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European co-ordination of long-term care benefits: the individual costs of migration between Bismarck and Belveridge systems. Illustrative case studies.

Paper

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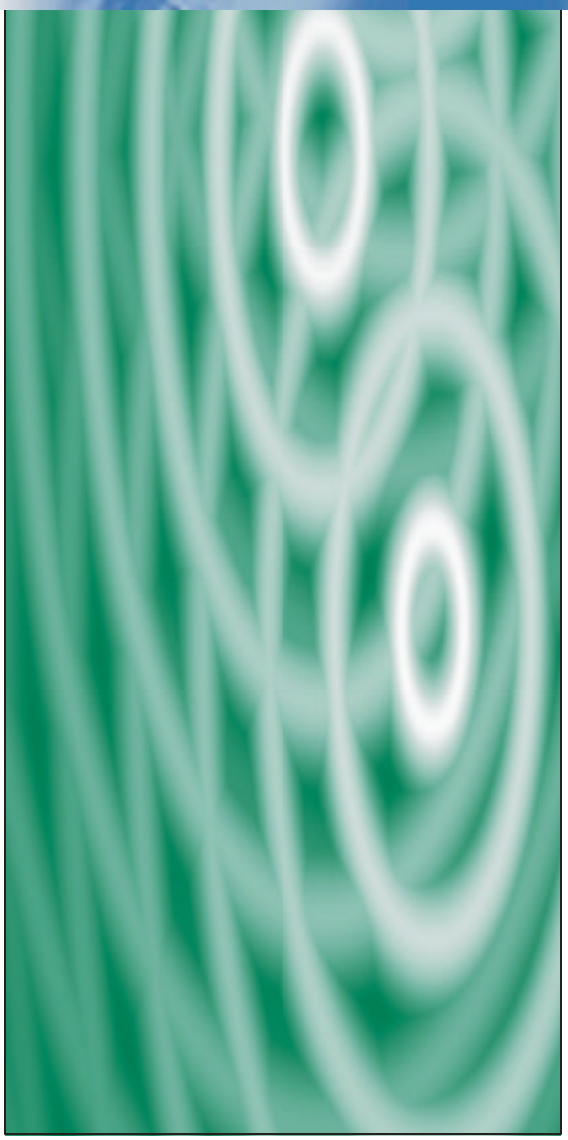
EUROPEAN CO-ORDINATION OF LONG-TERM CARE BENEFITS: THE INDIVIDUAL COSTS OF MIGRATION ILLUSTRATIVE CASE STUDIES



Timo Fischer

Abstract

The paper to be presented discusses the default in policy coordination or harmonisation in European Social Policy and the emerging private cost borne by migrating individuals. The different designs of national social security schemes imply administrative hurdles and incompatibilities. The latter may also discourage labour movements between EU-countries since migration could bring about a reduction or a loss of social security rights acquired on the basis of past employment and past contributions. The access to new benefits may be hampered as long as some national social security insurance programs demand a minimum coverage period as a prerequisite for benefit claims and disregard preceding insurance periods in other countries.

Taking present EU law into account, we design case studies to identify barriers to entry resp. to exit for individuals or households when migrating from one social security scheme to another. Within these scenarios, movements between national systems in Bismarckian tradition and Beveridge systems are of great interest.

The paper is based on a research project conducted at the Centre of Excellence of International Tax Coordination at the Vienna University of Economics and Business Administration.

1. Introduction

While the co-ordination of rules governing labour mobility in the Single European Market was enshrined in one of the earliest EC legislative acts of 1958, the matter of social security coverage for migrant workers has only recently been paid attention to. The areas of health and long-term care assume specific importance in this process: The European Parliament called for greater cooperation in health and long-term care. In spring of 2004, it also called on the Commission to present relevant proposals, allowing the Council to apply the "open method of coordination" on the subject and to adopt common objectives (see: COM(2004) 304 final 2004, p. 2). Given the enormous diversities in organisation as well as in the modalities of funding in the schemes of social protection in Europe, this task seems to constitute quite a challenge.

