0-18,000 EUR (0 – 12,000 GBP)	765.78 EUR (510.52 GBP)	1,154.10 EUR (770.52 GBP)
18,000-29,250 EUR (12,000-19,500 GBP) e.g. 27,000 EUR (18,000 GBP)	765.78 EUR (510.52 GBP) minus a tariff on capital assets of 144 EUR (96 GBP) remaining income *621.78 EUR* *(414.52 GBP)*	1,154.10 EUR (770.52 GBP)
more than 29,250 EUR (more than 19,500 GBP)	765.78 EUR (510.52 GBP) minus the whole service charge 600 EUR (400 GBP) remaining income *165.78 EUR* *(110.52 GBP)*	1,154.10 EUR (770.52 GBP)

Source: Author

In the first case, our care client migrates from a scheme with statutory long-term care insurance to a system without explicit provisions on long-term care. Depending on his/her capital assets, the migrating care client experiences a financial loss which is displayed in Table 8. In fact, poorer individuals are proportionally less disadvantaged in the course of the migration from Germany to England. Opportunity costs resulting from potential losses of advantages of the German system are undocumented.

Table 8 – Home care: Financial loss when migrating from Germany to England

capital assets	*Germany: remaining monthly income*	*England: remaining monthly income including mandatory allowance*	*financial loss suffered*
0-18,000 EUR (0 – 12,000 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP)	388.32 EUR (259.48 GBP)
18,000-29,250 EUR (12,000-19,500 GBP) e.g. 27,000 EUR (18,000 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP) minus a tariff on capital assets of 144 EUR (96 GBP) remaining income *621.78 EUR* *(414.52 GBP)*	532.32 EUR (355.48 GBP)
more than 29,250 EUR (more than 19,500 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP) minus the whole service charge 600 EUR (400 GBP) remaining income *165.78 EUR* *(110.52 GBP)*	988,32 EUR (659.48 GBP)

Source: Author

In the case of mirror migration, the financial situation of the model care client improves. Table 9 shows the amounts to be paid depending on the individual's capital assets. Especially richer individuals are proportionally more advantaged than poorer ones by migrating from England and Germany. Table 9 does not account for the benefits in kind, the individual could claim in Germany, since they are provided 'free of charge'. Of course, benefits normally require prior payment of contributions; however, for people moving into the German system when they already draw benefits the contribution-side may be neglected.

Table 9 - Home care: Financial betterment when migrating from England to Germany

capital assets	*Germany: remaining monthly income*	*England: remaining monthly income including mandatory allowance*	*financial betterment gained*
0-18,000 EUR (0 – 12,000 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP)	388.32 EUR (259.48 GBP)
18,000-29,250 EUR (12,000-19,500 GBP) e.g. 27,000 EUR (18,000 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP) minus a tariff on capital assets of 144 EUR (96 GBP) remaining income *621.78 EUR* *(414.52 GBP)*	532.32 EUR (355.48 GBP)
more than 29,250 EUR (more than 19,500 GBP)	1,154.10 EUR (770 GBP)	765.78 EUR (510.52 GBP) minus the whole service charge 600 EUR (400 GBP) remaining income *165.78 EUR* *(110.52 GBP)*	988.32 EUR (659.48 GBP)

Source: Author

As a result, migration which is directed from the English to the German system of long-term care has positive effects on the financial position of the model care client, whereas mirror migration bears negative ones.

7. Conclusion

The European coordination regime for social security concedes almost complete self-determination to each Member State. Consequently, the different national long-term care provisions imply diverse system-designs as well as benefit-levels which may have striking impact on the (financial) situation of migrants. At the same time, principles of coordination aim at avoiding disadvantages or privileges of migrating individuals. However, the case studies show that coordination of long-term care in Europe does not provide satisfactory results for a migrating individual. In fact, its social rights position changes when it comes to cross-border elements.

Sure enough, the case studies exhibit a very particular situation and real numbers of the supposed migration might be pretty low. However, the paper at hand intends to add a point of view to a topic which has not attracted much attention so far: the effectiveness of the European social security coordination regime from a micro-perspective. Further research of this kind could help to produce some additional arguments to the discussion about social policy harmonisation or competition in Europe.

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