Legal impact assessment for the revision of Regulation 883/2004 with regard to the coordination of long-term care benefits

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INTRODUCTION

THE PURPOSE OF THIS REPORT — LOOKING FOR A REPLY TO DIFFERENT CHALLENGES

It would be an underestimation to say that the coordination of long-term care benefits presents some challenges. Already in our first trESS Think Tank report of 2011 (A.C. 610/11) on the current situation and future prospects, we emphasised the many actual problems and challenges which the inclusion of national long-term care benefits into the regulatory framework poses. It is not our intention to repeat all these challenges in detail, for which we refer to the 2011 trESS Think Tank report, but to highlight the most important ones.

The problems are multiple. Firstly, challenges already arise because long-term care benefits do not fit in the classical policy on social risks and because hardly any Member State knows a comprehensive legal definition of long-term care benefits. It is therefore an important and difficult task to develop a common understanding on a definition of this concept. Our mapping of the national schemes has shown that several Member States have benefits that contain some elements of long-term care and that could be described as long-term care benefits. These benefits are either ‘distinct’ or are related to other branches in line with the national system, e.g. old age, invalidity, survivor’s benefits, work accidents and occupational diseases, family protection, sickness, social assistance. In addition, long-term care benefits can be in kind or in cash or even a mixture of both; they can be social security benefits or social assistance benefits, contributory or non-contributory; they can be provided for or awarded to workers, pensioners, family members, etc, or, to caregivers who can receive a direct benefit such as a salary or benefit indirectly as part of the cash benefits awarded to the dependent person; they are processed and managed by a multiplicity of bodies and institutions, which complicates their control; and so on. Consequently, it is easy to understand that differences in national systems and no common understanding of the concept complicate any coordination from the very beginning and that any general solution provided will always leave some unresolved issues and gaps to be filled.

Apart from these challenges related to the characteristics of long-term care benefits according to national legislation, the inclusion of long-term care benefits in the Chapter on Sickness and as such the current coordination of such benefits according to the Sickness Chapter poses additional challenges. Although choosing the Sickness Chapter for the inclusion of long-term care could be seen as the best option at that moment, it is generally recognised that long-term care benefits and sickness benefits, despite certain similarities, also differ in their aims, instruments and means. The challenges which the application of the Sickness Chapter resulted in also demonstrate that the sickness provisions were not always suitable. In this respect, we can refer to the application of the rules on priority of own rights above derived rights; the loss, withdrawal or suspension of long-term care benefits when the beneficiary changes his or her residence to another country; the accumulation of the benefits in cash of the competent Member State and the benefits in kind for the same purpose of the Member State of residence (Article 34 of Regulation (EC) No 883/2004); the application of Article 34 of Regulation (EC) No 883/2004 in relation to Member States which have opted for lump sum reimbursements; general aspects of accumulation of cash benefits and/or benefits in kind also outside Article 34 of Regulation (EC) No 883/2004; aggregation of periods; mismatches of concepts as a result of the inclusion of long-term care benefits in the Chapter on Sickness Benefits; residence in a Member State other than the competent Member State that recognises long-term care benefits based on residence; pensioners residing in a competent Member State which does not recognise long-term care benefits and who are, at the same time, entitled to a pension under the legislation of another Member State that does recognise long-term care benefits; benefits with elements of long-term care considered as benefits from other branches of social security by Member States; dependent people temporarily staying abroad; family members whose parents work in different Member States or pensioners of different Member States, etcetera.
This does not mean that alternatives would be without problems. Splitting long-term care benefits up in different chapters of coordinated benefits could imply more drawbacks than advantages, especially concerning legal certainty and transparency. Today, the provision of long-term care benefits at national level is not yet homogeneous. A single chapter for long-term care benefits (which have to be listed) with specific rules against overlapping would be desirable for the future, all in all considering that the new provisions should aim at eliminating the existing gaps and the lack of protection which the implementation of the current Chapter on Sickness could generate. This unfortunately neither is an easy nor clear-cut issue, as in some aspects a different coordination could be more advantageous for the persons concerned, e.g. long-term care type benefits which are closer linked to other branches such as family benefits or accidents at work and occupational diseases under the relevant chapters of Regulation (EC) No 883/2004.

However, all the challenges encountered clearly demonstrate that doing nothing and leaving the situation as it is, is not really an option and does certainly not contribute to legal certainty and appropriate protection for the beneficiaries and simplification for the administrations.

Therefore, this report’s first task was to refine the description of the various benefits and schemes of the Member States contained in the 2011 trESS Think Tank report. The second and most important task was to analyse the pros and cons of some options for changes to today’s way of coordination. It was not possible to examine all options which, from a theoretical point of view, may be doable. We restricted our work to some options which seemed the most interesting. If any future amendments are really intended (e.g. by way of a revision of Regulations (EC) No 883/2004 and No 987/2009) this cannot be done without an impact assessment of various seemingly possible options.

The following acronyms are used throughout the text (besides the usual acronyms):

- AC = Administrative Commission on social security for migrant workers or Administrative Commission for the coordination of social security systems, as the case may be;
- CJEU = Court of Justice of the European Union;
- EESSI = Electronic Exchange of Social Security Information;
- EC = European Commission;
- LTC = long-term care;
- MS – MSs = Member State – Member States;
- SED = Structured Electronic Document.
PART I
SYNTHESIS AND EVALUATION OF THE MEMBER STATES’ REPLIES

In last year’s Think Tank report (A.C. 610/11) trESS proposed various ways forward to coordinate LTC benefits under Regulations (EC) No 883/2004 and No 987/2009. To get a clearer picture of the attitude of the MSs towards these different options a questionnaire (A.C. 18/12) was sent to the members of the AC. This part of the trESS Analytic Report for 2012 has the task to sum up the answers received. This text is only a short summary. For further details, please read Annex 1 of this Report.

It has to be mentioned that a vast majority of the MSs answered the questionnaire. The answers give a good overview of national policies and as a rule give a clear indication as to where the description of the national scheme(s) and benefit(s) in the previous trESS Think Tank report should be amended (see Part II of this report).

Most important for further work, from our point of view, has been the attitude of the MSs towards the possibilities for legal changes (in Regulations (EC) No 883/2004 and No 987/2009) compared to the status quo. Therefore, the following points try to sum up those aspects which we think the MSs are interested in. In doing so, it very soon became evident that it will be nearly impossible to find a way for further action which is a priori acceptable to all MSs. Nevertheless, very often solutions are supported by many MSs.

The following elements were deduced which could be taken on board for a revision of Regulation (EC) No 883/2004:

- Regulation (EC) No 883/2004 should contain a definition of LTC benefits which is based on the definition proposed in the trESS Think Tank report; some additions could be made, especially a clarification of the element ‘over an extended period of time’ and the borderline to ‘normal’ sickness benefits and social assistance; it has to be assumed that such a definition covers the vast majority of LTC schemes and benefits existing in the MSs.
- This definition could be supplemented by a list of the benefits covered (the MSs have already supplied a lot of information to amend and update the lists contained in the trESS Think Tank report).
- A separate chapter for the coordination of LTC benefits seems to be welcome. However, the content of this chapter is not so evident:
  - One solution which seems to be acceptable for the majority is to keep the existing coordination as sickness benefits, but with additional clarifications taking into account the nature of LTC benefits; special attention should be given to the rule on overlapping (today Article 34 of Regulation (EC) No 883/2004).
  - A question which has to be further examined is whether all LTC benefits should be treated only under this new chapter or whether the existing coordination under the various chapters of Regulation (EC) No 883/2004 should be allowed to be kept as well.
  - The MSs do not seem to be overly enthusiastic about a totally new way of coordination, whereby e.g. the MS of residence should always be the competent MS to grant these benefits, as proposed in the trESS Think Tank report.
  - Benefits granted to the carer merit further attention; should they be regarded as income for the application of Title II of Regulation (EC) No 883/2004?
- Astonishingly the vast majority of MSs did not report many problems with the application of the existing system of coordination of LTC benefits and do not have concrete figures and data.
PART II
MAPPING OF NATIONAL SCHEMES

The present report also has the task to map national LTC schemes/benefits (for details see Annex 2 to the present report). This mapping is based on the 2011 trESS Think Tank report on coordination of LTC Benefits – current situation and future prospects (A.C. 610/11). Initial information for that report was based on the MISSOC tables, verified by the trESS national experts.

For the present report a questionnaire was sent to the AC members (A.C. 18/12 – see also under Part I), in which under point B questions were asked related to the definition, mapping and description of the national schemes. The vast majority of the MSs replied to the questionnaire and shared their view on the mapping of LTC benefits. Some MSs have merely corrected the amounts, some provided descriptions of certain LTC benefits and some already took a view on the possible effects which the social security coordination mechanism may have on some of the listed LTC benefits (made visible as an ‘Addendum’ to the respective descriptions of the MSs). These remarks have been incorporated into Annex 2 so that this annex could be regarded as more up to date and now has a higher degree of approval from the MSs compared to the first trESS mapping exercise which was based on an examination by the trESS national experts.

It should be noted that the identification of concrete LTC benefits to be coordinated depends on the agreed coordination rules, e.g. a new definition of LTC benefits, mentioning reliance on LTC as a social risk in Article 3 of Regulation (EC) No 883/2004 (with the duty of MSs to notify the EC in writing on the legislation and schemes referred to in Article 3) or listing LTC benefits (as such or merely under Article 34 of Regulation (EC) No 883/2004). It is subject to an agreement between the MSs or to decisions by the CJEU (and national courts of law) which benefits should be subject to the coordination regime and which coordination rules should be applied.

Therefore, the revised mapping of the LTC schemes/benefits again provides an overview of the wide range of benefits which might qualify as LTC benefits and – from our point of view – which might be subject to the EU social security coordination law.
PART III
THE DEVELOPMENT OF OPTIONS FOR THE COORDINATION OF LTC BENEFITS

A. Introduction

A guide to find your way through the possible solutions for the coordination of LTC benefits

As a result of the challenges, many decisions have to be taken before deciding how to coordinate LTC benefits in the future. As it is not easy to describe the possible options in a text, the diagrams on the next page should help. They show the way a decision maker could analyse all the different options and approach the final solution step by step. Some of these decisions are of a horizontal nature and could be taken irrespective of the way of coordination chosen; others are clearly separated paths of coordination. This makes it very complex to take a clear-cut decision. To avoid misleading paths for the decision maker we have split the diagram into two different parts: the first diagram shows the horizontal options which should be considered first (starting from the first option not to change anything); the following diagram (split into two separate ways towards a solution) shows the special options which could be chosen in addition to the horizontal options, or as a stand-alone possibility without any horizontal option.

Horizontal options B to G which might be chosen each of them on their own or in addition to any of Options H to U

<table>
<thead>
<tr>
<th>Ways to solution – Horizontal issues</th>
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<tbody>
<tr>
<td>A. Status quo = No Action</td>
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<tr>
<td>B. New Definition</td>
</tr>
<tr>
<td>C. Adding LTC to the risks of Art. 3</td>
</tr>
<tr>
<td>D. Adding a list of LTC benefits</td>
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<tr>
<td>E. LTC benefits granted as own rights</td>
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<tr>
<td>F. All LTC benefits coordinated in the same way</td>
</tr>
<tr>
<td>G. Special rules for carer’s benefits</td>
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</table>
Ways to solution under sickness logic

H. AC Decisions + add. clarifications by AC

Clarification in Reg. 883/2004

I. Add. provisions in Chapter 1

J. Rewrite in new Chapter

New Ways to solution

LTC benefits in cash by MS of residence if no such benefits in comp. MS

K. With reimbursement

L. Without reimbursement

Competence of MS of residence

M. Without reimbursement

With reimbursement

N. All benefits

O. Only benefits in kind

P. Other cost sharing

Competence of MS of residence

Q. Without supplement

With supplement

R. Supplement by comp. MS

S. Supplement by other MS [da Silva]

T. Supplement to avoid von Chamier

U. Coordination in the same way as family benefits
It should first be repeated that we have not examined all the options which are possible, but a selection taking into account the previous work of trESS on this issue and the mandate of the EC for this report.

1. The different options

To help the decision maker, each option (numbered in alphabetic order) is further explained in the following separate chapters showing the pros and cons.

Taking into account the mandate received the following options have been elaborated:

- Should the status quo remain as it is [Option A]? This is the benchmark for all the other options examined further on. Therefore, the other options will be evaluated as better as or worse than the status quo.
- Should we introduce new horizontal elements, either directly into Regulations (EC) No 883/2004 and No 987/2009 or in other documents such as decisions by the AC which could apply to any way of coordination further examined (horizontal options – these can be chosen one by one independently from each other)?
  - Should we insert a new definition into Regulation (EC) No 883/2004 [Option B]?
  - Should we add LTC benefits to the list of benefits listed in Article 3 of Regulation (EC) No 883/2004 [Option C]?
  - Should we add a list of the LTC benefits to be coordinated as LTC benefits either to the Regulations or e.g. by way of a decision by the AC [Option D]?
  - Concerning the persons covered, should we stick to the logic of the coordination as sickness benefits and deal with the persons who have rights on their own and other persons who derive rights from them or should we switch towards a concept of only own rights [Option E]?
  - Should all LTC benefits be coordinated in the same way or should we keep the current situation under which some of the benefits are also coordinated as e.g. family benefits, invalidity benefits, or benefits for victims of accidents at work and occupational diseases [Option F]?
- Should we include special rules for benefits granted not to the person in need of care but to the carer or should all these benefits be coordinated in the same way [Option G]?
- Should we further develop the existing way of coordination and introduce new elements related to the specific coordination of LTC benefits (for all of the following options one or more of Options B to G can be chosen and combined)? These different new ways of coordination could be summarised into the following packages:
  - The first package of such options is quite conservative as it stays within the logic of coordination of sickness benefits, but makes some additions compared with the status quo:
    - Should we stick to the coordination as sickness benefits but add explanatory elements such as decisions by the AC or new guides [Option H]?
    - Should we include additional provisions which keep the philosophy of coordination as sickness benefits either into the existing Title III, Chapter 1 of Regulation (EC) No 883/2004 (Sickness Chapter) [Option I] or into a new chapter based on the principles of the coordination of sickness benefits [Option J]?
  - The next package already takes it a step further and adds a new entitlement if the coordination as sickness benefit would not give any entitlement to LTC benefits in cash:
    - Should we add a new safeguard provision which helps if we keep the coordination under the sickness philosophy in situations where the MS of residence provides only LTC benefits in cash while the competent MS provides only LTC benefits in kind (total loss of any entitlement under the sickness rules); should such a
provision include the reimbursement by the competent MS of such benefits in cash granted by the MS of residence [Option K] or not [Option L]?

- Or, should we switch towards a new coordination principle under which the MS of residence is always competent to grant all LTC benefits in kind and in cash (it should be added that these options are not all mutually exclusive: e.g. the options concerning reimbursement could be combined with the options concerning the supplement)?
  - Should this be without reimbursement by another MS which might be competent to grant benefits under the Sickness Chapter [Option M]?, or
  - Should there be special rules for reimbursement, e.g.
    - reimbursement of all benefits in cash and in kind [Option N],
    - reimbursement of benefits in kind only [Option O], or
    - other kinds of reimbursement, e.g. cost sharing [Option P]?
  - Should another MS than the MS of residence be obliged to grant a supplement, which could mean the following:
    - no, no supplement is necessary [Option Q];
    - the MS competent to grant benefits under the Sickness Chapter should grant a supplement [Option R]; or
    - another MS should grant a supplement (e.g. the MS where a voluntary insurance for the risk of LTC is maintained after the end of the competence of that MS – in accordance with the da Silva Martins ruling – C-388/09) [Option S]?
  - Should we add special rules for LTC benefits in kind received outside the competent MS to avoid the negative effects of the von Chamier-Gliszinski ruling – C-208/07) [Option T]?

- Finally, we could opt for a totally different way of coordination as family benefits, where several MSs could be competent at the same time and we have only to determine which MS is competent by priority and which MS is only competent to grant supplements as secondarily competent if necessary [Option U].

2. The aspects evaluated

The different aspects we analysed for each of these options were the following ones: First, we tried to make links to perhaps more elaborated descriptions in previous trESS reports, as the huge amount of different options we had to examine does not allow for detailed descriptions and explanations. Second, we looked into the replies from the MSs in the AC to questionnaire A.C. 18/12 to find out about the MSs' attitude towards the different options (see also Part I).

Finally, we evaluated each option taking the following aspects into consideration:

- **Clarification**: Here we looked into the question whether the option is clear, easy to understand and transparent. From our point of view, the most important question with regard to clarification is whether persons concerned know in advance and without problems what their rights (and obligations) are. Naturally the option should be clear for institutions as well. However, as institutions would be involved in any case, also in complex legal situations, this does not weigh that strongly.

- **Simplification**: For this second aspect, we examined whether the solution is simple or complex. It was sometimes difficult to distinguish between this aspect and the first one, but also between the one on administrative burden. Therefore, these three aspects have to be seen as related to each other. It also has to be mentioned that any new way of coordination – as simple as it might seem if used for the first time – would also cause problems during a period of transition from the existing coordination towards the new coordination. We have, however, no longer mentioned this in our analysis of the different options. So even if the transition might be complex, non-transparent and arduous for the institutions we have
not changed our evaluation if the option itself – looked at in an abstract way – has to be regarded as positive compared to the status quo.

- **Protection of rights:** A very important issue is whether the rights of the person concerned are well protected. This means we had to check if really all benefits which could be claimed without a cross-border situation can be granted or if the person loses entitlements (and thus could in the worst case be left without any entitlements although the MSs involved know such benefits).

- **Administrative burden and implementation arrangements:** Here we deal with the institutions: is it easy to administer the option without large additional processes or do we have to set up new processes; does it need additional flows of information and does information have to be exchanged regularly; will institutions have to set up new implementing arrangements to put the coordination into practice? The mere fact that e.g. under EESSI new SEDs or flows will become necessary does in itself not mean that an option adds to the administrative burden, because this will be a standard situation in the future if we change the existing ways of coordination.

- **No risk of fraud or abuse:** It also has to be examined if the option favours situations where the persons concerned could easily influence and manipulate their situation in such a way that they receive more benefits than they would otherwise be entitled to. This is especially so if two MSs have to grant LTC benefits and if it cannot be excluded that they do not know about the other MS granting such benefits (the person concerned does not report the benefits received). We will also refer to cases where a person could try to influence the benefits he or she wants to receive (e.g. by transferring the residence to the MS with the highest benefits in question), which is sometimes called ‘benefit tourism’. Nevertheless, it has to be made clear from the beginning that this is not something which is evaluated as ‘fraud and error’, as these are rights (free choice) the person can exercise. Therefore, these aspects have to be taken into account under the next aspect, ‘fair burden sharing’, because situations where persons are likely to take such steps in order to claim the best benefits could require the financial participation of the other MSs involved.

- **Fair burden sharing:** The burden sharing between the MSs involved is an issue which is very difficult to evaluate. The ‘fair burden sharing’ between MSs also largely depends on the system the MSs apply. It could be said that MSs which for example have to reimburse benefits which their national legislations do not know are unfairly burdened. MSs which are obliged to grant all the benefits which they would have to grant already under national legislation (e.g. in residence based tax financed schemes for all residents) are not to be regarded as burdened. On the other hand, MSs with insurance based schemes could be regarded as burdened if they were to be obliged to grant/reimburse benefits for persons which are not insured there and thus also do not pay any contributions towards these MSs’ schemes. Any option evaluated by us could easily be regarded as burdening one of the MSs involved. Therefore, we had to take some additional assumptions: we have always considered it positive (with regard to fair burden sharing) when the MS of residence has to grant to all persons resident on its territory all its benefits; should this MS have an insurance based scheme, it could e.g. take steps towards fairer burden sharing such as the introduction or offering of a voluntary affiliation of the persons concerned.

### 3. ‘Performance’ indicators

We have also developed **indicators** which should help to find out the ‘performance’ of an option at a glance, e.g. whether it is appropriate to safeguard the protection of rights, whether it is easy to administer, whether it leads to a fair burden sharing etc. For all evaluation the status quo will serve as a benchmark, as the decision maker needs to know if an option is better or worse than the situation we are confronted with today. A ‘+’ indicates that a solution is better; a ‘-’ that it is worse.
than the status quo; and if an option does not change the existing situation, if it is neutral or if it is not clear what impact it might have exactly with regard to the aspects evaluated we will use ‘±’.

It furthermore has to be said that these marks (‘+’, ‘−’ or ‘±’) were not easy to agree on within the group. Our discussion of these marks always involved a very subjective element, as each author had a slightly different approach towards giving the marks. Consequently, these evaluations have to be regarded as not at all final or beyond any doubt, but we have decided to keep them nonetheless, as they might be helpful (but have to be read and interpreted with the necessary caution).

We also have to admit that these values are very rough and that they could be much more elaborated and refined. As an example we could cite the aspect ‘protection of rights’: if we e.g. look at the options in which the MS of residence is competent to grant all its LTC benefits, one could argue that – compared to the status quo – the option without a supplement is already better [Option Q], the option with a supplement granted by the competent MS is even better than the former [Option R] and the option with the additional ‘von Chamier’ supplement is the best [Option T]. In fact, that could justify proceeding from the indicator ‘+’ to indicators ‘+’, ‘++’ and ‘+++’. However, we think that such a detailed system of indicators would make it very difficult to evaluate all the different options in a systematic and coherent way and that the reader would be tempted to look only for the ‘+++’ options forgetting that the others might also have advantages which should not be neglected (especially in interaction with the other aspects). Therefore, we have refrained from such a complex system and have opted for the more simple way of using only the three indicators which guarantee a realistic and easily understandable evaluation.

The different aspects were not weighed. The protection of rights, for example, has therefore been evaluated in the same comprehensive way as, for example, simplicity or fair burden sharing. This is very important as the decision taken by the decision maker will always depend on an underlying political weighing of the different objectives. That is why the final result will be different if, for example, the protection of citizens’ rights or simplification is considered the most important.

Taking into account the different options mentioned at the beginning of this part, the aspects evaluated and the possible combinations of the various options, the following matrix can be drawn. As an aid for the decision maker, the results of our evaluation can be entered into that matrix (which will be done in our conclusions). Should the decision maker prefer other results of his or her evaluation, these could easily be inserted into the following blank matrix.
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<td>A. Leaving the status quo</td>
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<td>Benchmark</td>
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**Horizontal options**

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<td>B. New definition</td>
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<td>C. Addition Art. 3</td>
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<td>D. List of LTC benef.</td>
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<td>E. Only as own rights</td>
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<td>F. All benef. one coord.</td>
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<td>G. Special rules carer's benef.</td>
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**New coordination with sickness logic**

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<td>H. Sickness Chapt. + clarif.AC</td>
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<td>I. Sickness – in Chapter 1</td>
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**New coordination benefits in cash by MS of residence if no benefits in cash in competent MS**

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<td>K. MSoR + reimb.</td>
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<td>L. MSoR no reimb.</td>
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**New coordination competent is always MS of residence**

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<td>M. no reimb.</td>
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<td>N. + reimb. all benef.</td>
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<td>O. + reimb. benef. in kind</td>
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<td>P. + other reimb.</td>
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<td>R. + suppl CMS</td>
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<td>S. + suppl other MS</td>
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<td>B – G, M – P, T</td>
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<td>T. + Chamier suppl.</td>
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**New coordination as family benefits**

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<td>U. Coord. as family benef.</td>
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1. Clarification
2. Simplification
3. Protection of rights
4. Administrative burden and implementation arrangements
5. No risk of fraud and abuse
6. Fair burden sharing
7. Could be combined with other options
8. Member State of residence.
B. Examination of the different options

1. Option A: Keeping the status quo

A short description of the option: Today, LTC benefits examined by the CJEU have to be regarded as falling under the Sickness Chapter of Regulation (EC) No 883/2004. Only with regard to very few elements of LTC benefits under national legislation (e.g. mobility components) is another way of coordination (e.g. under Article 70 of Regulation (EC) No 883/2004) justified; there is neither a definition in the Coordination Regulations nor in the decisions by the AC; Article 34 of Regulation (EC) No 883/2004 contains a provision to avoid overlapping. Some LTC benefits are coordinated under chapters of Regulation (EC) No 883/2004 other than the Sickness Chapter.

One solution could be to change nothing and keep the coordination of LTC benefits as it stands today. In principle, it is not necessary to repeat all the challenges which result from the existing situation; this has already been done at several occasions (see e.g. the references to various trESS activities below). Neither is an evaluation of this status quo necessary – if it were positive we would not have to conduct this search for other options. As said before, the status quo is the benchmark for any other option proposed in this report. Therefore, in the evaluation we will include some of the elements already elaborated in previous reports to attribute them to the relevant aspects. The mark will, nevertheless, always be ‘±’ as it is the benchmark.

Reference to previous trESS reports: Part II of the trESS Think Tank report on coordination of LTC benefits (A.C. 610/11); Part II of the trESS Think Tank report on the analysis of selected concepts (A.C. 149/11).

The attitude of the MSs (Question 6 of questionnaire A.C. 18/12): Three MSs are in favour of not changing the existing system.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

± Clarification:
The existing system is not simple. The concept of own rights and derived rights, the distinction between benefits in kind and benefits in cash, the situation of the carer for which – at least with regard to some benefits – the same competences should apply as for the person in need of care, and the application of different chapters of Regulation (EC) No 883/2004 by various MSs make the existing system very complex.

± Protection of rights:
Possible rights under the legislations of the MSs concerned are not sufficiently protected. The CJEU has already added some elements to protect the rights of the persons concerned within the Sickness Chapter (e.g. case C-388/09, Da Silva Martins). Nevertheless, in many cases
persons concerned cannot claim benefits, e.g. in their MS of residence because another MS is competent for benefits in cash (and this MS does not have any such benefits). So it might happen that no benefits at all are granted although all MSs involved have such benefits (the competent MS having only benefits in kind). Therefore, the existing system is not able to protect the rights in all aspects.

**Administrative burden and implementation arrangements:**
The existing system is burdensome for institutions. Especially with regard to Article 34 of Regulation (EC) No 883/2004 many flows of information are necessary. Implementing arrangements and the exchange of information are very complicated because MSs very often disagree on what an LTC benefit is. As also LTC benefits have to be reimbursed this adds to the complexity of procedures.

**No risk of fraud or abuse:**
There is some risk of fraud and abuse. As moving to another MS does not automatically open entitlement to all LTC benefits (especially the benefits in cash) there is no high risk of ‘social tourism’. On the other hand, granting benefits (in kind) at the expense of another MS, which cannot always control the necessity of such benefits, could favour benefits being granted which are not really tailored to the needs of the persons concerned. Beneficiaries could, in their MS of residence, try to claim benefits (especially in kind) in addition to LTC benefits in cash exported from the competent MS without mentioning the benefits already received. It is very difficult and sometimes even impossible to reclaim benefits which have been unduly granted.

**Fair burden sharing:**
The existing situation has pros and cons. Article 34 of Regulation (EC) No 883/2004 tries to contribute to fair burden sharing. Nevertheless, in many situations an unfair distribution of burden could be found. MSs which do not have LTC benefits at all have to reimburse them if granted in the MS of residence; the same applies to MSs which have decided to only grant benefits in cash. MSs of residence which have decided to grant benefits in cash for the entire population do not have to grant these benefits for persons for whom another MS is competent.
Introductory remarks on Options B to G
Horizontal options which could be added to any of the options of new ways of coordination

These 6 options have to be understood as a package of different possibilities which are of a horizontal nature. That means that they can be combined with the following packages of new ways of coordination (Options H to J, K and L, M to T or U) or could also be inserted without any of these further options. They could be inserted all together or only selected ones could be inserted.

2. Option B: A new definition

A short description of the option: Today neither the Coordination Regulations nor AC decisions on LTC benefits provide a definition. Only the definition of benefits in kind for the purpose of sickness, maternity and paternity (including LTC benefits) was inserted in Article 1 (va) of Regulation (EC) No 883/2004 by Regulation (EC) No 988/2009 and subject to an interpretation by the AC in its Decision No S5 in 2009. A definition of LTC benefits is being developed on an ad hoc basis by the CJEU and is not yet settled. LTC benefits are linked to sickness benefits, but at the same time are not sickness benefits stricto sensu.

It could be argued that agreement (among the MSs) or further decisions (by the CJEU) on which benefits are LTC benefits, thus making them subject to the coordination mechanism, is essential for a proper application of any social security coordination rules. A new and clear definition would remove the uncertainty MSs are facing today in the coordination of LTC benefits.

Reference to previous trESS reports: Part I, Chapter 1 and Part III, Chapter 3.1. of the trESS Think Tank report on coordination of LTC benefits (A.C. 610/11); Part II, Point 1.3 of the trESS Think Tank report on the analysis of selected concepts (A.C. 149/11).

The attitude of the MSs (Questions 2 and 3 of questionnaire A.C. 18/12): Based on the definition proposed in the trESS Think Tank report on coordination of LTC benefits (see also Annex 1), as many as 21 MSs of those who replied to the questionnaire opted in favour of (or at least did not object to) a new definition. Many would prefer its insertion in Article 1 of Regulation (EC) No 883/2004. Some MSs agreed completely with the proposed definition, while others proposed broader or narrower definitions or further clarification of certain notions contained in the definition.

Some MSs would prefer a clear delimitation of regular sickness benefits and especially of social assistance. Some MSs for example proposed both benefits in kind and benefits in cash to be covered by the definition and some would prefer a specification of the abstract notion of ‘over an extended period of time’, although in concrete cases the duration of LTC benefits should be examined and set individually. Also other notions like ‘considerable help’ should be further specified. Furthermore, the definition should clarify whether only benefits to the recipient or also benefits to carers (see also Option G) are considered as LTC benefits. Only LTC benefits provided for by the ‘legislation’ of the MSs should be covered, hence excluding optional benefits.
Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

**+ Clarification:**
There is indeed clarification. A clear definition of LTC benefits would make it easier for MSs and citizens to know which benefits are subject to social security coordination rules. A new definition would lead to more legal certainty and transparency compared to the current legal situation. Even more clarity would be achieved if the definition were to be coupled with a list enumerating LTC benefits (Option D) for each MS. This would be required especially if no comprehensive definition could be agreed upon (like the one proposed by trESS) and a very basic definition with little legal meaning were to be adopted. Yet, it also has to be mentioned that the definition might not be sufficient as some MSs might still be tempted to regard their specific benefits not covered by that definition. Therefore, more clarity could be achieved by linking this definition to an obligation of notification (Option C), which would urge MSs to also show their decisions concerning their benefits to the public.

**± Simplification:**
The simplification is partial (but not sufficient to consider it as positive compared to the status quo). The new definition as such says nothing about the way LTC benefits should be coordinated, i.e. under one (within or outside sickness) chapter or several chapters. However, there would to a certain extent be simplification if MSs were aware of LTC benefits which are subject to social security coordination in their own country and in other MSs. This option will be closely linked to the question whether all LTC benefits are coordinated under one scheme or whether different ways of coordination will still be allowed under different branches (Option F). This question has to be dealt with under the definition, which could make it quite complex.

**+ Protection of rights:**
The protection of rights would be partially improved (enough to see it as positive compared to the status quo). The actual receipt of benefits in principle depends on the applicable coordination rules to be agreed on for the LTC benefits. However, it does contribute to a better protection of rights in the sense that there is more legal certainty about which LTC benefits are coordinated and could also be claimed in cross-border situations.

**± Administrative burden and implementation arrangements:**
With a new definition there would be little doubt which LTC benefits have to be coordinated. This additional clarity would, however, not make the administration of LTC benefits and the implementation of coordination rules easier. Nevertheless, if more LTC benefits, especially benefits from distinctive social security branches, would be subject to coordination (because there is no doubt that also they have to be regarded as LTC benefits – contrary to today’s practice), more institutions might be involved (which could make the coordination even more complex than today). A new definition says nothing on the actual coordination rules. Shaping these rules would be much more influential in (easier or more difficult) implementation arrangements.

**+ No risk of fraud or abuse:**
A clear and comprehensive definition would be better than the status quo, as additional clarifications will always make the legal situation clearer for the persons concerned and for the institutions (unclear legal situations are always a possible incentive for abuse and fraud). It is true that more substantive coordination rules for LTC benefits might have a greater impact on (enabling or preventing) fraud and abuse, but we think that this aspect of the
advantages of a clearer legal situation also with regard to the combatting of fraud and abuse should not be underestimated.

**Fair burden sharing:**
It is not easy to evaluate whether a new definition has any impact on fair burden sharing, so we have regarded this aspect as being neutral compared to the status quo. Due to the diversity of LTC benefits, some MSs would have to coordinate benefits which they do not today. Fair burden sharing would depend on actual coordination rules, among others relating to applicable legislation, (non-)exportability of certain benefits and possible reimbursement provisions.

3. **Option C: Adding reliance on LTC to the risks of Article 3 of Regulation (EC) No 883/2004**

**A short description of the option:** Despite the fact that rulings on LTC benefits were first made by the CJEU in 1998 (C-160/96, *Molenaar*) and 2001 (C-215/99, *Jauch*), before Regulation (EC) No 883/2004 had been passed, LTC benefits/schemes are not mentioned in its Article 3. This Article determines the (traditional) branches of social security covered by the material scope of Regulation (EC) No 883/2004.

However, both above mentioned CJEU cases are recognised in Recital 24 of Regulation (EC) No 883/2004, LTC benefits in kind are mentioned in Article 1 (va), and Article 34 contains rules on the prevention of overlapping of LTC benefits. Hence, (some of) the LTC schemes/benefits are already today covered by the material scope of Regulation (EC) No 883/2004.

Nevertheless, it would make a difference if LTC benefits were explicitly mentioned in Article 3 of Regulation (EC) No 883/2004. MSs have an annual obligation to notify the EC in writing of the legislation and schemes referred to in Article 3, and to these notifications the EC has to give the necessary publicity. The necessity of adding LTC benefits to Article 3 would be even more express if new coordination rules (within or outside of the Sickness Chapter) were to be adopted.

**Reference to previous trESS reports:** Part IV, Chapter 2.1. of the trESS Think Tank report on coordination of LTC benefits (A.C. 610/11).

**The attitude of the MSs** (not explicitly asked, but replied under Questions 6 or 7 of questionnaire A.C. 18/12): Two MSs explicitly opted for the solution of adding LTC benefits to Article 3 of Regulation (EC) No 883/2004. None of the other replying MSs expressed their view on this topic and none were explicitly against this solution (see also Annex 1).

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

**Clarification:**
There is indeed clarification. As mentioned above, according to Article 9 of Regulation (EC) No 883/2004 MSs have an annual obligation to notify the EC in writing of the legislation and schemes referred to in Article 3 and this has to be published in a way in which the necessary publicity is safeguarded. If LTC benefits were to be mentioned in Article 3 of the Regulation, e.g. as a new section (k) of Paragraph 1, the notification duty of the MSs would stretch to the legislation stipulating LTC benefits. This would very much contribute to legal certainty and transparent legislation. On the other hand, it might depend on the preferences/discretion of the MSs which legislation would be subject to notification and which not. Therefore, it would in the end be up to the CJEU to decide on every individual benefit (but this cannot take away the overall positive aspects).
Simplification:
There is no real simplification (therefore, we have regarded this option as neutral compared to the status quo), since the listing in Article 3 of Regulation (EC) No 883/2004 as such says nothing about the way LTC benefits should be coordinated. Nevertheless, it might already be a small simplification for administrative purposes, if MSs were certain which LTC benefits are subject to coordination rules.

Protection of rights:
Mentioning LTC benefits in Article 3 of Regulation 883/2004 would only partially improve the protection of citizens’ rights. The actual receipt of benefits depends more on the applicable coordination rules to be agreed on for the LTC benefits. Nevertheless, it might contribute to a better protection of rights, since there would be more certainty about which LTC benefits are coordinated and could also be claimed in cross-border situations. This positive aspect cannot be underestimated, so that we have decided to see this option as better than the status quo.

Administrative burden and implementation arrangements:
This option would in itself not change anything compared to the status quo (therefore it has to be seen as neutral). Expressly mentioning LTC benefits under the material scope of Regulation (EC) No 883/2004 and taking into account the notification duty of the MSs, there would be little doubt which LTC benefits have to be coordinated. In the end, this could lead to a situation where the administration of LTC benefits and the implementation of coordination rules would be a little bit easier. However, if more LTC benefits, especially benefits from distinctive social security branches, would be subject to coordination, more institutions might be involved. Anyhow, placing LTC benefits in Article 3 (1) of the Regulation as such says nothing about the coordination rules applicable to LTC benefits. Shaping these rules would have a much greater impact on (easier or more difficult) implementation arrangements.

No risk of fraud or abuse:
An insertion of the risk into Article 3 of Regulation (EC) No 883/2004 would be better than the status quo, as additional clarifications will always make the legal situation clearer for the persons concerned and for the institutions (unclear legal situations are always a possible incentive for abuse and fraud). It is true that more substantive coordination rules for LTC benefits might have a greater impact on (enabling or preventing) fraud and abuse, but we think that this aspect of the advantages of a clearer legal situation also with regard to the combatting of fraud and abuse should not be underestimated.

Fair burden sharing:
It is not easy to evaluate whether an inclusion of LTC benefits in Article 3 (1) of the Regulation has any impact on fair burden sharing, so we have regarded this aspect as being neutral compared to the status quo. Due to the diversity of LTC benefits, some MSs would have to coordinate benefits which they do not today. Fair burden sharing would depend on existing coordination rules, among others relating to applicable legislation, (non-)exportability of certain benefits and possible reimbursement provisions.

