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The case of the Belgian care insurance

The significance of territorial divisions and borders in shaping social policy in Europe: the case of the Belgian care insurance.

Introduction

The Belgian care insurance is designed to compensate for costs for non-medical care, namely help in activities of daily living such as washing and cleaning. Due to the fact that acute medical problems nowadays are more often prevented or cured, and in correlation with that, the ageing of the population, chronicle diseases like dementia and arthritis occur more frequently. These diseases make the patients in their daily living long term dependent upon other people's care.

Today, that care is often commodificated – i.e. outsourced to the market –, which is as a consequence expensive. This commmodification is often done out of necessity because in the private sphere no care-taker is available. Among others, the dual-earner model of the labour market makes housewives, which were cheap care-takers for a long time, rare.¹ Thus, direct family solidarity is excavated by the fact that there are no family members available to perform as care-taker. Therefore, care has to be bought at the market.

These two findings – firstly an increasing demand for care and secondly the higher cost of that care – make care and its funding one of the new social risks of our society. Therefore, this new risk is dealt with by several welfare states.²

¹ Some find that people's increasing age at good health will create a new body of rather cheap care-takers, namely pensioners at the beginning of their pension. I think that the take-up of care by these 'young pensioners' will not outweigh the increasing costs of the increasing demand for care, because often cooperation with professional care-takers is needed.

² In the 1990's a care insurance was introduced in, a.o., Flanders in Belgium, France, Germany and the Netherlands (see Breda (1998) and Pacolet (2004)).

To discuss how the social policy of the Belgian care insurance is influenced and shaped by territorial divisions and Europe, I will throw light on two themes. In the first part, I discuss the Belgian state structure and the place of the Belgian care insurance within that structure. This will reveal a complex policy network, which creates complex policy. The second part concerns Europe's impact on the Belgian care insurance. Out of its principles of free movement of persons, goods and services Europe fights every market protection, also when social policy is concerned.

1. No Belgian care insurance

1.1 The Belgian state structure

In 2005 Belgium celebrates two important anniversaries: its 175th birthday and the 25th anniversary of its defederalized state structure. In August 1980 the Special Law on the Reformation of the Institutions was adopted.³ By that law, Belgium abandoned its unitarian structure by empowering its main sub-spheres of government, namely the three regions and the three communities.⁴ Before going into detail on the division of competences, I will first explain the nature of the two main levels of government.

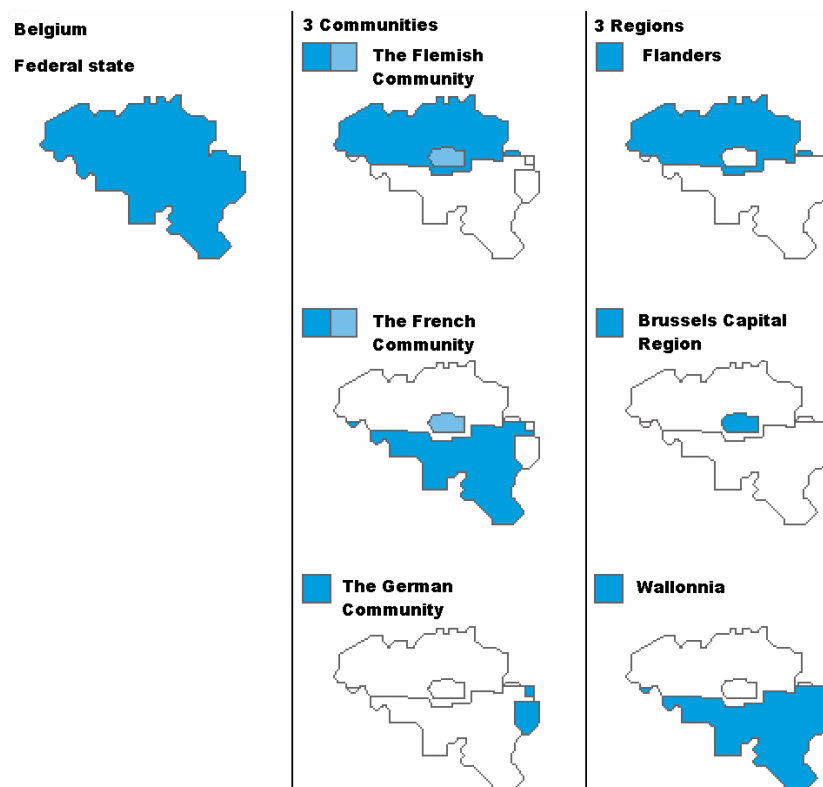
In Belgium, one has four levels of government: – starting at the smallest unit – the municipalities, 10 provinces, 3 regions and 3 communities, which together make the third level of government, and fourthly the federal authorities. Because the two smallest levels are of no importance for the care insurance, I leave them out of this analysis. And because the main structure of the federal authorities are not very different than those in other countries, I also will not expound on them. So, only the main sub-level of government needs to be explored.