Beyond the meta-level, the growing international mobility in Europe has repercussions on the social security position of individual migrant workers. Eventually, no migrant worker should be at a disadvantage simply by being employed or residing abroad, as compared to the immobile counterpart. The paper at hand seeks to analyse whether or not the current EC scheme of social security co-ordination meets the standards of this principle.

The paper is divided into four main sections. After a brief topic outline, the following section takes a look at two social protection systems designed in the tradition of BISMARCK and BEVERIDGE. More specifically, the different setups of the national long-term care systems in England and in Germany will be analysed. Section

three outlines the social security Community Law according to EC Regulation No 1408/71 (Reg. 1408/71) and its meaning for the co-ordination of long-term care provision between England and Germany. Section four presents two case studies to illustrate the outcome of co-ordination of benefits in cash and in-kind between the two Member States on a microeconomic level. The paper concludes with a summary of the results.

2. BISMARCK and BEVERIDGE: The Provision of Long-Term Care

This section contains a short statement about the selection of the countries and a brief description of the German and English systems of long-term care.

Motivation. Like most European countries, England and Germany reveal similarities in basic institutions, state of affairs and ascendancies. According to HAUSER, differences between countries are decreasing with more congruence in the fields of cultural tradition and social values, organisational framework (e.g. market economy), democratic institutions as well as processes, characteristic features of a welfare state and actual state of economic development and industrialisation (see: Hauser 1991, p. 195 et seq.).

In fact, in a larger perspective almost all European countries show large congruencies in the dimensions mentioned above. At the same time, England and Germany are polar cases within the field of social security: Historically, the roots of insurance-based social security date back to OTTO VON BISMARCK (1815-1898) whereas the idea of public welfare was born by WILLIAM BEVERIDGE (1879-1963) in England. Inasmuch, both countries are considered as sub-agents of lager BISMARCK- and BEVERIDGE-frameworks. Although today's social security systems of both countries still stem from these organizing frameworks, the polarities have diminished rigorously.

Consequently, Germany and England are a good departure for comparisons since they show congruencies in many dimensions affecting the situation of elderly people. For instance, both countries exhibit the same old-age ratio[1] and similar adjusted old-age ratios[2]. Furthermore expenses for *Services for the Elderly and Disabled People* differed only 0,063 % of GDP on average in the last three documented years (see: OECD: Society at a Glance 2002: OECD Social Indicators). At the same time, the two countries differ strikingly in their approaches to ling-term care. If dif-

[1] Old age ratio = population aged over 65 / population in total working age (15-64) = 24,1 (in 2000).
[2] Adjusted old age ratio = population aged over 65 / total employment for the age group: 34,2 UK; 36, 4 D (in 2000).

ferences in long-term care policies take effects on the welfare situation of elderly people, it should be easiest to expose them in a country case study for the two Member States.

The German Perspective. Following a parliament decision of 1994, a mandatory and universal long-term care insurance (*Soziale Pflegeversicherung*) was introduced throughout Germany one year later by the *Dependency Insurance Act* (*Sozialgesetzbuch – Elftes Buch, SGB XI*). The *Social Dependency Insurance* (SDI) was designed in a BISMARCKIAN tradition in the institutional setting of a pay-as-you-go-insurance under the roof of the German social security system (see: Schneider 1999, Scheil-Adlung 1995. Evans-Cuellar/ Wiener 1999, 2000).

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. SDI is mandatory for a significant part of the population, depending on salaried employment status and earned income. Wage-and salary-earners and their families with an income below the social security contribution ceiling are obliged to make contributions to and are entitled to get coverage by care funds (para. 20 (1), SGB XI and para. 8, SGB IV). Civil servants, the self-employed and employees with an earned income that allows them to opt out of the mandatory system, are compelled by law to enter into contracts providing for private care insurance.

Only individuals who comply with the legal requirements of the term *in need of long-term care* (para. 14, SGB XI) are eligible for the full extent of benefits after expiration of the qualification period (para. 33 (2), SGB XI). SDI guarantees long-term coverage to care clients regardless of age, financial need or cause of dependency. Furthermore it covers dependency on care resulting from disability, physical or mental illness.