4. **Option D: Adding a list of LTC benefits**

A short description of the option: Today, it is not very clear which benefits are considered as LTC benefits for the purposes of social security coordination. Article 34 (2) of Regulation (EC) No 883/2004 stipulates the duty of the AC to draw up the list of the LTC benefits in cash and in kind. So
far, only the ‘yes or no list’ was composed (in May 2010), which confirms whether in the respective MSs benefits in kind and in cash exist or not. The question is whether such a list could be considered as fulfilling the obligation that arises from Article 34? It is not a list of LTC benefits, since it does not mention any benefits at all. Moreover, such a limited list might have been correct at the time it was drawn up, but its correctness might be doubted at present. For example, for Portugal (PT) it is marked ‘none’ for both benefits in cash and benefits in kind. However, LTC benefits which are subject to social security coordination do exist in PT, which became clear after the judgement of the CJEU in the case C-388/09, da Silva Martins.

It seems that a more detailed list of LTC benefits is required already under the existing legislative framework. MSs would have to agree on such a list within the AC. However, the list under Article 34 might be limited only to LTC benefits which are linked to sickness benefits, since it is placed in the Sickness Chapter. Other LTC benefits linked to pensions, accidents at work or occupational diseases, or family benefits might be left out.

If new rules for LTC benefits would be agreed upon, the list of LTC benefits would have to be more comprehensive in order to cover all LTC benefits subject to coordination rules. Such a list could be agreed on within the AC, but it could also be inserted in Regulation (EC) No 883/2004 in the form of an annex.

Reference to previous trESS reports: Part III, Chapter 3.1. of the trESS Think Tank report on coordination of LTC benefits (A.C. 610/11).

The attitude of the MSs (Question 6, but replied under Questions 6 or 7 of questionnaire A.C. 18/12): As many as 13 of the replying MSs opted for a more detailed list of LTC benefits. Some advocated such a list in relation to the definition of LTC benefits (or other possible solutions) and some in relation to the application of the existing Article 34 of the Regulation. Some MSs pleaded for a (non-exhaustive) list of LTC benefits in (an annex of) Regulation (EC) No 883/2004. None of the MSs were explicitly against listing the LTC benefits.

Many MSs commented on the listing of possible LTC benefits in their respective countries, not only from a national, but also from the coordination perspective (mentioned in Annex 2 as a special ‘Addendum’). See also Annex 1 concerning the different attitudes of the MSs.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
  There is clarification. A list of LTC benefits would very much contribute to legal certainty and clarity about which benefits are covered by the social security coordination mechanism. The exact drawing up of the list depends on the actual coordination rules. The list might be limited to the Sickness Chapter (Article 34 of Regulation (EC) No 883/2004) or be more comprehensive and cover all LTC benefits. In the latter case it might be determined internally which benefits are coordinated under which chapter, if the solution to coordinate LTC benefits under various chapters would be adopted (see also Option F). If not limited to Article 34, this listing could be coupled with a definition of LTC benefits under Article 1 (Option B) and with explicit mentioning under Article 3 of Regulation (EC) No 883/2004 (Option C).

± Simplification:
  Listing LTC benefits would in itself not change the existing system of coordination, so that this aspect has to be regarded as neutral. The option could, to a small extent, abolish the uncertainty that exists today, and hence simplify coordination to a certain extent. However,
the (non-)simplicity of coordinating LTC benefits not only depends on listing them, but also on the actual coordination rules. In this respect the impact assessment of other options, e.g. whether coordinating LTC benefits under one (new) chapter or under distinctive chapters, with possible new rules should be considered as well. So, this option clears up doubts. Still, looking at the ‘endless’ list of benefits enumerated in Annex 2, one could also say that such a list could become very complex, which could easily counterbalance the positive aspects.

Protection of rights:
Composing a list of LTC benefits would positively contribute to the protection of citizens’ rights. There would be no doubt about which benefits can be claimed in a cross-border situation if the social risk of reliance on LTC would occur. Protection of rights also depends on the concrete coordination rules to be agreed on for LTC benefits.

Administrative burden and implementation arrangements:
A list would not change the coordination; therefore, it would not add administrative burden compared to today’s practice (therefore this aspect has to be regarded as neutral). Changes in the way of coordination would have a much bigger impact. But, writing and maintaining the list would be burdensome for the MSs, which also has to be mentioned, although this is not directly relevant for that aspect. Listing LTC benefits could initially involve an increased workload. Composing this list might require an agreement of the MSs, which could be reached either in the AC (e.g. if the list is limited to Article 34) or by the legislative bodies (e.g. if it is inserted as an annex to Regulation (EC) No 883/2004). After confirming the list of LTC benefits some transitional difficulties might be expected, since LTC benefits which are at present not subject to social security coordination could be listed and would consequently have to be coordinated. In countries with many distinctive LTC benefits, which fall under the responsibility of various social security institutions, a new liaison body for the coordination of LTC benefits might be required. However, it is believed that after this initial/transitional period, a list of LTC benefits would result in easier administration, without any doubts which benefits are coordinated. A marginal administrative burden would remain as the list would have to be updated regularly. The administrative burden would be more dependent on the actual coordination rules to be adopted.

No risk of fraud or abuse:
A clear list of LTC benefits would be better than the status quo, as additional clarifications will always make the legal situation clearer for the persons concerned and for the institutions (unclear legal situations are always a possible incentive for abuse and fraud). It is true that more substantive coordination rules for LTC benefits might have a greater impact on (enabling or preventing) fraud and abuse, but we think that this aspect of the advantages of a clearer legal situation also with regard to the combatting of fraud and abuse should not be underestimated. Nevertheless, it also has to be seen that if more LTC benefits were listed and coordinated, more possibilities for a social tourism could be opened up (as the persons concerned could more easily find out which benefits could be claimed). However, it has to be recalled that such behaviour must not be regarded as fraud or abuse. All in all, with clear coordination rules and proper implementation, the risk of fraud or abuse could be minimised.

Fair burden sharing:
It is difficult to assess the impact of a list of LTC benefits on fair burden sharing. Therefore, we could not say if it is better or worse than the status quo. This might be more influenced by other options of actual coordination rules to be applied. However, it might contribute slightly to fair burden sharing, if all MSs were to coordinate all LTC benefits (which would be listed), which some of them do not do today.
5. **Option E: LTC benefits granted as own rights**

**A short description of the option:** Under the sickness logic LTC benefits can be granted as ‘own’ rights for a person who opens the rights (e.g. a person subject to the legislation of a MS because of the exercise of gainful activities, a person receiving a pension or pensions, or an inactive person subject to the legislation of the MS of residence) and as derived rights for the family members of such a person. Therefore, a person could for example be subject to the legislation of a MS A as an inactive person but receive LTC benefits in cash from another MS B where this person’s partner is covered because of the exercise of an activity (the scenario in CJEU case C-286/03, *Hosse*). Under Option E this is changed: only the MS which is really competent for the person concretely in need of care will have to grant (or, as the case may be, reimburse) LTC benefits. So, under this option – if transformed in a very radical way – there would no longer be any derived rights (if the MS competent for the person in need of care under Title II of Regulation (EC) No 883/2004 would exclusively be declared competent to grant the LTC benefits provided under its legislation). More in the logic of sickness benefits would be a priority rule which declares own rights as superior to derived rights (an inversion of the rules currently included in Article 32 (1), second sentence of Regulation (EC) No 883/2004). In principle, as family members are usually inactive persons this would make the MS of residence competent to grant its LTC benefits; this would especially have an impact on LTC benefits in cash.

**Reference to previous trESS reports:** Part II, Chapter 14 and Part III, Chapter 3.2. of the trESS Think Tank report on LTC benefits (A.C. 610/11)

**The attitude of the MSs:** Only one MS favoured this option explicitly.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

- **Clarification:**
  Taking into account the pros and the cons of this option, the negative aspects compared to the status quo are dominant. To start with, it has to be said that the level of clarification will also depend on the way of coordination which is chosen. Today, under the Sickness Chapter the distinction between own rights and derived rights does not cause many problems with regard to clarity. Nevertheless, from a citizen’s point of view it is very often not understood why benefits which are provided for all residents cannot be claimed (because the person concerned has to be regarded as a family member of someone else subject to the legislation of another MS). Therefore, it could be said that, on the one hand, this option adds to clarity. On the other hand, this option will lead to different entitlements within one family, which is also difficult to explain to the persons concerned. If a husband works as a frontier worker in MS A and is in need of care (e.g. as a blind person) he receives these benefits from MS A while his wife, who resides in MS B and who might also be blind, would under this option receive LTC benefits from MS B, as this MS is competent for her. Such a situation gets even more complex if MSs still have problems distinguishing between traditional sickness benefits (which remain coordinated under the derived rights principles) and LTC benefits.

Switching to this principle would also necessitate a clarification of which MS is competent for pensioners. Is it under the principle of applicable legislation always the MS of residence or do we keep the principles under the existing Sickness Chapter, meaning that the MS responsible for reimbursing ‘traditional’ sickness benefits in kind granted in another MS has to be regarded as competent? A lot will depend on this decision, also with regard to simplification. Altogether, it can be said that this solution would be unclear compared to today’s situation.
Simplification:
Comparing the pros and cons of this option, the negative aspects seem to be dominant. In principle, if distinguishing between own and derived rights is no longer required, it could at first glance be said that this is a more simple solution. However, if this solution would include an inversion of the existing priority rules (which from our point of view would be necessary), thus leaving derived rights under the legislation of the MS competent for any person opening rights for his or her family members if no benefits are provided under the legislation which might give own rights for the person in need of care, this option is much more complex than the existing coordination.

Protection of rights:
This option would have many consequences for the persons concerned, some of which would mean a better situation, and some of which a worse situation compared to the status quo. It cannot be said which of these aspects are dominant. The main difference will be visible in relation to benefits in cash (as under all options additionally chosen, benefits in kind will be granted by the MS of residence with or without reimbursement – which only makes it a question of burden sharing between MSs).

As many MSs have constructed their LTC schemes on the basis of individualised own rights, it could be said that this option is best suited from a social policy point of view as this logic can also be applied in cross-border situations. It has the big advantage that the MS competent for a person always has to grant its LTC benefits in cash. So, for example, the MS of residence of an inactive person in need of LTC benefits has to grant its LTC benefits in cash to that person, whereas today such a person could be deprived of these benefits if another MS were competent due to the exercise of a gainful activity of another family member there. Thus a result is achieved which is also valid in relation to other risks related to LTC, e.g. invalidity (where only MSs which were competent for the person concerned have to grant benefits and not any other MS which might be competent for a family member of that person). Another issue is that in modern social security schemes own rights are more appreciated than derived rights taking into account the changed economic and social situation of family members.

Nevertheless, it could take away rights which exist today from a MS which is not competent for the person in need of LTC. It could also have a negative effect for MSs which have connected their LTC schemes to sickness insurance and are thus already under national legislation acquainted to own and derived rights. Yet, from our point of view this should not distract us from the fact that today many family members cannot benefit from LTC benefits in cash which could be granted under the legislation they are subject to, which very often is the legislation of the closest relationship of the person concerned. As especially the protection of rights will largely depend on the exact way this priority of own rights will be constructed and as every solution could have pros and cons we decided to regard this aspect as neutral compared to the status quo.

Administrative burden and implementation arrangements:
Again, there are many positive and negative aspects compared to the status quo, so that it is not possible to decide whether the option is better or worse than the status quo. It seems that this solution is slightly easier to administer than today’s coordination. The MS which has to grant the LTC benefits has a closer relationship to the person concerned than any other MS. Up until now inactive persons were the group of persons which could have to claim benefits from another MS than their MS of residence. With regard to these persons the MSs would in many cases no longer have to distinguish between their residents (all residents could receive the LTC benefits without any differentiation – letting aside the situation of
active persons and, depending on the solution chosen, also pensioners, in which case still another MS than the MS of residence would be competent to grant LTC benefits in cash).

The complexity of the whole system of coordination of LTC benefits will depend on the way of coordination chosen. Still, the administration, especially of the MS of residence, could in any case become easier compared to today. Examining persons who reside in another MS will no longer be needed. Nevertheless, MSs which have an insurance based scheme with derived rights will have to come up with a solution for persons who are subject to their legislation but have so far not contributed to their scheme (because such persons are regarded as family members). This would for example require that for such persons a voluntary insurance has to be possible, which might mean the obligation to amend national legislation correspondingly. If this leads to a new rule on priority it could easily become very complex and difficult to administer as it would need extended exchange of information between the MS competent by priority and the MS secondarily competent. Therefore, we have decided to regard this aspect as neutral compared to the status quo.

+ **No risk of fraud or abuse:**
Without any statistical data this is very difficult to assess, but we think that the positive aspects are stronger than the negative ones. On the one hand, it could be possible that it is slightly easier to change the competence of a MS by the person itself than by another person. On the other hand, if the MS of residence is competent to grant the LTC benefits in cash it is easier for that MS to also examine the degree of the need of LTC and to control if the conditions to grant the benefit are still met. Moreover, it is not so likely that a person obscures a benefit from another MS (derived right) when claiming a benefit in the MS of residence as might happen today. It could thus be easier to fight fraud and abuse.

+ **Fair burden sharing:**
As it will be very often the MS of residence of the person concerned which already under the national system has planned to assume the costs for all residents, this in principle seems to be a more balanced solution. This is from our point of view the most essential element. However, for MSs which currently have an insurance based scheme with derived rights this will mean that, although their contributions are calculated in such a way that family members of the insured persons are covered as well, they will no longer have to cover such family members in cross-border situations. On the other hand, they will also have to cover persons which have not been subject to the scheme yet (e.g. by way of a voluntary insurance). Anyhow, these slightly negative aspects cannot, from our point of view, take away the general estimation that it is a better situation compared to the status quo.

6. **Option F: All LTC benefits are coordinated in the same way**

A short description of the option: Today, some LTC benefits are coordinated under other chapters of Regulation (EC) No 883/2004, e.g. as family benefits, benefits for victims of accidents at work or occupational diseases, invalidity benefits or even as benefits listed in Annex X of the Regulation. It could be stipulated that all of these benefits have to be coordinated in the same way (e.g. under the Sickness Chapter (Option H to J) or any new way of coordination (Option K to U).

Reference to previous trESS reports: Part II, Chapters 9 and 15.10 of the trESS Think Tank report on LTC benefits (A.C. 610/11).

The attitude of the MSs (Question 7 of questionnaire A.C. 18/12): 11 MSs opted in favour of such a harmonised way of coordination. Nevertheless, there also were strong wishes to maintain the different ways of coordination as they are (see also Annex 1).
Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

**Clarification:**
There is clarification. If all LTC benefits have to be coordinated in the same way, it is easier for the citizens to understand their entitlements.

**Simplification:**
If all LTC benefits are coordinated in the same way, the existing distinction between the different ways of coordination depending on the systematic point of view of the MSs is abolished and thus the unified coordination becomes much simpler than the status quo.

**Protection of rights:**
Comparing the pros and cons of this option, the positive aspects appear to be dominant. The way chosen for the coordination would be more important for the protection of rights. On the one hand, it must not be forgotten that the coordination under some of the other chapters leads to a better protection as there might be more than one competent MS which has to grant the benefits (e.g. under the Family Benefit Chapter) or as a MS remains responsible to grant the benefit irrespective of the future coverage of the person concerned (under the Accidents at Work and Occupational Diseases Chapter). On the other hand, it is also very important that under this solution everybody would have the same rights. Would it be a solution to even improve the protection of rights by allowing MSs to continue with coordination under other chapters if it is proven that it is more advantageous for the person concerned? Anyhow, the plus in clarity will inevitably also result in a better protection of rights, as it may be said that under today’s uncertainty some rights are not claimed due to lack of knowledge of the persons concerned.

**Administrative burden and implementation arrangements:**
In principle, this is indeed also an option which is easier to administer. This is not questioned by the fact that many different institutions could be involved in granting all the different benefits under one way of coordination. These institutions are not used to cooperate with institutions of totally different branches (e.g. an institution granting family benefits would have to cooperate with a health insurance fund in another MS when applying Article 34 of Regulation (EC) No 883/2004 if this provision is kept). Moreover, they will have problems to understand the logic outside the chapter they usually apply (e.g. if LTC benefits have so far been granted by pension institutions as a supplement to the pension under the Pension Chapter). Therefore, there is a certain risk of wrong application, but this cannot take away the overall positive effect this option could have.

**No risk of fraud or abuse:**
As it may be said that only under one way of coordination control and avoidance of the receipt of undue benefits is easier to achieve, we think that this option could have a positive effect. Anyhow, the way of coordination chosen for LTC benefits would be much more important for this aspect.

**Fair burden sharing:**
As a final decision on this option is not possible today, we cannot decide if it is better or worse than the status quo. From an overarching perspective the option seems to be fair as all MSs have to apply the same principles. Nevertheless, in some cases MSs will be released from the obligation to provide benefits, which may not be easy for them to understand. This could sometimes also apply to entitlements based on contributions paid by the persons...
concerned. Therefore, the aspect of fair burden sharing and the comparison with the situation we have today has to be analysed much further.

7. **Option G: Special rules for carers' benefits**

**A short description of the option:** Because of CJEU case law also some advantages which are not granted to the person in need of care but to the person caring for the former (carer), e.g. free pension coverage, have to be coordinated in the same way as LTC benefits under the Sickness Chapter (CJEU case C-502/01, *Gaumain-Cerri*, C-31/02, *Barth*, and C-299/05, *Commission against European Parliament and Council*). Under this option special rules for carers’ benefits are proposed. As it is a horizontal solution it could be combined with any way of coordination for the LTC benefits granted directly to the person in need of care. However, it has to be clear from the beginning that it will be very difficult to define exactly the carers’ benefits this special coordination regime is applicable to. Annex 2 gives a good overview of what the great variety of such ‘benefits’ could look like (contributions to special branches of social security to safeguard coverage for the carer, allowances to the carer or even real income for the carer which is paid by social security institutions and not the person in need of care). Under this option a carers’ benefit could for example (only) be regarded as gainful income when it reaches the thresholds under the applicable legislation for coverage under that system. Carers’ benefits which do not meet that condition could still be regarded as benefits for the person in need of care and thus be coordinated in the same way as the benefits directly granted to the person in need of care. Or, also for these benefits a special way of coordination could be sought, e.g. competence of the MS which would be competent in case of gainful employment. Situations have to be examined in which two MSs could be competent to grant such benefits (e.g. a person in need of care receives an LTC benefit in cash from MS A which also grants allowances for the carer; the carer cares for this person in MS B which also has such allowances for the carer). Inverse effects could occur as well. Before a new way of coordination is fixed, all different aspects of these situations have to be examined in much more detail. Otherwise the changes and effects could be really disadvantageous for the persons concerned.

**Reference to previous trESS reports:** Part II, Chapter 13 of the trESS Think Tank report on LTC benefits (A.C. 610/11).

**The attitude of the MSs:** Three MSs reported an interest in this option.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

**+ Clarification:**
From a general perspective clear rules on how to treat these benefits could be helpful and avoid today’s unclear situation. But, it seems that without an additional definition of carers’ benefits any new way of coordination would be very difficult to understand. It has to be considered that also today a lot of confusion exists and that in many cases these carers’ benefits are treated as income with regard to the applicable legislation under Title II of Regulation (EC) No 883/2004 and not as LTC benefits.

**Simplification:**
From a legislative point of view, the existing coordination without any special mentioning of carers’ benefits seems to be simpler. Any additional and clarifying new rules for this type of benefits will inevitably add to complexity.
Protection of rights:
It is very difficult to foresee all consequences for the persons concerned, because this also largely depends on the way these benefits are coordinated today. Therefore, it was not possible for us to decide whether this option would be better or worse than the status quo. If we switch to a system where the carer’s situation is decisive to determine the legislation which grants carers’ benefits (the legislation applicable to him or her under Title II of Regulation (EC) No 883/2004), this could have negative effects because the benefit may easily no longer be granted. Let us take the example of a carer who in MS A looks after a person in need of care who only receives a pension from MS B. If MS B grants an ‘allowance’ directly to the carer in addition to LTC benefits in cash to the person in need of care, MS B should, under today’s coordination (if we regard also this benefit as an LTC benefit covered under the Sickness Chapter), also grant this allowance to the carer in MS A. If we introduce the principle that benefits for the carer have to be regarded as remuneration, this could make MS A competent for the carer, and as only the competent MS has to grant benefits, MS B would no longer be competent to grant carers’ allowances to the carer. So, if MS A does not have a corresponding benefit the carer would not receive any benefit.

Therefore, before such a switch is made, it is also very important to decide which MS should be competent to grant such benefits. Should the applicable legislation for the carer be determined after or before this decision is made? However, also the existing way of coordination is not ideal as it could lead to situations where a MS in which the care is actually given does not grant its benefits designed for the carer, because the person in need of care is covered by the legislation of another MS. All these questions and additional provisions to cover all possible situations seem to require a lot of further examination. For this reason, we consider that for the moment there are high risks that the carer and thus also the person in need of care would not receive the benefits which are intended for such a situation from a social policy point of view. Consequently, we think that from today’s point of view an evaluation of this aspect is not possible.

Administrative burden and implementation arrangements:
Any solution which gives the competence to grant benefits to the carer to a MS other than the one which is competent for the person in need of care will make the system very complex. This would necessitate a lot of additional flows of information between the two MSs involved.

No risk of fraud or abuse:
As it is not yet clear how the competence for the carer will be determined exactly, also this aspect cannot be evaluated today. The place where the care is actually performed could be decisive for the benefits to the carer and this place cannot easily be manipulated by the carer. Moreover, only one MS could be declared competent to grant benefits for the carer. For these reasons, the risk of fraud or abuse is quite low.

Fair burden sharing:
As this aspect has to be further analysed as well, we could not decide on it either. Especially if the benefits to the person in need of care and to the carer are considered a package, it is not coherent if they should be provided by different MSs. It could be questioned if a MS has to pay for a person in need of care for whom another MS is responsible. On the other hand, if this is completely divided and the MS responsible for the person in need of care grants its benefits for that person, while the MS where the care is provided is responsible to grant its benefits for the carer, this could easily lead to overcompensation (if both benefits from a social policy point of view have the same objectives). This could lead to the overburdening of some MSs. However, also this has to be further examined before a final evaluation is possible.
Introductory remarks on Options H to J
The introduction of new elements within the logic of coordination as sickness benefits

These three Options have to be understood as a package of different possibilities which try to introduce some new elements into the ways of coordination but keep the logic of the existing coordination as sickness benefits. They are of a horizontal nature. They can be combined with the horizontal options (Options B to G, with the exception of Option E, which seems to be too far from the sickness logic).

8. **Option H: Keeping the coordination as sickness benefits, but adding explanatory elements**

A short description of the option: As such, this option is not significantly different from the status quo, according to which—in line with the CJEU—LTC benefits are coordinated as part of the Sickness Chapter of Regulation (EC) No 883/2004. However, by presuming that LTC benefits are to be seen as sickness benefits, it might be forgotten that the Chapter on Sickness and Maternity under Regulation (EC) No 883/2004 was drafted without taking some of the characteristics of LTC benefits into account and that the actual challenges and problems which the coordination of LTC benefits involve may not fundamentally change. Decisions of the AC and guidelines could clarify certain problematic provisions and challenges (e.g. by including the definition of LTC benefits in the decisions of the AC; by clarifying the aspects of accumulation of cash benefits and/or benefits in kind, the reimbursement of benefits, etc). Important issues, for example whether LTC benefits can still be coordinated outside the framework of the Sickness Chapter, are however left unquestioned.

Reference to previous trESS reports: Part III, Point 1 and 4 of the trESS Think Tank report on the coordination of LTC benefits (A.C. 610/11).

The attitude of the MSs: There was no explicit question, but some MSs expressed their wish for further clarification for the coordination as sickness benefits.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ **Clarification:**
  Additional explanatory elements always add clarity compared to the status quo, but it also has to be accepted that this option is not a totally safe one. Although further coordination under the Sickness Chapter may be seen as a continuation of the current system applied by MSs every day, this option always depends on the presumption that the CJEU considers national LTC benefits as sickness benefits. Therefore, this option maintains a situation where the CJEU may decide on a case-by-case basis that a certain benefit is not a sickness benefit. Additional decisions by the AC or new guidelines would somewhat increase legal certainty, as certain concepts could be clarified (e.g. a definition and description of LTC benefits or some clarification of provisions like accumulation of benefits, etc.). However, full legal certainty cannot be guaranteed, taking into account the (lack of) the legal value of decisions by the AC or guidelines and the fundamental issues and challenges related to the coordination of LTC benefits as sickness benefits that will remain unresolved (classification as sickness benefits, the distinction between benefits in kind and in cash, supplements, own and derived rights, etc.). For these reasons, there would be clarification, but only to a limited extend.
**Simplification:**
This option would not change the principles of the status quo. We know that the current system is not simple, not the least due to issues such as the different concepts of own rights and derived rights, the fundamental distinction between benefits in kind and benefits in cash, the difficulty to apply the Sickness Chapter to LTC benefits, different problems of interpretation by various MSs, etc. All of these issues make the application of the current system complicated. Additional guidelines could simplify the system by avoiding some questions and misunderstandings, although the above mentioned fundamental challenges would remain. Further clarifying, for example, the concept of LTC benefits would make it easier for MSs to understand the possible application of the coordination provisions on their national benefits, without however clarifying its concrete impact. It will e.g. remain of particular relevance whether LTC benefits could be further coordinated under other chapters.

**Protection of rights:**
This option would not fundamentally increase the possibility that persons receive the rights they are looking for; therefore, we cannot regard it as better than the status quo. Additional guidelines or clarifications and decisions of the AC can as such not replace the existing lack of provisions that deprives persons of their benefits. As a result, the logical application of the Sickness Chapter still excludes certain persons from benefits (the most typical example being that persons are not entitled to benefits in their MS of residence because another MS, which does not have such benefits, is competent for benefits in cash). This option can therefore not guarantee that persons would further receive benefits in all circumstances.

**Administrative burden and implementation arrangements:**
The application of the Sickness Chapter to LTC benefits is very complicated from an administrative point of view and difficult to implement – this option would not achieve any improvements compared to the status quo. The difficulties in implementing the coordination system for LTC benefits have various causes: the fact that different benefits with LTC components share components of other benefits and other branches of social security; the multiplicity of bodies and institutions which are actually involved in the coordination of sickness benefits and which therefore also process and manage LTC benefits (although they are not always the competent institutions on a national level), etc. The same goes for, for example, the accumulation of benefits or the reimbursement of these benefits between the different MSs. Adding explanatory elements will not necessarily produce a solution to these administrative and implementation problems and, therefore, would not change the existing status quo.

**No risk of fraud or abuse:**
Due to the lack of statistics on LTC benefits until now, already today is it quite difficult to assess the possible risk of fraud or abuse. As this option does not change the situation compared to the status quo, we cannot say whether it is better or worse than today’s situation. However, as it is possible (see e.g. in case C-208/07, von Chamier-Gliszinski) that a person is not entitled to benefits, it may not be excluded that a person looks for the most advantageous MS. Despite the difficulty of assessing the number of people receiving an LTC benefit who would move abroad, one could presume that this number is less than with regard to the traditional sickness benefits. Any additional clarification of the existing rules could help to fight fraud and abuse (where fraudulent behaviour is not very often reported).
Fair burden sharing:
Also with regard to fair burden sharing this option would not change the current coordination rules, in particular those dealing with elements like (non-)exportability of certain benefits and possible reimbursement. Therefore, it cannot be regarded as better or worse than the status quo. Under the current situation, certain MSs are not obliged to grant LTC benefits in certain situations. In that respect, only a situation where all MSs would have to coordinate LTC benefits may contribute to fair burden sharing (which cannot be achieved by means of clarifying elements alone). However, one should not forget that due to the link between sickness benefits and LTC benefits and as it remains vague how national benefits should be classified, some MSs are currently still released from the obligation to provide benefits. Additional explanatory elements could force more MSs to apply the same rules to comparable benefits and thus contribute to a better distribution of the burden (which from our point of view would remain too small to regard it as a real improvement).

9. **Option I: The coordination of LTC benefits as sickness benefits under the existing Chapter on sickness benefits + additional legal clarifications**

A short description of the option: This option chooses to further coordinate LTC benefits in accordance with the Chapter on Sickness, which would only be a kind of facelift where the Sickness Chapter is renewed and where part of it is devoted to the particular characteristics of LTC benefits. Taking into account the specificities of the latter, a possible new scenario is to make derogations from certain provisions, while further keeping LTC benefits within the logic of sickness benefits. This option will in particular look for remedies for the challenges LTC benefits are confronted with within the existing logic of coordination in accordance with sickness benefits. Nevertheless, the idea this option will start from remains that LTC benefits are comparable to sickness benefits.

Reference to previous trESS reports: Part III, Point 4 of the trESS Think Tank report on the coordination of LTC benefits (A.C. 610/11).

The attitude of the MSs: There was no explicit question, but some MSs expressed their wish for further clarification for the coordination as sickness benefits.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

Clarification:
In this option, the wording of certain articles of Regulation (EC) No 883/2004 (like Article 19 with respect to a stay outside the competent MS; Article 20 on planned care outside the competent MS; Article 28 with respect to a special provision for retired frontier workers, etc) could be revised so that they are adapted to the ‘in principle’ application of the sickness provisions to LTC benefits. Such legal amendments will always bring more clarity compared to the status quo and on a more reliable level than the measures mentioned under Option H. Apart from modifying the wording, new provisions could be added as well to clarify certain issues that are not dealt with under the current Sickness Chapter (e.g. mutual acceptance of decisions on reliance on care, examinations of patients, equal treatment of claims, etc.). For other provisions, e.g. those related to the calculation of benefits in cash under Article 21, it could be clearly stated that they do not apply to LTC benefits. Adaptation of these concepts due to its mismatches in relation to sickness benefits would provide legal clarification and would make the Regulation better adapted to LTC benefits. However, as mentioned under Option H some of the big challenges will remain, in particular the distinction between benefits in kind and in cash.
± **Simplification:**
As this option would not change the principles of today's coordination, it cannot be regarded as better as or worse than the status quo. Nevertheless, it will bring some improvements: there is simplification to some, rather small, extent. This option would slightly contribute to a smoother application of the current provisions of the Sickness Chapter, without excluding that the coordination of some national benefits would not really fit into this logic of the Sickness Chapter. Therefore, it would not really mean a great simplification compared to the status quo.

± **Protection of rights:**
This option would not change the existing way of coordination and, therefore, would not dramatically alter the legal position of the persons concerned. Rights are protected to some extent. The adaptation of certain provisions for a better coordination of LTC benefits could contribute to a slightly better application of the coordination provisions in a cross-border situation, leading to more legal certainty and guaranteeing that citizens can rely on an effective implementation of the coordination system. However, these effects would be very small compared to the other options (discussed below), which would really fundamentally change the coordination mechanism.

± **Administrative burden and implementation arrangements:**
As mentioned under Option H, coordination in accordance with the Sickness Chapter is a difficult process for administering and implementing. This option would not change these principles, so the administrative burden would remain rather the same as under the status quo. It has to be mentioned, however, that the adaptation of certain rules could contribute to a slightly better implementation, as it clarifies certain problems that arise in a cross-border context. This is particularly true when MSs would be in a position to better understand which of their national benefits is subject to the coordination principles. However, all will depend on which modifications (if any) will be adopted. In general, it may be presumed that implementation will remain complicated due to the link with the Sickness Chapter, as long as no fundamental modifications take place.

± **No risk of fraud or abuse:**
This option does not change the situation compared to the status quo; therefore, we cannot say whether it is better or worse than today’s situation. As mentioned under Option H, it is very difficult to assess the possible fraud or abuse due to the non-existence of statistics, although any clarification of the current rules and a better adaptation to the particularities of LTC benefits should limit possible abuse to some extent. The current situation where a MS of residence that awards the benefits in kind is reimbursed by the competent MS could, however, limit the incentives for the institutions of the MS of residence to effectively control whether all conditions are met.

± **Fair burden sharing:**
Fair burden sharing remains the same as under the current coordination rules, in particular those dealing with elements like (non-)exportability of certain benefits and possible reimbursement provisions (therefore, there are no fundamental changes compared to the status quo, which would allow to regard it as better than today’s situation). Under the current situation, certain MSs are not obliged to grant LTC benefits in certain situations. In that respect, a situation where all MSs would have to coordinate LTC benefits may contribute to fair burden sharing (but it is not safeguarded that this can be achieved in a satisfactory way within the sickness logic). A MS of residence may consider it unfair that another competent MS does not contribute to the costs, if we change reimbursement rules for LTC
benefits (which could be an option within the sickness logic). However, one should not forget that due to the link between sickness benefits and LTC benefits and as it remains vague how national benefits should be classified, some MSs are currently still released from the obligation to provide benefits. Leaving the benefits within the sickness logic would not really change the burden sharing compared with the status quo.

10. **Option J: The coordination of LTC benefits sticking to the sickness logic but outside the existing Sickness Chapter of Regulation (EC) No 883/2004**

**A short description of the option:** Contrary to the option described under I, this option could go a step further than a simple facelift. It could result in a more in-depth change of the current Sickness Chapter, where a new Chapter on LTC benefits would be drafted with a coordination mechanism which is comparable to sickness benefits with regard to their purposes, but which includes some changes. This option may lead to the adoption of more comprehensive, additional provisions and may introduce more important amendments which somewhat deviate from the logic followed under the Sickness Chapter until now. Nevertheless, it preserves its analogy with the method of the sickness benefits, based on the argument that the CJEU once classified LTC benefits as sickness benefits. As an important change we would like to propose that the MS of residence has to treat all LTC benefits (in kind and in cash and any kind of mix) as benefits in kind and thus also grant them for persons for whom an institution in another MS has to reimburse sickness benefits in kind.

**Reference to previous trESS reports:** Part III, Point 4 of the trESS Think Tank report on the coordination of LTC benefits (A.C. 610/11).

**The attitude of the MSs:** There was no explicit question, but some MSs expressed their wish for further clarification for the coordination as sickness benefits.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

**Clarification:**
Legal clarification would be provided, as there would be a more in-depth change of the Sickness Chapter and a coordination system better tuned to LTC benefits, which do however remain within the logic of sickness benefits. Compared to the status quo, the existence of specific rules which take into account the specificities of LTC benefits would already be an important improvement. One of the most important clarifications which this option could entail is to abolish the distinction between and the different treatment of benefits in kind and benefits in cash for LTC benefits (e.g. all benefits including cash benefits could be declared as benefits to be provided by the MS of residence or stay and therefore as reimbursable benefits in kind within the sickness logic). This would lead to a modification from a more systematic point of view and would also make other articles superfluous (such as the current Article 34 of Regulation (EC) No 883/2004 on the accumulation of benefits). However, certain fundamental questions remain, in particular related to the option to still consider LTC benefits as sickness benefits *stricto sensu*, excluding coordination fully in line with other chapters or completely derogating from the logic of the Sickness Chapter. It may not be excluded that the CJEU would consider certain LTC benefits as not at all falling within the sickness logic. One difficulty will also lie in the question how far one can deviate from the Sickness Chapter without fundamentally questioning its further inclusion and coherence with regard to the coordination of (other) sickness benefits.
+ **Simplification:**
A fundamental adaptation of some of the basic starting points for the coordination of the Sickness Chapter, e.g. the actual splitting into benefits in kind and in cash, could lead to a simplification compared to the existing coordination system. However, this may also increase some of the MSs' obligations (treating benefits in cash as benefits in kind would increase the amounts to be reimbursed by the competent MS) and in turn again complicate matters (as reimbursement usually has to be regarded as more complex than a situation without reimbursement). Simplifications may therefore to some extent be counterbalanced by new complications. However, from our point of view the positive aspects of simplification would prevail, but the major challenges would remain.

+ **Protection of rights:**
As the MS of residence or stay would have to grant the whole package of LTC benefits (in kind and in cash) it would, without any doubt, be better than the status quo. This option would certainly avoid the current situation in which citizens can still be deprived of benefits in the MS of residence, and would make sure that persons will be granted benefits which will fundamentally contribute to the protection of rights. However, a burning issue would still remain, namely to what extent national benefits may be qualified as sickness benefits and therefore also be coordinated in accordance with this new chapter.

+ **Administrative burden and implementation arrangements:**
From a general point of view this option seems to be less burdensome for the administrations than the status quo. Anyhow, the complexity of the system depends on the way of coordination chosen. An amendment according to which benefits in cash have to be treated as benefits in kind would on the one hand simplify implementation and interpretation: difficulties with the division into benefits in cash and kind would be avoided, problems related to the avoidance of the accumulation of benefits would not be encountered and e.g. LTC benefits would no longer need to be exported. Circumventing the problems related to the distinction between benefits in cash and in kind will fundamentally reduce the amount of administrative problems. However, they may be counterbalanced to some extent due to the new administrative burden with respect to the reimbursement by the competent MS also of benefits in cash and relevant administrative problems.

± **No risk of fraud or abuse:**
As the fundamental principles of the sickness logic are kept and as the impact of this option on fraud and abuse largely depends on the concrete provisions which are included in the Regulation, it cannot be said whether this option is better or worse than the status quo. The same arguments could be used as under Options H and I. It is also very difficult to assess the impact due to the practically non-existing statistics. Every further clarification of the rules and adaptation to the characteristics of LTC benefits could help to reduce and prevent possible fraud. Including a provision according to which benefits in cash would be treated as benefits in kind may cause the MS of stay or residence to grant the benefits under its legislation and to guarantee the necessary benefits to persons in need of care, avoiding the accumulation of benefits and as such helping to prevent ways of fraud. However, this solution does not exclude that this MS should be reimbursed by the competent MS, which could lead to less incentives for effectively controlling the persons concerned.