The Belgian state is divided on the basis of both territorial and linguistic grounds. Because these two criteria do not exactly overlap, the split up of Belgium is rather complicated (see figure 1). Firstly, in Belgium three languages are spoken: Dutch, French and German. Therefore, the Belgian government recognizes three communities: the Dutch speaking, the French speaking and the German speaking

³ B.S. (*Belgian law gazette*) 15/08/1980

community. Secondly, Belgium is also subdivided on a territorial basis. From this perspective, Belgium has three political regions: the region of Flanders, the region of Wallonia and the Brussels Capital Region. Flanders is the Dutch speaking region in the north. Wallonia consists of the French and German speaking region in the South. And the Brussels Capital Region is officially bilingual, namely Dutch and French.

Figure 1. Belgium's state structure



Source: Belgian Federal Government (www.belgium.be)

When in 1980 the sub-level of government attained its competences from the federal authorities, the situation became even more complex. Some of the defederalized competences were distributed to the communities, namely education and cultural and

⁴ Already in 1970, during the ‘first state reform’, steps for this defederalization were taken by creating the communities and the regions. But they hardly received any competence until 1980, during the ‘second state reform’.

personal topics, other, more economic competences, to the regions.⁵ To demonstrate the increased complexity, I come to the actual topic of this paper: the care insurance.

1.2 The care insurance in the Belgian structure⁶

During the early 1990's politicians at the federal level were discussing the introduction of a Belgian care insurance. As the federal government is responsible for social security, it seemed logical that it was for the federal government to install a care insurance. However, the way they were to organize the care insurance caused a severe dispute on competences.

In 1980 competences with a direct link to persons were passed on from the federal state to the three communities. One of the personal related competences was social assistance. Therefore, social assistance, contrary to social security, became a community jurisdiction. Now, the instrument by which the federal politicians wanted to organize the refund of care was 'service cheques'. And these fitted perfectly into the social assistance system, not into the social security system. Following this observation, the Flemish community did not hesitate to start an infringement procedure and so became the legitimate organizer of a care insurance. Due to a lack of resources nor the French or the German community started up a care insurance for their inhabitants.⁷

1.3 The Flemish care insurance: its mechanism and difficulties in Belgium

The Flemish care insurance started up in October 2001.⁸ It is not the objective of this paper to go into detail on the regulation as a whole, so I will only give a brief summary. Everyone above 25, living in the Flemish Community is obligated to pay a flat rate yearly premium of €25 (or £ 15,64).⁹ When one becomes dependent upon others for care, which is assessed on the basis of an official dependency scale, one will receive a monthly benefit of €90 (or £ 56, 31) for non-residential care, and of €

⁵ Respectively art. 127 and 128, and art. 39 and 134 of the Belgian Constitution.

⁶ Based on Pacolet & Spinnewyn (1993) and Van Buggenhout et al. (2001).

⁷ The French Community wants to bring back the care insurance to the Federal level. Therefore, the French Community on their part started several infringement procedures. The Belgian Court of Arbitration, however, overruled these objections and reconfirmed that it is for the Communities to organise a care insurance (case 33/2001 of 13 March 2001 and case 8/2003 of 22 January 2003).