Benefits of the SDI are universal since services are provided for everybody by everybody (Titmus 1976, p. 129 quoted from Pratt 2001, p. 258). Benefits in kind are intended to be the dominant way of care provision in the German SDI, however, care clients can opt for cost reimbursements, as well. (see: Schaaf/ Vogel 1995, p. 155) In 2003, 49% of all individuals in need of long-term care made use of this option. (see: Leistungsempfänger der sozialen Pflegeversicherung im Jahresdurchschnitt nach Leistungsarten, www.bmgs.de). 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 SDI is not supposed to cover the entire cost of long-term care provision, supplementary, means-tested benefits can be obtained from

welfare schemes on the state and local levels (*Sozialhilfe*) which are subordinate to the social insurance benefits (see: Schulin 1997, cipher 42).

The English Perspective. As the "Magna Carta of the British welfare state" (Lampert 1985, p. 145) the BEVERIDGE-Plan provides the organising framework of public welfare. Traditionally, this tax-financed system has always been based on means-tested and non-contributory benefits (see: Karlsson 2004, p. 48).

Generally, every individual living in England is covered by the public welfare system if s/he meets the necessary requirements of residence and/ or presence. This means that the provision of benefits ceases to exist, as soon as an individual leaves the national solidarity community to join another system with different socio-cultural minimum requirements (see: Schulte 1991, p. 739).

Public provision for formal long-term care in England dates back several centuries. Apart from private for- and nonprofits, there are two main sources of long-term care provision in England, which are the local authorities and the *National Health Service* (NHS). Under the *Health and Social Care Act 2001*, nursing care services are universal and provided free of charge but personal care services are selective[3] which means potential beneficiaries need to satisfy a double criterion for free benefits: The individual must actually be in need of care and s/he must have a low income (see: Collard 1971, p. 38 quoted from Pratt 2001, p. 258). 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 (see: Robinson 2002, p. 37).

Unlike Germany, the provision of long-term care in England is not organised in a separate universal and mandatory social security scheme (see: Brall 2002, p. 207). Therefore benefits in kind mainly result from an interaction of different services of the NHS and the local authorities whereas the government disburses universal cash benefits. Resources for social protection are provided in a capped budget and concentrated on those individuals with the most need of care (see: Baldock 2003, p. 121).

Table 1 briefly juxtaposes the provision of long-term care in Germany and England. In the following section the European co-ordination scheme will be applied to the two systems.

[3] The benefit is selective in the whole United Kingdom but in England.

Table 1 – Comparison of the provision of long-term care in England and in Germany

Criteria	Germany	England
Applicable statutory basis	*Social Dependency Insurance - SDI* (*Gesetzliche Pflegeversicherung*): Social Code (*Sozialgesetzbuch*), Book XI *Social assistance* (*Sozialhilfe*): Federal Social Assistance Act (*Bundessozialhilfegesetz, BSHG*).	Social Security Contributions and Benefits Act 1992.
Legal objectives	- securing quality of basic primary care and home help - home care takes priority over stationary care - encouragement of informal care potential - financial relief for welfare schemes	- home care takes priority over stationary care - encouragement of informal care potential - financial relief for social welfare institution which provide long term care
Institutions	*SDI* Pflegekassen *Social assistance*: local authorities	- National Health Service - Department of social security - local authorities
Basic principles	*SDI*: Compulsory social insurance system financed by contributions, in accordance with compulsory affiliation and sickness insurance limits *Social assistance*: Tax financed	Non-contributory, state-financed system providing cash benefits and benefits in kind for elderly or disabled persons and their carers.
Risk covered	*SDI*: Persons in need of care (heath-assessment) who, as a result of a physical, emotional or mental handicap, permanently and regularly need substantial long-term assistance to execute usual and regularly recurring activities in their daily lives. carer-benefits (contributions to pension and accident insurance, training, respite care) *Social assistance*: For persons who are - are not insured under long-term care insurance - are insured but the limited benefits of long-term care insurance are not sufficient (e.g. supplementary benefits for cost-intensive most severe category of care). These benefits are granted according to income and assets.	*Attendance Allowance* (cash benefit): People aged 65 or over who have personal care needs during the day and/or night because of physical or mental disability.