± **Fair burden sharing:**
It was not possible for us to decide whether this option would be better or worse than the status quo. This evaluation would largely depend on the concrete content of the new provisions especially concerning the question of reimbursement. Under the current situation,
certain MSs are not obliged to grant LTC benefits in certain situations. In that respect, a situation where all MSs would have to coordinate LTC benefits may contribute to fair burden sharing. A MS of residence may consider it unfair that another competent MS does not contribute to the costs (if no reimbursement is provided). The new situation whereby benefits in cash are treated as benefits in kind would necessitate more reimbursement by the competent MS which could be regarded unfair from its point of view. On the other hand, it would release the competent MS from the obligation to export LTC benefits in cash. So, there will be a transfer of burdens between MSs, but it is not easy to say if this could be regarded as unfair. However, one should not forget that due to the link between sickness benefits and LTC benefits and as it remains vague how national benefits should be classified, some MSs are currently still released from the obligation to provide benefits.
General remarks on Options K and L
A new coordination under which LTC benefits in cash are granted by the MS of residence if no such benefits exist in the competent MS

A short description of the option: These are options which are still closely linked to the existing ways of coordination under the Sickness Chapter. The competent MS means the MS responsible to grant sickness benefits in cash, including LTC benefits in cash, also for persons who reside outside this MS. Only if this competent MS does not at all grant such benefits in cash should the MS of residence grant its LTC benefits in cash to avoid negative conflicts of law. These options do not cover situations in which the LTC benefits in cash in the competent MS are lower than the benefits in the MS of residence (therefore, no case of differential supplement). This way of coordination is possible with and without reimbursement, which will be further elaborated upon under Options K and L below.

Reference to previous trESS reports: Part III, Chapter 5 of the trESS Think Tank report on LTC benefits (A.C. 610/11), with the difference that there, the MS of residence is always declared competent to grant the LTC benefits in cash and not only by default.

The attitude of the MSs: Two MSs support the option that the MS of residence is competent to grant the LTC benefits, which could also mean Option M and its following options. Taking into account the general remarks, there also seems to be opposition against this solution.

11. Option K: LTC benefits in cash by the MS of residence if no such benefits exist in the competent MS – with reimbursement

A short description of the option: The benefits granted by the MS of residence (see the general remarks on Options K and L) have to be reimbursed by the competent MS. We will take a pensioner from MS A who resides in MS B as an example. MS A is responsible to reimburse sickness benefits in kind granted in MS B and also to export sickness benefits in cash. However, MS A does not have any LTC benefits in cash, whereas MS B does. Under this option, MS B would have to grant these LTC benefits in cash, but MS A would also have to reimburse them.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

Clarification:
This option would be less clear than the status quo. Many questions could arise. It has to be clarified what exactly is meant by the condition that the competent MS does not grant LTC benefits in cash. Does this mean that no LTC benefits in cash are provided under the national legislation or does it also cover situations in which this legislation knows such benefits but the person concerned does not fulfil the conditions for entitlement (e.g. because the relevant degree of need of care or the relevant age are not reached – a question similar to the question concerning the existing text for taking into account of child raising periods under Article 44 of Regulation (EC) No 987/2009)? For the MS of residence this would give rise to a lot of uncertainties. In relation to some MSs (which are competent for the persons concerned) LTC benefits in cash would have to be granted, whereas not in relation to others (in the same situation - depending on whether the competent MS grants such benefits or not).
It could also be questioned why this obligation only becomes applicable when the competent MS does not at all grant any LTC benefits in cash, but not if it grants an LTC benefit in cash which is lower than the benefit in the MS of residence.

- **Simplification:**
  There is no simplification; the option is worse than the status quo. Possible obligations whereby a benefit is to be granted by a MS other than the competent one are always a complex solution. In addition, some of the arguments concerning the complexity mentioned under ‘Clarification’ have to be taken into account. For the MS of residence it could become very complex in case it also has benefits in kind. Which of these benefits should this MS grant by priority (both benefits will be reimbursed); could the competent MS refuse the reimbursement of the more expensive version? Options with reimbursement are usually more complex than without reimbursement.

- **Protection of rights:**
  It is – without any doubt – an improvement compared to the status quo because it helps to overcome the loss of any rights if the competent MS does not have any LTC benefits in cash (e.g. only benefits in kind) and the MS of residence (also) has LTC benefits in cash. Nevertheless, it is not a perfect solution for the person concerned. This could only be achieved if also the obligation to grant a differential supplement would be included.

- **Administrative burden and implementation arrangements:**
  This option adds administrative burden compared to the status quo; it would necessitate a very complex and burdensome cooperation between the institutions of the two MSs involved, especially if the obligation of the MS of residence depends on the actual granting of LTC benefits by the competent MS (and not on the question whether or not such benefits are included in that legislation; if not, a list of the MSs concerned could help which is at least comparable to the list which exists today for the application of Article 34 of Regulation (EC) No 883/2004). Reimbursement adds to complexity for the institutions involved. As the reimbursement of benefits in cash was up until now restricted to unemployment benefits (Article 65 (5) and (6) of Regulation (EC) No 883/2004) institutions which are involved in LTC benefits do not have any experience. Problems comparable to problems in the field of unemployment could possibly also arise (very lengthy discussions on the cases and the procedures of reimbursement).

- **No risk of fraud or abuse:**
  It could be said that this solution is a little more prone to being misused than the existing way of coordination. The MS of residence is best suited to control if all conditions are met for the granting of LTC benefits in cash. However, as it only concerns competent MSs which do not export any LTC benefits in cash, it could in such cases be an incentive to move to MSs which do provide such benefits (it could also be assumed that LTC benefits already granted by the competent MS are not declared). As the benefits granted are reimbursed there might not be an incentive of intense examination and control by the MS of residence, if the conditions to grant benefits in these special situations (no benefits by the competent MS) are really met.

- **Fair burden sharing:**
  Reimbursement could already be a step towards burden sharing, but in this option the negative aspects compared to the status quo are dominant. It has to be considered that it is – at least as regards the administrative burden of granting benefits – a transfer from the competent MS to the MS of residence. Then again, it could be said that it is an additional burden for the competent MS, which might deliberately make a decision to compensate the risk of LTC only by way of benefits in kind. This MS would thus also have to reimburse
benefits in cash. This would be the first time under the Regulation (not taking into consideration the reimbursement of unemployment benefits under Article 65 of Regulation (EC) No 883/2004).

12. **Option L: LTC benefits in cash by the MS of residence if no such benefits exist in the competent MS – without reimbursement**

**A short description of the option:** The same solution as under Option K with the only difference that the MS of residence does not receive any reimbursement from the competent MS.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

- **Clarification:**
  For the same reasons as explained under Option K this option is less clear than the status quo. In addition, problems could also arise in relation to insurance based schemes. Would the obligation to grant LTC benefits in cash also include the obligation for the persons concerned to pay contributions thereof (although, for example, in case of a pensioner from another MS sickness contributions, as the case may be also covering the risk of LTC, have to be paid in the competent MS)? It would also be necessary to clearly distinguish between benefits in kind (reimbursement) and benefits in cash (no reimbursement), which up until now has always been a problem.

- **Simplification:**
  Many of the arguments mentioned under Option K also go for this option; therefore we keep the negative mark. Nevertheless, the more complex solution of reimbursement is abandoned here. Therefore, this solution is a little simpler; but compared to the status quo it is still quite complex, as all the situations have to be explained in detail under which in addition to the obligations of the competent MS, the MS of residence has to grant its LTC benefits in cash.

- **Protection of rights:**
  We think the same reasons as under Option K are valid here, which makes this option a better solution than the status quo. Reimbursement or no reimbursement does not make a difference.

- **Administrative burden and implementation arrangements:**
  As there is no reimbursement the solution is slightly less burdensome than Option K. Nevertheless, it still necessitates a lot more co-operation than today, so that it has to be regarded as worse than the status quo.

- **No risk of fraud or abuse:**
  Although some of the arguments elaborated under Option K are still valid, this option could be seen as comparable to the status quo with regard to the risk of fraud or abuse, as there is no reimbursement, which would be an incentive for the institution of the MS of residence to be more watchful than under Option K.

- **Fair burden sharing:**
  Although it is not easy to make a comparison, we think that this option is more balanced than the status quo. It is true that the MS of residence might consider it an unfair burden to grant benefits only because the legislation of the competent MS does not provide for such benefits (with regard to MSs which follow the same philosophy as the MS of residence and also grant LTC benefits in cash no such obligation is given). But, on the other hand, in case of residence
based LTC schemes it could be argued that this entitlement already exists under national legislation (in case of family members and pensioners the MS of residence is also the competent MS), which seems to be an argument that is becoming more and more important (CJEU cases C-352/06, Bosmann or C-611/10 and C-612/10, Hudzinski and Wawrzyniak). In case of insurance based schemes this MS of residence would also be entitled to collect the necessary contributions. If a MS has to grant its benefits which are already due under national legislation, we cannot say that this is an unfair burden for that MS.
Introductory remarks on Options M to T

New coordination under which the MS of residence is always competent to grant its LTC benefits

A short description of the options: Under Options M to R the MS of residence is always competent to grant LTC benefits. This way of coordination constitutes a breach with the existing way of coordination based on the Sickness Chapter, because LTC benefits would be the object of a separate coordination and no Sickness Chapter rule would remain applicable to them. The same provisions apply to benefits in kind and to benefits in cash. Nevertheless, the separation from the Sickness Chapter does not prevent from retaining an analogy with the treatment of sickness benefits in kind, given that it is intended to systematically give the MS of residence competence to provide benefits in accordance with the conditions of its legislation, including with regard to the nature of the benefits provided depending on whether they are considered benefits in kind or in cash (even if they are provided as a mix of benefits in kind and benefits in cash). The dichotomy between the applicable legislation (competent MS) and the legislation applied (MS of residence) is complete although tempered by the differential supplements considered below. Option T is a possible addition to these options under which also with regard to benefits in kind granted outside the normal way of coordination a reimbursement possibility is introduced to offer elements which have already been developed by the CJEU with regard to freedom to provide services in relation to planned health care abroad.

The evaluation is different for each of these options.

Reference to previous trESS reports: These options are described more fully in Part III, Chapter 6 of the trESS Think Tank report on LTC benefits (A.C. 610/11).

The attitude of the MSs: In their responses to questionnaire A.C. 18/12 from the EC, the MSs had little opinion on these solutions, except for two MSs who expressed their preference. However, the following MSs may be added to the latter: the two MSs that are open to any solution, the MS that wishes specific rules for the coordination of LTC benefits and the MS that believes that all LTC benefits should for this purpose be considered as benefits in kind. The following MSs were not specifically opposed to this solution, but did have rather negative opinions about it: the three MSs that do not want to see the current LTC benefits coordination system changed, the two MSs that do not want benefits in kind and benefits in cash to be coordinated under the same rules and the MS that believes that these benefits should not be coordinated in the same way as sickness benefits.

13. Option M: Competence of the MS of residence without reimbursement

A short description of the option: This way of coordination is perfectly conceivable without a system of reimbursement, in particular for the reasons mentioned under Option L. Moreover, it could be considered that for LTC benefits there is complete devolution to the MS of residence’s competence, thereby differentiating from the classic sickness benefits, taking into account the nature of the benefits.
Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
  This option offers more legal certainty and transparency with regard to the applied legislation than the status quo and also than the previous Options K and L, because the beneficiaries are able to know in advance which legislation will systematically apply to them depending on the MS where they will reside. There will be no doubts even if it is not clear under the relevant legislation whether a certain benefit is a benefit in cash or in kind.

+ Simplification:
  As only one MS is at stake, this solution is simpler than the status quo, as especially the different treatment of benefits in cash and in kind is no longer relevant. Also the deletion of any reimbursement adds to simplicity. However, additional measures might be necessary, e.g. concerning LTC contributions in the competent MS.

+ Protection of rights:
  The question whether the option is better or worse than the status quo largely depends on the decision whether or not a supplement is provided (therefore, see Options Q to S which we have all assigned a ‘+’). Still, it gives entitlements to all the benefits which are provided for the residents of a MS. This can in itself be seen as positive compared to the status quo, as usually the situation in the MS of residence is the most decisive with regard to LTC benefits.

+ Administrative burden and implementation arrangements:
  This option needs less coordination than today’s solution. Granting only the benefits by the MS of residence seems to be easy; anyhow in case of insurance based schemes additional measures have to be taken concerning the possible affiliation of persons who have another competent MS.

+ No risk of fraud or abuse:
  This option could be regarded as safer concerning fraud and abuse than today’s situation. As this solution is without reimbursement it could be assumed that all the conditions under the legislation of the MS of residence are carefully examined. It could thus be guaranteed that only persons who are really entitled to the benefits receive them. Nevertheless, this option could to a small extent – however difficult to measure – be an incentive for certain transfers of residence with the purpose of optimising the LTC benefits (which in itself cannot be regarded as fraud or abuse); an element that should also be weighed against the overall positive aspects considered and that is certainly not more important than what exists with regard to the provision of benefits of the Sickness Chapter as a whole.

+ Fair burden sharing:
  This option can be regarded as providing a fairer burden sharing than the status quo, as – in case of residence based schemes – this MS should provide these benefits anyhow under its national legislation (see also Option L). But, it also has to be mentioned that the MS of residence might regard it unfair that there is another competent MS which does not contribute to the costs at all (although there might even be an insurance that covers the risk of LTC). As this option would cover all cases and not only the special situation of competent MSs which do not grant LTC benefits in cash at all, from this point of view it could be regarded as being more critical than Option L, but this cannot take away the overall positive effect of this aspect.
Introductory remarks on Options N to P
Competence of the MS of residence with different ways of reimbursement

A short description of the options: This way of coordination (competence of the MS of residence) may also be perfectly possible with a system of reimbursement to the MS of residence of benefits provided if a transfer of competence is not considered appropriate and taking into account the amounts of money at stake, in particular for MSs with a lot of elderly persons who receive a pension from other MSs only (pensioners who are former frontier workers or movement of pensioners). The reimbursement would also be justified if entitlement under the legislation of the MS of residence could not be opened without the provisions of the Regulation (no insurance and no pension provided under that legislation). This way of coordination is further subdivided under the following three options.

14. Option N: Competence of the MS of residence with reimbursement of all benefits provided

A short description of the option: If a reimbursement system is chosen, it would seem logical that this reimbursement concerns all benefits, both in kind and in cash, since this option hypothetically speaking does not make a difference in treatment between those two categories of LTC benefits. Also problems resulting from the sometimes difficult decision which benefits are in kind and which benefits are in cash could be avoided. There might be great similarity to Option J (if benefits in cash are treated under the sickness logic as benefits in cash and are thus reimbursable). However, the difference would be in the possibility to also provide supplements under Options R to T and in the concept of Option J itself (which is generally speaking a new chapter on LTC benefits under the sickness logic where treating benefits in cash and in kind is only one possible way forward within any other possible solution).

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
  For the person concerned this option is much clearer than the status quo, as the whole package of LTC benefits (in cash and in kind) of the MS (and only these) can be claimed (in this respect there is no change compared to Option M); for the institutions involved it would also be clear which institution has to do the reimbursement.

+ Simplification:
  This option, although comprising reimbursement, (an option with reimbursement is always more complex than one without reimbursement), is more simple than the status quo under which problems might arise if the borderline between benefits in cash and in kind is not clear. As all benefits have to be reimbursed this seems to be the simplest way under the Options N to P with reimbursement (compare also Option J).

+ Protection of rights:
  As all the benefits of the MS of residence have to be granted, this option is better than the status quo (the reasoning is the same as under Option M). The reimbursement does not affect this aspect.
Administrative burden and implementation arrangements:
A solution with reimbursement is always more complex (also with regard to administration involved) than without. As it concerns all benefits it is still the simplest solution of Options N to P and is simpler than the status quo where the differentiation between benefits in cash and kind is needed (compare also Option J).

- No risk of fraud or abuse:
This option could be regarded as worse than the status quo. As all benefits are reimbursed it might be assumed that the MS of residence is not so much interested in control than without reimbursement. Under the status quo, where LTC benefits in cash have to be granted by the competent MS (which also has to bear the financial costs of these benefits), at least with regard to these the necessary control can be safeguarded. There is also less incentive for the MS of residence than under Options O or P. Nevertheless, as there is no supplement this option could be regarded as more neutral than Options R to T, but this cannot take away the negative aspects that still exist.

- Fair burden sharing:
This option has to be regarded as less fair with regard to burden sharing than the status quo. The same reasoning as under Option K may be made here.

15. Option O: Competence of the MS of residence with reimbursement only of the benefits in kind provided

A short description of the option: Under the principle of competence of the MS of residence it is also possible that the reimbursement only concerns benefits in kind. This is another philosophy, comparable to Option L above, according to which LTC benefits in kind, treated as health care benefits in kind, are reimbursed, whereas LTC benefits in cash are not. The difference with Option L would be that in all cases LTC benefits in cash have to be granted by the MS of residence, while under Option L this is only the case if the competent MS does not at all have LTC benefits in cash. So there is no difference with regard to the benefits in kind, but only with regard to the benefits in cash.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
With regard to the situation of the persons concerned this option is much clearer than the status quo. Nevertheless, compared to Option N, this option is more unclear as it might not be clear if certain benefits are benefits in cash or in kind. However, the complexity only concerns the relation between institutions.

± Simplification:
The necessary distinction between benefits in kind and in cash makes this option comparable to the status quo and more complex than Option N.

+ Protection of rights:
As all the benefits of the MS of residence have to be granted, this option is better than the status quo (the reasoning is the same as under Option M). The reimbursement does not affect this aspect.

± Administrative burden and implementation arrangements:
This option is, from an administrative point of view, comparable to today’s situation, but more burdensome for the administration than Option N due to the differentiation between benefits in kind and in cash. It is, however, not as difficult to administer as Option P.

**± No risk of fraud or abuse:**
This option could be regarded as being comparable to the status quo (the MS granting the LTC benefits in cash is the one which also has to bear the financial burden of these benefits, while benefits in kind are reimbursed). As benefits in cash are not reimbursed it could be assumed that the MS of residence makes more effort concerning control than under Option N. Nevertheless, it cannot be considered as positive as Option M, as not only one MS has to bear the financial burden for all the benefits, as a result of which overcompensation can be avoided.

**+ Fair burden sharing:**
The splitting into benefits in kind reimbursed and benefits in cash not reimbursed could be regarded as more balanced than the status quo. Moreover, this option could also better cope with the different national systems than Option N. Nevertheless, the obligation to grant LTC benefits in cash (without any financial compensation) is transferred from the competent MS to the MS of residence, which is a shift of the financial burden compared to the status quo. Taking into account that within residence based schemes the national legislation already stipulates that the MS of residence should assume the costs of these benefits in cash, in this option the burden sharing could be regarded as fairer than today.

16. **Option P: Competence of the MS of residence with another way of reimbursement**

**A short description of the option:** The question of the financial burden and of the burden sharing between the MSs concerned may be approached in another way than with the alternative (total) reimbursement or non-reimbursement of benefits provided by the MS of residence. It is also conceivable, taking into consideration the nature of the risk of reliance on care and its benefits as well as their separation from the classic health care benefits, to tackle this point directly in terms of cost sharing according to key factors to be defined. These factors could take into account, e.g. the number of cases encountered, the relative weight of the benefits provided, the insurance careers in different MSs, the different types of LTC schemes and benefits or the duration of residence in those MSs. The cost sharing could simply be, as for health care, in the form of reductions on reimbursable amounts, but also in the form of partial or limited reimbursements, in the form of sharing of the provision of benefits allocated to beneficiaries or in the form of any other mechanism developed. Therefore, under this option, the challenge is to find a balance between the best burden sharing and a limitation of administrative burden caused by the implementation of balancing mechanisms.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

**+ Clarification:**
This option would be better than the status quo. The added complexity only concerns the relation between the institutions. The situation of the persons concerned is not touched. In this respect, it is comparable to Option M.

**- Simplification:**
The necessary complex rules to define the concrete rates of reimbursement would be a deterioration compared to the status quo. Any provision which deviates from the principle that 100 % of the costs have to be reimbursed would necessitate complex rules of calculation
and evaluation (see e.g. Article 64 (5) of Regulation (EC) No 987/2009 concerning health care lump sum reimbursement rates).

**Protection of rights:**
As all the benefits of the MS of residence have to be granted, this option is better than the status quo (the reasoning is the same as under Option M). The reimbursement does not affect this aspect.

**Administrative burden and implementation arrangements:**
This option is very burdensome (much more than the status quo), as it requires a lot of additional work for the institutions (e.g. the fixing of average/lump sum costs by the Audit Board, the fixing of different reductions for every MS taking into account the specific legal situation in that MS).

**No risk of fraud or abuse:**
This option could be regarded as having the same risk of fraud or abuse as the status quo (splitting of the financial burden between two MSs). As parts of the benefits are not reimbursed, it could be assumed that the MS of residence makes more effort concerning control than under Option N. Nevertheless, it cannot be considered as positive as Option M, as not only one MS has to bear the financial burden for all the benefits, as a result of which overcompensation can be avoided. Therefore, this option is comparable to Option O in this respect, unless the ways of reimbursement provided take away the incentive for the MS of residence to take any control measures (in that case our evaluation would shift towards ‘-’).

**Fair burden sharing:**
Burden sharing could be regarded as better than the status quo. This option would allow adapting the reimbursement to each MS’s individual situation and may also take into account the situation in the different competent MSs. It would thus allow looking for the most balanced solution.
Introductory remarks on Options Q to T
Competence of the MS of residence with different possibilities for supplements

A short description of the options: The principle of competence of the MS of residence could also be further elaborated as regards the question whether any other MS should be involved as well by being obliged to grant a supplement in addition (in case LTC benefits in cash are provided under the legislation of that other MS, they could be claimed in the concrete case – meaning that the relevant conditions are met – whereby these benefits are higher than the ones granted by the MS which has to grant these benefits by priority). The different possibilities concerning such a supplement are further elaborated under the following Options Q to S. In addition, we offer an Option T whereby supplements to benefits in kind would also be provided following the rights developed by the CJEU with regard to patient mobility.

17. Option Q: Competence of the MS of residence without any supplement

A short description of the option: The principle of competence of the MS of residence may be kept in all its purity, thereby not considering any possible supplement from another MS whose benefits which may be provided (exported) in the MS of residence are higher than those in the latter MS, provided in the first place to beneficiaries. In this case, the choice could be dictated by the concern of the ease of management and a strict equal treatment in the MS of residence between the persons who fall under this State’s legislation and the persons who fall under another legislation or who at least enjoy benefits pursuant to the legislation of a MS other than the MS of residence.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
The competence of the MS of residence only for granting all the LTC benefits provided under its legislation would be much clearer than the status quo. This option provides even more legal certainty and transparency with regard to the applied legislation than the following ones, because the beneficiaries are able to know in advance which legislation will systematically apply to them depending on the State where they will have their residence.

+ Simplification:
This option also seems to be simpler than the status quo, as it would only be the MS of residence that grants its benefits and no other MS would have to apply its legislation.

+ Protection of rights:
The rights of the persons concerned are better protected than under the status quo. If looked at from the angle of the MS of residence this option guarantees that all residents receive the benefits which are intended to cover the local population, which protects the rights of all residents (under today’s coordination they can be taken away if another MS is competent). On the other hand, benefits from MSs with which a close relationship exists (e.g. the competent MS) are not granted, which could be regarded as a slight disadvantage of this option, especially compared to the following options. Anyhow, this option would for example also solve the problems connected to the question on derived rights or own rights (see Option E).
**Administrative burden and implementation arrangements:**
This option is less burdensome than the status quo. As it is only the MS of residence which has to grant its benefits, this option does not need further implementing arrangements. There is no need for cooperation between the MSs for the purpose of granting the benefits (the beneficiaries reside in the MS which has to grant its benefits).

**No risk of fraud or abuse:**
It was not possible to decide whether this option is better or worse than the status quo. It seems that for the protection against fraud and abuse it might be more relevant whether reimbursement is granted or not (concerning the efforts of the institutions of the MS of residence). As there is no supplement, there is no danger that the beneficiaries dissimulate benefits received from other MSs to their MSs of residence. But, it could be said that under this option persons might have an incentive to move to MSs with very attractive LTC benefits, which, as mentioned above, is not in itself fraud or abuse.

**Fair burden sharing:**
This option could be regarded as neutral compared to the status quo. It completely removes any obligations which could exist under the legislation of any other MS than the MS of residence. However, if this leads to unfair burden for specific situations and MSs, this effect could be overcome by selecting one of the options with reimbursement (Options N to P).

18. **Option R: Competence of the MS of residence with a supplement by the competent MS**

A short description of the option: This option allows taking into consideration the rather common situation in which the amount of the benefits provided in the MS of residence by that MS is less than the amount of the benefits which the competent MS (e.g., under the sickness logic, think of a MS that provides a pension) may allocate in a similar situation. In this hypothesis, the existence of a differential supplement to the benefits of the MS of residence provided by the competent MS in such cases allows to complete the basic coordination mechanism so that the beneficiary may ultimately enjoy the highest national amount of the benefits, but without unjust accumulation of benefits above this amount. This technique is frequently implemented for the application of the Regulation’s Chapter on Family Benefits (therefore, see also Option U).

It should be noted that such a supplement is limited to benefits in cash exportable from the competent MS when the amount exceeds the amount of the benefits in kind and/or in cash provided by the MS of residence (so a further developed option would be to include all benefits granted in the MS of residence into the calculation of the supplement). We could even go a step further and also include benefits in kind which could be granted (e.g. as a cost refund) or reimbursed under the legislation of the competent MS. However, as this is a horizontal question we have further elaborated this most extended calculation of a supplement under Option T.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

**Clarification:**
This option seems to be slightly clearer than the status quo (comparable to the situation under Regulation (EC) No 883/2004 concerning family benefits where the distribution of the different competences is in principle also clear). Today’s coordination of LTC benefits is often not so clear (e.g. concerning possible entitlements for family members). The MSs involved would always know that they have to grant benefits (the MS of residence always the whole range of benefits; the competent MS a top-up of these benefits in case its benefits are
higher. Furthermore, the person concerned would know that no loss of benefits is possible. The division of tasks between MSs would be clear and would not depend that much on peculiarities of the national legislation.

- **Simplification:**
  As this option would open simultaneous entitlements under the legislations of more than one MS this is more complex than the status quo. The provision of supplements is never simple; we could learn from family benefits experiences. The legislator has to draft complex rules concerning priority, the benefits to be included into the calculation of the supplement (benefits in cash or also benefits in kind, what ‘amount’ of the benefits in kind etc) and rules for procedures to settle these supplements.

+ **Protection of rights:**
  This option is without any doubt an option which is much better than the status quo, as it very effectively seeks to avoid that rights are lost, as the highest benefits are always safeguarded.

- **Administrative burden and implementation arrangements:**
  This is a very complex option and thus worse than the status quo, as it necessitates an extensive exchange of information between the two MSs concerned. Especially if also benefits in kind are included it could lead to different supplements every month. It would necessitate a lot of new business flows and SEDs under EESSI.

- **No risk of fraud or abuse:**
  This option could be regarded as worse than the status quo, although it is very difficult to choose the competent MS which has to grant the supplement and, therefore, this supplement cannot be easily influenced by the person concerned. Yet, it is a solution where two MSs could be competent to grant benefits at the same time, as a result of which the persons concerned could be tempted not to inform the competent MS of the receipt of benefits under the legislation of the MS of residence. Usually, misuse is avoided by cooperation between the institutions of the two MSs. However, there could be cases where the institution of the MS of residence does not see any necessity for such a cooperation (e.g. because the institution in the competent MS belongs to a totally different branch of social security – this could especially be the case when benefits in kind are also involved), so that in reality two benefits are granted without any reduction. It has to be admitted that the risk is not very high, but that it is slightly higher compared to the status quo, so that we have decided to evaluate this aspect with a ‘-’.

+ **Fair burden sharing:**
  As two MSs which have close links to the person concerned are involved in granting the benefit it could be regarded as a fairer balance than the status quo although it depends on the level of benefits in the MS of residence if a supplement comes into play. Then again, it does not change the situation of the MS of residence. Some MSs could thus still regard it as not sufficiently balanced. Therefore, a combination with reimbursement which could further add elements of fairness should not be excluded.

19. **Option S: Competence of the MS of residence with a supplement by another MS than the competent MS**

A short description of the option: This option refers to case C-388/09, *Da Silva Martins*, extending the supplement mentioned under the previous Option R to situations in which the beneficiaries have or may be granted a right to LTC benefits of a MS other than the MS of residence or than the
competent MS, in particular by means of a voluntary or optional continued insurance scheme (as it is necessary to avoid overly complex solutions from the beginning it does not seem realistic to consider an alternative in between the two, but to only consider a choice between the supplement under Option R and the supplement under this option).

As for the supplement under Option R, this supplement may only concern benefits in cash or may also be aimed at benefits in kind or even include the mechanism under Option T.

**Evaluation of the option** in the light of the following objectives (social, economic and political pros and cons):

- **Clarification:**
  
  As the entitlement to the supplement depends on the decision to take up/continue a coverage giving entitlement to LTC benefits, entitlements should be clearer than the status quo. This option also seems clearer for the persons concerned than Option R, because it will usually be an informed choice to opt for a voluntary insurance in another MS with the expectation to get a supplement (which could be 100 %) from that MS. Nevertheless, in practice some of the problems mentioned under Option R will also occur.

- **Simplification:**
  
  This option is more complex than the status quo. The same as under Option R goes for this option; for the MS of residence it is even worse because a third MS could be involved and this can never be easily predicted. It is also not clear from the beginning if the person concerned makes use of the choice of a voluntary insurance or not.

- **Protection of rights:**
  
  The protection of rights is better than the status quo for the same reasons as described under Option R and maybe even better, as the person concerned has a choice in case of a voluntary insurance.

- **Administrative burden and implementation arrangements:**
  
  A solution with supplements is much more difficult to administer than the status quo. The same as under Option R goes for this option.

- **No risk of fraud or abuse:**
  
  This option includes more dangers of fraud or abuse than the status quo. First, something has to be clarified: it cannot be said that a person who takes the advantage of a voluntary coverage in another MS commits fraud or abuse by making use of that option. On the other hand, it enables the person to select a MS with very high and advantageous LTC benefits, so that this option cannot be regarded as neutral with regard to ‘social tourism’, which, as already said, can neither be regarded as fraud or abuse. However, as under Option R, two MSs could be competent to grant benefits, whereby the second one (the one with the option for a voluntary coverage) is not known in advance to the MS of residence. Consequently, the risk that benefits are granted in parallel without the MSs involved knowing about the other MS granting benefits as well is even higher than under Option R.

- **Fair burden sharing:**
  
  In case the person concerned opts for a voluntary insurance in another MS this could add to a burden sharing which is fairer than under today’s coordination. It would safeguard that schemes under which contributions have to be paid for financing LTC benefits have to grant such benefits as well. Nevertheless, from the point of view of the MS of residence this option could still be regarded as not so balanced, because this is not an obligation. Therefore, if this
possibility is not taken the evaluations under Options M to R are valid. Nevertheless, it also has to be mentioned that the real impact of this option consequently depends on many details, especially the conditions under which affiliation with the system of another MS is allowed.

20. **Option T: Competence of the MS of residence with benefits in kind granted/reimbursed by the competent MS or another MS**

A short description of the option: The situation in case C-208/07, von Chamier-Gliszcinski, is prominent in this option. However, this option could go beyond the cases dealt with in this ruling as the MS of residence or stay may provide both benefits in kind and benefits in cash, or even a mix of both (combi-benefits) and some of these benefits are part of social security (which could be granted free of charge for the person concerned or reimbursed as the case may be under the legislation of that MS) and others are outside the material scope of Regulation (EC) No 883/2004 (like in von Chamier), which causes the person concerned to have no chance to receive anything in the MS where the benefits have been awarded (Situation 1).

The same applies in cases in which the beneficiary does not meet the conditions for the provision of benefits by the MS of residence or stay, because such benefits are for example indeed provided, but only for persons aged 65 or over, and the person concerned is a younger person in need of care (Situation 2). Or, the amount of the benefits which this MS may provide is lower than the amount of the benefits in kind which another MS may provide (e.g. reimbursement to the person concerned – Situation 3).

The benefits in kind of that MS would be added entirely in the first two situations (if the conditions for the provision of those benefits are of course met in the competent MS – meaning no entitlement if also the competent MS e.g. in Situation 2 has an age limit of 65) or in the form of a differential supplement in the third situation. Technically speaking, it would be a provision that corresponds to the granting of benefits under Article 26 (6) and (7) of Regulation (EC) No 987/2009 extended to all LTC benefits in kind granted outside the competent MS. This new way of coordination is not entirely new for MSs, as it only copies the principles developed by the CJEU for persons who make use of patient mobility. As stated above, this new form of a differential supplement may be created separately or blended into a supplement under Options R or S in case they are also extended to benefits in kind. This option is, therefore, applicable in case Options R or S are not chosen, if these options are restricted to benefits in cash or even if these options cover both benefits in kind (restricted to the benefits granted in the MS of residence and covered by the material scope of Regulation (EC) No 883/2004) and benefits in cash.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

**Clarification:**
As this option clarifies questions which are not crystal-clear today it has to be regarded as better than the status quo. It would be clear that no entitlements are lost with regard to benefits in kind. Questions if and under what circumstances the general principles of the TFEU (e.g. the freedom to provide services) apply also with regard to LTC benefits would not need case-by-case decisions by the CJEU. MSs would be obliged to indicate the tariffs for LTC benefits for the citizens as well.

**Simplification:**
With regard to simplification, the option is much more complex than the status quo and seems to be comparable to Options R and S. It would be necessary to construct a system of
rules comparable to Article 26 of Regulation (EC) No 987/2004, which e.g. also set up an obligation to fix clear tariffs for all benefits, to define the conditions under which these tariffs can/have to be reimbursed to the person concerned, etc.

**Protection of rights:**
This option seems to help to protect at least the rights with regard to benefits in kind and is therefore better than the status quo. Nevertheless, concerning benefits in cash it is not the best solution and therefore should be combined with Options R or S.

**Administrative burden and implementation arrangements:**
This option would add administrative obligations (e.g. exchange of information on tariffs) and is thus more burdensome than the status quo, but a little easier to administer than Option R, as only benefits in kind are involved.

**No risk of fraud or abuse:**
There is a greater danger of abuse and fraud than under the status quo, as there are two MSs involved. It cannot be excluded that the reimbursement of costs paid to a service provider are claimed twice in both MSs involved. Some of the arguments used under Option R go for this option as well.

**Fair burden sharing:**
This option has to be regarded as better than the status quo, as a cost sharing of the competent MS would be possible irrespective of the structure of the services for persons in need of care in another MS (as a part of the social security scheme or outside of it) and the level of that coverage. The same as under Option R goes for this option, but as it only concerns benefits in kind, it is not as favourable.

**Option U: An alternative way – Coordination in the same way as family benefits with a MS competent by priority and a secondarily competent MS**

A short description of the option: This way of coordination is presented as an alternative path for the coordination method described under Options M to T. Like the latter, it constitutes a breach with the existing way of coordination based on the Sickness Chapter and is not possible without the creation of a separate chapter for LTC benefits. No rule of the Sickness Chapter would be applied to these benefits any longer; instead adapted rules would equally apply to benefits in kind or in cash (as also the coordination for family benefits – at least in theory – covers benefits in kind as well as benefits in cash – see Article 1 (z) of Regulation (EC) No 883/2004). The major difference with the previous options lies in the fact that this method does no longer preserve the analogy with the method of the classic sickness benefits, but gets its logic from the Chapter on Family Benefits.

Here, the principle is in fact that of the direct provision of benefits by the competent MS in the MS of residence of the beneficiaries. In case of overlapping benefits provided under several legislations a priority rule (analogous with the rule in Article 68 (1) of Regulation (EC) No 883/2004, but more simple) is applied:

- rights on different bases (activity, pension and residence): priority is given to rights that arise from an activity, then to rights that arise from a pension, and finally to rights that arise from residence (it could be explicitly clarified that there is always a right under the legislation of the MS of residence even if another MS is competent under Title II of Regulation (EC) No 883/2004 to optimise all possible entitlements);
- rights on the same basis: this situation, which makes complete sense for family benefits, because each parent or equivalent person may be entitled to competing rights for the same children, is not expected here since the rights are a priori only given to a single person, viz
the person in need of care, whether they be direct rights or derived rights as a family member of another person, and since the principle of a single applicable legislation for example makes the overlapping of benefits as a result of the performance of two or more activities in different MSs void.

The MS that has priority pays its benefits (or reimburses them in case of benefits in kind granted under the legislation of the MS of residence or stay) and the other MS or MSs that do not have priority pay, where appropriate, a differential supplement if the amount of the benefits which they may provide exceeds the amount of the benefits paid by the MS that has priority (again including also benefits in kind – similar to Option T).

In fact, cases where such a supplement is paid only occur when it concerns, on the one hand, overlapping of benefits of the MS competent as a result of activities with those of the MS of residence (rights based only on residence) and, on the other hand, overlapping of benefits of the MS(s) competent as a result of pensions among themselves or with those of the MS of residence (rights based only on residence). If we stick to the sickness logic with own rights and derived rights (see also Option E) this could also concern derived rights as a family member of an active person/pensioner under the legislation of the MS competent for that person and own rights in the MS of residence.

The mechanisms that are thus created do not need to consider externally those kinds of supplements mentioned under Options R, S or T, as they integrate them in the way they function. On the other hand, and contrary to family benefits for which no reimbursement of benefits is provided (except in the case included in Article 58 of Regulation (EC) No 987/2009), this method of coordination may work with rules on the sharing of additional burden in the form of partial reimbursements of, for example, benefits provided on a priority basis if the MSs consider it useful.