⁸ Decree of 30 March 1999 on the organization of the care insurance, *B.S. 28 May 1999*.

125 (or £ 78,21) for residential care. So, the care insurance reveals a Beveridgean logic, with mainly horizontal solidarity and less vertical solidarity.¹⁰

Already within the Belgian context, the importance of territorial divisions in social policy becomes clear. While the basic mechanism of the care insurance rests upon the obliged membership in the insurance, this is not true for the people living on the territory of the Brussels Capital Region. There, people can join the care insurance voluntarily. This is a consequence of the Belgian state structure.

The Brussels Capital Region is officially bilingual: Dutch and French speaking. The jurisdiction of the Flemish Community – the organizer of the Flemish care insurance – regards only the Dutch speaking citizens. On the territory of Flanders all citizens are considered to be Dutch speaking. On the territory of the bilingual Brussels Capital Region, this is of course not the case. And because nobody can be obliged to proclaim his or her linguistic register, the Flemish Community does not know which inhabitants of the Brussel Capital Region fall under her jurisdiction. Therefore, in the Brussels Capital Region the Decree of the Flemish care insurance is not binding, but voluntary for all its citizens, also the French speaking part. This voluntariness could provoke unwanted use of the care insurance. Therefore, the system has two prevention mechanisms built in.

Firstly, there is the possibility of adverse selection – i.e. the fact that people only join the insurance when they are eligible for benefits. To prevent this, a waiting period comes into being before an eligible person receives care benefits. The waiting period is four months for every year one could but did not join the insurance scheme. Thus, persons who have always lived in the Brussels Capital Region and have joined the insurance scheme at the age of 25 will not have to wait for benefits the moment they become long term dependent. Persons who have only joined the care insurance system when they were 35, will once they become eligible, have to wait forty months before they get their first care benefit.

⁹ The premium of some social categories, like that of pensioners and disabled people with a limited income, is reduced to €10 (or £ 6,26).

¹⁰ The vertical solidarity, namely between income groups, is increased by the fact that the Flemish care insurance is partly funded by general tax revenues.

The second possible unwanted use of the Flemish care insurance in the Brussels Capital Region is a possible take-up of benefits by the French speaking citizens of Brussels. The Flemish Community co-funds the care insurance with general tax revenues. With that money it does not want to finance social benefits for citizens who in fact fall out of its scope of jurisdiction. Another government, namely the French Community, is responsible for those citizens. So, the Flemish Community wants to prevent French speaking citizens of Brussels from joining the Flemish care insurance. Therefore, people who want to receive care benefits in Brussels have to receive care in a care house or from a professional care-taker which is formally recognized by the Flemish Community.¹¹ Of course, the Flemish Community only recognizes Dutch speaking care-takers or care houses. Thus, one it is expected that the take-up by French speaking citizens will be minimal.

1.4 First conclusion

The analysis of the Flemish care insurance within the Belgian context demonstrates the impact that territorial division can have on social policy. In Belgium (social) competences are divided between the regions and communities, which do not exactly overlap. Consequently, to make sure that policy measures reach the right people, they necessarily become complex. However, the complexity is not insurmountable. It is only that all parties, both politicians and citizens, need to be fully aware of this complexity.

2. Europe's comments on the Flemish care insurance

Several rules of the Flemish care insurance conflict with Europe's free movement of persons, goods and services. Europe attaches great interests to conflicts as these because the principles of free movement are at the heart of the European construction. Namely, the free movement of capital, goods, persons and services form an essential link in the success of the economic project that Europe in the first place is (a.o. Bean et al. 1998; Falkner 2000). Before I discuss the concrete points of conflict, I will outline the essentials of the free movement principles.

¹¹ Due to a shortage of exclusively Dutch speaking institutions, bilingual institutions can also be recognized by the Flemish authorities.

2.1 Europe's free movement of persons and services

In the past, the free movement of persons was hindered by national legislation. For example, foreign labour did not yield social rights in the home country. Therefore, in 1958 regulation 3 was issued¹², in which the 'social security of migrating workers' was treated. After regulation 3 was changed for fourteen times, it was rewritten into regulation 1408/71.¹³ The aim is to avoid cross-border conflicts of competences concerning the social protection of migrating workers (Vansteenkiste 2004: 55). In order to achieve this, a mechanism of coordination is placed above the national regulations.