Field of application	*SDI*: Nearly the entire population is insured. *Social assistance*: Persons not insured under long-term care insurance, insured persons who do not meet certain criteria (see above) or insured persons receiving (supplementary) benefits because the limited benefits of long-term care insurance (e.g. for cost-intensive most severe category of care) are not sufficient or because the insurance does not cover certain costs occurring in the case of institutional care (costs of room and board, investment costs).	All residents with an unrestricted right to remain in the UK.
Benefits in kind – home care	*SDI*: Monthly benefits in kind (basic care and housework provided by itinerant care centres or isolated persons) for the value of: disability level I: up to € 384, disability level II: up to € 921, disability level III: up to € 1,432, in cases of particular hardship: up to € 1,918. Cash benefits and benefits in kind may be combined. *Social assistance*: Benefits up to the amount of need.	Local authorities can provide home-care, meals on wheels, special aids and equipment, adaptations to the home and attendance at day care centres.
cash benefits	*SDI*: Instead of residential benefits in kind, the patient in need of care can decide to receive care benefits for a monthly amount of: disability level I: € 205 disability level II: € 410 disability level III: € 665 Cash benefits and benefits in kind may be combined. *Social assistance*: The same benefits as under the long-term care insurance.	*Attendance Allowance:* Higher rate: GBP 56.25 (€ 86) Lower rate: GBP 37.65 (€ 58)
Participation of the beneficiary	*SDI*: SDI beneficiaries that do not make use of vendor services have to schedule for *Pflicht-Plege-Einsätze* (advisory visits by authorized care providers) at least twice a year.. *Social assistance*: According to income and assets.	If a disabled person is receiving care or other services from the local authority, reasonable charges may be made for that care or those services depending on ability to pay.
Taxation	Benefits granted under the statutory long-term care insurance and under guaranteeing minimum resources are not subject to taxation for the person in need of care.	Cash benefits and benefits in kind not taxable, except Carers Allowance.

Financing	*SDI* contribution funding 1,7% SDI contribution rate of the earned income, shared equally between employer and employees and rare co-payments *social assistance* general taxation	tax funding - NHS through general taxation - local authorities through government grants and council taxes - co-payments

Source: http://www.europa.eu.int/comm/employment_social/missoc/2003/index_en.htm. Mager 1999, p. 146-161. Alaszewski et al 2004. Schneider 1999.

3. The Community Provisions on Social Security

3.1 Principles of co-ordination of long-term care benefits

In theory, internationally mobile individuals could retain – or partly retain – their claims from insurance or welfare based systems when moving to another country, or lose them altogether, depending on the transferability of claims as provided in the respective systems. The framework for co-ordination of social security benefits in case of cross-border mobility in Europe is set up by Community Law. The key pieces of EU legislations are the *Regulation on Provisions on Social Security for Migrant Workers* (Reg. 1408/71) and the corresponding co-legislation (Regulation No 547/71) (see: Eichenhofer 1998, p. 127). The aim of the two regulations is to develop a common international social law and to exempt it from national competence. Consequently, a member state can no longer insist that its benefits only apply to its territory and thus may only be consumed there. However, the national social policies of each Member State remain one of the key realms of policy competence where national governments reign supreme (see: Klie/ Krahmer 2003, para. 34, cipher 5). Basically social legislations of Member States exist independently and clearly detached from each other. Community Law merely targets cross-border cases.