Reference to previous trESS reports: The trESS Think Tank report on LTC benefits (A.C. 610/11), which did not strive for completeness, does not discuss this option. However, it can be considered as included indirectly in the conclusions and proposals for further action of the report in Part IV, Chapters 2.5 and 2.6.

The attitude of the MSs: As it is not mentioned in the report this solution has not resulted in structured opinions from the MSs in their responses to questionnaire A.C. 18/12. Nevertheless, the last part of Question 6 clearly invited the MSs to propose other solutions which are not mentioned in the report and which they give preference to. One MS for example explicitly mentioned the possibility to set up a coordination system for LTC benefits which follows the same principles as those used for the coordination of family benefits.

Evaluation of the option in the light of the following objectives (social, economic and political pros and cons):

+ Clarification:
  This is also an option which is better than the status quo, as it clarifies a lot in terms of legal certainty and transparency in the legislation, because only the competent, and therefore clearly indicated, legislations play a role, possibly including the legislation of the MS of residence on the basis of residence only. Nevertheless, this option necessitates a priority system preliminary to determining the legislation or legislations to be applied and the extent to which they are applied. The option which copies the ideas behind the coordination of family benefits would achieve a similarly clear situation as with regard to these family benefits. With regard to the many questions of interpretation involved, from our point of
view this option is comparable to Options R and T and therefore the positive overall aspects this option might prevail.

- **Simplification:**
  This option seems to be more complex than the status quo. Due to the system of priority between the competent legislations when several are competent, always more than one MS is involved. The institutions involved have to work closely together. Moreover, today’s system for family benefits is not simple.

+ **Protection of rights:**
  This option is much better than the status quo, as it allows to properly reach the objective of the protection of rights because, like the previous Options R or S, it guarantees the beneficiaries the right to the highest amount of the different amounts of benefits which they may claim pursuant to the national legislations which they fall under or may fall under.

- **Administrative burden and implementation arrangements:**
  This option is more burdensome for administrations than the status quo. Despite the apparent clarity of its mechanism, this option does not avoid the burden connected with the management of the priorities and of possible differential supplements, let alone the possible coordination problems if LTC benefits remain spread over several chapters. Nevertheless, there is a positive element. As mentioned above, the priority game in case of rights pursuant to at least two legislations by definition has to be played less than with regard to rights to family benefits.

- **No risk of fraud or abuse:**
  This option has higher risks of fraud or abuse. It involves more than one MS which has to grant benefits. As today under the family benefits coordination it cannot be excluded that the person concerned does not inform all institutions on the benefits he or she receives (which has to be regarded as fraud or abuse) and that consequently there might be more benefits than there is entitlement to. This option could to a small extent – however difficult to measure – also justify certain transfers of residence with the purpose of optimising the amount of the benefits provided; an element that should also be weighed against the positive other aspects considered and that is certainly not more important than what exists with regard to the provision of benefits of the Sickness Chapter as a whole.

+ **Fair burden sharing:**
  Finally, with regard to fair burden sharing between the MSs, this option is also much better than the status quo, as it differs from the others in the extent to which its mechanism divides, where appropriate, the burden between the legislation that has priority and the legislation(s) that do(es) not. Only the legislations which are in one way or another competent bear the burden of the benefits provided. If, however, in case several legislations are applicable, the part which the legislation that has priority bears in the total burden of the benefits is considered too large, the lawmaker has every opportunity to provide for a compensatory mechanism, for example such as the one in the last paragraph of Article 58 of Regulation (EC) No 987/2009 for certain situations of priority for the provision of family benefits. Furthermore, also elements of reimbursement could be combined with this option in order to achieve an even greater fairness.
C. Evaluation and discussion of the results concerning the different options

The different options which were analysed in this report, the six indicators used for their evaluation (clarification, simplification, protection of rights, administrative burden and implementation arrangements, no risk of fraud or abuse, fair burden sharing) and a valuation as a result of this evaluation can now be presented in our matrix (a blank version of which was shown already at the beginning of this report).

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<td>A. Leaving the status quo</td>
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<td><strong>Horizontal options</strong></td>
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<td>B. New definition</td>
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<td>+</td>
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<td>C - U</td>
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<td>C. Addition Art. 3</td>
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<td>+</td>
<td>±</td>
<td>+</td>
<td>±</td>
<td>B, D - U</td>
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<tr>
<td>D. List of LTC benef.</td>
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<td>B, C, E - U</td>
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<td>E. Only as own rights</td>
<td>-</td>
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<td>±</td>
<td>±</td>
<td>+</td>
<td>+</td>
<td>B-D, F, G, M-T</td>
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<td>F. All benef. one coord.</td>
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<td>B - E, G - U</td>
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<td>G. Special rules carer’s benef.</td>
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<td>B - F, H - U</td>
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<td><strong>New coordination with sickness logic</strong></td>
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<td>H. Sickness Chapt. + clarif.AC</td>
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<td>B - D, F, G, I, J</td>
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<td>I. Sickness – in Chapter 1</td>
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<td>B - D, F, G, H</td>
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<td><strong>New coordination benefits in cash by MS of residence if no benefits in cash in competent MS</strong></td>
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<td>K. MSoR + reimb.</td>
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<td>B - G, H - J</td>
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<tr>
<td>L. MSoR no reimb.</td>
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<td>+</td>
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<td>±</td>
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<td>B - G, H - J</td>
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<tr>
<td><strong>New coordination competent is always MS of residence</strong></td>
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<td>M. no reimb.</td>
<td>+</td>
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<td>B - G, Q - T</td>
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<td>N. + reimb. all benef.</td>
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<td>+</td>
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<td>+</td>
<td>-</td>
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<td>B - G, Q - T</td>
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<td>O. + reimb. benef. in kind</td>
<td>+</td>
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<td>B - G, Q - T</td>
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<td>P. + other reimb.</td>
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<td>B - G, Q - T</td>
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<tr>
<td>Q. no suppl.</td>
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<td>B - G, M - P, T</td>
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<td>R. + suppl CMS</td>
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<td>S. + suppl other MS</td>
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<td>B - G, M - P, T</td>
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<td>T. + Chamier suppl.</td>
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<td>B - G, M - S</td>
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<tr>
<td><strong>New coordination as family benefits</strong></td>
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<tr>
<td>U. Coord. as family benef.</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>B - G, T</td>
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</tbody>
</table>

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9 Clarification
10 Simplification
11 Protection of rights
12 Administrative burden and implementation arrangements
13 No risk of fraud and abuse
14 Fair burden sharing
15 Could be combined with other options
16 Member State of residence
The options chosen are schematically presented in Part III.A, as the report obviously does not aim to be exhaustive here, and include those options that seem the most evident and feasible. These options were already considered in the 2011 trESS Think Tank Report A.C. 610/2011 or were added, as is the case for option U, in order to further open up the range of possible solutions.

These options are grouped under three distinct categories, purposely divided in the diagrams under Part III.A and in the matrix above. The first category may not be excluded a priori from the analysis and has been included for the sake of completeness. It solely consists of Option A to keep the status quo, which means no action by the lawmaker and/or by the AC. The second category contains six options (B to G), which are considered horizontally as they represent answers to certain initial questions that are common to the different ways of coordination which may otherwise be chosen. The third category contains fourteen options (H to U) representing fourteen ways of coordination of LTC benefits or elements of such coordination.

If the choices which may be made between the horizontal options on the one hand, and between the options of new coordination on the other are in principle independent, it however seems that a choice in favour of certain strong horizontal options does not automatically lead to, but logically favours the choice for options of new coordination that are more elaborate or more innovative. On the other hand, choosing certain coordination options logically implies choosing one or the other, or even several horizontal options that are qualified as strong.

After all, the horizontal options are not equally important. For instance, the question that underlies Option G (special rules for carers’ benefits) cannot be ignored, but seems less important than the questions that underlie for example Options B (insertion of a new definition) or C (adding LTC benefits to the list under Article 3). Furthermore, it should be noted that this Option G (special rules for carer’s benefits) also requires to determine in advance whether or not rules should be provided for with regard to the carers, whether these rules are normal existing rules or are to be created or whether they are special rules (so a lot of additional decisions are needed before this option could be put in practice), and that before deciding on Option D (insertion of a list of LTC benefits – including the characteristic of a list which is possibly legally disputable), it should be first decided whether LTC benefits are a priori considered as special benefits, as an exception to normal benefits otherwise coordinated, or as new normal benefits added to the material scope of the Regulation and to be otherwise coordinated. After all, these options can be combined and the choice has to be made between choosing none of the options, choosing a set to be put together or choosing all of them.

The connections between the different options of the third category are more complex. For instance, if Option U (coordination as family benefits) were to constitute an option completely unrelated to the other options, Options M to T (new coordination where the MS of residence is always competent to grant LTC benefits) for example would represent a range of choices or one mega-option declined into several options that encloses all of them and that could be referred to as ‘competence of the MS of residence’ (see the diagram in Part III.A). Certain options can be considered alternatively, such as Option I (following the sickness logic within the Sickness Chapter) or Option J (following the sickness logic in a separate chapter), Option K (LTC benefits by the MS of residence if there are no LTC cash benefits in the competent MS with reimbursement) or Option L (LTC benefits by the MS of residence if there are no LTC cash benefits in the competent MS without reimbursement), Option Q (LTC benefits by the MS of residence without supplement by the competent MS) or Option R (LTC benefits by MS of residence with supplement by the competent MS), Option M (LTC benefits by the MS of residence without reimbursement) or Option U (coordination as family benefits), whereas other options are to a certain extent independent from each other and may even complement each other, e.g. Option M to P / Q to T.
For the evaluation, the report uses a code which is quantitative and non-numerical, in order to avoid an overly simplistic or inappropriate calculation, and which is rather restricted (only three values: (+) for positive, (±) for neutral and (-) for negative), so as to put the assessment in perspective and particularly so as not to try to pre-empt a solution and not to overly direct the choice which will be implemented by the EC and the MSs. The values (+) or (-) mean that the option in question produces a positive or negative result with regard to the indicator concerned; the value (±) means that the option is neutral or has no connection with the indicator or that the estimated result is not significant to justify a value (+) or (-). Thus, it is deliberately so that this three-value code offers only a limited number of valuation possibilities and that according (+) to two options does not necessarily mean that the results with regard to an indicator are considered identical. A more differentiated valuation scale could be according (+) to one option and (++) or (+++) to another. However, the discussions between the authors of the report have shown the difficulty to objectively agree on a more detailed valuation for certain options, taking into account the different analytical perspectives which may be adopted to assess the options which are at this stage not necessarily defined in detail and the necessary comparison to other options.

The results are diverse. If – with one exception – none of the Options B to U (Option A, keeping the status quo, thereby being considered separately given its special status) receive only (+)’s or (-)’s, they all combine the three types of values in varying degrees.

Even if the comparisons have to be made precautionary, as mentioned above, as a result of the different indicators not being equally important – a valuation would be required here, but would itself be the subject of discussion and of a variation in valuation – of the horizontal options, Option E (only as own rights) and option G (special rules for carers’ benefits) (both received two (-)) are most negatively assessed, whereas Option B (insertion of a new definition), option C (adding LTC benefits to the list under Article 3) and Option D (insertion of a list of LTC benefits) are generally positively assessed (three (+) and three (±)) and Option F (all LTC benefits are coordinated in the same way) very positively (five (+) and one (±)).

Of the options of new ways of coordination, even though the general valuations are less diverse, it should nevertheless be considered that Option K (LTC benefits by the MS of residence if there are no LTC cash benefits in the competent MS with reimbursement) gets the poorest valuation (five (-) and one (+)) and that Option M (LTC benefits by the MS of residence without reimbursement) gets the best valuation of all the options (six (+)). However, the authors again emphasise that certain options are not independent and must be seen within a set of options and that the indicators should not be considered in the same manner, but that the objectives of clarification and protection of rights should take priority or should at least not be excluded.

Eventually, and with every precaution listed above, the authors agree that a good solution for a sound and efficient coordination of LTC benefits could be built around the two following elements:

- horizontal Option B (insertion of a new definition), Option C (adding LTC benefits to the list under Article 3), Option D (insertion of a list of LTC benefits) and Option F (all LTC benefits are coordinated in the same way) cannot be ignored and should all be considered;
- choosing a new coordination, thereby maximising the indicators of clarification and protection of rights, will have to be done within the set of Option M (LTC benefits by the MS of residence without reimbursement), Option N (LTC benefits by the MS of residence with reimbursement of all benefits), Option O (LTC benefits by the MS of residence with reimbursement of benefits in kind) or Option P (LTC benefits by the MS of residence with another form of reimbursement), plus Option R (LTC benefits by the MS of residence with supplement by competent MS), plus Option S (LTC benefits by the MS of residence with supplement by other MS) and plus Option T (LTC benefits by the MS of stay or residence with von Chamier supplement). Also Option U (coordination as family benefit), which has a
more synthetic presentation, should not be excluded from the beginning. Hereby, the other indicators and options should at this stage of the analysis not be overlooked and certain of them seem likely to justify a more narrow choice of solutions which will have to be done in future.
ANNEX 1
DETAILED SUMMARY AND ANALYSIS OF THE ANSWERS OF THE MEMBER STATES TO THE QUESTIONNAIRE ON THE FUTURE COORDINATION OF LTC BENEFITS

This summary is based on the following notes (in chronological order) from Luxembourg (LU) A.C. 54/12, Denmark (DK) A.C. 166/12, Austria (AT) A.C. 168/12, Estonia (EE) A.C. 169/12, Liechtenstein (FL) A.C. 170/12, Poland (PL) A.C. 171/12, Greece (EL) A.C. 172/12, Germany (DE) A.C. 173/12, Latvia (LV) A.C. 174/12, Slovakia (SK) A.C. 175/12, Ireland (IE) A.C. 176/12, Bulgaria (BG) A.C. 178/12, Portugal (PT) A.C. 185/12, Italy (IT) A.C. 186/12, Sweden (SE) A.C. 187/12, the Czech Republic (CZ) A.C. 190/12, Hungary (HU) A.C. 202/12, Spain (ES) A.C. 207/12, Lithuania (LT) A.C. 213/12, Slovenia (SI) A.C. 214/12, France (FR) A.C. 215/12, the Netherlands (NL) A.C. 222/12, Finland (FI) A.C. 226/12, Belgium (BE) A.C. 285/12, Romania (RO), A.C. 321/12 and Norway (NO), A.C. 345/12. Replies to Questionnaire A.C. 018/12 on the coordination of long-term care benefits were not received from Cyprus (CY), Iceland (IS), Malta (MT), Switzerland (CH) and the United Kingdom (UK).

A DETAILED ANALYSIS OF THE NOTES IN A COMPARATIVE WAY

This part is based on the structure of questionnaire A.C. 18/12; the concrete questions are repeated at the beginning of each part.

Preliminary remarks: This is only a short summary. For further elements and aspects the relevant notes have to be read.

Any new way of coordination is a highly sensitive and political issue; the existing scheme is not sufficiently stable as any new cases before the CJEU can introduce a new element: AT. Decisions on definitions and listing of benefits depend on amendments of the coordination. Therefore, at this moment no definite position is possible: AT.

A. Background

1. Please briefly describe the policy approach of your Member State with regard to the persons in the need of LTC, including the recent or future policy developments, trends (such as regionalisation of benefits, etc.).

The MSs described the general principles of their LTC benefits and schemes. These descriptions were especially important in relation to the following questions (when the MSs mention that the descriptions in Annex 1 are not correct or incomplete).

Nevertheless, many of these descriptions gave a lot of elements to consider. As an example, we refer to the SK reply, which tries to justify the social assistance nature of the scheme under discussion by stating that two individuals with the same severe disability do not necessarily have to be compensated with identical compensation, but that this depends on the individual circumstances. Also the descriptions of other MSs show the many differences between the national schemes and benefits, but also in the understanding of social security.
B. Defining, mapping and describing the national schemes

2. Is the definition proposed in the report for LTC benefits (last paragraph of Chapter 1.4. of the Report) enough elaborated to cover all LTC benefits of your Member State? If not, what elements have to be changed?

The definition is regarded as sufficiently elaborated to cover the LTC benefits: LU, DK, AT (depending on the further decisions taken), EE, LV, BG, PT, IT, CZ, ES, SI, NL, or at least as a good starting point for further discussions: FI, BE.

Proposed amendments:

It is too broad: PL (as it also covers benefits in kind regarded as sickness benefits), SK, LT (social assistance has to be excluded)

The notion ‘over an extended period of time’ should be clarified: PL, EL, SK (more than 12 months), IE, HU.

Other remarks: It should be added that benefits in kind and in cash are covered; in addition, it has to be clarified whether really all LTC benefits are intended to supplement sickness benefits: DE. In addition a clear distinction concerning classical sickness benefits has to be made (taking into account the da Silva Martins ruling): PT. The reference to ‘(an)other person(s)’ should be deleted: IT. It should be added that the person is in need of permanent nursing and not only of assistance: LT. An examination of the word ‘considerable’ is necessary as well as an addition to make it clear that also benefits for the carer are included and that the definition covers only benefits based on legislation, which excludes social assistance type benefits: FR. Amendments for the trESS specifications concerning the national system are recorded: SI. The definition seems to cover long-term medical care, which does not form part of the national health insurance: RO.

3. Should this definition be inserted into the Regulation for coordination purposes?

Yes: LU, EE, PL (for benefits in cash only), EL, DE, LV, BG, PT, IT, CZ, ES, SI, FR, NL, FI, RO;

No: FL, SE;

No comment: AT, DK, LT.

The definition should be more elaborated: AT, SK (separating benefits in kind and in cash, inserting also a definition for ‘social assistance’, also LT);

The definition has to solve the situation in relation to LTC benefits which should remain coordinated under other chapters (definition for the rest of LTC benefits): HU;

The definition may be in a Decision of the AC for the application of Article 34 of Regulation (EC) No 883/2004 only: LT;

A definition (not clearly specified if this could be the one proposed) should be included: BE.
4. **Is the list of benefits concerning your Member State in Annex 1 correct? Are all benefits (including regional or local) covered by the definition mentioned? Please explain corrections made.**

Yes: LU, EE, NL, FI;
No: SE (social assistance benefits are included);

Benefits listed as benefits in cash should be regarded as benefits in kind: DK, FL;

**Proposal for a revised list:** AT, PL (if not revised – see remarks under Question 7), EL, DE, LV, SK (showing especially the social assistance elements of some benefits), IE, BG, PT (some updating necessary), IT, CZ, HU, ES, LT (the benefits which belong to social assistance have to be taken out), SI, FR (benefits which should not be coordinated as LTC benefits should be taken out), BE.

C. **Challenges**

5. **Are there other challenges than those elaborated under Part II of the Report, which should be mentioned? If possible, quantify the problems you have identified in terms of number of cases, impact and trends.**

The following additional challenges were mentioned:

- Problems to establish the degree of reliance of care: LU;
- Due to the differences between schemes (linking of the conditions for entitlement to the special situation in the relevant MS) there might neither be benefits from the MS competent for sickness benefits in cash nor from the MS of residence: SK;
- Most problems with disability allowances which have been classified as sickness benefits in cash: FI.

D. **Proposed solutions**

6. **Do you think that the Regulation should be amended to better coordinate LTC benefits? Which solution should be chosen (please select a preferred one(s) from the ones proposed in Part III of the Report? Are there other solutions (not mentioned in the Report) that you would favour?**

Open to any solution: HU, FI;

There should be a separate Chapter for LTC benefits (including also a definition and elaborated list): LU, AT, EL, SK, IE, PT, CZ, LT, SI;

**Special rules for LTC benefits** (irrespective of the place – new chapter or Sickness Chapter): NL;

No change of the existing system of coordination: PL, SE, FR;

All benefits should be regarded as benefits in kind: DK;

**No coordination as sickness benefits:** EE;

Competence only of the MS of residence: AT (if safeguarded that no differential payments or subsidiary competence of any other MS – some parameters are elaborated in the note), LT;
Always the first MS which grants LTC benefits should remain competent is not acceptable: CZ, LT; LTC benefits should not be coordinated as pensions: LT, RO (as invalidity benefits);

Benefits granted to the carer should be regarded as income and so Title II should apply to the carer: PL, IE (also the existing system seems to focus more on direct benefits than on the provision of services), HU;
A detailed list for the application of Article 34 of Regulation (EC) No 883/2004 should be made: PL, BG, LT, FR;

Rights to LTC benefits should be treated as individual rights: SI;

Other remarks: Whatever solution is sought, it must be stable, easy to administer and transparent for the citizens, and social tourism must be avoided: AT. Further rulings of the CJEU should be awaited: FL. An introduction of a specific equalisation of claims for LTC benefits: PL. Special rules for LTC benefits should be included in the Sickness Chapter: IT. Another possibility would be to follow the same principles as under the Family Benefits Chapter: CZ. There should be a non-exhaustive list of LTC benefits: ES. First the work should focus on the application of Article 34 of Regulation (EC) No 883/2004 and on the various CJEU rulings concerning LTC: LT. Article 66 (2) of Regulation (EC) No 987/2009 has to be amended to allow for reimbursement of LTC benefits via a separated liaison body: FR. A better coordination seems to be necessary (it is not yet clear which one): BE.

7. Do you consider that all LTC benefits should be coordinated in the same way (ie. one set of coordination rules), or should it be still possible to coordinate them under different Chapters?

All LTC benefits and schemes should be coordinated under one Chapter: LU, DK, FL, EL, BG, PT, CZ, ES, SI, FR, NL, RO;

Open to both solutions: FI;

LTC benefits should be inserted in Article 3 of Regulation (EC) No 883/2004: LU;

There should be a more elaborated list of all the LTC benefits covered by the new coordination: LU;

LTC benefits should remain coordinated as today under the various chapters of Regulation (EC) No 883/2004: IT, HU (new coordination only for the rest not covered by these special chapters), some MSs refer to some of these cases explicitly;

Social assistance benefits cannot be coordinated as other LTC benefits: AT (at least this has to be further examined), PL, DE (this also applies to LTC benefits for victims of war), SK, LT;

Special family allowances for handicapped children shall remain coordinated as family benefits: AT, LV; same opinion concerning medical care allowances for children and supplement to family benefits which are treated as family benefits: PL;

LTC benefits granted under the accidents at work and industrial diseases scheme should remain coordinated under the relevant chapter, as this is more favourable for the persons concerned: AT, DE, LV;

Benefits which up until now have been regarded as invalidity benefits cannot be treated as LTC benefits: PL, DE;
Benefits in kind and in cash should not be coordinated in the same way: EE, SK; A better coordination seems to be necessary (it is not yet clear which one): BE.

E. Other questions

8. What have been so far your experiences with the application of Article 34 of Regulation (EC) No 883/2004?

Various reported problems: With regard to the granting of LTC benefits in kind in other MSs, LU reports problems which have been solved in relation to DE but which are more complicated in relation to FR and BE (as BE does not regard these benefits as LTC but as sickness benefits). Application is very complicated and complex (benefits only during the same period, problems with benefits in kind which are only granted on a sporadic basis, no legal possibility under national legislation to recover overpaid LTC benefits in cash: AT. Major problems if the MS of residence or stay cannot inform in due time about the reimbursement rates: DE. Problems because of more than 100 departments which might be competent: FR.

Up until now no benefits in kind have been granted: LT.

No problems: LV, FI;

No information gathered: DK, SK, BG, PT, HU, ES.

9. Please supply any data and statistics that you have regarding the situations of cross-border LTC concerned by today's coordination, the trends and the amount of money involved.

Concrete data were provided: AT, CZ, LT (data available concerning received SEDs), SI;

No data were available: EE, PL, DE, LV, IE, BG, PT, HU, FI.

10. Please provide any other input/comment that you might consider useful in the future discussions in the Administrative Commission on this topic.

Further discussion of the da Silva Martins ruling of the CJEU is needed: PL;

Proposal for a further entry into Annex X of Regulation (EC) No 883/2004: LV;

If benefits that are treated today as social assistance would have to be regarded as covered by Regulation (EC) No 883/2004 this would also mean taking away benefits resident in a MS for whom another MS is competent to bear the costs of sickness benefits: SK.
ANNEX 2

BENEFITS WHICH COULD BE CLASSIFIED AS LONG-TERM CARE BENEFITS IN THE MEMBER STATES\textsuperscript{17}

Preliminary remarks

A first list has been drafted as an Annex 1 to the trESS Think Tank Report 2011 on coordination of LTC benefits (A.C.610/11). With questionnaire A.C. 018/12, members of the AC were invited to analyse this list and report any necessary changes. The revised list is attached.

Notes from delegations of the following MSs (in alphabetical order) have been considered: Austria (AT) A.C. 168/12, Belgium (BE) A.C. 285/12, Bulgaria (BG) A.C. 178/12, the Czech Republic (CZ) A.C. 190/12, Denmark (DK) A.C. 166/12, Estonia (EE) A.C. 169/12, Finland (FI), A.C. 226/12, France (FR) A.C. 215/12, Germany (DE) A.C. 173/12, Greece (EL) A.C. 172/12, Hungary (HU) A.C. 202/12, Ireland (IE) A.C. 176/12, Italy (IT) A.C. 186/12, Latvia (LV) A.C. 174/12, Liechtenstein (FL) A.C. 170/12, Lithuania (LT) A.C. 213/12, Luxembourg (LU) A.C. 54/12, the Netherlands (NL) A.C. 222/12, Norway (NO) A.C. 345/12, Romania (RO) A.C. 321/12, Poland (PL) A.C. 171/12, Portugal (PT) A.C. 185/12, Slovakia (SK) A.C. 175/12, Spain (ES) A.C. 207/12, Slovenia (SI) A.C. 214/12, Sweden (SE) A.C. 187/12. They should be consulted directly for more detailed explanations of the views taken by the delegations of the responding MSs. Anyhow, some MSs have not reported any need for a revision – in such cases the previous content has been taken over into the new list attached.

Replies to Questionnaire A.C. 018/12 on the coordination of long-term care benefits were not received from Cyprus (CY), Iceland (IS), Malta (MT), Switzerland (CH) and the United Kingdom (UK).

It should be noted that benefits listed below could be classified as LTC benefits according to the legislation of the respected MS. It is subject to an agreement between the MS (either in a form of an AC decision or amendment of Regulation (EC) No 883/2004) or decisions of the Court of Justice of the EU (CJEU) which benefits \textit{in concreto} should be subject to the coordination regime and which coordination rules should be applied. When certain MSs have already taken a view concerning the coordination of certain benefits listed, this is specifically mentioned.

\textsuperscript{17} “The currency is converted on 18 October 2011 via http://www.tijd.be/wisselkoersen”. Some amounts have been updated to the year 2012 by the Notes of the delegations of the MSs Concerned.
Austria

Applicable statutory basis

Cash benefits:

Benefits in kind:

Benefits in kind

1. Home care
Mobile and outpatient care, such as:
- visiting service,
- Social homecare (home-helpers),
- 24-hour-care,
- meals on wheels,
- family support,
- personal assistance,
- medical home care,

2. Semi-residential care
- semi-stationary care in care facilities, e.g. in day centres or residential care facilities
- day centres for people with disabilities

3. Residential care
- residential care facilities, e.g. nursing homes
- comprehensive care in residential communities
- short-term care
- residential care facilities for people with disabilities

4. Other benefits
A consulting and information service for persons in need of care and their relatives, such as:
- long-term care phone service
- legal counsel for disabled persons
- case- and care Management
- support groups / self-help groups

Cash benefits

* Pflegegeld: under the Bundespflegegeldgesetz (BPGG) or one of the Landespflegegeldgesetze of the nine provinces. The latter have been repealed as of the beginning of 2012 and all entitlements are determined now under the federal law.

Pflegegeld is a tax-financed benefit granted irrespective of the cause of need, the recipient’s income, assets or age. There are seven different levels of Pflegegeld depending on the intensity of the need of care and assistance.
Pflegegeld (per Month):
Level 1  € 154.20
Level 2  € 284.30
Level 3  € 442.90
Level 4  € 664.30
Level 5  € 902.30
Level 6  € 1,260.00
Level 7  € 1,655.80

In case of semi-residential long-term care (e.g. in a day centre), long-term care benefits are due.

In case of providing residential care in a care facility, a maximum of 80% of the long-term care benefit is transferred to the institution bearing the cost of residential care. The monthly spending money amounting to € 44.30 is left to the person in need of care.

The long-term care benefit (Pflegegeld) is paid directly to the person in need of care and can be spent by him or her for the financing of the long-term care at his or her sole discretion. In case of improper use of the long-term care benefit, it can be replaced by benefits in kind.

* Zuwendungen aus dem Unterstützungs fonds (§§ 21a, 21b BPGG; directives released by the Federal Minister of Labour, Social Affairs and Consumers' Protection): Means-tested allowances can be granted by supporting funds (but without legal entitlement)
  a) to persons giving care to close relatives who are entitled to Pflegegeld of at least level 3 (even level 1 will be sufficient if the recipient of the Pflegegeld is suffering dementia or is underage) as long as they have to take leave. The allowance shall enable them to make use of substitutional professional care during that rest period and amounts from € 1,200 up to € 2,200 (subject to the level of Pflegegeld) per year.

  b) to the person in need of care him or herself or their relatives as long as they make use of 24-hours-assistance by professional caregivers: The allowance amounts to € 550 per month if the professional caregivers are self-employed and to € 1,100 per month for employed caregivers.

* erhöhte Familienbeihilfen für erheblich behinderte Kinder

Combination of benefits

Cash benefits from the State and Länder as well as benefits in kind via public and private providers.

A combination of benefits is possible. If recipients of Pflegegeld make use of professional services at home or in a nursing home they (and sometimes even close relatives, at least their spouses) have to pay means-tested cost shares taking into account up to 80 per cent of the Pflegegeld.

These cost shares have to be considered as one of the main reasons that – as recent studies show – only one third of recipients of Pflegegeld make use of professional services.

18 It is argued in the Austrian note that higher family benefits for considerably disabled children could fall under the definition of LTC benefits. However, they are coordinated as family benefits, which might be more beneficial for the entitled persons.
Benefits for the Carer

- Zuwendungen aus dem Unterstützungsfonds (see above, Cash benefits)
- Pension insurance for caring family members: an option of a preferential voluntary insurance and preferential continuation of affiliation to the pension insurance from category 3. The federal government pays contributions for voluntary self-insurance or optional continued insurance in the field of pension insurance entirely and for an unlimited period of category 3 and above.
**Belgium**

**Applicable statutory basis**

No specific legislation at federal level. However, certain benefits are provided for in the legislation on sickness and invalidity insurance and on guaranteeing sufficient resources namely the:

- Health Care and Sickness Benefit Compulsory Insurance Act (Loi relative à l’assurance obligatoire soins de santé et indemnités / Wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen), coordinated on 14 July 1994; and the
- Act of 27 February 1987 on disabled persons’ allowances (Loi relative aux allocations aux personnes handicapées / Wet betreffende de tegemoetkomingen aan gehandicapten), respectively.

At the level of the federated entities (Flemish Community): the Decree of the Flemish Parliament of 30 March 1999 on the organisation of care insurance (Decreet houdende de organisatie van de zorgverzekering), last amended in March 2011 to take account of the modernised EU social security Coordination Regulations; and Orders of the Flemish government of 28 September 2001.

**Benefits in kind**

1. **Home care**  
   *Sickness and invalidity insurance:*  
   Nursing care at home for heavily dependent patients. The insurance covers part of the fixed costs of this care according to the state of physical dependence of the patient:

   - dependency category A:  
     - €15.94 with preferential scheme,  
     - €12.13 without preferential scheme;

   - dependency category B:  
     - €30.93 with preferential scheme,  
     - €28.05 without preferential scheme;

   - dependency category C:  
     - €42.40 with preferential scheme,  
     - €38.37 without preferential scheme

2. **Semi-residential care**  
   *Sickness and invalidity insurance:*  
   No benefits in kind in case of semi-residential care.

3. **Residential care**  
   *Sickness and invalidity insurance:*  
   Rest and nursing homes, psychiatric nursing homes and rest homes for the elderly: a single lump sum determined by the institution.

4. **Other benefits**  
   *Sickness and invalidity insurance:*  
   No other benefits.
**Cash benefits**

**Sickness and invalidity insurance:**
A single person or a cohabiting person without dependants who draws invalidity benefit (indemnité d'invalidité / invaliditeitsuitkering) receives a higher compensation rate (65% instead of 55% or 40%) if he or she is recognised as being in need of constant care.

Disabled persons who have dependants and who fulfil the conditions to be recognised as being in need of the assistance of a third party are entitled to a flat-rate allowance of € 12.99 per day.

**Care insurance (Zorgverzekering/Assurance soins):**
Insurance coverage for community-based care and home care: a fixed monthly amount of € 130. The same amount is granted if the person resides in an institution other than a service flat.

The benefit is paid to the user.

**Integration allowance (allocation d'intégration / integratietegemoetkoming) and allowance for assistance to the elderly (allocation pour l'aide aux personnes âgées / tegemoetkoming voor hulp aan bejaarden):**

Integration allowance:
- Category I: € 1 082.50
- Category II: € 3 688.76
- Category III: € 5 894.18
- Category IV: € 8 587.07
- Category V: € 9 741.49

Allowance for assistance to the elderly:
- Category I: € 925.06
- Category II: € 3 531.18
- Category III: € 4 293.35
- Category IV: € 5 055.29
- Category V: € 6 209.71

**Sickness and invalidity insurance, care insurance (Zorgverzekering/Assurance soins), integration allowance (allocation d'intégration/integratietegemoetkoming) and allowance for assistance to the elderly (allocation pour l'aide aux personnes âgées/tegemoetkoming voor hulp aan bejaarden):**

Discretionary use.

Benefits are paid on a flat-rate basis. The actual provision of care to the beneficiary need not be proven.

The **supplementary allowance for children with disabilities** under the age of 21. The amount of this allowance, which is a supplement to the child benefit, varies according to the degree of disability, taking into account the physical and mental consequences of the disability, the consequences for the participation of the child in daily life (mobility, learning capacity, personal hygiene) and the consequences for the family.

Some benefits of the Flemish and Walloon agencies for disabled persons (VAPH/AWIPH, respectively), notably the **personal assistance budgets**. These are (earmarked) budgets (i.e. no discretionary use) awarded to disabled persons in order to, among other things, ensure their independent living, in particular by allowing them to personal assistants (employed or not, respectively) for help in activities of daily living.
In the case of **accidents at work and occupational diseases**, a **supplementary allowance** can be awarded of a maximum of 12 times the average monthly guaranteed income, according to the degree of need, index-linked from the beginning of the period of compensation and terminated as of the 91st day of hospitalisation.

**Mixed benefits**

*Sickness and invalidity insurance:*
The possibility of mixed benefits in case of heavily dependent patients. See “Benefits in kind”, “1. Home care” and “Cash benefits”, “1. Amount”.

*Care insurance* (Zorgverzekering/Assurance soins), *integration allowance* (allocation d’intégration/integratietegemoetkoming) and *allowance for assistance to the elderly* (allocation pour l'aide aux personnes âgées/tegemoetkoming voor hulp aan bejaarden):
No mixed benefits.

No free choice between benefits in kind and cash benefits.

**Benefits for the carer**

No specific benefits for the carer.
Applicable statutory basis

Long-term care in Bulgaria is not a separate social risk. The possible benefits in such cases are of various natures – social insurance, public assistance, etc. They are regulated in many statutory acts. The most important of these acts are:

- the Social Insurance Code,
- the Social Assistance Act,
- and the Regulation for the Implementation of the Social Assistance Act,
- the Integration of Persons with Disabilities Act,
- and the Regulation for the Implementation of the Integration of Persons with Disabilities,
- the Family Allowances for Children Act,
- the Wars Veterans Act,
- and the Regulation for the Implementation of the Wars Veterans Act,
- the Ordinance on the Medical Expertise of the Working Capacity,
- the Tariff of the Fees for Social Services Financed by the State Budget.

Benefits in kind

Depending on the content of these benefits they may be divided as follows:

1. **Home care.**
   People receive the necessary care in their home. The forms of such benefits are:
   - The delivery of food, cooking and help with eating,
   - Shopping and the delivery of necessary household goods,
   - Maintaining personal and home hygiene,
   - Support in taking medicines, accompanying during doctor visits, etc,
   - Support in the supply of technical facilities in case of invalidity or severe disease,
   - Administrative and everyday necessities services (payment of electricity, phone and other utilities, filling in administrative forms, etc),
   - Assistance in communication and social contacts.

2. **Semi-residential care**
   In these cases people live in their homes, but receive some care in specialised establishments. The main forms of such care are:
   - *Day care centre* – provides a complete package of services to the persons during the day, including the provision of meals as well as the provision of the daily health, educational and rehabilitation services plus the organisation of free time and personal contacts.
   - *Centre for social rehabilitation and integration* – performs rehabilitation, legal consultations, educational and professional training and guidance elaboration and performance of individual programmes for social inclusion.

3. **Residential care**
   People receive the necessary care out of their homes, in specialised establishments. The types of these establishments are:
   - *Centre for family-type accommodation.* A complete package of social services delivered in an environment similar to the family environment for a limited number of persons are provided in such centre.
   - *Home for medical and social care.* A complete package of services for children up to 3 years of age is provided here.
• **Home for children with physical disabilities** – provides a complete package of services for children between 3 and 18 years of age.

• **Home for children with mental backwardness** – a complete package of services for children between 3 and 18 years of age is the characteristic of this home.

• **Home for adults with mental backwardness** – the same as the previous, but for people over 18 years of age.

• **Home for adults with mental disorders.** A complete package of services for people over 18 years of age depending on their situation.

• **Home for adults with physical disabilities** – the same as the previous.