The construction of that mechanism of coordination is complex, because Europe consists of very diverse welfare states. As a consequence, the rules of regulation 1408/71 are intricate and often modified and supplemented.¹⁴ Also, some stipulations are so vague that the real scope only becomes apparent after the jurisprudence of the European Court of Justice (De Nys 2001: 3; Leibfried & Pierson 1996: 196).

a) Regulation 1408/71: *ratione personae*

Who is protected by regulation 1408/71? In article 2 of the regulation four categories of persons are enumerated:

- 1) employed or self-employed persons who are or have been subject to the social legislation of one or more member states^{15, 16}.
- 2) students who are or have been subject to the social legislation of one or more member states.

¹² *OJ no. 30 of 16 December 1958 P 0561*, further elaborated in regulation 4 (*OJ nr. 42 of 16 December 1958 P 0597*).

¹³ *OJ no. L149 of 05 July 1971 P 0002-0050*, of which the application is elaborated in regulation 574/72, *OJ no. L074 of 27 March 1972 P 0001-0083*.

¹⁴ For the repertorium of this regulation:

http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=en&numdoc=31971R1408&model=guicheti

¹⁵ These are, firstly, the member states of the European Economic Area (EEA: EU-25 + Iceland, Liechtenstein and Norway). Since June 2002 the regulation also applies to Swiss citizens (Agreement between the European Community and its Member States, of the one part, and the Swiss Confederation, of the other, on the free movement of persons, *OJ No. L114 of 30 April 2002 P 0006-0072*). In further references to 'member states' all these countries are included.

¹⁶ Since 01 June 2003 a nationality requisite no longer exists (Council Regulation (EC) No 859/2003 of 14 May 2003 extending the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 to nationals of third countries who are not already covered by those provisions solely on the ground of their nationality, *OJ L124 of 20 May 2003 P 0001-0003*). Furthermore, because of different international treaties, national social security legislation may not discriminate on grounds of nationality for citizens of Algeria, Morocco, Tunisia and Turkey (EC 2002).

- 3) stateless persons and refugees residing in one of the member states.
- 4) family members of the previous categories.¹⁷

b) *Regulation 1408/71: ratione materiae*

For which social rights does the regulation offers protection? On this topic, there is a lot of discussion. The starting point is the enumeration in article 4, 1 of eight branches of social security¹⁸:

- sickness and maternity benefits
- invalidity benefits
- old-age benefits
- survivors benefits
- benefits in respect of accidents at work and occupational diseases
- death grants
- unemployment benefits
- family benefits

Regulation 1408/71 wants to coordinate social security branches, not social, nor medical *assistance* (art. 4,4). Therefore, social assistance must be distinguished from social security. The splitting up generates many problems of interpretation, for different reasons. Firstly, the regulation does not postulate strict definitions to determine the distinction between social assistance and social security. Secondly, the manner of financing the system (contributions, premiums or general tax funded) is explicitly expelled as criterion for distinction (art. 4,2). In practice, the European Court of Justice uses a double distinction criterion. To fall under the social security system there, firstly, must be a direct link with one of the eight enumerated social security branches, and secondly, the beneficiary must find himself in a statutory situation in which social rights can not be refused. When this is not the case, if in other words the social worker has discretionary powers to grant benefits or if there is no direct link with the previous mentioned social security branches, then aid must be classified as social assistance. As will be discussed further, the Flemish care insurance falls under the *ratione materiae* of the regulation, namely as a sickness benefit.

c) *Regulation 1408/71: which protection is offered?*

¹⁷ Their rights are limited to derived rights, such as survivor pensions which are received not on a personal basis, but on the fact that one is the relative of a person who built up personal rights (Deffet & Nuyens 1999).

¹⁸ These are taken from the ILO Convention No. 102 of 1952.

The regulation's main principle reads that someone who acquired social rights in one member state, retains these rights after immigration to another member state. To materialise retention of social rights, four basic mechanisms are introduced.