The social risk of dependency does not explicitly fall within the material scope of art. 4 Reg. 1408/71. Still, case law of the *European Court of Justice* has qualified allotments in cases of long-term care demands as sickness benefits (see: Hanau/ Steinmeyer/ Wank 1990, cipher 13 and ECJ Case C-160/96 of 5 March 1998 - MOLENAAR). Long-term care benefits are therefore treated as *social security benefits*, regardless of whether they originate from contribution-based/ employment-oriented or tax-financed/ residence-oriented systems. Consequently, long-term care benefits are within the scope of Reg. 1408/71, irrespective of how they are classified in national law (see: Landholt 2001, p. 120 et seq. and Schumacher 2001, p. 182). As a result, the *Council* and the *European Parliament* explicitly allude to long-term care benefits within art. 34 Regulation No 883/2004 on the co-ordination of social secu-

rity systems which was adopted in spring 2004 to fundamentally reform as well as a to simplify the rules for co-ordination in the field of social security.

For the paper at hand, two regulations of the Community Law are of special interest: First of all, the aggregation of qualifying periods for benefits (art. 18 Reg. 1408/71) and secondly, the principle of exportability of social security benefits (art. 19 Reg. 1408/71), both of which will be outlined in the following paragraphs.

The aggregation of periods of insurance, employment or residence is a basic rule of Community Law. Art. 18 states that the competent institution of a Member State whose legislation makes the acquisition, retention or recovery of the right to benefits conditional upon the completion of periods of insurance, employment or residence shall, to the extent necessary, take account of periods of insurance, employment or residence completed under the legislation of any other Member State as if they were periods completed under the legislation which it administers.

With regard to the principle of exportability of social security benefits, Community Law basically follows the territorial principle: Individuals are subject to the statutory provisions of the Member state in whose sovereign territory they are employed (*lex loci laboris*). The wording of art. 19 says that an employed or self-employed person residing in the territory of a Member State other than the competent State who satisfies the competent state's condition for entitlement to benefits shall receive benefits in the state where s/he is resident:

(1) *benefits in kind* are to be provided on behalf of the competent institution (see: art.1 (o) Reg. 1408/71) by the institution in the country of residence. The latter distributes benefits in accordance with the provisions of the legislation it administers itself as though the recipient was insured with it;

(2) *cash benefits* have to be provided by the competent institution in accordance with the legislation which it administers.

In both cases, the requirements whether or not an individual in need of long-term care can assert a claim are determined by the protection system of the Member State s/he actually belongs to. The set of rules for the provision of benefits in kind are determined by the statutory provisions of the state of residence. As a result, loopholes in an individual's social coverage may arise if the institution of the place of residence (see: art. 1 (p) Reg. 1408/71) does not provide the same sort of benefits as the competent institution.

As a result, co-ordination of European social security systems seems to be limited by differing services of each Member State which means that effective co-

ordination calls for adequate '*homogenisation*' of social policy in the first place (see: Eichenhofer 2001, p. 138 and Leibfried/ Pierson 1999, p. 23).

3.2 Co-ordination between BISMARCK and BEVERIDGE-Systems

At first glance, the co-ordination of the English and German provisional systems for long-term care seems to be complex. For further analysis, it is essential to distinguish between two cases: (1) If a migrant worker integrates completely into another Member State's social protection scheme without any cross-border issues, co-ordination is manageable. (2) However, the situation seems more difficult if a migrant worker remains in his/ her social protection scheme despite of moving abroad. In other words, s/he does not integrate into the social protection scheme of his/her receiving country. This problem will be dissolved in the following paragraph with the aid of the European co-ordination scheme outlined in section 3.1.

As established earlier, long-term care benefits are subject to co-ordination according to Reg. 1408/71, regardless of their national labelling. As a result, the principle of exportability of social security benefits must be applied and possible qualifying periods must be aggregated. Furthermore, the question as to whether long-term care benefits classify as special non-contributory benefits arises for two reasons: Firstly, special non-contributory benefits are liable to the principle of exportability and subject to the general system of co-ordination within the meaning of art. 4 (2a) Reg. 1408/71 (see: Landholt 2001, p. 125). Secondly, special non-contributory benefits listed in Annex II Part III form part of the opting-out possibility of art. 4 (2b) Reg. 1408/71 and are therefore exempted from the European co-ordination scheme (see: Lafrenz 2002, p. 19). Moreover, according to art. 10a (1), benefits can be exempted from the principle of exportability if they are listed in Annex IIa Regulation No 1408/71.