• **Home for adults with sensor disorders** – the same as the previous.

• **Home for adults with dementia** – the same as the previous.

• **Home for elderly people.** People having reached the statutory retirement age, including those with disabilities receive a complete package of social services for people in such homes.

4. **Other benefits**

Here, we may point out the targeted assistance the purchase and repair of technical supportive devices, facilities and medical appliances for compensation of the disability. The assistance is provided in the form of reimbursement of actual expenditures made by persons with disabilities for the purchase and repair of the devices, facilities and appliances.

**Cash benefits**

These are provided by various sources. Such benefits are:

• **Family benefits for children with permanent disabilities.** These are paid by the state budget and are:
  - The monthly benefit for raising a child with permanent disabilities. It is paid until the child reaches the age of 2 years regardless of family income.
  - The monthly benefit for a child with a permanent disability until the completion of secondary education.
  - The monthly supplement for children up to 18 years of age with a permanent disability.

• **Benefits for social integration of persons with permanent disabilities.** The state budget pays these benefits. These are:
  - **Monthly allowances.**
  - **Targeted allowances depending on the particular needs of the person.**

• **Supplement to the pension of pensioners with reduced working capacity over 90% who need permanent assistance of a carer.** This is paid by the state social insurance.¹⁹

**Combination of benefits**

No mixed benefits.

Free choice between cash and/or benefits in kind not possible.

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¹⁹ In the Bulgarian note it is argued that this benefit (top-up for a personal assistant to persons with a 90% disability in need of assistance in their day to day life) is essentially the only LTC cash benefit. Some benefits have been removed from the list (Invalidity pensions, Cash allowance when the insured person does not meet the requirements for invalidity pension and Santorium and resort treatment compensation).
Benefits for the carer

Persons (parents, spouses, individuals) employed under the National Programme “Assistants for People with Disabilities” and the National Programme “Social Services in Family Environment” receive a monthly remuneration the amount of which is equal to the statutory monthly minimum wage.
Applicable statutory basis

Social Welfare Services (Υπηρεσίες Κοινωνικής Ευημερίας):

The Public Assistance and Services Act of 2006 (Ο περί Δημοσίων Βοηθημάτων και Υπηρεσιών Νόμος του 2006, N. 95(I)/2006)

The Public Assistance and Services Regulations (Οι περί Δημοσίων Βοηθημάτων και Υπηρεσιών Κανονισμοί)


Benefits in kind

1. Home care
This includes services such as personal hygiene, house cleaning, washing of clothes, cooking, payment of bills, shopping, etc. It is provided to people entitled to a public assistance benefit or people who cannot meet their special needs with their income. This support provided to vulnerable groups of people aims to enable the latter to live at home. Social Welfare Services employ carers who visit people in need of care at their own premises and who provide services according to their needs. Carers can also be employed by Community Councils or may be self-employed. The salary of the last two categories is paid by the Public Assistance Fund.

2. Semi-residential care
The day care service offers the elderly and the disabled persons the opportunity to live at home as long as possible. People who cannot care for themselves can spend their daytime at their local day centres where they are offered cooked meals and laundry facilities. Day care centres are operated by the Community Welfare Councils and are financed by the Scheme of State Funding.

Additional sources of information:

- Feedback provided by Social Welfare Services, Ministry of Labour and Social Insurance, Cyprus, on June 2011
- Other sources, including relevant developments on Cyprus at ec.europa.eu/social/ajax/BlobServlet?docId=2602&langId=el, as at 17.6.2011
- A private database providing updates on legislation and case law in Cyprus (www.leginet.com)
- MISSOC tables.
3. Residential care

Residential care is strictly provided for people when their individual needs cannot be met on a 24-hour basis by their family or other supportive services. The Social Welfare Services place people in need of Residential Care in governmental, community or privately owned Residential Homes.

It should be noted that “Houses in the community” are houses providing accommodation for up to five disabled persons. They function on the basis of The Homes for the Elderly and Disabled Persons Law of 1991. Foundations may run such “Houses in the community”.

“Shelters for the elder and people with disabilities” provide residential care. They are subject to the Homes for the Elderly and Disabled Persons Act of 1991.

4. Other benefits

The Social Welfare Services subsidises the Pancyprian Volunteerism Coordinative Council which may, among others, offer training courses for non-governmental home carers.

Telecare services have been suspended as of September 2010.

- The National Action Plan for the Elderly 2005-2015, elaborated by the Ministry of Health, provides a programme on the development of geriatric services. The latter aim at the timely diagnosis and treatment of diseases which lead to the dependency of the elderly, the extension of their capacity to take care of themselves and the improvement of the quality of their life. We are not aware of the state of progress of this action plan.
- Specialised programmes in the framework of the Community Nursing Mental Health policy concerning the elderly with mental problems, the persons suffering from Alzheimer or other disorders, etc. Mental Health Community Centers notably direct their services towards individuals, including the elderly, with chronic mental health problems that require continuous support and mobilisation in their families and professional environment.
- The Scheme on Social Assistance on Improving Housing Conditions (Σχέδιο Παροχής Κοινωνικής Αρωγής για τη Βελτίωση των Συνθηκών Στέγασης), which provides a lump sum principally to the recipients of public assistance in view of improving their housing conditions.
- The Scheme on the Support of Families for Caring for the Elder and/or Disabled Members (Σχέδιο για την Ενίσχυση Οικογενειών για τη Φροντίδα Ηλικιωμένων ή/και Αναπήρων Μελών τους), which aims to enhance the families in view of keeping their elderly and/or disabled members at home via the adjustment of their housing conditions.
- The Scheme on the Funding of Local Authorities, in view of providing technical or financial assistance by the Social Welfare Services, under the form of a State subsidy, for the development of actions in local societies.
- Care Programmes for Drugs: programmes including prevention, timely intervention, treatment and social inclusion of persons that are addicted to drugs.
- Care Programmes at Prisons for condemned persons who are mentally ill and require long-term treatment and care. We are not aware of the state of progress of said programme.

Cash benefits

According to data provided by the national administration, cash benefits relating to home care amount to € 6 per hour or a maximum of € 240 per month; cash benefits relating to day care vary from € 85 to € 137 per month, depending on the services offered to the recipient concerned, and cash benefits relating to residential care vary from € 623 to € 744 per month.
With regard to home helpers, in the case of a person in need of 24-hour home care who is entitled to public assistance, it was reported by Social Welfare Services that from 1.7.2011, their salary amounts to €326, plus social insurance contributions amounting to €83.

- **Care benefit**: intended for paraplegics and quadriplegics who are in need of personal care due to wheelchair use and limited body functioning.
- **Financial Assistance for Technical Equipment Benefit**: addressed to disabled persons aiming to improve their quality of life by using technical means that contribute to their autonomy at the workplace and at home.
- **Financial Assistance for Wheelchairs Benefit for People with Severe Mobility Impairment**. The scheme aims at ensuring a financial aid in view of covering certain additional needs of persons with severe motor disabilities. The persons concerned cannot walk and permanently sit in the wheelchair.
- There is an **allowance concerning the blind** (ειδική χορηγία για τυφλούς) which is granted on an annual basis by the Service of Grants and Benefits of the Ministry of Finance under the conditions provided in Article 6 of the Law on Special Grants of 1996 (Ο περί Παροχής Ειδικών Χορηγιών Νόμος του 1996). The allowance should enable the beneficiaries to deal with the specificities concerning their disability (e.g. purchase of special devices, adaptation of their domicile in view of improving their conditions of living, etc).
- **A child benefit** is granted under the conditions provided in the Act on Child Benefits of 2002 (Ο περί Παροχής Επιδόματος Τέκνου Νόμος του 2002). Its personal scope of beneficiaries includes children aged under 18, unmarried dependants aged 18-25 doing their military service or aged 18-23 engaged in education, dependants aged 23-25 engaged in education for the same duration as their military service and children, regardless of their age, who are permanently deprived of their capacity for self-preservation.

**Combination of benefits**

Recipients of public assistance who are in need of short or long-term care may be provided services in kind and/or cash benefits for care.

Care services include day care, residential care and home care. Cash benefits include the monthly fees paid for residential/day care, the Home Helper’s salary and social insurance contributions, and pocket money for persons who live in public residential homes and Community Homes.

The claimant cooperates with a welfare officer to develop his or her personal care plan (e.g. type of care, frequency) based on individual needs for care services in kind and/or cash benefits.

The claimant has the choice to decide on the type of care (in cash and/or in kind) needed.

**Benefits for the carer**

*Social Welfare Services (Υπηρεσίες Κοινωνικής Ευημερίας)*:

The State may pay (fully or partly) a private home carer who may be a family member. It is possible to compensate a family member who provides long-term care (if a family member is required to stop working for that purpose, or if he or she is of low socio-economic standing), or a friend or a non-governmental organisation, offering home care services for the provision of long-term care to persons entitled to public assistance who are in need of care.

Moreover, the state may pay the salary and the social security contributions of a Home Helper in the case of a person in need of 24-hour home care who is entitled to public assistance.

In the case of informal caregivers a contract is signed between the Social Welfare Services, the person in need and the caregiver (if the amount allocated for care exceeds a certain amount).
CZECH REPUBLIC

Applicable statutory basis

- Act No. 108/2006 on social services (Zákon o sociálních službách).
- Act No. 20/1966 on Care for Public Health (Zákon o péči o zdraví lidu).
- Act No. 48/1997 on Public Health Insurance (Zákon o veřejném zdravotním pojištění).

Benefits in kind

The benefits in kind are regulated especially by Act 108/2006 on social services. Among the social services, the home services, home social care services and personal assistance are regulated. There are also special health care facilities provided to people in need of LTC, regulated by Act 20/1966 and financed by the health insurance system. This service is, however, financed for a definite time only. When the situation of the patient does not improve, there are classical social services offered.

1. Home care

Health care facilities:
Special outpatient facilities: home health care, home health care agencies (note that home care workers ensure only medical care), palliative care, and hospices.

Social services:
Home services (in clients’ home ensuring social assistance and support apart from specialised medical treatment):
- home social care services (domiciliary care provides assistance in the care of one’s own person, organising meals and assistance in running a household to people with a limited ability in the area of personal and home care),
- personal assistance (intended for people whose capabilities are limited because of disabilities, age or illness for example in the areas of personal care, use of public places, household care, contact with family and broader society. The service is provided in the environment where the individual lives, works, etc. The personal assistance services include reading, interpreting and guiding services),
- emergency care,
- early intervention services (oriented towards entire families with a young child whose development is at risk because of a disability or illness. The service includes the use of educational, social and health care measures. The objective is to return or maintain the parents' competence to raise the child and create suitable conditions for the child's development. The services are provided in the household and specialised day care institutions, usually free of charge)
- social counselling (part of every kind of social service).

2. Semi-residential care

In case the person only needs day care, especially when the health situation of the person allows it, there are day care centres available according to the Social Services Act.

Day and week care centres are intended for people whose capabilities are limited, particularly in the areas of personal care and household care and who cannot live at home on a daily basis without someone else’s assistance. Providing temporary housing may be part of the service.

In the same vain, there are also some specific outpatient services, like day service centres, respite care services etc., again regulated by the Social Services Act.

Respite care is the assistance for families that take all year-long care of a disabled person or a senior. The provider supplies services to the individual at times when the family members are at work, on
holiday, do common errands outside the home, etc. The care is provided in the household or in specialized residential institutions (day care or short-term stays of up to three months).

3. Residential care

Health care facilities:
Aftercare health care facilities: establishment for the long-term ill, expert and rehabilitation treatment institutes, mental hospitals.

Social services:
Residential services are mainly provided under the social services act, which envisages establishing residential services facilities: weekly short-stay social welfare institutions, homes for the elderly and persons with disabilities and special purpose homes (for the mentally ill, for drug addicts, persons with Alzheimer’s dementia, etc.).

Stays in homes for the elderly and homes for the people with learning disabilities are intended for people whose capabilities are limited, particularly in the areas of personal care and household care and who cannot live at home in this situation. Providing housing in accommodation that is specifically designated for such a purpose and substitute homes for the users are a part of the service. The service is not restricted by time.

Protected and supported housing is intended for people whose capabilities are limited, particularly in the areas of personal care and household care and who want to live independently in the standard environment. Providing housing in an apartment that represents a home for the user, is managed by the provider and is part of a standard housing complex, is a part of the service.

Other social services and special purpose homes are intended for persons in specific situation, e.g. homelessness, drug addiction, poverty etc.

The residential care services are mainly run by the public local authorities – often established by the cities or municipalities – there are, however, also some NGOs, especially the church NGOs, which also establish residential care services for people in need of LTC.

4. Other benefits

No other benefits are directly applicable.

Some additional social assistance benefits might be mentioned, if also rehabilitation and occupational and empowerment activities would be considered as LTC. The social assistance benefits are regulated by Act No. 100/1988 Coll. on social security and by order of the Ministry of Labour and Social Affairs No. 182/1991 Coll. on implementing the act on social security. Under this legislation, a benefit for compensation assistance tools – like a wheelchair, stocks etc. – can be claimed, as well as an allowance to buy a car for a handicapped person or to rebuild a house or a flat in order to make it barrier-less. However, these benefits do not fall under the coordination and, from the coordination’s point of view, are not considered as LTC benefits.  

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This argument is underpinned by the Czech note stating that the reference to the additional social assistance benefits is no longer up-to-date, however, as these benefits do not come within the material scope of coordination rules, it is not necessary to amend the list.
Cash benefits

In case of LTC, the most important cash benefit seems to be the "care allowance," as regulated in the Social Services Act. Care allowance is a benefit paid to individuals dependent on care to arrange for necessary care or services. The rate of the care allowance varies according to the age of the beneficiaries (aged under or over 18) and the degree of dependency (based on an assessment of self-care capabilities - ADL, IADL). There are four levels of amount of the care allowance according to the seriousness of health problem, disability and incapability of self-sufficiency etc. Users pay for care and have a choice to use care allowance for either professional or informal care.

Combination of benefits

Benefits in kind and cash benefits can be combined.

The person in need of care may not choose between benefits in kind and cash benefits, but has a choice to use a cash benefit (care allowance) for either professional or informal care.

Benefits for the carer

Carers are not entitled to specific benefits. They receive the care allowance from dependent persons. The State pays health and social insurance contributions for those registered as informal carers. Periods of caring are taken into account for the purposes of old-age pension calculation.

However, Respite care as assistance for families is provided (see point 2. Semi-residential care, above).
**DENMARK**

**Applicable statutory basis**

- Consolidated Act No 81 of 04/02/2011 on Social Service Benefits (*om social service*).
- Consolidated Act No. 103 of 11/02/2011 on Social Housing (*om almene boliger*).
- Consolidated Act No. 663 of 14/06/2011 on Housing Subsidies (*om individual boligstøtte*).
- Consolidated Act No. 666 of 17/06/2010 on Housing for elderly and handicapped persons (*om boliger for ældre og personer med handicap*).
- Consolidated Act No. 743 of 27/06/2011 on Help with the purchase of equipment and consumables after the Consolidated Act on social services benefits (*om hjælp til anskaffelse af hjælpemidler og forbrugsgoder efter serviceloven*).

**Benefits in kind**

1. **Home care** (consolidated Act on Social Service Benefits, Section 83)
   Personal hygiene, domestic help and assistance to a person to maintain his or her capacities (rehabilitation).
   In some cases, the accompanying person under 67 years (for persons who are severely disabled the accompanying service includes 15 hours monthly).

2. **Semi-residential care** (consolidated Act on Social Service Benefits, Section 108)
   The municipal council shall provide accommodation in facilities suitable for long-term accommodation for persons in need of extensive assistance for general day-to-day functions or care, attendance or treatment, where such needs cannot be addressed in any other way.

   The municipal council can offer people who have need for it, a temporary stay in a care centre or nursing home.
   After specific individual evaluation, relief can be granted to a family or a person taking care at home of a person with a reduced mental or physical functional capacity. This relief can take the form of care in a day centre or of an overnight stay in a nursing home.

3. **Residential care** (Consolidated Act on Social Housing)
   There are many different types of housing (mainly for elderly, but also for disabled persons):
   - Family home
   - Close-care accommodation
   - Private nursing home
   - Private nursing home/private dwelling

   The local authority decides whether a citizen requires assistance which cannot be given in the form of home care. If a citizen is offered residential accommodation, she or he can choose between different alternatives within the municipality or even in other municipalities.

4. **Other benefits**
   - the adaptation of the dwelling and provision of special equipment, consolidated Act on Social Service Benefits, Section 100.
   - The replacement and relief of a person who is providing his or her partner or a close relative care at home, the consolidated Act on Social Service Benefits, Section 84.
   - Subsidies for the purchase of cars. Consolidated Act on Social Service Benefits, Section 114:
   - Subsidies for the purchase of cars shall be available for persons with permanently impaired physical or mental function substantially reducing their freedom of movement or
substantially reducing their possibilities of finding or maintaining employment or completing an education without the use of a car.

- Technical aids. Consolidated Act on Social Service Benefits, Section 112 (1):
The municipal council shall grant support for technical aids for persons with permanent impairment of physical or mental function, where the aid
  (i) will remedy the permanent effects of the functional impairment significantly;
  (ii) will facilitate daily life in the home significantly; or
  (iii) is necessary to enable the person to carry out an occupation.
The municipal council may direct that a specific aid shall be supplied by particular contractors. In connection with the conclusion of supply contracts by the municipal council, representatives of the users shall be involved in the drafting of performance specifications. In some cases there are free choices, e.g. hearing aid.

- Housing subsidies: Consolidated Act on Housing Subsidies section 2a:
Owners or members of private housing cooperatives who are severely physically disabled and whose dwelling is suitable for such purpose, shall upon application be eligible for housing benefits under this Act. The same shall apply for persons who are severely physically disabled, and who share a household with a tenant, an owner or a member of a private housing cooperative, and who live in a dwelling suitable for severely physically disabled persons.

- Food service (Madservice-ordning)
The Consolidated Act No. 81 of 04/02/2011 on Social Service Benefits, Chapter 16, Section 83: The municipality must offer citizens in need food service. The citizen can receive the food service after a specific individual evaluation. The food service requires payment from the citizen.

Cash benefits

Subsidies in cash:
- The Consolidated Act on Social Services, Section 95 (1): If the municipal council is unable to provide the necessary assistance for a person in need of assistance under sections 83-84, the municipal council may instead pay a subsidy towards any assistance engaged by such person.
- The Consolidated Act on Social Services, Section 96 (1): The municipal council shall offer citizen-controlled personal assistance. Citizen-controlled personal assistance shall be offered in the form of subsidies to cover the cost of employing care assistants and supervision and attendance of citizens with considerably and permanently impaired physical or mental function who require special support.

Necessary extra costs in relation to disability:
The Consolidated Act on Social Service Benefits, Section 100 (1): The municipal council shall pay any necessary extra costs relating to the personal day-to-day maintenance of persons between the age of 18 and the state pension age, cf section 1 a of the Act on Social Pensions, with permanent impairment of physical or mental function, and of persons with permanent impairment of physical or mental function who have deferred their claim for old-age pension pursuant to Section 15 a of the Act on Social Pensions. It shall be a condition that the extra costs are a result of the impaired function and are not recoverable under any other legislation or under other provisions of this Act.

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22 In Danish note it is argued that for coordination purposes benefits mentioned under “cash benefits” seem to be better placed under “benefits in kind” in accordance with the definition given in Art. 1 (va) of the Regulation 883/2004.
Combination of benefits

No mixed benefits.

Benefits for the carer

The Consolidated Act on Social Service Benefits, Section 84: A person with a gainful activity who wishes to take care of a closely related person suffering from a significant disability can be employed by the municipality where the disabled person lives.
ESTONIA

Applicable statutory basis


Benefits in kind

1. Home care
Home care is provided by local government, helping them to manage in their usual environment, excluding the care that requires physical contact.

Long-term supportive services are continuously provided for people living independently to enable them to use general public services.

Home services are, for example, cleaning and caring for the house, the procurement of food, pharmaceuticals, other necessities and firewood or other fuel, and information and assistance in administrative matters.

2. Semi-residential care
Provided by local government, to support a person or his or her family to maintain capacity in institutions where the person spends the day. Day care is provided by day centres where social services, developmental and hobby activities are offered during the day. An elderly or disabled person can visit the day centre as often as he or she wishes (has need for).

Day care centres can offer services for people with dementia – family members/caregivers bring a person diagnosed with dementia to the day care centre and professionals take care of him or her.

The purpose of day centres is to maintain the welfare and activity of their clients; and to support them in staying at home for as long as possible.

3. Residential care
Nursing homes, homes for the elderly and disabled.

4. Other benefits
Technical appliances (including prostheses) financed by the State and community based mental health services for people with special mental needs, partially provided by the State and partially by the local government.

Activities aimed at improving the mobility of persons (various transportation subsidies/services) could also be considered. The reason is that the freedom of mobility plays the most important role in ensuring people’s independence and awareness of social activity.

It seems important to add that the organisation of LTC is predominantly done by local authorities. Local governments provide a flexible approach to a wider opportunity for LTC services with existing local needs and resources.

Cash benefits

No cash benefits. Estonia only has benefits in kind. It is believed that at the moment it is not the most appropriate time to create the cash benefit system. It is argued that long-term care, in particular, first needs a variety of services and assistance, and less direct forms of financial assistance.
Combination of benefits

No cash benefits.

Benefits for the carer

The Caregiver’s Benefit (hooldajatoetus): provided by the local governments to caregivers who support persons with an assessed degree of disability in everyday activities (paying bills, organising transportation to a doctor or to a bank when needed) and who also provide care service at home (personal assistance in eating, clothing, washing; home assistance in cleaning, cooking, buying products). In some local governments this benefit is paid to the disabled person.

The conditions are regulated by the local governments and may therefore differ. The main condition is that the caregiver or the family member who provides the care has been appointed by the local government. The amount is different (€ 25.56 – 31.96), plus national insurance contributions. The benefit is applicable for the informal caregiver.
**FINLAND**

**Applicable statutory basis**

- The Act on interpretation services for disabled persons (*Laki vammaisten henkilöiden tulkkauspalveluista*) of 19 February 2010.
- The Act on Support for Informal Care (*Omaishoidon tuki*) of 2 December 2005.
- The Act on Special Care for Handicapped Persons (*Laki kehitysvammaisten henkilöiden erityishuollosta*) of 23 June 1977

The Finnish legislation concerning disability benefits has been changed as of the 1st of January 2008. Disability benefits are gathered under one Act Concerning Disability Benefits (*Laki vammaisetuuksista*) (570/2007).

The child care allowance has been abolished and replaced by a benefit called the **Disability allowance for persons under 16 years of age**.

The Finnish Disability allowance which was mentioned in annex IIa of Regulation 1408/71 is also abolished from Finnish legislation and replaced by a benefit called **The Disability allowance for persons aged 16 years or over**.

The **Pensioners’ care allowance** has been transferred from the Act concerning National Pension to the Act Concerning Disability Benefits (*Laki vammaisetuuksista*) (570/2007). There is also a fourth benefit covered by the same act, namely the **Dietary Grant for persons with celiac disease**.

It might be argued that only benefits provided under the Disability Benefits Act should be considered as LTC benefits for the purpose of the social security coordination. The other benefits (housing allowance for pensioners) and services mentioned might not be considered as LTC benefits, but as social services which seem to be outside the scope of the Regulations. All services mentioned are provided by the municipalities with a wide discretion on the need to provide these services in the municipality in question. The person in need of care does not have a right to a specific service, but it is the municipality that evaluates which type of services can and should be provided in the situation in question.

**Benefits in kind**

1. **Home care**
   Home services and services for the disabled (transport services, a personal assistant, house alteration).
   Support for informal care (care allowance, statutory leave for the caregiver, support and counselling).

2. **Semi-residential care**
   Service housing for older people and people with disabilities who need outside support and assistance, which cannot be arranged in an ordinary dwelling.
3. Residential care
Statutory institutional care services include the institutional services provided in homes for elderly, in
the inpatient wards of municipal health centres and in specialised care units for people with mental
disabilities. Long-term institutional care is given in various types of nursing homes and homes for
disabled war veterans. NGOs and private firms also provide institutional care in old people’s homes
and private hospitals.

4. Other benefits
Technical equipment, when needed.

Cash benefits

Pensioners’ care allowance (Eläkkeensaajien hoitotuki): € 57.55 per month.
Increased rate: € 143.27 per month.
Special rate: € 302.96 per month.
Pensioners’ housing allowance (Eläkkeensaajien asumistuki)
Disability allowance for persons under 16 years of age and disability allowance for persons aged 16
years or over (Alle 16-vuotiaan ja 16 vuotta täyttäneen vammaistuki):
Both benefits have three rates depending on the degree of strain: € 85.93, € 200.51 or € 388.80 per
month.

The Disability Allowance for persons under 16 years of age is payable at three rates.
- Basic rate (€ 85.93 per month)
The disability allowance at the basic rate is payable for a child who on account of an illness, injury or
handicap needs treatment and rehabilitation at least weekly, placing the family under additional
strain for at least 6 months.
- Middle rate (€ 200.51 per month)
The disability allowance is paid at the middle rate if the treatment and rehabilitation of the child
imposes a considerable daily strain for at least 6 months.
- Highest rate (€ 388.80 per month)
The disability allowance is paid at the highest rate if the treatment and rehabilitation of a child
imposes an extreme, around-the-clock strain on the family for at least 6 months.

Disease-specific evaluation
The amount of disability allowance payable does not solely depend on the diagnosis but also on the
strain that the illness or injury imposes on the family and the level of commitment it requires. Certain
diseases are relatively uniform in terms of the amount of care and assistance they demand, the strain
they impose and the level of commitment they require. These diseases and the special needs
associated with them are defined in the administrative guidelines applied by Kela.

The effect of other benefits and income
Eligibility for the disability allowance does not depend on the income or assets of the child or family,
nor is the award of the allowance prevented by other benefits or compensations. However, if the
child is in receipt of a foreign benefit comparable to the disability allowance, this foreign benefit may
be deducted from the Finnish allowance. Similarly, if the child is in receipt of a care allowance or a
supplementary handicap benefit from a workers’ compensation or motor vehicle insurance plan, it is
deducted from the disability allowance.

The disability allowance for persons over 16 years of age is payable at three rates depending on the
need of assistance, guidance and supervision as well as special expenses.
- Basic rate (€ 85.93 per month)
You can receive a disability allowance at the basic rate if you have an illness or injury that causes you significant hardship and continuous expenses. The expenses must be at least equal to the amount of the basic disability allowance per month.

- **Middle rate** (€ 200.51 per month)

You can be paid a disability allowance at an increased rate if the hardship is considerable and you need outside assistance or supervision at least weekly or you have expenses that are at least equal to the amount of the increased disability allowance per month.

- **Highest rate** (€ 388.80 per month)

The disability allowance at the highest rate can be awarded to persons with severe disabilities who need substantial outside assistance on a daily basis or who incur substantial expenses from their disability. The expenses have to be at least equal to the amount of the highest disability allowance per month. Persons who are blind, unable to move or prelingually deaf are always entitled to the highest rate of disability allowance.

The **Care Allowance for Pensioners** is payable at three rates depending on the need of assistance, guidance and supervision as well as on special expenses.

- **Basic rate** (€ 57.55 per month)

You may be eligible for the basic rate if your illness or injury results in at least a weekly need of assistance in personal activities of daily living or guidance or supervision with them. If your illness or injury causes special expenditure that is at least equal to the amount of the basic rate, you may be eligible for the allowance. Persons who are blind or unable to move are always eligible for the basic rate at least.

- **Middle rate** (€ 143.27 per month)

You may be eligible for the middle rate if your illness or injury results in a daily need of several personal activities (such as eating, getting dressed, washing) or if you need regular guidance and supervision. If your illness or injury causes special expenditure that is at least equal to the amount of the middle rate, you may be eligible for the allowance.

- **Highest rate** (€ 302.96 per month)

You may be eligible for the highest rate if your illness or injury results in an around the clock assistance and guidance by another person. If your illness or injury causes special expenditure that is equal to the amount of the highest rate, you may be eligible for the allowance.

- The Care Allowance for Pensioners is a tax-free benefit.

**Special expenses**

For disability benefits purposes, ‘special expenses’ refers to necessary additional costs incurred on account of an illness or injury in respect of work, study or activities of daily living. Usually, only regular expenses lasting at least 6 months (and not one-time costs) are covered.

Are for example recognised as special expenses:

- the costs of medical care and medication
- additional transportation costs
- the costs of home health care and home help.

Are for example not recognised: normal expenditures for food or clothing, hobbies, purchases of equipment or car ownership costs.

The amount of the **Dietary Grant** is € 21.00 per month.

The use of the Pensioners’ Care Allowance (Eläkkeensaajien hoitotuki), the Pensioners’ Housing Allowance (Eläkkeensaajien asumistuki), and the Disability Allowance for persons under 16 years of age and the disability allowance for persons aged 16 years or over (Alle 16-vuotiaan ja 16 vuotta täyttäneen vammaistuki) is at the discretion of the beneficiary.
**Combination of benefits**

Depending on the degree of disability and the need of care. Both cash benefits and benefits in kind are provided through different schemes.

No free choice between cash benefits and benefits in kind. Municipalities can provide a service voucher (benefit in kind).

**Benefits for the carer**

Caregiver’s allowance: depends on the municipality, the minimum is € 336.41 per month. Those caregivers who have made an agreement with the municipality have the right to 3 free days per month.
**FRANCE**

**Applicable statutory basis**

The supplement for assistance of a third party (*majoration pour aide d'une tierce personne*): Articles L. 341-4, L. 355-1 and L. 434-2 of the Social Security Code (*Code de la sécurité sociale*).

The special education supplement for a disabled child (*complément d'allocation d'éducation de l'enfant handicapé*): Article L. 541-1 of the Social Security Code (*Code de la sécurité sociale*).

The disability compensation allowance (*prestation de compensation du handicap - PCH*): Article L. 245-1 of the Social Action and Family Code (*Code de l'action sociale et de la famille*).

The allowance for loss of autonomy (*allocation personnalisée d'autonomie - APA*): Article L. 232-1 of the Social Action and Family Code (*Code de l'action sociale et de la famille*).

**Benefits in kind**

1. **Home care**

   The disability compensation allowance (*prestation de compensation du handicap - PCH*) and the allowance for loss of autonomy (*allocation personnalisée d'autonomie - APA*):

   Assessment of the assistance required for staying at home. The amount of the benefit depends on the assistance plan used, less the participation of the beneficiary, calculated according to his or her means.

   France chose to treat dependency and disability differently by creating two distinct types of benefit: the allowance for loss of autonomy (*allocation personnalisée d’autonomie, APA*) for older people and disability compensation allowance (*prestation de compensation du handicap, PCH*). These benefits are granted to older or disabled people living at home (APA and PCH) or in institutions (APA).

   The APA and the PCH are compulsory benefits governed and granted outside the French legal framework for social insurance and without the involvement of a social-security body: they are managed by local authorities or departments (*conseils généraux*) under social-assistance legislation. Social-assistance benefits and benefits granted under social-insurance schemes (social security, supplementary schemes) together make up the social-protection system in France.

   The APA was created by Act No 2001-647 of 20 July 2001 on provision for the loss of independence of older people and the personal independence allowance. This law laid down the right to APA of any older person unable to cope with the consequences of a lack or loss of independence due to his or her physical or mental state. Any person aged over 60 may apply for APA; the amount to be granted depends primarily on the degree of dependence, with remaining costs to be met by the person concerned at a level commensurate with his or her resources. The four most severe levels of dependence (1 to 4) always confer a potential right to assistance. The maximum amounts granted under the assistance plans directly financing benefits range from € 552.03 for people registered as GIR 4 to € 1 288.09 for GIR 1 (the most severe level). These assistance plans are paid for by the local authority where the older person’s income is less than € 725.23 per month.

23 GIR = *Groupe iso-ressources* [iso-resource group]
This benefit in kind directly finances a very wide range of services: expenditure linked to remuneration for a home help, temporary reception costs (with or without accommodation) in institutions, payments for services rendered by foster carers and the costs of transport, technical aids, adaptations to dwellings and any other expenditure enhancing the beneficiary’s independence.

To cope with the rapid rise in the costs of this benefit and the corresponding costs for the departments, various reforms have been introduced with a view to financing the APA. One important provision of the Act of 30 June 2004 on solidarity for the independence of older and disabled people was to create the Solidarity Day, which takes the form of an extra, unpaid working day for employees and an "independence solidarity" contribution of 0.3% for employers, based largely on wages and salaries. The funds collected are managed by the National Solidarity Fund for Independence [Caisse nationale de solidarité pour l’autonomie – CNSA], a State-administered public enterprise.

The Act of 11 February 2005 on equal rights and opportunities, participation and citizenship for persons with disabilities provided for disability compensation allowance [prestation de compensation du handicap or PCH]. This benefit takes the form of personalised financial assistance to cover needs linked to the loss of independence of people having become disabled before age 60, provided that it is applied for by age 75 at the latest. These needs are recorded in a personalised plan drawn up by a multidisciplinary team from the Maison départementale des personnes handicapées (MDPH) (the department’s disabled people’s centre) on the basis of a life plan expressed by the person concerned.

This benefit in kind covers the costs linked to a need for human or technical assistance, adaptations to the disabled person’s dwelling or vehicle, any additional transport costs or specific or exceptional expenditure, such as the costs of acquiring or maintaining products associated with the disability or assistance animals.

Although the departments manage both the APA and the PCH, these benefits are not financed entirely from the local authorities' own tax resources. The national solidarity fund contributes in the form of assistance paid to the departments by the CNSA. This assistance is supplied by the independence solidarity contribution (CSA), supplemented for the APA by part of the general welfare contribution (contribution sociale généralisée - CSG). The CSA and CSG are taxes under French law, not social-security contributions. The CNSA contributes 29% of APA funding and 58% of PCH funding.

Public expenditure on financing dependence is not limited to the APA and the PCH; other institutions also contribute:

- the State in the form of the tax expenditure linked to income tax exemptions or reductions linked to dependence;
- health insurance for expenditure on care by social and medico-social establishments and services, hospital and non-hospital care, the costs of social services and regional health insurance funds and exemptions from social contributions linked to dependence financing;
- the National Solidarity Fund for Independence (CNSA) also helps to finance establishments, the promotion of innovative schemes, the improvement of professional skills, publicity, prevention and studies and to co-finance investment operations;
- the National Old-Age Insurance Fund [Caisse nationale d’assurance vieillesse – CNAV], the Central Agricultural Mutual Insurance Fund [Caisse centrale de mutualité sociale agricole – CCMSA] and the self-employed persons' social scheme [Régime social des indépendants – RSI] cover the costs of support at home and in communal establishments;
- the National Family Allowances Fund [Caisse nationale d’allocations familiales – CNAF] finances social housing allowances and personalised housing assistance.
In 2011 the Government organised a major national debate on the dependence of older people that gave rise to several working groups, analytical reports and proposals. The results of this work should feed into the discussions on a reform of dependence financing in 2012. This has been postponed until after the presidential elections.

2. Semi-residential care
The disability compensation allowance (prestation de compensation du handicap - PCH) and the allowance for loss of autonomy (allocation personnalisée d'autonomie - APA):
The possibility to receive the benefit in case of day care in a specialised centre. The number of hours granted depends on the evaluation of the need of assistance. See point 1. Home care, above.

3. Residential care
Accommodation in a social or medico-social institution, hospitalisation in a health institution. The Institution for accommodating elderly dependent persons (Établissement pour hébergement pour personnes âgées dépendantes, EHPAD).
In case of accommodation in a specialised institution, the amount of the benefit corresponds to the amount of the expenses corresponding to the degree of loss of autonomy according to the institution’s tariffs, minus the participation of the beneficiary him or herself.

4. Other benefits
Technical aids granted for the purchase or renting of specific equipment, adaptation of frequently used equipment, housing support (adaptation), transport-related support, specific or exceptional help, assistance animals.

Some other benefits might be mentioned as well:
- the aide ménagère (household aid) is a social assistance benefit granted by local authorities or by local social security institutions. They cover costs such as house cleaning, meal preparation or delivery, 24-hour medical assistance, etc. Usually, it is a means-tested benefit. It can be either a cash benefit or a benefit in kind (the amount based on actual expenses);
- the majoration pour tierce personne is provided to pensioners who, before age 65, need the assistance of a third person to accomplish their daily life activities;
- the SSIAD are service providers who provide special care for dependent persons who stay at their home.

Cash benefits
The supplement for assistance of a third party (majoration pour aide d'une tierce personne):
40% increase of the pension, with a monthly amount of at least € 1,038.36.

The special education supplement for a disabled child (complément d'allocation d'éducation de l'enfant handicapé - Aeeh):
6 categories of supplements ranging from € 93.41 to € 1,038.36 per month.
A specific increase for dependent children of a single parent, who is benefiting from the allowance and from a supplement for a disabled child of at least the 2nd category (between € 50.60 and € 416.44).

Discretionary use.

The adult disability allowance (allocation aux adultes handicapés - AAH) could be mentioned as well.
It is a cash benefit which provides a minimum income for disabled persons. It is completed by the majoration pour la vie autonome (supplement for independent life).
Combination of benefits

No mixed benefits.

Choice between the special education supplement for a disabled child (complément d'allocations d'éducation de l'enfant handicapé) and the disability compensation allowance (prestation de compensation du handicap). The choice is made on the basis of the proposals in the personalised compensation plan.

Benefits for the carer

The employed carer is entitled to benefits on the same basis as other employees.

The beneficiary of the allowance can make use of home services offered by specialised organisations (services organised by the municipality, by State authorised associations or by undertakings). She or he can also opt to remunerate these organisations by using a universal service employment cheque (chèque emploi service universel, CESU). The beneficiary can choose to be employer him or herself, either directly or by proxy.