The first mechanism concerns the equality of treatment (art. 3). This means that social regulations in any of the member states cannot discriminate against citizens of other member states. Hereby, it is made sure that an EU-citizen can build up social rights in any member state.

The second mechanism assigns which member state's legislation applies in case of migration. Different assignment rules (art. 13-17a) must avoid that persons fall under the social regime of more than one member state at a time (positive conflict of law) or under none of them (negative conflict of law). In general terms, two situations are possible: either the state where the person concerned executed her or his work is entitled (work state principle or *lex loci labori*), or the state where the person concerned lives (state of residence principle). The principle rule is that of the work state principle. For example, a Belgian working in the United Kingdom is subject to the British social security system. However, there are many exceptions to this basic rule. When, for instance, the Belgian from the former example also works in Belgium, then he will be subject not to the British, but to the Belgian social security system. The exceptions will not be elaborated on here. They are dependent on the personal situation of the beneficiary, not on the specific social security scheme, and are therefore not relevant for this.

The final two mechanisms relate to the preservation of social rights. The third mechanism is the aggregation of required periods. To be entitled to social security rights, it is often required that beneficiaries have paid contributions or premiums for a certain period. To protect migrating workers, the regulation makes sure that a worker's labour history is not set to zero when he or she moves to another member state. The regulation¹⁹ stipulates that, to meet the required periods of insurance, the insurance periods in other member states also have to be taken into account.

The fourth and final mechanism is the exportability of benefits. Formally this means that member states cannot, to grant benefits, impose conditions of residence (art. 10).

In practice this means that one continues to receive benefits after immigration to another member state.²⁰

d) Regulation 1408/71: two of the innumerable exceptions

After having explained the main rules of the regulation, I now discuss two exceptions which are important for the Flemish care insurance. However, I first have to explain a preliminary matter. As I said earlier, the distinction between social security and social assistance is crucial in the regulation: social security falls under the regulation, social assistance does not. I also stipulated that the manner of funding (contribution or premium based, or not) is expelled as distinction criterion. However, the manner of funding is crucial to determine the two exceptions. The reason is that both exceptions relate exclusively to non-contributive systems, i.e. systems funded by general government revenues. I discuss the exceptions separately.

Non-contributive social schemes can fall both inside or outside the scope of regulation 1408/71. This only depends on the existence of a direct link to one of the eight social security branches, or on the non-classification as social assistance (ut supra). A non-contributive schemes could not fall under the regulation, for example because it concerns social assistance, but when the offered protection is ‘supplementary, substitute or ancillary’, then the regulation does apply, but not entirely. In this case one speaks of ‘mixed benefits’: they have features from both social assistance and social security. For these mixed benefits, all the rules of the regulation apply, except the exportability (art. 10a, 1).²¹ Thus, the supplementary non-contributive benefits are only granted within the state of residence, according to the rules and financing of the state of residence.²² This is done to avoid that the general budget of one member state is used to maintain a minimal living standard in another member state.

¹⁹ Art. 18 (sickness and maternity), art. 64 (death grants), art. 67 (unemployment) and art. 72 (family benefits).

²⁰ For unemployment benefits this exportability is limited in time (at most three months) (art. 69, 1c), because a control on one’s willingness to work cannot take place abroad.

²¹ As an additional condition, member states have to register the scheme concerned in annex IIa of the regulation. This is a necessary but insufficient condition. Namely, the ECJ can overrule such registration as unlawful (see ECJ 08 March 2001, Jauch-case, C-215/99).

²² Actually, two exceptions to the general rules are introduced here: firstly, the exportability is abrogated, and therefore, secondly, also the general assignment rule is abrogated. Instead of being based on the work state principle, the eligibility is based on the state of residence principle.

The second exception to the general rules also relates to non-contributive benefits. When such a benefit applies only to a part of a member state's territory, then the benefit never falls under the regulation (art. 4, 2b).²³ It is of no import then whether the benefit, if it applied to the entire territory, would or would not fall under the regulation. All non-contributive benefits with a limited territorial application fall out of the scope of regulation 1408/71.