The application of the principle of exportability to the German and English benefits for long-term care is illustrated in Table 2.

Table 2 – Are national long-term care benefits subject to 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 a 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] See: Spitzenverbände der Pflegekassen 2002, p. 34.
Source: Author

Germany. According to case law of the European Court of Justice, SDI cash benefits are subject to the *Regulation on Provisions on Social Security for Migrant Workers*. Table 2 shows that cash benefits are disbursed to the insured of German care funds even if they live 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.

An individual immigrating to Germany has full access to the German provisions for long-term care as long as s/he is covered by the sickness insurance of another Member State. S/he is not subject to means testing if they draw benefits from the SDI.

England. English long-term care provision and exportability are different from the German concept. Cash benefits (*Attendance Allowance*) are conceived as special non-contributory benefits by the opting-out regulation according to art. 10a Reg. 1408/71. Even though benefits in kind are means-tested and resemble welfare benefits, they are classified as special non-contributory benefits within the meaning of art. 4 (2a) Reg. No 1408/71. Consequently, these benefits are bound to the principle of exportability.

Individuals moving to England qualify for *Attendance Allowance*, since it is a residence-oriented universal benefit. Moreover, immigrants are entitled to benefits in kind according to English law. Consequently, potential care clients have to un-

dergo financial assessment although their competent institution would grant benefits without financial assessment.

The following section analyses the European scheme of co-ordination of long-term care benefits and its impact on individuals' differential access to long-term care provisions in a case-study framework.

4. Case Studies

The object of investigation is an individual eligible for legal long-term care benefits. In a first step, the case-studies outline a cross national perspective by analysing similar situations in England in Germany. But the analysis does not centre on national policies. In a second step, the interactions of Member States' policies and Community Law in the case of mobility of a benefit recipient 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 – one about cash benefits and the other about benefits in kind. The case-studies are subject to the following assumptions:

- The individuals investigated are senior citizens (persons aged 65 or over[4]), in need of long-term care. These model care clients are integrated into the co-ordination framework since they are covered by the social security system of a Member State. (see: Frenz 2004, p. 589 cipher 1537).
- The migrating individuals do not integrate into the social protection schemes of the receiving Member State. These *non-integrators* reside in one Member State and are insured in another. The paper at hand refers to non-integrators as non-active persons, e.g. pensioners, survivors, students and/ or family members of the above mentioned persons. (see: Reyes 2003, p. 16)
- The object of investigation is solely the legal provision of long-term care. Other subsidiary systems remain out of consideration.
- The status quo of the current policy regimes is assumed to be the fictitious underlying body of legislation.
- Neither financing, nor quality, nor take-up of benefits are 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.

[4] Attendance Allowance is only granted to people aged 65 or over, whereas the German SDI has no age limit.

4.1 Case Study 1: Cash Benefits

Cash benefits are generally provided by the competent institution in accordance with the legislation which it administers. England and Germany handle the provision, the financing and the type of long-term care cash benefits differently. Table 3 summarises the different eligibility requirements for cash benefits.

Table 3 - Eligibility requirements for cash benefits

	Germany	**England**
benefit	*Pflegegeld* (para. 37 SGB XI) (monthly)	*Attendance Allowance* (weekly)
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*.

Pflegegeld and *Attendance Allowance* are comparable although they are part of two different social systems. Moreover, for both (types of) cash benefits the level of payment correlates positively with dependencies of the individual and the respective care needed. German law knows three disability levels, whereas English regulations specify two: *Attendance Allowance* is payable at a higher rate if a person needs help both day and night and at a lower rate if a person needs either day or night care. English disability levels can be subsumed under the German terminology of para. 15 (1), SGB XI. Table 4 compares the two cash benefits.

Table 4 – Comparable disability levels and monthly benefits[5]

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	337.50 EUR (225.00 GBP)

Source: Author

Supposing that the purchasing power[6] 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.