In addition, persons who take care of a dependent person can get tax advantages. There is also a waiving of tax contributions on the salary of a person employed by a dependent.

Addendum: Social security coordination aspects

According to the Note of the French delegation, the listing essentially puts four major benefit or assistance categories:
- the "dependency" benefits: the allowance for loss of autonomy (APA) and disability compensation allowance (PCH);
- the social-security benefits coordinated in chapters of the Regulation other than sickness, such as the supplement for permanent assistance from another person which constitutes an old-age benefit, or the supplement paid with disability benefit;
- the special non-contributory benefits mentioned in Annex X of the Regulation, such as the disabled adults' allowance (allocation aux adultes handicapés, AAH);
- assistance arising from social assistance or from social action by organisations.

The local assistance able to be granted by local authorities or social-security bodies is a non-compulsory fringe benefit whose grant criteria, amount, purpose and conditions of use vary according to the territories, authorities or bodies paying it, which are not obliged to grant it. This would be very hard to coordinate under Regulation 883/2004, which according to the Note of the French delegation means that it should not be covered by the Regulation.

Apparently, only the APA and the PCH constitute long-term care benefits within the scope of the proposed definition in the trESS 2011 report, and should remain on this list. These benefits, and the APA in particular, have for several years been treated as social-security benefits in the Union law, particularly in the light of the findings in the Molenaar (1998) and Jauch (2001) cases; under French national law these benefits are classed as social-assistance benefits. They are granted subject to on-the-spot assessment of the specific situation and needs of each applicant; the content and extent of the assistance are individualised on the basis of this assessment. Lastly, these benefits are non-contributory and are financed by taxes.
The AAH was recognised in the Union law as a special non-contributory benefit and is mentioned as such in Annex X to the Regulation. According to the view of the Note of the French delegation, this classification need not be reviewed, since it is a social minimum unrelated to the sickness risk, optional in use and intended to combat monetary poverty.

The other social-security benefits should continue to be coordinated according to the current rules in the Regulation. The types of assistance arising from local social action (municipality, department) or from social-security funds or other organisations, provided that they are optional, are not suitable for coordination by Regulation, and it is suggested in the Note of the French delegation that they be removed from this list.
**GERMANY**

**Applicable statutory basis**

Statutory long-term care insurance (*Gesetzliche Pflegeversicherung*):

Social assistance (*Sozialhilfe*):

According to the Note of the German delegation, long-term care benefits are not only provided by the statutory and the private long-term care insurance and the social assistance scheme, but also e.g. by the work-accident insurance, if the need for long-term care ensues from an industrial accident or an occupational disease. The need for such long-term care is basically taken into account by a care allowance („Pflegegeld“). This benefit currently ranges from € 310 to € 1 2140 (West) and from € 272 to € 1 086 (East) depending on the amount of care needed. At the request of the insured person, nursing care at home („Hauspflege“) or in an appropriate residence („Heimpflege“) may also be provided.

Benefits in case of need for long-term care or supplements are also provided according to the Federal Law on War pensions („Bundesversorgungsgesetz“), where the contingency occurred in the course of the exercise of a military or similar service or due to an accident suffered during such a service.

The amounts below have been adjusted (increased) as of the beginning of 2012.

**Benefits in kind**

1. **Home care**
Monthly benefits in kind (provision of basic care, general care and domestic help by outpatient care centres or individual carers) which amount:
   - Category I: up to € 440;
   - Category II: up to € 1 040;
   - Category III: up to € 1 510;
   - In cases of particular hardship: up to € 1 918.

Several persons in need of care, especially in new forms of housing, can combine entitlements to benefits in kind (the so-called “pooling”) and the increased efficiency, especially of care benefits, are to be used in favour of the “pooling” participants.

2. **Semi-residential care**
Monthly benefits in kind for care in day and night centres in addition to home care which amount:
   - Category I: up to € 440;
   - Category II: up to € 1 040;
   - Category III: up to € 1 510.

Apart from the entitlement to day/night care, a 50% entitlement to the respective outpatient care benefit in kind or care allowance remains.
3. **Residential care**

A lump-sum payment of the costs for care, medical care treatment and social care expenses as a monthly benefit in kind in the following categories:

- Category I: € 1 023
- Category II: € 1 279
- Category III: € 1 510
- In cases of particular hardship: € 1 825.

In addition, the care insurance pays care providers for additional care of persons with significant general need for long-term care. For every 25 persons an additional carer could be engaged.

4. **Other benefits**

- Benefits for home care are complemented by aids and appliances to facilitate the provision of care, unless, as a result of illness or disability, they have to be provided by another fund, and by technical aids and appliances for household activities, used for the alleviation of home care or mitigation of ailment of the person in need of long-term care or to support an individual way of life of such a person. Expenses for aids and appliances meant for usage are reimbursed up to € 31. Technical aid is preferably provided on loan. In certain circumstances participation of 10% is due, but not more than € 25.

- Courses of instruction in the provision of care for caring family members and other voluntary carers.

- Respite care (*Pflegevertretung*) provides carers a break from normal caring duties and thus alleviates the burden of caregiving: payment up to an amount of € 1 510 for a maximum of 28 days in the calendar year for the substitution of a carer, if he or she is on holiday or ill. The carer must, however, have provided care for at least twelve months prior to the date of his or her absence. If the stand-in is a professional carer or works for a home care service, the long-term care insurance fund will cover the cost up to a maximum amount mentioned above. This amount can likewise be claimed if the stand-in is a neighbour or distant relative (i.e. not a first or second degree relative or in-law).

- Short-term care (*Kurzzeitpflege*): In case of absence of a carer or following the inpatient care, the costs of residential care during a short period up to a maximum of 28 days per year are covered for an amount of € 1 510. Short-term care for children in need of care up to 18 years is also possible in the support institutions for disabled people or in other appropriate institutions.

- Additional care benefits for persons with an extensive general need of care (e.g. people with dementia, mentally disabled and people with mental illnesses) up to € 100 per month (basic amount) or up to € 200 per month (increased amount). The care must comprise at least 14 hours per week within the home area of the person in need of care and may not be rendered on a commercial basis (the care allowance passed to the caregiver is not considered to constitute such “commerce”).

- The reimbursement of expenses for measures to improve the living environment up to € 2 557 per measure with regard to appropriate participation.

**Cash benefits**

*Statutory long-term care insurance:*

If a person in need of care provides for the care him herself, he or she can get care allowance in order to assure necessary basic care and household assistance in an adequate way. For this benefit the monthly amount is:

- Category I: € 225;
- Category II: € 430;
- Category III: € 685.
Care allowance can be claimed instead of home care services.

**Social assistance:**
The same benefit amounts as under the long-term care insurance.

**Combination of benefits**

**Statutory long-term care insurance:**
Cash benefits and benefits in kind may be combined: if the person in need of care only claims the benefits in kind partly, he or she is entitled to receive proportionate care allowance next to it. The care allowance is reduced by the percentage corresponding to the claimed benefits in kind. The person in need of care is bound by the decision relating to ratio between cash benefits and benefits in kind for a period of six months.

There is free choice between benefits in kind and cash benefits.

In order to exercise their right to self-determination the person in need of long-term care in principle has the free choice between home care and residential care, as well as the choice between several licensed facilities and services. Together with the notice of approval, the care funds provide a list with a comparison of services and prices of the facilities in the catchment area, the nearest care station (*Pflegestützpunkt*) and suggestions for individual care consultation. Since January 2009, the insured person has the right to additional care consultation vis-à-vis their care funds or private insurance organisation. Normally, the care advisers are staff members of the care funds, they analyse the need of care on the basis of an MDK report, set up a plan for the provision of the needed social benefits and rehabilitation in the individual case, of healthy, preventive, curative or other medical care and care based social assistance and they work towards approval and conduction of the corresponding measures. If so-called care stations (*Pflegestützpunkte*) are set up, the care advisers have to be placed there.

**Benefits for the carer**

**Statutory long-term care insurance:**
Payment of pension insurance contributions for caring family members and other informal carers by the long-term care insurance. A protection without contribution is also provided for these persons by the accident insurance. Contributions to the statutory pension insurance are also paid during the carer’s holidays.

Employees in companies with at least 15 employees have an entitlement to unpaid leave for up to 6 months in order to take care of a relative (so-called care time, *Pflegezeit*). As a general rule, their family health insurance continues during this time and the pension insurance continues via the long-term care insurance fund. The entitlement from the unemployment insurance remains because of the contributions of the long-term care insurance fund. The contributions for health insurance and long-term care insurance are borne by the long-term care insurance fund up to the minimum contribution amount if necessary.

If a person suddenly becomes dependent on long-term care, employees can stay away from work at short notice for up to 10 days in order to ensure care in need during this time or organise suitable care (so-called short-term work incapability, *kurzzeitige Arbeitsverhinderung*).

**Social assistance:**
The payment of the contributions for the carer for adequate old-age provision, unless this is provided otherwise.
GREECE

Applicable statutory basis

No special scheme.

According to the Note of the Greek delegation, the policy on long-term care benefits is undergoing restructuring and has not yet been finalised. The conditions demanding restructuring are firstly the necessity to re-examine all benefits of this type, in order to avoid one person being able to accumulate benefits, and secondly the rationalisation of the terms and conditions for granting benefits with the ultimate aim of economising resources and distributing them to people who are really in need.

To help achieve this aim, significant administrative alterations have already taken place in the structure of the Services through the transfer of the Social Welfare Section from the Ministry of Health and Welfare to the Ministry of Labour and Social Security under Article 9(5) of Law 4052/2012, and the gradual integration of all the branches of sickness benefits in kind into the EOPYY (National Health Services Organisation).

However, under Article 138 of the recent Law 4052/2012, a Home Care Programme for Pensioners was established with the aim of ensuring independent living conditions for elderly and disabled pensioners at home. This programme will cover pensioners belonging to primary insurance funds that come under the Ministry of Labour and Social Security, although those receiving a pension from OGA (Agricultural Insurance Organisation) as uninsured elderly people, pensioners from NAT (Mariners' Retirement Fund), public sector pensioners and those qualifying for welfare benefits may also be included in the scheme. The programme will be implemented after the publication of the provisions by the same law of Ministerial decisions, and from 1 September 2012 a special levy to fund the benefits will be established for those who are insured by bodies that come under the Ministry of Labour and Social Security, those who will retire after 1 January 2015 and fulfil the criteria for benefitting from the programme.

Hence, the benefits mentioned below are currently being reassessed in Greece.

Benefits in kind

1. Home care
The Programme "Aid at Domicile" (ΒΟΗΘΕΙΑ ΣΤΟ ΣΠΙΤΙ) is part of the primary social care services, providing nursing care, social care services and domestic assistance to elder people who live alone continuously or at certain times of the day and cannot sufficiently take care of themselves, and also to disabled people who face situations of isolation, exclusion or family crisis. Its aim is to support and care for the elderly in their home, to enhance the quality of their life, to inform society and to attract volunteers. It is implemented under the responsibility of the Local Authorities in municipalities throughout the country, primarily in remote mountainous and island areas.

2. Semi-residential care
During the day, in urban and suburban areas, the Day Care Centres of the Elderly (ΚΕΝΤΡΑ ΗΜΕΡΗΣΙΑΣ ΦΡΟΝΤΙΔΑΣ ΗΛΙΚΙΩΜΕΝΩΝ – Κ.Η.Φ.Η.) accommodate elderly people who cannot care for themselves (due to physical difficulties, dementia, etc), and whose family members are not able to take care of them due to their work or serious social or economic problems or health problems.

The Day Care Centres of the Elderly are established and operated by municipal enterprises, joint municipal enterprises, municipal business associations of local authorities and, also, by private non-
profitable entities. They cooperate with local organisations providing social services such as health units and the Welfare Directorates of the Prefectures of the country providing social services.

3. Residential care
Hospitalisation in a public hospital, a contracted clinic or a social welfare centre for the chronically ill.

Elderly Care Units (ΜΟΝΑΔΕΣ ΦΡΟΝΤΙΔΑΣ ΗΛΙΚΙΩΜΕΝΩΝ), which can be established and operated by charitable associations, the Orthodox Church or the local authorities and, in this case, are non-profitable, or they can be established by individuals (and, thus, are profitable). The Ministry of Health and Social Solidarity, in the framework of its social policy, has contracted with private Elderly Care Units for the provision of some beds, in order to care for indigent elderly who cannot be served by State institutions due to lack of or insufficient beds. The cost of these beds is covered by the national budget.

4. Other benefits
The Open Protection Centres of the Elderly (ΚΕΝΤΡΑ ΑΝΟΙΚΤΗΣ ΠΡΟΣΤΑΣΙΑΣ ΗΛΙΚΩΜΕΝΩΝ - Κ.Α.Π.Η.) are open programmes that involve the elderly over 60 years without socio-economic criteria, in order to integrate and socialise all members of the community. They provide all forms of organised recreation, medical care, physiotherapy treatment, occupational therapy, social work, hospital care and all kinds of material and psychological support services to the elderly.

Cash benefits

The benefit for non-residential care (ΕΞΩΙΔΡΥΜΑΤΙΚΟ ΕΠΙΔΟΜΑ):
A benefit of € 660.80. Conditional upon the insured person having completed:

- the days of work that are required for acquiring sickness benefits in kind, during the year of the application (70 days from 1/1/2010, 80 days from 1/1/2011, 90 days from 1/1/2012 and 100 days as of 1/1/2013 and beyond) and at least 350 days of insurance during the last 4 years before the invalidity, or
- 1,000 days of insurance in total.

The total invalidity benefit (ΕΠΙΔΟΜΑ ΑΠΟΛΥΤΟΥ ΑΝΑΠΗΡΙΑΣ):
Paid to pensioners because of invalidity, as long as they are in a state that requires continuous care from another person (total invalidity), to pensioners because of death and exceptionally, to pensioners because of old age who, after their retirement, became blind. The amount corresponds to 50% of the invalidity pension paid.

Housing allowance (ΣΤΕΓΑΣΤΙΚΗ ΣΥΝΔΡΟΜΗ):
A benefit in the form of a rental fee, paid to uninsured and financially weak elderly over 65 years who live alone or in a couple and do not own a house. The programme was implemented by the Directorate of Social Welfare of the Prefectures of the country. Amount: € 362. It is suggested by the Note of the Greek delegation (without any explanation though) that the housing allowance is removed from the list of LTC benefits.

No discretionary use, but the cash benefits may be used to pay both professional providers and informal caregivers. Free choice of provider.

Combination of benefits

No mixed benefits.
No free choice between cash benefits and benefits in kind.
Benefits for the carer

Provisions for retirement at a lower age and/or with fewer years of insurance for parents of children with a level of invalidity of at least 67% and for spouses of persons with a level of invalidity of at least 80%.
HUNGARY

Applicable statutory basis

In case of long-term care services providing personal social care (social services):

The Act III of 1993 on Social Administration and Social Assistance (törvény a szociális igazgatásról és szociális ellátásokról) supplemented by Government and Ministerial decrees.

There is no separate insurance system for long term care in Hungary. Those requiring long term assistance can rely on the services provided by the health and social care system.

According to the Note of the Hungarian delegation, municipalities are responsible for long term care benefits in kind (different social services have to be provided, according the number of inhabitants living there). Until 2012, county municipalities were responsible for operating residential care for elderly, people living with mental problems, or addictions, people with disabilities or homeless people, but from 2012 these institutions with many other cultural, educational ones became governmentally operated institutions. The purpose of this reorganisation is to streamline the organisation, develop and make services more efficient and economical. Besides, many other, non-governmental or church organizations also provide long term care for people in need.

The key elements of the ongoing governmental intentions:
- streamlining the organizations,
- develop services to be more efficient and economical,
- build appropriate environment for the residential services users (e.g. smaller institutions),
- ensure all conditions for people in need living either at home or in institution without burdens and barriers.

There have not been major changes relating to the long-term care benefits in kind and no changes are foreseen at present.

Benefits in kind

1. Home care

Home care is provided to persons who are unable to care for themselves in their home and who have no one to care for them.

According to statistics, about 46 000 persons were cared for at home in 2007. (This means that, of the 60+ population, the number of care recipients per ten thousand was 209.6).

2. Semi-residential care

Day care facilities are provided for:
- Elderly persons;
- People with disabilities;
- Psychiatric patients;
- Persons with addictions;
- Homeless persons.

Day care allows persons who live in their own homes (as well as homeless people) but who need social and mental support due to their health condition or old age, persons who are partly or wholly unable to cater for themselves, persons with disabilities or autistic persons in need of supervision, psychiatric patients and persons with addictions to find daytime shelter, to maintain social relations...
and to satisfy their basic hygienic needs, and, if required, organises the daytime meals for the care recipients.

Day care facilities are usually open from 8am to 4pm or from 9am to 5pm, but it depends on the need of the users.

Day care is provided primarily in (separate) day care facilities but can be provided at care homes too.

3. Residential care

Residential care is provided in four types of institutions:

a) care facilities providing nursing and care;

b) institutes of rehabilitation;

c) residential care homes;

d) institutes providing temporary placement.

a) Care facilities providing nursing and care:

They provide comprehensive care for persons who are unable to care for themselves, or for those who are able to do so only with continuous help (meals provision, housing, care, health care).

Types:

- elderly homes,
- care homes for psychiatric patients,
- care homes for persons with addictions,
- care homes for persons with disabilities,
- care homes for homeless persons.

b) Institutes of rehabilitation:

Rehabilitation institutions serve to develop or restore the ability of residents to lead independent lives.

Types:

- rehabilitation institutes for psychiatric patients
- rehabilitation institutes for persons with addictions,
- rehabilitation institutes for persons with disabilities,
- rehabilitation institutes for homeless persons.

c) Residential care homes

The residential care homes are small care homes with 8-12 residents. They are more modern, more homely and more personalised.

Residential care homes provide care in compliance with the health condition and the degree of independence, to disabled persons, psychiatric patients and victims of addiction.

d) Institutions providing temporary placement:

They provide care for a maximum of one year (which can be prolonged), with the exception of the temporary shelter and night shelter of homeless people.

Main types of these institutions:

- care homes for the elderly,
- care homes for persons with disabilities,
- temporary homes for psychiatric patients,
• temporary homes for persons with addictions,
• night shelters,
• temporary accommodation for homeless persons.

4. Other benefits
Signalling home care (or alarm system based home care) is a kind of service to persons living in their own homes and needing such assistance due to their health and social conditions, in order to overcome crisis situations that arise.

Cash benefits

Nursing fee (ápolási díj) as a flat rate, non-contributory benefit is payable to persons who provide long-term care to family members who are disabled or under 18 years of age and permanently ill. The amount of benefit is 100% of the basic amount (alapösszeg) defined by the Act on the Central Budget (HUF 29,500 or € 107), or 130% (HUF 38,350 or € 139) in case of an increased need of nursing. The third form of the nursing fee is provided by the local government; the amount is determined by the local governments and may be no less than 80% of the basic amount (HUF 23,600 or € 86). However the first and second form of nursing fee is not means-tested; the benefit is regulated among social assistances in the Act on Social Benefits and Social Administration. It is administered by the local governments, which means there are about 3200 authorities who are potentially competent.

A nursing fee (ápolási díj) is paid to the carer (the carer has to be a family member) and not to the person in need of care. This means that from the side of the care recipient one can neither speak of a free choice, nor of discretionary use.

Combination of benefits

Not applicable.

Benefits for the carer

A nursing fee (ápolási díj) is paid to the carer (not to the person in need of care) – the carer has to be a family member.

In the case of persons with severe disabilities, the assistance amounts to 100% of the basis amount defined by the Act on the Central Budget, while in the case of persons with severe disabilities in need of intensive care this is 130%.

In 2011, the basis amount is HUF 29 500 per month. See above Cash benefits.

The amount of the cash benefit (nursing fee) does not cover the full costs of the carer; rather it tries to compensate her or him for the lost income.

According to the Labour Act (Act XXII of 1992 on the Labour Code), those who are taking care of their relatives can take unpaid leave for a maximum of 2 years.
ICELAND

Applicable statutory basis

Constitution of the Republic of Iceland, (Stjórnarskrá Lýðveldisins Íslands) No. 33/1944: Article 76:
The law shall guarantee for everyone the necessary assistance in case of sickness, invalidity, infirmity by reason of old age, unemployment and similar circumstances.
The law shall guarantee for everyone suitable general education and tuition.
For children, the law shall guarantee the protection and care which is necessary for their well-being. 2)L. 97/1995, 14. gr.


Act on payments to parents of chronically ill or severely disabled children (Lög um greiðslur til foreldra langveikra eða alvarlega fatlaðra barna) No. 22/2006 of April 2006.


Act on Social Service (Lög um félagslega aðstoð) No. 99/2007 of May 2007. The Act provides assistance both in cash and kind such as home care, cleaning, basic financial assistance etc.

Benefits in kind

1. Home care
The Act on the Affairs of the Elderly (Lög um málefni aldraðra) No 125/1999 emphasize on assisting the elderly to stay at their own home as long as they wish so to do. To acquire that objective, home care is increasing, often together with some day-care or leisure activities. It is possible to receive nursing and some assistance at home, (meals, cleaning, personal assistance, physiotherapy, nursing etc.) provided by health care authorities, The Social Insurance Administration and municipalities as well as private contractors.

2. Semi-residential care
Day-care centres are provided for persons living at their own house but are not capable of staying home alone the whole day. The duration is max. 8-10 hours per day, 5 days per week. Medical and personal assistance and counselling as well as leisure activities available. Temporary care in a nursing home can be provided.
3. **Residential care**
Nursing homes and homes for the elderly and persons with disabilities.
   a) Public nursing homes for the elderly.
   b) Private nursing homes for the elderly.
   c) Public residential care for persons with disabilities.
   d) Public residential care for the elderly.
   e) Service-flats and housing for persons with disability.

4. **Other benefits**
Telecommunications service, technical aids, assistance for home-improvement, transport service, etc. can be provided under certain circumstances, mostly from municipalities.

**Cash benefits**

1. The elderly and persons with disability may be paid a supplement for purchasing a car they require because of a mobility handicap. A supplement may also be granted to the provider of a motor-impaired child receiving home-care payments.
2. Reimbursement of exceptional high medical costs.

**Benefits for the carer**

1. Home-care allowances are financial assistance to parents having children who are grappling with a handicap or serious illness. This is social assistance that is provided when care is demanding, and the cost because of healthcare service, treatment and training has become considerable and severe for parents.
2. A caregiver benefits card provides parents with discounts on medical services for children.
3. Spouse’s benefits *(makabætur)* to spouse or close relative who wishes to take care of a closely related person suffering from a significant disability or illness.
IRELAND

Applicable statutory basis

The Health Act of 1970:
Home Care

The Health (Nursing Homes) Act 1990: Nursing Home Subvention Scheme.
According to the Note of the Irish delegation, since the commencement of the Nursing Homes Support Scheme Act, 2009, no further applications under The Health (Nursing Homes) Act 1990 (Nursing Home Subvention) will be considered.

The Nursing Homes Support Scheme Act 2009: Nursing Homes Support Scheme
It should also be noted that, with regard to the Nursing Homes Support Scheme, the Health Service Executive pays the balance of the cost of care directly to the nursing home where the person is residing.

The Social Welfare Consolidation Act 2005:
• Constant Attendance Allowance
• Carers’ Benefit
• Carers’ Allowance
• Respite Care Grant
• Domiciliary Care Allowance

It might also be mentioned that the rates of weekly pensions are higher in Ireland than the rates of weekly benefits for those below pension age, because people on reaching pension age will have lost and will continue to lose a certain amount of personal autonomy for the reasons listed in the definition.

Similarly, allowances for travel, telephone, electricity, gas and fuel are paid to qualified pensioners over pension age, but to those below pension age only on grounds of long-term disability.

One of the key objectives of this range of benefits is to enable such people to have personal autonomy as long as possible and to considerably limit the extent to which they require assistance from others. Accordingly, if these cash benefits were not provided, many of these recipients could require assistance from family or other persons.

According to the Note of the Irish delegation, investment in the supply of more and better care for older people in the community and in residential settings will be a priority. Additional funding will be provided each year for the care of older people. This funding will go to more residential places, more home care packages and the delivery of more home help and other professional community care services.

The Nursing Homes Support Scheme system of financing nursing home care will be reviewed with a view to developing a secure and equitable system of financing for community and long-term care which supports older people to stay in their own homes.

Finally, it should be noted that LTC may be statutory based (e.g. the Nursing Homes Support Scheme) or not (e.g. HSE Home Support Services). Any future developments would be dependent on evolving service priorities and overall resource availability.
Benefits in kind

1. Home care
Home Care Packages are an additional support on top of the existing mainstream community services, and are designed to enhance rather than replace existing home support services. The packages were first introduced in 2005, with the primary objective of supporting older people to continue to live in their own communities.

Carers’ Allowance:
Free Travel, Telephone Allowance, Electricity or Gas Allowance and Television Licence. These benefits seem to be provided without reference to the care needs of the beneficiary and might as well be excluded from the scope of long-term care allowances (although listed in the MISSOC tables under the chapter on long-term care).

According to the Note of the Irish delegation, there have been changes to these schemes which take effect from April 2012. These provide that new applicants for Carers’ Allowance, who are not living with the person to whom they are providing care, are no longer entitled to the Household Benefits package (Telephone Allowance, Electricity / Gas Allowance and Television Licence) in their own right.

2. Semi-residential care
Day care centres providing services such as a midday meal, a bath, physiotherapy, occupational therapy, chiropody, laundry and hairdressing services. A number of hours is not specified, but depends on individual circumstances.

3. Residential care
Public nursing home care is provided subject to charges. For all new entrants to public nursing homes after 27 October 2009, the charge is equal to the cost of care but financial support towards this cost can be provided via the Nursing Homes Support Scheme.

4. Other benefits
Grants for home adaption are available from the Department of the Environment.

Cash benefits

The Nursing Homes Support Scheme:
The financial assessment determines the applicant’s co-payment towards their care. The HSE will pay the balance of the cost of care. The price charged by the private nursing home is agreed in advance with the National Treatment Purchase Fund. The price charged by public nursing homes (i.e. the full cost of care) is also published.

The Carers’ Benefit:
In respect of a single care recipient: € 205.00 per week.
In respect of several care recipients: € 307.50 per week.

The Carers’ Allowance:
Maximum amounts:
In respect of a single care recipient: € 204 per week (€ 239 if aged 66 or over).
In respect of several care recipients: € 306 per week (€ 358.50 if aged 66 or over).
The Constant Attendance Allowance: € 205.00 per week.
This is payable in respect of persons who receive a disablement benefit resulting from an occupational injury or disease and who require constant care. This payment is made directly to the care recipients, although it is not payable during periods when they are in hospital or other residential institutions.

The Domiciliary Care Allowance:
Maximum rate per month: € 309.50 per child with a disability.

The Respite Care Grant: € 1 700 (annual rate for each person being cared for).
The Carers’ Benefit, Carers’ Allowance, Constant Attendance Allowance, and Respite Care Grant are paid directly to the carer as a Social Welfare income support payments to meet his/her own needs and the amounts are not different according to dependency levels. Domiciliary Care Allowance is a monthly payment for a severely disabled child who is under age 16 and needs full-time care and attention far beyond what is normally required by a child of the same age. It is paid to the person with whom the child is living and who is providing for the care of the child.

The Nursing Home Subvention: This can only be paid directly to the nursing home where the person is residing. Since it is paid directly by the HSE to the residential home, and the benefit is the care provided, this subvention might as well be categorised as a benefit in kind.

The Carers’ Benefit, Carers’ Allowance, Domiciliary Care Allowance, Constant Attendance Allowance and Respite Care Grant are paid to the informal caregiver who has discretion as to how the cash benefit is spent.
It might be worth mentioning that the Carers’ Benefit, Carers’ Allowance, Respite Grant and Domiciliary Care Allowance are paid to the carers as income to meet their own needs. Normally, the care recipients are also getting benefits, e.g. pensions, in their own right. The care they receive from those getting the care benefits or allowances would, therefore, for them appear to be benefits in kind. If such ‘carers’ were not available, they would probably need to be cared for in a residential home and would thus be regarded as receiving benefits in kind.

**Combination of benefits**

**Home Care:**
In most cases the person receives the service. However, in a very small number of cases, the person receives a weekly payment from the Health Service Executive and purchases the service privately. This practice is being phased out.

Nursing Home Subvention: The person’s weekly entitlement is paid directly to the nursing home where he or she is residing.

**Benefits for the carer**

Carers’ Benefit / Carers’ Allowance / Constant Attendance Allowance / Domiciliary Care Allowance / Respite Care Grant: as outlined above.

In addition to Carers’ Allowance and Benefit, carers may also qualify for other social insurance payments such as Illness Benefits or State Pension Contributory. Where a person qualifies for another social insurance payment the Carers’ Allowance etc. will be paid at a half rate.

According to the Note of the Irish delegation, for the reasons outlined above the Domiciliary Care Allowance could not be considered as a benefit for the carer and should not be referenced here.
ITALY

Applicable statutory basis

According to the Note of the Italian delegation, the bulk of social services to be provided to the elderly and/or disabled is split into four service sectors:

- **Home assistance (ADI/SAD):** As it is provided by regions, this service is not yet homogeneously spread, geographically-wise.
- **Family carer attendance:** is now playing a growing, almost structural role which is not simply limited to the domestic functions, but integrates and sometimes replaces, the public service – both social and health services.
- **The hospital or elderly-home stay accounts for nearly 3% of the granted services with high peaks in the North.**
- **Money transfers, attendance allowances and care allowances:** account for a large part of the public expenditure, with 10 billion euro spent only towards financing the constant attendance allowances.


According to the Note of the Italian delegation, these are special non-contributory benefits, included in Title III, Chapter 9 of the Regulation 883/2004.

Act No. 18 of 11 February 1980 on mobility allowances (Legge 11 Febbraio 1980, n. 18 - Indennità di accompagnamento agli invalidi civili totalmente inabili).

According to the Note of the Italian delegation, it is a special non-contributory benefit, included in Title III, Chapter 9 of the Regulation 883/2004.

Act No. 104 of 5 February 1992, Article 33 (Framework act on disability) (Legge 5 Febbraio 1992, n. 104 - Legge-quadro per l'assistenza, l'integrazione sociale e i diritti delle persone handicappate).

According to the Note of the Italian delegation, the law only provides for rules related to labour law (paid leave).

Legislative Decree No. 112 of 31 March 1998 on the transfer of legislative tasks and administrative competences from the State to the Regions and local entities (Decreto Legislativo 31 Marzo 1998, n. 112 - Conferimento di funzioni e compiti amministrativi dello Stato alle regioni ed agli enti locali, in attuazione del capo I della Legge 15 Marzo 1997, n. 59).

According to the Note of the Italian delegation, the law is related to territorial organization of the State.


According to the Note of the Italian delegation, the law only provides for rules related to labour law (paid leave).

Benefits in kind

It is explained in the Note of the Italian delegation that according to the Italian legislation, there is not a specific notion of long term care benefits (LTC), i.e. is not established any specific category of benefits in kind for LTC differing from the other benefits in kind. The Health System covers all the
health needs required by the insured people, irrespective of the forecasted or the effective length of
time of the treatment concerned. Therefore notwithstanding the LTC are not namely quoted in the
Italian legislation as such, they should be regarded as health benefits in kind tout-court.

1. Home care
Home care services are provided for at local level. They generally include home help, meal delivery,
medical treatment and nursing care.

Home healthcare is provided directly by the Health System only in some Regions and inside them in
very few territories. It concerns only the medical treatments and the nursing service.

2. Semi-residential care
The possibility of staying in a day care centre.

In the Health System there are centres of this kind but their availability in giving assistance cannot
cover the overall demand. They provide only the medical treatments and moreover the nursing
service. All this means that such LTC are granted both by the Health System and in many cases by the
private providers who have not any agreement with the Health System. In the latter cases the
relevant costs shall be covered by the insured persons.

3. Residential care
Residential care is provided for in the most serious cases. The length of the stay varies according to
the seriousness of the situation of dependency.

In the Health System there are centres of this kind but their availability in giving assistance cannot
cover the overall demand. They provide only the medical treatments and moreover the nursing
service. All this means that such LTC are given both by the Health System and in many cases by
private providers who have not any agreement with the Health System. In the latter cases the
relevant costs shall be covered by the insured persons.

4. Other benefits
Technical aids are provided for in the most serious cases.

Provision for benefits contributing to the purchase of prostheses or other necessary medical
equipment; the purchase or adaptation of private means of transport; the purchase of tools making
it possible to carry out a self-employed activity.

The granting of the electronic appliances or prostheses is up to a previous ascertainment of the
relevant need by the competent institution and the relevant procedure for providing the
aforementioned benefits depends on the ground of the need.

Cash benefits

Invalidity and incapacity insurance:
The invalidity allowance (assegno ordinario d'invalidità, AOI) and Incapacity pension (pensione di
inabilità).
In the coordination of social security systems, these are invalidity benefits, included in Title III,
Chapter 4 of the Regulation 883/2004.

Guaranteeing sufficient resources:
The attendance allowance (Indennità di accompagnamento) for disabled people: € 480.47 (€ 472.45
for recipients of the incapacity pension; € 783.60 for totally blind people).
Disabled people, deaf-mutes and totally blind persons in hospitals and partially blind persons: € 256.67 (€ 277.57 for non-hospitalised totally blind persons).

The Special allowance for partially blind persons (Indennità speciale per ciechi parziali): € 185.25.

The communication allowance for deaf-mutes (Indennità di comunicazione per sordomuti): € 239.95.

All these benefits are for the coordination purposes considered to be special non-contributory cash benefits, included in Title III, Chapter 9 of the Regulation 883/2004.

Discretionary use.

**Combination of benefits**

The possibility to combine cash benefits and benefits in kind.

No free choice between benefits in kind and cash benefits.

**Benefits for the carer**

No specific benefits for the carer. However, periods of leave to take care of a disabled family member are taken into account as periods of insurance for the purposes of a pension insurance.

**Addendum: Additional social security coordination aspects**

According to the Note of the Italian delegation, it is not possible to say if the list of LTC benefits is correct neither if it is complete, because:

- at the moment such benefits are coordinated in different chapters of the Regulation (e.g. sickness, invalidity, AWOD, special non-contributory benefits). So it is necessary to specify exactly the AC’s purpose: to create a new kind of coordination or a list of benefits, or modify the Regulation according to the judgments of the Court etc.

- as far as the local benefits are concerned, monitoring such heterogeneous benefits granted by 8.092 municipalities, 115 provinces and 20 Regions is quite impossible.
LATVIA

Applicable statutory basis

The Act on Social Services and Social Assistance (Sociālo pakalpojumu un sociālās palīdzības likums) of 31 October 2002.

The Regulations of the Cabinet of Ministers No. 1046 "Health care organisation and financing procedure" of 19 December 2006.

Benefits in kind

1. Home care
Care by a trained or other person (informal caregiver) to perform housework and to deliver meals. If (social) home care is provided by family members, the local authority supports them by training, consulting and if necessary also by providing benefits in cash.

The provider of health care at home (main tasks):
- plans the health care of the patient;
- prescribes diagnostic and therapeutic manipulations;
- assists the doctor during the diagnostic and therapeutic manipulations;
- carries out the palliative care;
- trains the patient and his or her family members in the care provision.

2. Semi-residential care
Is provided for various groups – care and possible involvement in physical and mental activities is provided to elderly, disabled with physical disorders, people with mental disorders, persons after serious and continuous diseases.

The number of hours that the recipient may attend the institution and any specialised services are set by the municipalities according to agreements with care institutions.

Day care centres are run by municipalities or NGOs. Day care centres for people with mental disabilities are partly financed by the State.

3. Residential care
Fulltime care is provided by long-term social care institutions for:
- orphans and children deprived of parental care,
- people of retirement age and the disabled with physical disorders or blind people,
- children with serious mental disorders, and
- adults with serious mental disorders.

Long-term care institutions are run by State and municipalities.

4. Other benefits
The state provides technical aids (tehniskie palīglīdzekļi) for persons to help prevent or reduce the functional incapacity caused by long-term or irreversible functional disorders of the body or anatomic defects:
- disabled of categories I, II or III,
- disabled children under the age of 18 years,
• children for whom the technical aids are necessary to reduce or eliminate functional inability,
• adult persons for whom the technical aids are necessary to reduce or eliminate functional inability,
• persons with anatomic defects who need a prosthesis or orthopaedic footwear
• persons with anticipated disability according to an individual rehabilitation plan.

Health care at home taking into account a person’s health and health care needs can be provided. Patients with the following diagnoses are entitled to health care at home:
• Immobile patients with cancer diagnosis (C00-C97; D37- D48);
• Patients with mental disorders (F00-F03; F06.0-F06.3; G10- G32; A81);
• Patients with bedsore (L89);
• Patients with cerebral stroke and other paralytical syndromes (G80-G83);
• Patients who need respiratory therapy (Z99.1);
• Patients with mobility disorders and the following diagnoses: B20-B24; E10-E11; G35; I60-I69; T91.3; Z48; Z93; Z94; Z98.

The referral from a general practitioner or specialist (if health care at home is needed after release from the hospital) is needed. The referral must contain: the health care services required, the statement of reasons for health care at home, the duration of health care at home.

Another benefit - care of disabled child benefit - could be also considered as long-term care benefit according to the trESS 2011 definition. Persons who permanently reside in the territory of Latvia have the right to State social allowances - also care of disabled child benefit. According to the national legislation and Regulation 883/2004 it falls under family benefits.

**Cash benefits**

Local authority may provide benefits in cash for a person in need if he or she is not receiving home care services. Cash benefits are also available for family members who provide care. The municipality can grant additional benefits.