The attentive reader has noticed that none of the two exceptions apply for the Flemish care insurance, because that scheme is largely funded by individual premiums. Nevertheless, these exceptions are important to evaluate the Flemish care insurance and to discuss possible future developments (see 2.2.b).

e) Regulation 1408/71: benefits in cash or benefits in kind

In this section I discuss a final key element of regulation 1408/71 with regard to the Flemish care insurance. Benefits can be both in kind or in cash. The ECJ speaks of benefits in kind when aid is delivered literally in kind, or when it relates to the reimbursement of actual incurred expenses.²⁴ Benefits in cash, on the contrary, aim to compensate *expected* costs: an estimated account irrespective of the actual spending. The consequences of this distinction are complex. Therefore, I discuss them only for 'sickness benefits', the social security branch under which the Flemish care insurance falls.

The consequences of the distinction between benefits in kind and benefits in cash all relate to the exportability of benefits. This is the situation when people want to receive benefits outside the country where their rights were built up. The costs for the benefits are always defrayed by the competent member state, unless otherwise agreed (art. 19, 1 a and b, art. 22, 1, i and ii). The competent member state is that state where the social rights were built up. In most cases, this is the work state. The question, however, is how much the competent state should pay: as much as applicable in the competent state, or as much as applicable in the state where care is searched for? The general principle of regulation 1408/71 is that persons residing out of the work state still receive the same benefits as the inhabitants of the work state (*ut supra*). A Briton, by example, who lives in the United Kingdom, but works in Belgium, will receive the

²³ See note 21. Here it concerns annex II, section III.

same benefits in Britain as a Belgian in Belgium. The competent state, in this example Belgium, can't refuse the exportability²⁵, not even when care is searched for outside the state of residence (in this example any other member state than Britain). For benefits in kind, however, these general rules do not apply.

The take-up of benefits in kind abroad is effected on the basis of the regulations of the state where care is searched for. This means that benefits in kind outside the competent state are only allowed when in the state where the care is searched for an equivalent social protection scheme exists. Furthermore, the application will be treated as if the guest state was fully competent: its eligibility criteria are in force, its benefit amounts are applicable, etc. When care is searched for outside the state of residence, the competent state can enforce a requirement of approval for the reimbursement of care searched for abroad.²⁶ Usually this approval is refused. In some occasions, however, the approval cannot be refused, e.g. when refusal is unacceptable on medical grounds.

f) Regulation 1408/71: consistency with the free movement of services

Until now, I have discussed the free movement of persons and the retention of their social rights. There are, however, related principles which also have a major impact on social policy. The most important of them is the free movement of services.

The freedom of services is settled in the EC-Treaty, in articles 49 up to and including 55.²⁷ Restrictions on the provision of services are prohibited (art. 49). Because this is a provision of a Treaty (primary European law), it has priority on other stipulations in European law (secondary European law). This means that the rules of regulation 1408/71, which relate to the social protection of free moving persons, must be in accordance with the free movement of services. Because the free movement of services is, for the time being, a strict economical principle, it bears no special attention to social policy (Mossialos & McKee 2002: 31). Therefore, when

²⁴ ECJ 30 June 1996, Molenaar-case C-160-96.

²⁵ Regulation 1408/71 provides for a possibility for the competent authorities to refuse the exportability (art. 22, 2), but this is overruled by the ECJ on grounds of the free movement of services. This is discussed in the next section: *f) Regulation 1408/71: consistency with the free movement of services*.

²⁶ As in note 25 this requirement of approval is also, be it partly, overruled by the ECJ. See section *f) Regulation 1408/71: consistency with the free movement of services*.

²⁷ The ECJ considers the free movement of services applicable to both supply and demand of services (ECJ 31 January 1984, Luisi and Carboni-case C-286-82).

instruments of social policy are in conflict with the basic economic freedom, those social policy instruments always come off worst. In some of its most prominent cases, the ECJ pointed out such incongruences.²⁸

Regulation 1408/71 states that the reimbursement of care outside both the competent state and the state of residence can be refused by the competent state (see section e). According to the ECJ, this forms a clear restriction on the free movement of services. The court rules that eligible people must always have the possibility to have their care reimbursed in any member state *according to the legislation of the competent state*.