Migration from Germany to England. In the course of migration from one Member State to another, dependency becomes a cross-border issue. Table 5 outlines the relevant characteristics of the situation.

Table 5 – *Pflegegeld*: Germany as competent state and England as state of residence

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

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 SDI, and secondly, his/her new place of residence grants *Attendance Allowance*. Since legislation administered by the English institution does not make arrangements for reductions or retirement provisions, the foreign benefit in the form of *Attendance Allowance* is fully deducted from the German *Pflegegeld* (see: Spitzenverbände der Pflegekassen 2002, p. 34). As a result, a dependent individual at disability level *"low"* receives more than his/ her immobile German equivalent. At disability level "*medium*" or "*severe*" his/ her position remains the same, but the benefit is partly drawn from both countries.

[5] 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.

[6] See 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).

The third column shows the differences in usual 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 his/ her 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.

Migration from England to Germany. In the case of laterally reversed migration *Attendance Allowance* is excluded from the principle of exportability within the meaning of art. 10a (1) Reg. 1408/71. According to the *Deutschen Verbindungsstelle Krankenversicherung – Ausland* (the division for foreign affairs of the German health funds alliance), the immigrant is eligible for German cash benefits (*Pflegegeld*). S/he could as well be eligible for benefits in kind, however this section is about financial allotments, only. The former will be analysed in section 4.2.

At disability level "*medium*" or "*severe*" the immigrant in need of long-term care is better off in Germany than in England. The individual financial improvement is displayed in the last column of Table 5. Consequently, the mirror migration meets the principle of horizontal equity in the receiving country.

As a result, the amounts of long-term care cash benefits vary when it comes to cross-border issues between England and Germany. Depending on the disability level and the destination country, the individual long-term care budget can change for the better or the worse.

4.2 Case Study 2: Benefits in kind

The object of investigation of the second case study are benefits in kind for home care services. Following an overview in table 6 comparing the country-specific eligibility requirements for home care services, an analytic framework is presented and effects of migration are evaluated.

Table 6 - 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

An analytic framework can be based on the German *Dependency Insurance Act* which characterises a care client with a *substantial* functional dependency (para. 15, SGB XI). In Germany, nearly 57 per cent of all care clients in need of home care require a *substantial* degree of assistance in performing activities of daily living (ADL) (see: Bundesministerium für Gesundheit und soziale Sicherung 2004, www.bmgs.de). 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 (para. 15 (3), SGB XI). English law does not include a comparable precise circumscription for care needs. However, the

weekly time input can be used for 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 is executed as follows:

The first six weeks of home care are provided free of charge. During this period, a Financial Assessment 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 some15 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. (see: Cumbria County Council Social Services (edt.) 2003, p. 7 et sqq.)

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 feigned with 1,154.10 EUR (770 GBP)[7]. Capital is variable by assumption.

In Table 7 the 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), assuming different levels of capital assets.

[7] 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, 13).

Table 7 – Monthly income of an English care client in weekly need of 10 hours of care

capital assets	*monthly income after financial assessment of which home care has to be paid*	*monthly charge for home care*	*remaining monthly income after care charge (excluding the mandatory allowance)*
0-18,000 EUR (0 – 12,000 GBP)	380.24 EUR (253.48 GBP)	380.24 EUR (253.48 GBP)	nil
18,000 EUR (12,000 GBP)	674,24 EUR (449.48 GBP)	600 EUR (400 GBP)	74.24 EUR (49.48 GBP)
29,250 EUR (19,500 GBP)	854.24EUR (569.68 GBP)	600 EUR (400 GBP)	254.24 EUR (169.68 GBP)

Source: Author

Table 7 shows that, after financial assessment and charge for care services, between 0 and 254.24 EUR (169.68 GBP) are left (excluding the mandatory allowance). Taking a look at direct costs for the provision of home care, the dependent individual is charged between 380.24 EUR (253.48 GBP) and 600 EUR (400 GBP) for his / her care needs. Within the first interval of 0-18.000 EUR (0-12.000 GBP), 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 are responsible for the remaining sum.