The amount and conditions for the provision of cash benefits depend on the municipality and the internal regulations they approve.

No discretionary use.

**Combination of benefits**

No mixed benefits.
No free choice between cash benefits and benefits in kind.

**Benefits for the carer**

Depends on the municipality’s decision.
The conditions for the provision of benefits for the carer depend on the municipality and the internal regulations they approve.
Addendum: Social security coordination aspects


According to the Note of the Latvian delegation, another benefit should be added - An allowance for a disabled person for whom care is necessary (Law on State Social Benefits of 1 January 2003) which is in force since 2008. After having re-examined this request Latvia has decided to withdraw this request again.

Care of disabled child benefit is considered as family benefit according to national legislation and the Regulation 883/2004 and the latter sets up priorities to determine the competent MS.
LIECHTENSTEIN

Applicable statutory basis

- The Act on Sickness Insurance of 24 November 1971 (Gesetz über die Krankenversicherung, KVG).
- The Act on compulsory Accident Insurance of 28 November 1989 (Gesetz über die obligatorische Unfallversicherung, UVersG).
- The Act on Invalidity Insurance of 23 December 1959 (Gesetz über die Invalidenversicherung, IVG).
- the Act on the granting of allowances for blind persons of 17 December 1970 (Gesetz über die Gewährung von Blindenbeihilfen).
- The Act on Old-age and Survivors' Insurance of 14 December 1952 (Gesetz über die Alters- und Hinterlassenenversicherung, AHVG).
- the Act on Supplementary Benefits to the Old-age, Survivors' and Invalidity Insurance of 10 December 1960 (Gesetz über Ergänzungsleistungen zur Alters-, Hinterlassenen- und Invalidenversicherung, ELG).
- The Act on Social Assistance of 15 November 1984 (Sozialhilfegesetz, SHG).

Benefits in kind

1. Home care

KVG:
Examinations, treatment and care at the home of the patient by doctors and chiropractors24 as well as, on the basis of a medical prescription, by nurses or homecare organisations (= SPITEX);
UVersG:
- treatment at the home of the patient by doctors and chiropractors25,
- care at the home of the patient, prescribed by a doctor and provided by nurses or homecare organisations (= SPITEX);
ELG (special medical measures): treatment at home by a doctor or, on prescription, by paramedical staff.

2. Semi-residential care

In no field envisaged according to MISSOC. (See, however, Gesundheitsgesetz, Article 37, and below under “Supplementary benefits [according to ELG]”.)

3. Residential care26

KVG: examinations, treatment and care in a hospital or in a medico-social establishment as well as the stay in the general ward of the hospital.
ELG (special medical measures): treatment, board and accommodation in the general ward of a hospital.

4. Other benefits

Auxiliary equipment

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24 Assuming that the notion of „ambulant“ is the same as in Switzerland.
25 Assuming that the notion of „ambulant“ is the same as in Switzerland.
26 UVersG not for long-term care.
Simple and adequate model. Appear on a list.

- **KVG**: therapeutic equipment prescribed by a doctor;
- **UVersG**: therapeutic equipment; auxiliary equipment to compensate for physical damage or loss of a function;
- **AHVG and IVG**: auxiliary equipment necessary for the insured person in order to move about, establish contacts with her or his entourage or develop personal autonomy;
- **ELG**: therapeutic and auxiliary equipment.

### Cash benefits

**Helplessness allowance**

Depends on the degree of helplessness. Monthly amounts.

- **ELG:**
  An amount depending on the degree (slight – moderate – severe) of helplessness; for persons over 65 in principle only in case of moderate and severe degree of helplessness; a supplement for minors living in an institution.

- **UVersG:**
  An amount depending on the degree (slight – moderate – severe) of helplessness.

**Allowances for the blind** *(Gesetz über die Gewährung von Blindenbeihilfen)*:

As a compensation for the additional expenses due to the visual impairment.

An amount depending on the degree of visual impairment.

### Supplementary benefits (according to ELG)

Also designed to cover (up to a certain amount) particularly the costs of a stay in a medico-social establishment or in a hospital (particularly daily fee), of health care, of home care (in part including costs for loss compensation in favour of caring family members) and semi-residential care as well as of therapeutic and auxiliary equipment.

### Support and care allowance (according to ELG)

For covering costs borne by the assisted person for compensating his or her home carer. The latter can also be a family member receiving a salary from the person in need of assistance or care. Six levels.

**Compensation for expenses for home care in case of special medical measures being carried out at the home of the patient** *(according to ELG)*

- Home care by medical nursing staff: compensation for adequate expenses for nursing staff.
- Home care by other persons: flat rate compensation; 4 levels (need of intensive care of 8 hours a day at least – need of intensive care of 6 hours a day at least – need of intensive care of 4 hours a day at least – need of intensive care of 2 hours a day at least or need of continuous surveillance).

A priori bearing of part of the long term care costs by the State (not in the form of cash benefits to the persons in need of long term care themselves; **KVG**).

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27 For this situation see above under benefits in kind – home care – **ELG**.
Contributions according to the OHG: contributions for long-term help of third persons and compensation by the State (both insofar as not covered particularly by social security or the author of damage).

Social assistance (insofar as not covered particularly by social security).

Combination of benefits

The benefits are provided by several branches of social security: benefits in kind and cash benefits, which are often granted to a person for the same period of time. In general, the person does not have freedom of choice as to whether he or she prefers a benefit in kind or a cash benefit.

Benefits for the carer

A person caring for family members or (only for non-profit care) for other persons who are helpless to a moderate degree in terms of the ELG at least and who live with him or her in the same (or a neighbouring) household may claim a bonus for caretaking. The yearly bonus corresponds to 48 times the amount of the minimum monthly old-age 1st pillar pension. The bonus is part of the determining income for the calculation of the carer’s 1st pillar pension.

See also above under “Supplementary benefits (according to ELG)” and “Support and care allowance (according to ELG)”.

Contributions according to the OHG (see above)²⁸.

Addendum: Social security coordination aspects

At the beginning of 2010 Liechtenstein introduced an ‘attendance and care allowance’ for care at home. According to the Note of the Liechtenstein delegation, this is a sickness benefit in kind within the meaning of Regulation No 883/2004 (rather than a cash benefit). The attendance and care allowance must be used to pay for care services provided by third parties. Evidence of this must be produced, otherwise there is no entitlement. There is no regionalisation.

²⁸ Assuming that the Liechtenstein law is interpreted in the same way as the Swiss law.
LITHUANIA

Applicable statutory basis

- Temporary Act on Social Benefits’ Re-calculation and Payment (Socialinių išmokų perskaiciavimo ir mokėjimo laikinasis įstatymas) of 9 December 2009 (No. XI-537).
- Act on Social Services (Socialinių paslaugų įstatymas) of 19 January 2006 (No. X-493).
- Act on Health Insurance (Sveikatos draudimo įstatymas) of 21 May 1996 (No I-1343).
- Act on the Health care System (Sveikatos sistemos įstatymas) of 19 July 1994 (No I-552).
- Act on Health Care Institutions (Sveikatos priežiūros įstaigų įstatymas) of 6 June 1996 (No. I-1367).

In Lithuania there is a central system of LTC which is supplemented on a municipal level:
1) Lithuanian Government adopts long-term national programs, strategies, requirements and standards.
2) Municipalities are directly responsible for organisation and planning of provision of social services; for determination of individual needs for social services; for supervision of social services. They prepare and implement municipal programs of disabled social integration, also organise the primary health care (financed by Compulsory Health Insurance Fund. Municipalities are also responsible for granting target compensations for nursing or attendance (financed by State budget).

LTC is organised in day centres, home care centres, residential social care institutions and nursing or general hospitals.

There is no single legal act regulating LTC. LTC for the persons in need is provided by through several branches: social services, target compensations for nursing or attendance and long term healthcare.

Benefits in kind

Benefits in kind are the most important part of LTC benefits.

1. Home care
One of the main principles of providing social services at home is to help to an adult with a disability to create conditions for him to live at home, in his family and organising the assistance co-ordinated with education, employment, personal health care and special assistance measures, helping to develop or compensate for his abilities to care for his personal (family) life and to participate in the labour market.

People in need of home help are regularly visited by social workers or social workers assistants.
Social attendance or social care at home includes performance of housework and care by home helpers.

Social care services includes services which are provided by a team of specialists (social workers, social workers assistants, health care assistants and others depends on the need) at a person’s home. Elderly and disabled people can receive day care services at home from 2 hours till 8 hours per day up to 7 times per week, short - term care up to 8 hours per day till one month at person’s home.

Services financed from municipal budget and if person is with severe disability could be financed from special targeted subsidies of the State budget to municipal budgets and persons (families) payments.
Cash allowance. In some cases, when it is expedient to organise social services at home in monetary form, services may be changed into a cash allowance. This cash allowance is paid for person (family) to pay for a help of assistance. Cash allowance financed from the municipal budgets.

Primary health care institutions are responsible for the organisation and provision of nursing services at home.

Palliative care and nursing services can be provided at home by a team of specialists: a doctor, nurse and social workers. Social care services includes services which are provided by various specialists at a person’s home.

Nursing at home financed from the Compulsory Health Insurance Fund.

2. Semi-residential care
Elderly and disabled people can receive day care, social care services in day care centres from 3 hours per day up to 5 days per week in institution.
Short-term social care for elderly and disabled people providing not less than 12 hours per day till 6 months per year or 5 days per week or termless in institution.
Long term care in residential social care institutions depending on the kind of recipients of the services, for elder persons no less than 6 months per year or termless.
Semi-residential care is financed from the municipal budgets or special targeted subsidies of the State budget to municipal budgets and persons (families) payments.

3. Residential care
Residential care is financed from the State, municipal budgets or special targeted subsidies of the State budget to municipal budgets, and persons (families) payments.
Residential care is provided for children deprived of parental care, children and adults with disabilities and elderly people by foster families, social care houses (old-age homes, housing for disabled, specialised social care homes, etc.).
Nursing and maintenance treatment is provided in nursing or general hospitals.
Palliative care is provided in the general, cancer and nursing hospitals.

4. Other benefits
Other benefits in kind include the provision of special equipment. Disabled people receive special aid for purchasing a car, they are provided with wheelchairs, their flats are arranged according to their disability.
However, these benefits might be provided to a larger scope of beneficiaries and not only to long-term care recipients.

Respite care is the assistance for families that take care all year – long of disabled person or senior not less than 12 hours per day till 6 months per year or 5 days per week or termless in institution. For persons with severe disabilities could be providing social care (in day centres, at home, in institutions) and financed from special targeted subsidies of the State budget to municipal budgets.

Cash benefits

The Special Compensation for Care Expenses (Slaugos išlaidų tikslinė kompensacija): Paid for disabled children with a severe degree of disability, to disabled persons with a reduction in capacity for work of 75% - 100% or to the persons of retirement age if the need of permanent care is determined. The amount is 250% of the social insurance basic pension (currently LTL 900 (€ 261)). Temporarily, for the period 2010-2011, benefits are paid at 85% of the above-mentioned amounts.
The Special Compensation for Attendance Expenses (Priežiūros (pagalbos) išlaidų tikslinė kompensacija): Paid to disabled children with a severe and moderate degree of disability whether or not the need of permanent care is determined and to disabled persons with a reduction in capacity for work of at least 60% and to persons of retirement age if the need of permanent attendance is determined. The amount is 50% or 100% of the social insurance basic pension depending on the category of the recipient (respectively LTL 180 (€ 52) or LTL 360 (€ 104)). Temporarily, for the period 2010-2012, benefits are paid at 85% of the above-mentioned amounts.

The person has the free choice to use cash benefit at his or her own discretion.

Combination of benefits

Mixed benefits.
No choice between cash benefits or benefits in kind.

However, if a person who receives residential care is at the same time entitled to special compensations mentioned above, the compensations are paid, and the amounts are included in the income of this person. A person may not pay more than 80 per cent of his or her full income for residential care. The rest is covered by local governments. So it may happen that up to 80 per cent of the special compensations (being a part of person’s income) are deducted as a payment for residential care. Payment could be more than 80 per cent of income, if a person has a property above a certain limit (i.e. if person’s property exceeds the ration established by the legislation, 1 % is calculated in respect of property value exceeding the ration), but in any case no less than 20 per cent of income leaves for person to ensure daily life expenses. The similar rule is also applied in the case of home care (in this case not more than 20 per cent of the income is deducted).

Benefits for the carer

No benefits for the carer, but the periods of care influence his or her entitlement and amount of social pension, means-tested social benefit, etc.
**Applicable statutory basis**

The Act of 19 June 1998 introducing the dependency insurance, in force since 1 January 1999 amended several times, but not fundamentally, in order to better ensure the correct use of the benefits provided and to adapt provisions to practical problems which appeared while applying the legislation. No major reform planned at short term.

Insurance system financed by contributions paid by insured persons and determined on professional income and all other income, plus financial participation of the State budget.

All persons covered by Luxembourg health insurance are automatically covered by dependency insurance.

Benefits in kind are care services provided by professional carers. Up to a certain limit professional care may be provided by an informal carer (family member, friend, hired person) and in this case benefits in kind are replaced by a cash benefit which has to be paid to this informal carer.

**Benefits in kind**

1. **Home care**
   - Assistance and care necessary for the basic everyday activities;
   - assistance for the general upkeep of the house and laundry;
   - assistance in the form of support activities. These might include a presence in the home of a person who cannot stay alone, specialised individual supervision, accompaniment for an outing or shopping, or group support activities, notably visiting a semi-stationary centre;
   - assistance in the form of professional advice aimed at maintaining the autonomy potential of the person and teaching those in the dependent person’s social circle the adequate actions for providing assistance and care.

   Technical and adaptation assistance:
   - reimbursement of the cost of purchasing or renting technical assisting devices: wheelchair, adapted bed, walking stick, seats;
   - measures for adapting the accommodation in order to improve its accessibility;
   - financial aid for the purchase of products necessary for the assistance and care.

2. **Semi-residential care (in approved centres)**
   Visiting a semi-stationary centre constitutes a group support activity (see “Benefits in kind”, “1. Home care”). The assistance and care which the dependent person requires during his stay in a semi-stationary centre are granted in accordance with the person’s care plan.

3. **Residential care**
   - Assistance and care necessary for the basic everyday activities;
   - Assistance in the form of support activities. These might include specialised individual supervision or group support activities;
   - Reimbursement of the cost of purchasing or renting technical assisting devices that are not included in the standard equipment of an institution.

Products necessary for the assistance and care are provided free of charge to the dependent person. They are paid by the administering institution by calculating the monetary value.
4. Other benefits

No other benefits.

Cash benefits

Cash benefits may totally or partially replace benefits in kind (home care only). The monetary value of the cash benefit amounts to € 25 per hour. The maximum weekly amount is € 262.50 (10.5 hours).

The dependent person must use the cash benefits to obtain the care and assistance provided in the care plan, outside contracted professional services. Since the Act of December 23, 2005, the cash benefit may only be used to »remunerate« the informal caregiver.

Combination of benefits

The possibility to combine benefits in kind and cash benefits (with the legal limitations mentioned above).

The person can choose the type of benefit which he or she would like to receive: benefits in kind, cash benefits or mixed benefits (combination of benefits in kind and in cash).

Benefits for the carer

The dependency insurance pays pension insurance contributions on behalf of the informal caregiver, who provides home care.
Malta

Applicable statutory basis
Social Security Act (Att dwar is-Sigurta’ Socjali) (Cap. 318).

State-Owned Institutions and Hostels Rates Regulations.

Transfer of Funds (Government Financed Beds) Regulations.

Specified State-Owned Institutions and Hostels Regulations.

Benefits in kind

1. Home care
Home care helps to provide assistance to persons in need. It offers help of a personal and light domestic nature in order to allow older persons and/or persons with special needs, to continue living in their community in as much of an independent manner as is feasibly possible. It also provides respite and support for informal carers, and averts/delay demand for long-term residential care.

Benefits in-kind available as home care include:
- meals on wheel service (meals are supplied by a non-governmental organisation against a subsidised charge),
- handyman service (The objective of this service is to help older adults and persons with special needs to continue living as independently as possible in their own home. The Handyman Service offers a range of around seventy repair jobs that vary from electricity repairs to plumbing, carpentry and transport of items. The service is normally requested by phone.),
- home care help,
- incontinence service,
- community nurse service.

2. Semi-residential care
There are thirteen state-run day care centres that open daily from 8.30am to 4.00pm. Occupational therapy is offered in these centres.

3. Residential care
One central institution for permanent elderly residents, supplemented by seven regional residences – all state run. There are also private residential homes.
In addition, there is a state run central mental institution that provides treatment and care for mentally impaired persons who need psychiatric treatment.
Another central and state run institution/hospital provides long-term care for cancer patients and other malignant diseases.

4. Other benefits
The incontinence service: essentially a benefit-in-kind which provides adult nappies at a reduced cost.

Cash benefits
There is no special benefit related solely to long-term care. Benefits are directly payable to person needing long-term care or his/her legal guardian.

Beneficiaries are free to use the money received as they deem to fit.
Combination of benefits
The same person can be entitled to both cash and in kind benefits.
Free choice between cash and benefits in kind is possible.

Benefits for the carer
A Carers’ Pension is paid to a person who is either single or a widow/er and who takes full-time care of a sick relative who is bedridden or confined to a wheel-chair and living in the same household. The rate of benefit is € 95.58 per week and is paid to the carer.

A Carers’ Allowance (Pensjoni tal-Wens) is paid to a person who is either single or a widow/er and who takes constant care of a sick relative living in the same household. The rate of benefit is € 69.24 per week and is paid to the carer.
THE NETHERLANDS

Applicable statutory basis

The General Exceptional Medical Expenses Act (Algemene wet bijzondere ziektekosten, AWBZ), of 14 December 1967.

According to the Note of the Dutch delegation, the government has started a program aimed at restructuring long term care in the Netherlands. The aims of this program are to improve the quality of LTC, to align the care as much as possible to the wishes of the recipients, to decrease the amount of regulations and to better control the costs of LTC.

Benefits in kind

Care is provided in the form of “products”. For example home care, admission to a care home, nursing home, institution for the development or physically disabled are all products offered under the AWBZ. A product consists of a single function or a combination of functions.

Long-term care is defined in five broadly defined functions. Next to personal care, also nursing (e.g. administering injections), supportive guidance (assistance in managing daily activities), treatment (e.g. specific treatment by a geriatric specialist, a doctor for the developmentally disabled or a behavioural scientist) and accommodation are provided as benefits in kind.

1. Home care
Care provided at home by an institution to insured persons with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability. The activities in the field of personal care are supported or taken over, with a view to compensate for the (temporary) inability of the insured person to live independently.

Home care includes the loan of nursing equipment for a maximum period of 26 weeks.

2. Semi-residential care
Care provided by an institution to insured persons with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability. The care is aimed at the promotion or preservation of the ability to live independently and serves to prevent institutionalisation or neglect of the insured person.

3. Residential care
Care in an institution which is necessary due to the need for a protected living environment, therapeutic environment or permanent supervision of an insured person with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability.

4. Other benefits
Several specific benefits for specific kinds of patients such as psychiatric treatment and treatment for persons with visual or hearing impairments.

In addition to care functions, there is also entitlement to, for example, patient transport, nursing supplies, care and support related to sign language, hospital care after one year, rehabilitation care, prenatal care, research into certain congenital metabolic disorders, and vaccinations included as part of a vaccination programme.
**Cash benefits**

Within the framework of an experiment, the insured person can opt not to obtain care provision in kind, but to receive a personal care budget (*persoonsgebonden budget, PGB*) to enable him or her to purchase care independently. The budget is only available for certain functional forms of care, such as nursing, general care and guidance; the budget is not available for treatment or institutional accommodation. The amount of the personal care budget is dependent on the required care.

Discretionary use.

The Netherlands’ government has the intention to end this experiment and make the personal care budget an entitlement as a benefit in cash under the AWBZ.

**Combination of benefits**

The AWBZ basically provides for benefits in kind. However, within the framework of an experiment, the insured persons have the choice between receiving the benefit in kind or in the form of a personal care budget (*persoonsgebonden budget, PGB*); a combination of the two is also possible.

Free choice between cash benefits and benefits in kind.

**Benefits for the carer**

An amount of € 250 per year is granted to informal caregivers who provide long-term care at home to a person with an indication for long-term care.
NORWAY

Applicable statutory basis

- The Municipal Health Services Act (lov om helsetjenesten i kommunene) of 19 November 1982.
- The Social Services Act (lov om sosiale tjenester) of 13 December 1991.
- The new Act on Municipal Health and Care Services (lov om kommunale helse- og omsorgstjenester mm.) of 24 June 2011.

Benefits in kind

1. Home care
   Practical assistance and care at home according to the need. Home care services are available day and night (round-the-clock). Community care housing is both a supplement and alternative to nursing homes and institutions.

2. Semi-residential care
   Short-term stays in nursing homes (weekends etc) are offered as a relief measure for the family of patients cared for at home. No time limit.

3. Residential care
   Provided in municipal nursing homes, day and night service flats, homes for elderly, housing for disabled children, etc.

4. Other benefits
   Both the nursing homes and the home care services are supported by other municipal health and social services, such as short-term technical aids (walker, etc). The home care services are also supported by long-term technical aids from the National Insurance Scheme (folketrygden), such as wheelchairs, telecommunication services, etc.

Cash benefits

For the disabled: The Basic benefit (grunnstønad) and Attendance benefit (hjelpestønad) from the general National Insurance Scheme (folketrygden) are paid directly to the person who is in need of care.

The Basic benefit to cover extra expenses due to permanent illness, injury or deformity. There are 6 different rates of benefit according to the level of extra expenses, ranging from NOK 7 572 (€ 1 031) to NOK 37 860 (€ 5 157) per year.

The Attendance benefit to cover the need for special attention or nursing. The standard rate is NOK 13 572 (€ 1 849). For disabled children under 18, the benefit can be paid at 3 different higher rates, up to NOK 81 432 (€ 11 092).

A condition for the Attendance benefit is that the care is provided by an informal caregiver.

The Discretionary cash benefit (omsorgslønn) paid by the municipality to an informal carer who has a particular burdensome care work.

No discretionary use. The cash benefits are a supplement to the benefits in kind.
**Combination of benefits**

Mainly benefits in kind.

Combined benefits are possible. It is for the local municipality authorities to decide how the person’s needs can be fulfilled, with different combinations of benefits in kind and cash benefits. The cash benefits are a supplement to the benefits in kind.

No free choice between cash and/or benefits in kind.

**Benefits for the carer**

Discretionary cash benefit (*omsorgslønn*) paid by the municipality to an informal carer who has a particular burdensome care work.

It is for the local municipality authorities to decide in each single case if the caregiver has “a particular burdensome care work”. The level (amount) of the benefit is also determined by the local authorities.
Applicable statutory basis

In Poland there is no integrated long term care system regulated by single legal act. People who need such care are entitled to certain benefits under various legal acts, such as e.g. from the field of social assistance, health care, family benefits or benefits for disabled persons. The amounts of benefits are the same for all regions of Poland.

- The Act on Health Care Services financed from Public Means (Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych) of 27 August 2004.
- The Act on Social Assistance (Ustawa o pomocy społecznej) of 12 March 2004.
- The Act on Social Pension (Ustawa o rencie socjalnej) of 27 June 2003.
- The Act on Vocational and Social Rehabilitation and Employment of Disabled Persons (Ustawa o rehabilitacji zawodowej i społecznej oraz zatrudnianiu osób niepełnosprawnych) of 27 August 1997.

In addition, some other legal acts might be mentioned:
- The Act of 24 January 1991 on veterans and some victims of war and post-war repressions
- The Act of 25 June 1999 on cash benefits from social insurance for sickness and maternity
- The Act of 30 October 2002 on social insurance for accidents at work and occupational diseases
- The Ordinance by the Ministry of Labour and Social Policy of 27 July 1999 on rules and procedures for medical certification under the social Insurance Institution
- The Ordinance by the Ministry of Labour and Social Policy of 14 December 2004 on certifying incapacity to work
- Ordinance No. 61/2007/DSOZ by the President of National Health Fund (NFZ) of 19 December 2007 on the contracts under the provisions on long-term care

Benefits in kind

1. Home care
Specialised care services, including those for people with mental disorders, are one of the basic forms of assistance in kind.
Bedridden and chronic patients who stay at home and who require systematic nursing services due to existing health problems may receive long-term nursing care in the home based environment. Persons with chronic diseases, aggravating disability, sick persons who are not eligible for hospitalisation but need permanent professional nursing, rehabilitation and care are eligible for this type of care. In such cases, long-term care is provided in the home based environment, as long-term nursing care at the patient’s home.

2. Semi-residential care
Support centres, which are organisational units of day care social assistance. Support centres include, among others: community mutual-aid houses for persons with mental disorders, day care assistance houses and mutual aid clubs.
3. **Residential care**
Social assistance centres, family-based assistance houses, social assistance houses, family support centres.

4. **Other benefits**
There is a possibility to award certain “accompanying measures” to persons who have the legal assessment of disability. Such measures include possibilities to obtain the co-financing of, for example,

- the participation of disabled persons and their attendants in rehabilitation stays,
- provision of rehabilitation equipment, orthopaedic equipment and auxiliary devices allocated to disabled persons under separate provisions,
- liquidation of architectural and technical barriers in connection with individual needs of disabled persons,
- rehabilitation of children and the young.

Disabled persons may also participate in occupational therapy workshops, which are organisationally and financially separated establishments allowing for social and vocational rehabilitation of disabled persons incapable of work, aimed at gaining or recovering skills required to pursue employment. Occupational therapy workshops may be organised by foundations, associations or other entities, and the costs of establishment and operation of such workshops, or resulting from the increased number of the workshop participants, are co-financed by the State Fund for Rehabilitation of Disabled Persons (Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych, PFRON), from the funds of local governments or other sources.

In addition, the Act on social assistance provides assistance in the form of protected housing (mieszkania chronione)

- For a person who, because of the difficult life situation, age, disability or illness needs support in everyday life, but does not require the services provided in the specialised, stationary care facilities, in particular, a person with a mental disorder, a person leaving the foster family, childcare facility, youth educational centre or youth detention centre, as well as foreigners who reside in Poland on the basis of a status of refugee or subsidiary protection.
- Protected housing is a form of social assistance that prepares its tenants, under the care of specialists, to live independently, or provides housing in lieu of a facility that assures 24-hour care. Protected housing provides the conditions for independent functioning in and integration into the local community.
- Protected housing can be conducted by any entity of social assistance or by a public benefit organisation.

The National Health Fund finances, inter alia, the provision of long-term care in the form of home care and residential care services:

- Care and treatment facilities, nursing and care facilities (zakłady opiekuńczo-lecznicze i pielęgnacyjno-opiekuńcze). They provide nursing, rehabilitation and pharmacological treatment (previously provided during hospital treatment) for patients who have completed the process of diagnosis, surgery or intensive medical treatment and do not need further hospitalisation, but are chronically ill, dependent and suffer from a partial or advanced disability and therefore need permanent medical control, professional nursing and rehabilitation, which involves the necessity of staying in the care facilities.

- Long-term care homes for mechanically ventilated adults, children and youth (zespoły długoterminowej opieki domowej dla dorosłych, dzieci i młodzieży wentylowanych mechanicznie) provided for people with respiratory failures that need permanent or temporary respiratory therapy (either through tracheotomies or through other devices)
without the necessity of being hospitalised on an intensive care unit, but they need a permanent, specialist and professional care, nursing and rehabilitation.

- Hospital departments for LTC and palliative services (świadczenia w oddziale medycyny paliatywnej/hospicjum stacjonarnym) for terminally ill with a progressive, life-threatening disease.
- Home care hospices for adults and children (świadczenia realizowane w hospicjum domowym dla dorosłych i dzieci) – doctors, nurses, psychologists and physiotherapists engaged in these hospices can help families in the care of a sick person who is staying at home.
- The provision of palliative care medicine in the clinic – (świadczenia w poradni medycyny paliatywnej) for the sick who are in a stable state of health and can come to the clinic.

**Cash benefits**

The Medical Care Supplement (Dodatek pielęgnacyjny) - PLN 181.10 (€ 41.46) per month and Medical Care Allowance, (Zasiłek pielęgnacyjny) – PLN 153.00 (€ 35.02) per month. Medical Care Allowance can be granted for disabled children up to the age of 16, disabled persons over the age of 16, persons over the age of 75.

The Training and Rehabilitation of Disabled Child supplement (dodatek z tytułu kształcenia i rehabilitacji dziecka niepełnosprawnego) – PLN 60 per child until the child is 5 or PLN 80 per child between 5 and 24.

Social Pension (Renta socjalna) – PLN 593.28. According to the Note of the Polish delegation, Social Pension under provisions of the Law of 27/6/2003 on Social Pension (also in Annex X of Regulation) is granted for adults (aged 18 years and over), and those whose invalidity began before the age of 18 years (25 years in the case of full-time students). It is financed from the State budget and granted to those who are totally incapable of work but they do not require (considerable) assistance/care from other persons to carry out essential daily activities. This benefit is similar to “normal” invalidity pension and could not be treated as LTC.

The Permanent Allowance (Zasiłek stały) – awarded to an adult person keeping a single household and totally incapable of work due to age or disability, provided that the income of that person is lower than the income criterion for a person keeping a single household, and to an adult person staying with the family, completely incapable of work due to age or disability, provided that the income of that person, as well as the income per person in the family, is lower than the income criterion per person in the family. Amount: maximum PLN 444.

Earmarked allowance (Zasiłek celowy) – awarded for the coverage, in full or in part, of the costs of the purchase of food, medicine and treatment, fuel, clothing, daily necessities, minor apartment repairs, and funeral costs. The amount depends on the individual situation.

The Periodic Allowance (Zasiłek okresowy) – awarded due to any chronic disease or disability to a person keeping a single household whose income is lower than the income criterion for a person keeping a single household and to a family whose income is lower than the income criterion for the family. Amount: maximum PLN 418 (€ 95.69).

A form of financial assistance paid directly to persons in need of long-term care services are the Medical Care Allowance (Zasiłek pielęgnacyjny) and the Medical Care Supplement (Dodatek pielęgnacyjny), which are granted for a partial coverage of expenses resulting from the need to provide a disabled person with care and assistance of another person due to his or her incapacity for independent existence. The person concerned has a free choice and can use the money for the services he or she prefers. There is no difference if a cash benefit is used for professional care
providers or informal caregivers. The amount of the benefits does not relate to the level/scale of dependency.

In addition, some other cash benefits might be mentioned. The Family allowance (Zasiłek rodzinnym): The entitlement to a family allowance is, among others, subject to means-testing. The right to the family allowance is awarded if the income per person in a family or if the average monthly income of a learning person does not exceed PLN 504. If there is a child with a certified disability or with a certified moderate or severe disability in the family, the family is entitled to a family allowance if the average monthly income per capita in the family or the average monthly income of a learning person does not exceed PLN 583.

Some benefits for veterans might be mentioned as well (although they are not necessarily linked to long-term care). They may include direct benefits and reduced transport tariffs.

The Care allowance (Zasiłek opiekuńczy) granted on the basis of the Act on cash benefits payable for sickness and maternity from the social insurance of 25 June 1999. The Care Allowance is granted when it is necessary to take care of:

a. a child up to 8 years of age in case of:
   b. an unexpected closing of a day nursery, a kindergarten or a school which the child attends,
   c. childbirth or sickness of the insured person's spouse who permanently takes care of the child if the childbirth or sickness make them unable to take care of the child,
   d. a stay of the insured person's spouse who takes care of the child in a health care institution,
   e. a sick child is up to 14 years of age,
   f. any other sick member of the family (spouse, parents, parents-in-law, grandparents, grandchildren, siblings, and children over 14 – if they stay in the same household with the insured person).

If care is taken of the child up to 14 years of age, the care allowance is granted for the period of caretaking, which cannot exceed 60 days per calendar year. If a child is older or if care is taken of another member of the family care allowance is granted for a maximum period of 14 days in the calendar year. Care allowances are jointly granted for taking care of children and other members of the family for the period not exceeding 60 days per calendar year. The allowance is payable at the rate of 80% of the basis of contribution rates (average salary).

The incapacity to work pension (Renta z tytułu niezdolności do pracy) might be considered as a long-term care benefit only if a person has a certificate of the ZUS-authorised physician to the medical commission of the social security institution about the total inability to perform any kind of work and in the case of finding that the ability of the organism has been impaired to a degree which makes it necessary for the person concerned to be under permanent or long-term care to satisfy her or his basic living needs and the inability to conduct independent existence is announced.

**Combination of benefits**

Cash benefits and benefits in kind.

As a general rule, there is a free choice between cash benefits and benefits in kind. Nevertheless, the cash benefits usually do not include the possibility to receive benefits in kind.
**Benefits for the carer**

The nursing benefit (Świadczenie pielegnacyjne) – established to support people who do not undertake or resign from employment or other paid work due to the necessity of taking care of a disabled child. The child (under 16 years old) must be in possession of a certificate confirming his or her disability with recommendations of constant or long-term care or help, related to a limited ability of the child to independent existence and a necessity of the everyday participation of a caretaker in the process of medical treatment, rehabilitation and education, or (if the child is older than 16 years) of a certificate confirming a considerable degree of disability. A caregiver can receive the nursing benefit only if he or she is one of the parents or the factual guardian of the child. The amount of money paid directly to the caregiver is PLN 520 (€ 119.04) per month. The caregiver can have his or her social insurance contributions paid from the state budget.

A social assistance centre pays the contribution to an old-age and pension insurance. The amount is subject to income criteria per person in the family, to a person that gives up employment due to the necessity to exercise direct, personal care for a member of the family suffering from a long-term or serious disease, and for a non-cohabiting mother, father, or for siblings, provided that the actual income per person in the family of the person exercising such care does not exceed 150% of the amount subject to income criteria per person in the family, and provided that the person exercising such a care is not covered by mandatory old-age or disability pension insurance under other titles and receives no old-age or disability pension. The above also refers to individuals who – due to the necessity to exercise such a care – are on unpaid leave. The contribution to old-age and pension insurance – in the amount specified under relevant provisions on the social insurance system – is paid for the duration of exercising such care.

**Addendum: Social security coordination aspects**

According to the Note of the Polish delegation, the above listed benefits in kind represent a mix of sickness benefits and social services that are not considered as part of social security system (health care) in Poland but that belong to the sphere of social assistance.

The Polish delegation noted that according to their view only Medical Care Supplement (Dodatek pielegnacyjny) and Medical Care Allowance for adults (Zasiłek pielegnacyjny) can be treated as LTC cash benefits.

They have emphasized that according to the Judgement of The Court (C-333/00 Mahheimo) a benefit such as the home child-care allowance is a family benefit within the meaning of Article 4(1)(h) of the Regulation 1408/71. That is why Medical Care Allowance should be treated as LTC only in the case of adults (not in case of children).

According to the view of the Polish delegation, Supplement to family benefit (Training and Rehabilitation of Disabled Child supplement, dodatek z tytułu kształcenia i rehabilitacji dziecka niepełnosprawnego) cannot be coordinated as sickness benefits. All supplements to family allowances in Poland are integral part of “main” family allowance (they cannot be granted separately). All supplements to family allowances are recognized as family benefits under the Regulation 883/2004.

The Polish delegation expressed their believe that social assistance benefits cannot be coordinated as LTC benefits, since the Regulation No 883/2004 does not apply to social assistance. In Poland the duty of guaranteeing the implementation of social assistance tasks rests upon territorial self-government units/communes and governments administration. They prepare an evaluation of social support resources based on an analysis of local social and demographic situation, which affects the
assistance aimed at people in need. When granting assistance, family background interview shall be conducted to determine personal and financial situation, family income and assets of individuals and families.

The nursing benefit (Świadczenie pielegnacyjne) is established to support people who do not undertake or resign from employment or other paid work due to the necessity of taking care of a disabled child. It is granted to the carer (not to a disabled child/person); the carer can have his/her social insurance contributions paid from the State budget. The carer’s activity is regarded as a gainful activity under Polish legislation, where the activity is exercised. In this situation we should treat this person (carer) in accordance with Article 1 and Title II of Regulation (EC) No. 883/2004.
PORTUGAL

Applicable statutory basis

Social insurance:

Guaranteeing sufficient resources:

Social security system and National Health Service:
Statutory Decree 101/06 of 6 June 2006.

Benefits in kind

1. Home care
Home care (apoio domiciliário).
Daily care, personal comfort, cleaning, meal delivery, accompaniment during medical visits etc.

Foster families (famílias de acolhimento).
Temporary or permanent integration of elderly persons or disabled adults (maximum 3) in foster families who ensure that their basic needs, including in terms of medical care, are met.

Integrated home care teams (Equipas de Cuidados Continuados Integrados) - Health and Social community multidisciplinary teams, for citizens in convalescence with functional dependence or terminal illness that do not need in-patient care.

2. Semi-residential care
A Night Centre (Centro de Noite) for elderly people who are isolated and, accordingly, in need of assistance during the night (from 6pm to 8am);

Day care centres (Centro de dia) for elderly persons. At least 8 hours per day;

Centres for day care and promotion of autonomy (Unidades de dia e de promoção da autonomia): 8 hours per day;

Sheltered workshops (centro de actividades ocupacionais) for seriously disabled persons;

Centres for social and occupational measures (forum sócio-ocupacional) for persons with minor mental disorders;

Nursing homes for temporary stay (lar temporário) of disabled children and youngsters between the age of 6 and 16 years.