This jurisprudence is partly in conflict with regulation 1408/71, and partly supplementary. For benefits in cash, contrary to benefits in kind, no requirement of approval is longer permissible. The regulation itself already states that benefits in cash are fixed according to the legislation of the competent state, as the ECJ prescribes. Only, the reimbursement can no longer be refused. The situation is somewhat different for benefits in kind.

As stated above, the jurisprudence is also partly supplementary to regulation 1408/71. According to the regulation, benefits in kind are determined by the legislation not of the competent state, but of the guest state. And to get reimbursement, approval by the competent state can be required. With its judgements the ECJ does not overrule these stipulations. What the ECJ judgements do imply, is that according to the free movement of services, there should always be a possibility to have benefits in kind reimbursed at the rates of the competent state. In other words, for benefits in kind now two manners of reimbursement exist (Palm 2005): one to guarantee the free movement of persons (according to the legislation of the guest state and dependent on approval by the competent state), and another to guarantee the free movement of services (according to the legislation of the competent state, not dependent on approval).

To conclude, Europe's free movement of persons and services guarantees its citizens the consumption of acquired social rights in any member state. Exceptions to this rule are rare, especially because of the large scope of the chiefly economic free movement of services. The reimbursement on the basis of the free movement of services can

²⁸ A.o. ECJ 28 April 1998, Decker-case C-120/95, ECJ 28 April 1998, Kohl-case C-158/96.

only be refused under strict conditions, namely when it can be shown that the public order, public health or the public interest are at stake. At first sight, a member state could plea that the exportability of benefits would imply a threat to the financial balance of the national social security system. The ECJ, however, judges that when reimbursements take place according to the tariffs of the competent state, there is no threat for the financial balance of that competent state. Namely, the financing occurs as if the person concerned received treatment in the competent state.

2.2 The Flemish care insurance versus the European regulations

After the elaboration on the European regulations, I can now discuss the concrete points of conflict between the Flemish care insurance and the European regulations. These points of conflict have recently been resolved.²⁹ Still, before examining the adjustments and making a critical analysis of them, I will discuss the Flemish care insurance before the adjustments were made.

What strikes one immediately is the unanimity about the fact that the Flemish care insurance falls inside the scope of regulation 1408/71. Both the European Commission (2002) and the Commission of experts (2003)³⁰ consider the Flemish care insurance as a 'sickness benefit'. This conclusion can also be derived from the Molenaar-case, in which the ECJ classified the German care insurance (*Pflegeversicherung*) as 'sickness benefit'.³¹

The attentive reader notes that this classification in European law is diametrically opposed to the classification in Belgian law, where the care insurance is considered to be a social assistance scheme (see 1.2). However, this conflict in classification has no impact, neither in European law nor in Belgian law (EC 2002; Goyens 2002). This is completely rational from the principle of subsidiarity, which Europe applies in social policy.³²

²⁹ Decree of 30 April 2004 on the modification of the decree of 30 March 1999 on the organization of the care insurance, *B.S. 09 June 2004*. A new decree, that's in the pipeline, will finish this adjustment.

³⁰ This Commission was established by the Flemish government to analyse the incongruences between the Flemish care insurance and the European regulations (*B.S. 04 June 2003*)

³¹ See footnote 24.

³² Art. 5, EC Treaty; inserted by the EU Treaty (art. 8,5) 7 February 1992, *OJ C191 of 29/07/1992 P 0006*.