In contrast, the German care client with a *substantial* functional dependency receives (*Pflegestufe I*) monthly benefits in kind to the value of 384 EUR (256 GBP). Assuming that the benefit in kind covers all individual care needs, the entire income of 1,154.10 EUR (770.52 GBP) remains untouched with given capital assets.

Despite comparable financial endowments of the model care clients in England and in Germany, each of them features different individual monetary positions. Table 8 draws a direct comparison between the income of the model care client in England and in Germany, depending on his / her individual capital assets. The German individual is better off in any case.

Table 8 –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 EUR (12,000 GBP)	840.02 EUR (560 GBP)	1,154.10 EUR (770.52 GBP)
29,250 EUR (19,500 GBP)	1,020.02 EUR (680.20 GBP)	1,154.10 EUR (770.52 GBP)

Source: Author

Migration from Germany to England. In the stated scenario, an individual in need of long-term care migrates from a scheme with mandatory and universal long-term care insurance to a system without explicit long-term care provisions. Depending on

his/ her capital assets, the migrating care client experiences a financial loss which is displayed in Table 9. Opportunity costs resulting from the loss of advantages of the German system are undocumented. Remarkably enough, dependent individuals with low capital assets are disadvantaged the most when migrating from Germany to England. Still, the principle of horizontal equity in the receiving country is fulfilled.

Table 9 – 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 (770.52 GBP)	765.78 EUR (510.52 GBP)	388.32 EUR (260 GBP)
18,000 EUR (12,000 GBP)	1,154.10 EUR (770.52 GBP)	840.02 EUR (560 GBP)	314.08 EUR (210.52 GBP)
29,250 EUR (19,500 GBP)	1,154.10 EUR (770.52 GBP)	1,020.02 EUR (680.20 GBP)	134.08 EUR (90.32 GBP)

Source: Author

Migration from England to Germany. In the mirror migration the financial situation of the model care client improves. Table 10 shows the payable amounts relating to the individual's capital assets. Especially poorer individuals are proportionally advantaged by migration between England and Germany. Table 10 does not account for the benefits in kind of the German Social Dependency Insurance, since they are provided free of charge to the model care client.

Table 10 - Home care: Financial betterment when migrating from Germany to England

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 (770.52 GBP)	765.78 EUR (510.52 GBP)	388.32 EUR (260 GBP)
18,000 EUR (12,000 GBP)	1,154.10 EUR (770.52 GBP)	840.02 EUR (560 GBP)	314.08 EUR (210.52 GBP)
29,250 EUR (19,500 GBP)	1,154.10 EUR (770.52 GBP)	1,020.02 EUR (680.20 GBP)	134.08 EUR (90.32 GBP)

Source: Author

As a result, migration which is directed from the English to the German system of long-term care takes a positive effect on the financial position of the model care client whereas the mirror migration bears a negative one. In both cases the principle of horizontal equity is met in the receiving country since the emigrant is neither better nor worth off than the comparable native care client.

5. Conclusion

The European co-ordination scheme for social security concedes as much self-determination to each Member States' system as possible. At the same time, EU

endeavours aim at homogenisation of social security schemes in order to avoid disadvantages or privileges of migrant workers.

Bearing the aims of Community Law in mind, the co-ordination of long-term care benefits in kind and cash between a BISMARCK and a BEVERIDGE system brings about surprising effects. Two case studies show that the present co-ordination scheme has not proved satisfactory results for bringing together contribution-based/ employment-oriented and tax-financed/ residence-oriented systems. At the least, the co-ordination of long-term care benefits does not seem to fulfil expectations and thus requires improvement. Undoubtedly, more harmonisation could smooth out the shortcomings of co-ordination and give migrants more security about the consequences of transference to a foreign social security system.

The framework presented above is a starting point for further research of possible microeconomic effects. It shows the basic direction for future investigation by stating principal thoughts about equity, efficiency and migration.

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