3. Residential care
Nursing homes for permanent stay (lar de idosos) of elderly persons who are or risk to become severely dependent;

Homes (residência) for persons over the age of 16 years with permanent or temporary disabilities;
Centres for supported life (*unidade de vida apoiada*) for persons with permanent mental disabilities;

Centres for protected life (*unidade de vida protegida*) for adults who suffer from serious psychological problems likely to become permanent;

Centres for autonomous life (*unidade de vida autónoma*) for adults who suffer from serious psychological problems likely to become permanent, but who maintain a certain degree of autonomy;

Temporary Reception Centres for Emergencies (*Centro de Acolhimento Temporário de Emergência*) for elderly persons in a difficult social situation;

Convalescent centres (*Unidades de convalescença*) for medical rehabilitation care following hospitalisation;

Medium-term and rehabilitation centres (*Unidade de média duração e reabilitação*), in conjunction with the hospital, for medical rehabilitation care and social / psychological support;

Long-term and maintenance centres (*Unidade de longa duração e manutenção*) for social support and maintenance treatment of persons suffering from chronic pathologies;

Centres for palliative care (*Unidades de cuidados paliativos*) for the support, in a hospital environment, of seriously ill persons.

4. **Other benefits**
The provision of technical aids.

Premature intervention (*Intervenção Precoce*) integrated aid measure combining education, health and social assistance for children up to 6 years old with disabilities or with a serious risk of mental retardation.

**Cash benefits**

**Social insurance:**
The Long-term care supplement (*complemento por dependência*) paid to recipients of invalidity, old-age and survivors' pensions who are reliant on care. A monthly amount is indexed to the amount of the social pension (*pensão social*) and annually updated. In 2012 this amount is € 97.70 regarding 1st degree of dependency and € 175.86 concerning 2nd degree of dependency.

14 benefits paid yearly. The Christmas and holiday bonus: amount equal to the benefit paid for the corresponding month.

The allowance for the assistance by a third party (*subsídio por assistência de terceira pessoa*) is a family benefit granted to severely disabled descendants who are incapable to carry out their basic needs and need the permanent help of a third person. In 2012 it mounts to € 88.37.

**Guaranteeing sufficient resources:**
The long-term care supplement (*complemento por dependência*): paid to recipients of invalidity, old-age and survivors' social pensions who are in need of permanent assistance of a third party. Monthly amount indexed to the indexing reference of social support (indexante dos apoios sociais, IAS): € 94.77 or € 170.59 according to the degree (1st or 2nd) of dependency.
Allowance for assistance by a third party (*subsídio por assistência de terceira pessoa*): see above.

Discretionary use. However, the benefits are paid to the care provider in case the beneficiary is incapacitated or if she or he resides in a social support (or assimilated) institution.

**Combination of benefits**

No mixed benefits.
Not applicable. Accumulation possible.

**Benefits for the carer**

No specific benefits for the carer.
ROMANIA

Applicable statutory basis

Law 448 of 6 December 2006 on Protection and Promotion of the Rights of Persons with Handicap (Legea privind protectia si promovarea drepturilor persoanelor cu handicap), with subsequent amendments.

Law 17 of 6 March 2000 on Social Assistance of Senior Persons (Legea privind asistenta sociala a persoanelor varstnice), with subsequent amendments.

Benefits in kind

1. Home care
   Persons with handicap:
   Personal Assistant (asistent personal) – care and protection for a period longer than 24 hours.

   Senior persons:
   Caregiver (persoana de ingrijire) – social and socio-medical services for a period longer than 24 hours.

2. Semi-residential care
   Persons with handicap:
   Qualified Personal Assistant (asistent personal profesionist) – care and protection for a period longer than 24 hours,
   Day centres – social services integrated with medical, education, housing, labour force employment and other similar services up to 24 hours.

   Senior persons:
   Day, night, and other specialised centres for senior persons – socio-medical services up to 24 hours.

3. Residential care
   Persons with handicap:
   Residential centres – social services integrated with medical, education, housing, labour force employment and other similar services for a period longer than 24 hours in:
   Care and assistance centres,
   Recovery and rehabilitation centres,
   Integration centres providing vocational therapy,
   Centres of training for an independent life,
   Crisis centres,
   Centres for community and training services,
   Sheltered housing, etc.

   Senior persons:
   Homes for senior persons – social, socio-medical and medical services for a period longer than 24 hours.

4. Other benefits
   Persons with handicap:
   e.g. Gratuities by Urban Transportation (calatorii gratuite la transportul urban).
Cash benefits

Persons with handicap:
The Indemnity (indemnizatie) which is an alternative to the Personal Assistant (asistent personal) is paid to the person with severe handicap. It is equal to the net wage for a certain category of social worker.
The amount is at his/her discretion.

Senior persons:
Not applicable.

Combination of benefits

Persons with handicap:
Cash and in kind benefits.
The person with severe handicap may freely choose between Indemnity (indemnizatie) and Personal Assistant (asistent personal) (includes inter alia relatives and spouses).

Senior persons:
In kind benefits.

Benefits for the carer

Persons with handicap:
As the Personal Assistant (asistent personal) (includes inter alia relatives and spouses) and the Qualified Personal Assistant (asistent personal profesionist) have employment contracts, they are covered for different risks.

The Personal Assistant and the Qualified Personal Assistant are entitled to benefits in kind such as free urban and inter-urban transportation, etc.

Senior persons:
As the Caregiver (persoana de ingrijire) has an employment contract, he/she is covered for different risks
**SLOVAK REPUBLIC**

**Applicable statutory basis**

The Act on Social Services (*Zákon o sociálnych službách*) No. 448/2008.


The Act on Health Care Providers, Medical Workers and Professional Medical Associations (*Zákon o poskytovateľoch zdravotnej starostlivosti, zdravotníckych pracovníkoch a stavovských organizáciách v zdravotníctve*) No. 578/2004.


**Benefits in kind**

1. **Home care**
   Attendance services to help with personal activities of daily living, with keeping up the household and with basic social activities.

2. **Semi-residential care**
   Semi-stationary care is provided in the social services facilities e.g. Daily Stationary Facility (*Denný stacionár*). It is provided as a daily or a weekly care (with persons returning home during the weekend). Different activities like specialised services, nursing etc., are provided there. There are no exactly defined daily hours during which the recipient may attend the facility.

3. **Residential care**
   Nursing home care is provided in social services facilities: Shelter Facility (*Zariadenie chráneného bývania*), Social Service Home (*Domov sociálnych služieb*) and Home of Supported Inhabitation (*Zariadenie podporovaného bývania*). For a temporary period, the nursing home care is provided also in the Attendance Service Facility (*Zariadenie opatrovateľskej služby*) and in the Rehabilitation Centre (Rehabilitačné stredisko).

4. **Other benefits**
   Social Guidance (*Sociálne poradenstvo*), Interpretation (*Tlmočenie*), Social rehabilitation (*Sociálna rehabilitácia*). According to the Note of the Slovak delegation these benefits do not satisfy the aspects of LTC benefits.

The social services system, in which providers (self-government of municipalities and upper regional units, public and non-public providers) offer social services to persons in social need (disabled persons, elderly, single parents, homeless persons, etc).

**Cash benefits**

For professional providers within home care the Personal Assistance Benefit (*Príspevok na osobnú asistenciu*) is set: the sum of 1.39% of the subsistence minimum per hour of assistance required (maximum of 7 300 hours per year). This benefit is granted to the person who is in need of care and whose income is lower than 3 times the subsistence minimum, otherwise the benefit is lower.
Personal assistant is not necessarily a professional caregiver. It can be any natural person who has reached 18 years of age, is legally competent and with whom the severely disabled person has concluded an agreement on the performance of personal assistance.

For informal carers (relatives) within home care the Attendance Service Benefit (Príspevok na opatrovanie) is set: up to the level of 111.32% of the subsistence minimum per month if only 1 person receives home care and up to the level of 148.42% of the subsistence minimum per month if 2 or more persons receive home care. The benefit is paid directly to the carer (obviously a family member) in the carer’s own right. An increase of the benefit by the sum equivalent to € 49.80 per month is granted if a severely disabled child is in home care and the provider has no other income.

The Benefit for Purchasing, Repairing, Adjusting and Training of Utilisation Equipment (peňažný príspevok na kúpu, úpravu alebo opravu pomôcky): maximum benefit of € 8 630.42.

Purchasing a Hoisting Device Benefit (Peňažný príspevok na kúpu zdvíhacieho zariadenia): maximum benefit of € 11 617.88.

Purchasing and Adjusting a Car Benefit (Peňažný príspevok na kúpu alebo úpravu osobného motorového vozidla): maximum benefit of € 8 298.48.

Transportation Benefit (Peňažný príspevok na prepravu): maximum benefit is 51.02% of the subsistence minimum (Životné minimum) per month.

Adaptation of a Residence or a Garage Benefit (Peňažný príspevok na úpravu bytu, rodinného domu alebo garáže): maximum benefit of € 8 298.48.

The Compensation of Enhanced Costs Benefit (Peňažný príspevok na kompenzáciu zvýšených výdavkov): monthly supplements for special dietary requirements (up to 18.56% of the subsistence minimum), personal and domestic hygiene, clothing, shoes and housing equipment (9.28% of the subsistence minimum), operation of a car (16.7% of the subsistence minimum), maintenance of a guide dog (22.27% of the subsistence minimum).

Combination of benefits

Cash benefits as well as benefits in kind at home and in institutions can be combined; however, for selected benefits, the combination is not possible (e.g. the Attendance Service Benefit (Príspevok za opatrovanie) with the Personal Assistance Benefit (Príspevok na osobnú asistenciu)).

Free choice between cash benefit and benefit in kind possible.

Benefits for the carer

The state pays contributions on the carer’s old-age and invalidity insurance. It is possible to take a paid leave in order to care for a dependent person (relief service).

Addendum: Social security coordination aspects

In the Note of the Slovak delegation it is stressed that for cash allowances the income and the assets of the person with a severe disability, as well as all the jointly assessed persons, are established, which is regularly reviewed once a year, indicating the fact that the allowances can be provided only to such a group of persons with severe disabilities that are at a lower social level. They are linked to
the socio-economic situation in the Slovak Republic and their amount depends on the subsistence minimum.

Cash allowances are provided on the basis of individual and discretionary review of particular situation and circumstances of the applicant and his or her family (the social assessment activity) for the purpose of compensating for the social consequences of severe disability. The cash allowances are not claimable, are not awarded automatically to persons meeting certain criteria, and are of the discretionary nature. Their aim is contributing to the support of autonomy as well as social integration of disabled persons, helping them to lead a life comparable with that of persons not having disabilities. Therefore care allowances should not be exportable.

According to the view of the Slovak delegation, expressed in their Note, cash benefits for compensation of a severe disability are social assistance benefits. If they were to be regarded as long-term care benefits, the list should give only two cash benefits that can have some of their features:
- the cash allowance for care, which is provided to the caregiver and
- the cash allowance for personal assistance, which is provided to a natural person with a severe disability but subject to monthly produced statements of the number of hours of personal assistance, as well as the receipts of the fees paid to the personal assistant, without which cash allowance cannot be paid out. For this reason it is debatable whether this cash allowance should not be regarded as an LTC benefit in kind.
SLOVENIA

Applicable statutory basis

No specific law related to long-term care.

Long-term care benefits are included in the following acts:

The Social Assistance Act (Zakon o socialnem varstvu, ZSV) (Official Gazette of the Republic of Slovenia, No. 36/04)

Financial Social Assistance Act (Zakon o socialno varstvenih prejemkih, ZSVarPre) (Official Gazette of the Republic of Slovenia, No. 61/2010)

Rights Enforcement from Public Funds Act (Zakon o uveljavljanju pravic iz javnih sredstev, ZUPJS) (Official Gazette of the Republic of Slovenia, No. 62/2010)

The Parental Care and Family Benefits Act (Zakon o starševskem varstvu in družinskih prejemkih, ZSDP) (Official Gazette, No. 110/2003, 10/2008- official consolidated text)

The Mentally and Physically Handicapped Persons Act (Zakon o družbenem varstvu duševno in telesno prizadetih oseb, ZDVDTP) (Official Gazette SRS, No. 41/83)

The Health Care and Health Insurance Act (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju, ZZVZZ) (Official Gazette, No. 100/2005).

Benefits in kind

1. Home care
Home care is provided by the following services:
- Community services provide medical-social care at home. The user is provided nursing care services, preventive home visits and assistance in obtaining adequate social treatment. The costs of nursing care services are covered by the compulsory health insurance.
- Community psychiatry is a team approach to the treatment of patients after their discharge from treatment at the secondary (specialist) level into home care, providing their social inclusion, maintenance and follow-up of their health condition.
- Social home help is organised locally, provided within the public service network by the Social Work Centres, homes for elderly and special institutions for home care. Home help is available for a maximum of 4 hours a day or 20 hours a week.
- Personal assistance is a program ran by persons with disabilities themselves, and is financed by the state, local community and user funds (it is not available across the country).
- Social alarms/telecare is organised locally, not provided within the public service network; available only in some municipalities (currently there are essential changes).
- Meals on wheels is a commercial service unless when is being part of home help service package.
- Sheltered housing emerged in recent years and is funded by public sector (municipal housing funds, Pension Real Estate’s Fund by private investors or as public-private partnership ventures).

2. Semi-residential care
Day care centres are organised locally and include the following services: protection, food supply, health care, social integration, social activities and transport.
Day care is usually performed in the welfare employment centres, in homes for elderly (domovi za starejše) and in private institutions on a basis of a concession contract concluded between institutions performing day care and the state or on the basis of a work permit.

Group homes and day centers for people with mental health problems (stanovanjske skupine) are organised locally, not provided within the public service network; available only in some municipalities; financed by the state, local community and user funds (it is not available across the country).

3. Residential care
Residential care is mainly a public responsibility: in terms of the establishing and maintaining facilities, of developing the network of social care homes. The system of financing the residential care is a combination of public and private responsibility: people have to cover the expenses of accommodation, food and social care services, but if income is insufficient, the state (municipality) supplements the payment up to the entire price.

Residential care in Slovenia is provided by:
- homes for the elderly,
- special social care homes,
- centres for care and training (residential institutions for people with learning disabilities),
- institutions for training of severe and profound mentally disabled children.

Homes for the elderly have the longest tradition in Slovenia and are operating in the public and private domain (private institutions with concessions). Special social care homes and institutions for training of severe and profound mentally disabled children are only public and there are no private partnerships. The centres for care and training operate in both the public and private domain. In the public sector the providers of homes for the elderly are municipalities and in the private sector the providers are private social institutions who have acquired a license or concession.

Health care is covered from the compulsory health insurance by the Health insurance Institute of Slovenia (HIIS) according to the contracts between the HIIS and above-mentioned institutions.

Nursing hospitals could also be mentioned. Although several Slovenian hospitals already operate departments for non-acute medical treatment, the first nursing hospital in Slovenia was opened in February 2011 in Ljubljana. Nursing hospitals should be opened in other cities as well. The purpose of such hospitals is to accept patients who have concluded an acute medical treatment, but are not yet ready to lead an independent live at their home or in a home for elderly. The nursing hospital is thus a transitional stage between a hospital treatment and living at home (again) or in the home for elderly. It is not intended for indefinite hospitalisations. The decision on the admittance is taken by the team of experts, according to the overall plan of treatment and care. In a nursing hospital the emphasis is on care activities, therefore a stable medical condition is one of the conditions to be accepted to a nursing hospital. Also the majority of staff are nurses, and only few are physicians.

Within the framework of non-acute hospital care, hospices perform the following services:
- extended hospital treatment (EHT) where patients are treated after completed acute therapy because they are unable to return to their home environment due to their current health condition; where they are provided with an adequate rehabilitation programme, a relatively rapid improvement of their condition may be expected, which enables them to return into their home environment (expected health improvement, a list of hospitals that offer such rehabilitation programmes);
- **nursing care** is provided for a short period of time when the health condition after completed acute therapy has deteriorated so that the patient’s return to their previous environment is impossible while no improvement may be expected and therefore it is necessary to provide suitably adjusted conditions (social care; return into home care is not possible);

- **non-acute palliative care** (terminal stages – short-term conditions, in this case short life expectancy; no improvement of the condition may be expected; institutional care placement in such a short time is not feasible).

4. Other benefits

The right to technical aids (orthopaedic, hearing and other aids intended for home care – special beds, sanitary medical equipment, etc) available under compulsory health insurance. Costs are covered in full for children with severe and profound mental disabilities, the disabled and other persons who rely on the assistance of another person for all or most of their existential functions, disabled persons who have at least 70% physical disability according to regulations on pension and invalidity insurance, persons over 75 years, and social assistance recipients (for the latter co-payments are covered by the State).

**Cash benefits**

Cash benefits are paid directly to a person in need of care. Cash benefits are intended to cover additional costs arising from a need for care of another person (professional or informal caregiver).

The Supplement for Care and Assistance (**dodatek za tujo nego in pomoč**) granted to disabled persons who are incapable of performing basic life functions and for which they require the constant help of another person. This supplement amounts from 20% to a maximum of 30% of the national average net personal income per employee if a person needs assistance of another person in performing all of his or her basic life functions (€ 165.07), and 10% to 20% if help of another person is required in performing a majority of the basic life functions (€ 82.54).

The Assistance and Attendance Allowance (**dodatek za pomoč in postrežbo**): available to lawfully permanent resident recipients of old-age, invalidity, widow/widower’s and survivor’s pension, should they need permanent help to satisfy their vital necessities. It amounts to at least 70% of the minimum pension for a full pension qualifying period for persons, who are in need of assistance and attendance provided by a third person to help him/her with all of basic day-to-day activities (€ 290.15) or half of the amount for persons who need assistance in performing a majority of basic day-to-day activities (€ 145.08) or 100% of the minimum pension for a full pension qualifying period for the most severely handicapped (€ 414.50).

The Special Childcare Allowance (**dodatek za nego otroka, ki potrebuje posebno nego in varstvo**): provides financial assistance to a family with a child with special needs who are permanent residents, and is intended to cover the higher cost of caring for such a child. The benefit is paid until the age of 18 or 26 if the child is in education. The monthly amount is € 101.05; for children who are in need of special care 24 hours a day the monthly amount is € 202.17.

The Partial Payments for Loss of Income (**delno plačilo za izgubljeni dohodek**): Paid to one of the parents who has left his or her job in order to care for a child with special needs. The child and one of the parents must be permanent residents and EU citizens. The monthly amount equals to the national minimum wage (€ 734.15 – gross value).

The Assistance and attendance allowance (**dodatek za pomoč in postrežbo** for social assistance recipients, who due to old-age, illness or invalidity are incapable of independent living and require the assistance of another person (Article 31.a of the Social Assistance Act of 1992 with later
amendments). It is of a subsidiary (social assistance) legal nature. The same rules apply as for the assistance and attendance allowance as a supplement to an old-age, invalidity, widow’s or family pension (described above). It is also foreseen in the new social assistance act, which should come into force in 2012.

The Assistance and attendance allowance for war invalids (of a certain degree), according to the War Invalids Act (of 1996 with later amendments, Article 22 and following). The same criteria as for the assistance and attendance allowance as a supplement to an old-age, invalidity, widow’s or family pension apply (described above). There are some special provisions, mainly to the benefit of the allowance recipient. This allowance could be classified as an LTC benefit for victims of war.

The person has a free choice and can use the money at his own discretion. There is no control on how the money is spent.

**Combination of benefits**

There is a combination of cash benefits and benefits in kind. Cash benefits are paid directly to the beneficiary.

Free choice between cash benefits and benefits in kind.

**Benefits for the carer**

The benefit is paid to a carer in case a person entitled to residential care opts for the right to choose a family assistant (družinski pomočnik) instead. The locally competent Centre for Social Work awards the family assistant to a disabled person who requires help with performing all of the activities of daily living. A family assistant is paid by the local municipalities (€ 578.55 per month – gross value).

The Partial Payments for Loss of Income (delno plačilo za izgubljeni dohodek) have already been mentioned above. It is rather automatically transformed to a benefit for a family assistant when the child reaches maturity.
Spain

Applicable statutory basis


It seems that in Spain a formal criterion is followed, i.e. as long-term care benefits are considered only those regulated by the above-mentioned legislative act.

However, it is obvious that the “need of care” can be also protected by other social security benefits (partially also linked with long-term care):

- maternity benefits for parents while nursing their children
- Contributory and non-contributory invalidity pensions

Both branches only specifically guarantee financial help to persons in need of nursing care when they satisfy two requisites: to be legally qualified as disabled and to require the help of another person to carry out the most essential day-to-day activities, as a result of the loss of "functional or anatomical capacity", which should be determined by the medical services.

Under Spanish law, four different degrees of invalidity may be distinguished, depending on their consequences for the person’s capacity to work: partial permanent incapacity; total permanent incapacity; absolute incapacity, and extreme disability.

Extremely disabled is a worker or an employee, who not only suffers from a total permanent incapacity to perform any kind of job, but also needs the help of someone to perform the most essential acts of life such as eating, getting dressed, walking, or any other similar examples, due to their anatomical or functional shortcomings.

- Family benefits: there is only one example in which Spanish rules take into account the case of those young people suffering from an extreme incapacity that demands non-medical nursing care: when the person is 18 years old or over, he or she is affected by the loss of anatomical or functional capacity, at least for a degree of 75% and he or she needs the help of another person to carry out the daily activities.

Benefits in kind

1. Home care
Different forms of assistance in the home of the person in a situation of dependence. Services aimed at promoting personal autonomy and preventing dependency are stipulated in Article 15(1)(a) of the Act 39/2006.

Tele-assistance and prevention are provided for.

2. Semi-residential care
Attendance at day and night care centres. The duration and the type of care depend on the individual need of the dependent person.

3. Residential care
Long-term care provided in institutions, mainly old-age homes and centres for the disabled.
4. Other benefits

No other benefits.

Cash benefits

The amounts are fixed by law and vary according to the degree of dependency. The maximum monthly amount: € 833.96.

With regard to cash benefits, the Act 39/2006 mentions three types of benefits, two of which, despite being monetary, are of the same nature as the benefits in kind for the coordination purposes.29

a) Financial benefit linked to a service (Article 17)
This is periodical and is only granted when access to a public or organised care service is not possible, in accordance with the degree and level of dependency and economic situation of the beneficiary, pursuant to the provisions of the agreement between the General State Administration and the corresponding Autonomous Community.
This personal financial benefit is, in any case, linked to the acquisition of a service. Therefore, this financial benefit is of the same nature as a benefit in kind.

b) Financial benefit for personal care (Article 19).
The objective of the financial benefit for personal care is to encourage highly dependent persons to be more autonomous. The aim is for this benefit to contribute towards the hiring of a personal assistant for a number of hours, which will facilitate the beneficiary's access to education and work and will give them a more autonomous life in terms of pursuing basic, day-to-day activities.
Therefore, this financial benefit is of the same nature as a benefit in kind.

c) Financial benefit for care in the family and support for non-professional carers (Article 18).
In exceptional circumstances, when the beneficiary is being cared for in the family environment, financial benefit for care in the family is granted as long as certain conditions and requirements are met. The carer must adhere to the rules on Social Security registration, membership and contributions laid down by law.

The Spanish legislation on protection against dependency does not provide for any care allowance to pay for housing or to supplement the benefit.

With regard to the tax benefits in the personal income tax, there are a number of measures which exempt persons with disabilities from paying taxes, or deduct or reduce their tax rate. Some of these may benefit persons with disabilities in a recognised situation of dependency, such as the measures to award net income from work or economic activities for contributions to listed heritage or for pension schemes, etc.

29 In the Spanish note it is argued that two cash benefits should be considered as benefits in kind according to case law of the Court of Justice of the European Community (CJEU), Decision No 175 of 23 June 1999 of the Administrative Commission of the European Communities on Social Security for Migrant Workers on the interpretation of the concept of ‘benefits in kind’ in the event of sickness or maternity pursuant to Council Regulation (EEC) No 1408/71, and more recently, Decision No S5 of the Administrative Commission for the Coordination of Social Security Systems of 2 October 2009 on the interpretation of the concept of ‘benefits in kind’ as defined in Article 1(va) of Regulation (EC) No 883/2004 in the event of sickness or maternity.
With regard to the personal income tax in the specific case of persons declared dependent under Act 39/2006, there are a number of measures in place which are set out in Act 35/2006 of 28 November 2006, as well as other implementing provisions.

**Combination of benefits**

The benefit compatibility scheme (mixed benefits) is regulated at territorial level by each of the Autonomous Communities.

**Benefits for the carer**

Cash benefits are payable to the beneficiary, who pays the informal caregiver. Compulsory inclusion of the informal caregiver in the Social Security System.
Applicable statutory basis


Benefits in kind

1. Home care
   This is the most common service.

   If a person is in need of medical care that does not involve hospital care he or she should, according to the Health Care Act, be given that kind of care in his or her own home. The assistance in the form of home help shall also be given in a person’s own home. The municipality cannot refuse to give anyone in need assistance in their own home. There is no legal responsibility for spouses or children to care for their elderly relatives.

2. Semi-residential care
   Exists in the form of short-term stay, as a complement to home care.

3. Residential care
   Mainly for people with Alzheimer disease or persons with severe medical conditions or persons who suffer severely from anxiety and loneliness.

4. Other benefits
   Day care, rehabilitation, security alarms etc.

   Persons with the lowest pension are entitled to a state financed income-tested housing supplement. Although, its purpose seems to be to top up the regular pension from an economic point of view, rather than a complement due to special care needs.

Cash benefits

Based on individual assessment.
The amount depends on municipalities.

Cash benefits as an alternative to municipal provision are not intended to be used as payments to informal carers.

In addition, other benefits might be mentioned as well:
The care benefit (vårdbidrag), according to Chapter 22 of the (2010:110) Social Security Code.
This is paid to the carer (normally the legal parent) of a disabled (or sick, in the need of care for at least six months) child from 0-19 years of age. It is a flat-rate benefit of SEK 107 000 a year (SEK 8 917 a month). There is also the possibility of extra cash benefits for extra expenses.

This is paid to the carer of certain disabled children of 16-21 (23) years of age when the child is occasionally ill with a maximum of 120 days per year.
This is paid to disabled persons of 19 years of age or older (at 19 the right to a care benefit, see above, expires). This is a benefit to cover extra expenses due to care of assistance.

Assistance benefit (*assistansersättning*), Chapter 51 of the (2010:110) Social Security Code
This is a cash benefit paid per hour of assistance to those who, due to a severe handicap, is in the need of assistance with a minimum of 20 hours per week concerning basic human needs.

This is a special benefit for the disabled with permanent (at least 9 years ahead) difficulties to use public transportation.

**Combination of benefits**

Benefits in kind.
Elderly care, such as home help is usually provided as a benefit in kind.

Cash benefits are allowed but not very common. A voucher-like system gives the individual a right to a certain amount of help related to a cost per hour or presumed result. This approach is considered to better target the quality issues.

Mixed benefits: could be possible, but are very uncommon.

Free choice between cash and/or benefits in kind is possible, but uncommon.

**Benefits for the carer**

Support from the municipality, e.g. providing information, support groups for carers, relief on demand or scheduled relief, centres for carers with activities.

Cash benefits, including the allowance to a relative, are usually calculated according to the number of hours of care. The payment can also be based on other criteria than number of hours. There is no national framework for the cash benefits and they are not paid out in all municipalities. Care benefits and occasional parental benefits paid to the carer have been mentioned above among the cash benefits.

**Addendum: Social security coordination aspects**

According to the Note of the Swedish delegation the aid and benefits granted in accordance with the Swedish Social Services Act (2001:453) are considered to cover benefits that clearly fall within the category of social assistance and therefore fall outside the material scope of Regulation 883/2004. Moreover, in Sweden, such benefits and measures are – with certain exceptions - established entirely at municipal level. It is only in the event of special obligations being imposed on the municipality by the Social Services Act that the municipalities’ freedom to decide on their course of action in the said area is limited.
Switzerland

Applicable statutory basis


2. The Federal Law on Accident Insurance of 20 March 1981 (Bundesgesetz über die Unfallversicherung, UVG/Loi fédérale sur l'assurance-accidents, LAA/Legge federale sull'assicurazione contro gli infortuni, LAINF).

3. The Federal Law on Invalidity Insurance of 19 June 1959 (Bundesgesetz über die Invalidenversicherung, IVG/Loi fédérale sur l'assurance-invalidité, LAI/Legge federale sull'assicurazione per l'invalidità, LAI).

4. The Federal Law on Old-age and Survivors’ Insurance of 20 December 1946 (Bundesgesetz über die Alters- und Hinterlassenenversicherung, AHVG/Loi fédérale sur l'assurance-vieillesse et survivants, LAVS/Legge federale sull'assicurazione per la vecchiaia e per i superstiti, LAVS).

5. The Federal Law on Supplementary Benefits to the Old-age, Survivors’ and Invalidity Insurance of 6 October 2006 (Bundesgesetz über Ergänzungsleistungen zur Alters-, Hinterlassenen- und Invalidenversicherung, ELG/Loi fédérale sur les prestations complémentaires à l'AVS et à l’AI, LPC/Legge federale sulle prestazioni complementari all’assicurazione per la vecchiaia, i superstiti e l’invalidità, LPC).


9. Cantonal laws concerning the funding of long-term care.

10. Cantonal laws on social assistance.

Benefits in kind

1. Home care
   - KVG/LAMal:
     - examinations and treatment at the home of the patient by doctors and chiropractors;
     - contribution to care at the home of the patient by nurses or home care organisations (= SPITEX), on the basis of a medical prescription and of an established need for care;
   - UVG/LAA/LAINF:
- treatment at the home of the patient by doctors and chiropractors;
- care at the home of the patient, prescribed by a doctor and provided by nurses or home care organisations (= SPITEX) (on a discretionary basis\(^{30}\) contribution for home care provided by other persons);
- \textit{IVG/LAI} (medical measures of the IV/AI): treatment at home by a doctor or, on prescription, by paramedical staff;
- \textit{MVG/LAM}: Examinations, treatment and care at home.

2. Semi-residential care

- \textit{KVG/LAMal}:
  - examinations and treatment of outpatients in a hospital or in a medico-social establishment, as well as outpatient care in hospitals by doctors, chiropractors, and persons providing services on prescription or according to medical orders (partly qualification as ambulant);
  - contribution to outpatient care provided in day or night care facilities or in a medico-social establishment, on the basis of a medical prescription and of an established need for care.
  - Semi-residential care also exists as far as the \textit{UVG/LAA/LAINF}, the \textit{IVG/LAI} and the \textit{MVG/LAM} are concerned (partly qualification as ambulant).

3. Residential care

- \textit{KVG/LAMal}:
  - examinations, treatment and care in a hospital by doctors, chiropractors and persons providing services on prescription or medical orders, and stay in the general ward of the hospital;
  - examinations and treatment in a medico-social establishment by doctors, chiropractors, and persons providing services on prescription or medical orders;
  - contribution to care provided in a medico-social establishment, on the basis of a medical prescription and of an established need for care;
- \textit{UVG/LAA/LAINF}, \textit{IVG/LAI} (medical measures of the IV/AI) and \textit{MVG/LAM}: treatment, board and accommodation in the general ward of a hospital.

4. Other benefits

\textit{Auxiliary equipment}

Simple and adequate model. Appear on a list (except for \textit{MVG/LAM}).

- \textit{KVG/LAMal}: diagnostic or therapeutic equipment prescribed by a doctor (reimbursement up to a maximum amount);
- \textit{UVG/LAA/LAINF}: therapeutic equipment; auxiliary equipment to compensate for physical damage or loss of a function.
- \textit{AHVG/LAVS}: auxiliary equipment necessary for the insured person in order to move about, establish contacts with her or his entourage or develop personal autonomy;
- \textit{IVG/LAI} and \textit{MVG/LAM}: therapeutic equipment; auxiliary equipment necessary for the insured person in order to move about, establish contacts with her or his entourage or develop personal autonomy.

Cash benefits

Helplessness allowance
Depends on the degree of helplessness. Monthly amounts:

- IVG/LAI:
  slight: CHF 464;  
  moderate: CHF 1 160;  
  severe: CHF 1 856.

The helplessness allowance paid to insured persons living in an institution is half these amounts.

Minors who need intense care and who are not living in an institution are entitled to a supplement to the helplessness allowance, which is CHF 1 392 a month if there is a need of care for 8 hours a day at least, CHF 928 if there is a need of care of 6 hours a day at least and CHF 464 if there is a need of care of 4 hours a day at least.

Probably from the 1st of January 2012: assistance allowance in addition to the helplessness allowance.

- AHVG/LAVS:
  slight: CHF 232 (not for insured persons living in an institution);  
  moderate: CHF 580;  
  severe: CHF 928.

- UVG/LAA/LA INF:
  slight: CHF 692;  
  moderate: CHF 1 384;  
  severe: CHF 2 076.

- MVG/LAM: also a sort of helplessness allowance in the form of supplementary allowances for persons receiving home care and facing supplementary costs for care (also by non-medical staff\(^{31}\)) or assistance.

Yearly supplementary benefit (according to ELG/LPC)
Also designed for covering the daily fee of a stay in a medico-social establishment or in a hospital. Paid monthly. The cantons can limit the amount to be taken into account (they can also provide more extensive benefits than those provided by the ELG/LPC).

Reimbursement of special costs (according to ELG/LPC)
Reimbursement (up to a maximum amount; in addition to supplementary benefits to the old-age, survivors’ and invalidity insurance) of the costs for help, care, assistance and auxiliary equipment (home and semi-residential care; according to MISSOC cash benefit, according to national law benefits in kind). The cantons specify which costs are reimbursed (they can also provide more extensive benefits than those provided by the ELG/LPC).

\(^{31}\) H. Landolt, op cit, 1238 (concerning family members especially).
The a priori bearing of part of the long-term care costs by cantons/municipalities according to cantonal laws concerning the funding of long-term care (not in the form of cash benefits to the persons in need of long-term care themselves).\textsuperscript{32}

Contributions according to the OHG/LAVI/LAV: contributions for long-term help of third persons and compensation by the canton\textsuperscript{13} (both insofar as not covered particularly by social security or the author of damage).

Social assistance (cantonal legislation; insofar as not covered particularly by social security).

**Combination of benefits**

The benefits are provided by several branches of social security: benefits in kind and cash benefits, which are often granted to a person for the same period of time. In general, the person does not have the freedom of choice as to whether he or she prefers a benefit in kind or a cash benefit.

**Benefits for the carer**

A person caring for relations in ascending or descending line or for siblings who are entitled to an AHV/AVS or IV/AI helplessness allowance for a degree of helplessness which is at least moderate and who live with him or her in the same household may claim a bonus for caretaking. The yearly bonus corresponds to three times the amount of the minimum yearly old-age 1st pillar pension (in 2010: CHF 41 760). The bonus is part of the determining income for the calculation of the carer’s 1st pillar pension.

See also above at footnotes 30 and 31.

Contributions according to the OHG/LAVI/LAV (see above).

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\textsuperscript{32} Of course, 26 cantonal legislations could not be analysed, but an example was found (Zürich) in a decision of the Federal Court of 24 March 2011, 2C_864/2010.

\textsuperscript{33} Cf Konferenz der kantonalen Sozialdirektorinnen und Sozialdirektoren (ed.), Empfehlungen der Schweizerischen Verbindungsstellen-Konferenz Opferhilfegesetz (SVK-OHG) zur Anwendung des Bundesgesetzes über die Hilfe an Opfer von Straftaten (OHG) (21 January 2010).
UNITED KINGDOM

Information in this Annex relates to England only. Competence for social care (benefits in kind) is devolved to Scotland, Wales and Northern Ireland.

Local authorities are responsible for identifying the needs of their local population and commissioning social care services to meet them. Services are delivered through the public, private and voluntary sector.

Applicable statutory basis

The Health and Social Care Act 2008.


Benefits in kind

1. Home care
Local authorities can provide home care, meals on wheels and special aids and equipment.

2. Semi-residential care
Local authorities can provide attendance at day care centres.

3. Residential care
Local authorities can arrange the admission to residential and nursing homes.

4. Other benefits
Local authorities can provide adaptations to the home and temporary respite care.

People on low income may be able to get help with paying for prescriptions, dental treatment, sight tests and reasonable travel costs to and from hospital.

Cash benefits

Attendance Allowance:
Higher rate: GBP £73.60 (€ 81.46). Lower rate: GBP £49.30 (€ 54.56).

A person receiving an Attendance Allowance may get extra money for severe disability paid as part of:
- a Pension Credit,
- a Housing Benefit,
- a Council Tax Benefit.

The Disability Living Allowance:
Three rates for care needs:
GBP £19.55 (€ 21.63), GBP £49.30 (€ 54.56) or GBP £73.60 (€ 81.46).
Two rates for mobility needs:
GBP £19.55 (€ 21.63) or GBP £51.40 (€ 56.88).

The receipt of a Disability Living Allowance might increase the amount of the following benefits that a person is entitled to:
- Income Support;
• Income-related Employment and Support Allowance;
• Income-based Jobseeker’s Allowance;
• Pension Credit;
• Housing Benefit;
• Council Tax Benefit;
• Working Tax Credit;
• Child Tax Credit.

The Attendance Allowance and Disability Living Allowance are the cash benefits payable to people with care needs. The use is at the discretion of the claimant.

**Combination of benefits**

No mixed benefits (but see above).
No free choice between cash benefits and benefits in kind.

**Benefits for the carer**

The *Carers’ Allowance* is payable to help people who look after someone who is disabled. They do not have to be related to or live with the person that they care for.
Amount: GBP 55.55 (€ 67) a week. Dependant additions are also available.

A person who receives a Carers’ Allowance or who has an underlying entitlement to it will qualify for the carer premium in Income Support and income-based Jobseeker’s Allowance, worth up to £31.00 (€ 34.30) per week and an increased entitlement to Pension Credit.