Subsidiarity means that policy competences are appointed to the smallest level possible which still generates efficient outcomes. Only on grounds of efficiency, competences can be moved to a higher policy level. With regard to social protection, this entails that national governments are responsible for social security and that no European harmonization is enforced. Therefore, regulation 1408/71 is only a coordination system to settle cross-border cases. If the classification according to the regulation – whether social security or social assistance – would affect the classification in the national context, then this would imply some sort of harmonization of social policy by Europe. For the Flemish care insurance, it would mean that the Flemish Community would no longer be entitled to organize the care insurance. Therefore, the European and the national classification between social security and social assistance are not interrelated. It seems that only an interrelation between the two would have practical consequences, and that the non-interrelation has no such practical consequences. However, I will point out some concrete consequences of the non-interrelation below (see 2.2.b). First I discuss the three stipulations of the Flemish care insurance which Europe considers illegitimate.

a) The Flemish care insurance versus the European regulations

Firstly, there can be no obligation for people living in Flanders, but working abroad to join the Flemish care insurance (EC 2002). Here, former article 4, §1 of the decree on the care insurance conflicts with article 13, 2, a and b of regulation 1408/71. Namely, the decree on the care insurance used the state of residence principle where it should have used the work state principle. This also holds another implication.

The state of residence principle was used in the granting stipulations. Initially, one had to live in Flanders to claim benefits from the Flemish care insurance (art. 5, 1, 3°). This is totally in contrast with the exportability of regulation 1408/71 (concerning sickness benefits: art. 19, 1b; art. 25, 1b; art. 28, 1b). To resolve this inconsistency, Flanders cannot introduce a requirement of approval. The ECJ case-law about the free movement of services clearly states that citizens do not need approval to receive reimbursement of care searched for abroad.

A third inconsistency between the Flemish care insurance and regulation 1408/71 concerns the aggregation of insured periods (EC 2002). Many social insurance

schemes require, before one can become eligible for benefits, preceding insured periods, and so does the Flemish care insurance. Migrating citizens from other member states could regulate the compulsory period, and thus avoid a waiting period, by paying all premiums for the compulsory period at once (art. 5, 2). Thus, this stipulation does not take into account the history of insurance of migrating persons. In other words, for people who previously fell under the social security of a member state, the required regulation payments are illegitimate.

b) How to adapt the care insurance to the European regulations?

The Flemish government followed the majority of a commission of experts (2003: 3-5), and added mainly two paragraphs to article 4 of the decree of the Flemish care insurance.³³ The first new paragraph (2bis) states that the Flemish care insurance does not apply to persons falling under the social security of another member state, by example Flemings working abroad. The other new paragraph (2ter) states that people living outside Belgium, but who work in Flanders, are obliged to join the care insurance. When migrant workers work in the Brussels Capital Region, then they can join voluntarily.

In other words, these new stipulations leave the old regulations unchanged. They only provide for cross-border situations. This solution is only possible because the European cross-border coordination rules do not interact with regulations that deal with situations within a member state. Again, this is completely sound from the subsidiarity principle, which Europe maintains on social security. However, this has peculiar consequences: people migrating within Belgium, namely from Wallonia to Flanders, will be treated differently from people migrating from another member state to Flanders. The different treatment has two dimensions.

The first difference concerns the access to the Flemish care insurance. International migrants can join the Flemish care insurance, they are even obligated to do so when they work in Flanders. Walloons, however, when they come to work in Flanders, cannot join the Flemish care insurance. For them, the old regulation still applies.

The second difference in treatment concerns the place of take-up of care. Since the adaption to the European regulations, eligible persons in the Flemish care insurance

can export their benefits. However, for intramural care, Flemings who reside in a Wallonian care home cannot appeal to the Flemish care insurance. A Frenchman on the contrary, who worked in Flanders and therefore is insured under the Flemish care insurance, when he now resides in a Wallonian care home, will be eligible for benefits for residential care. For international migrants, namely, the free movement of persons and services is applicable on the entire territory of all the member states.

At first sight, these differences in treatment between international migrants and intra-national migrants seem to violate the principle of equality. Juristically however, it does not concern an unequal treatment, but the treatment of unequal situations (Vansteenkiste 2004: 59). The question is whether this juridical word play will hold in the future. The Wallonian authorities have already put down an appeal for annihilation of the adaptations to the European regulations.³⁴ Some experts think this appeal could hold (see Ruz Torres 2004). If so, the Flemish care insurance will need a new adjustment to the European regulation.

Such an alternative adjustment was already proposed by a minority of the Commission of experts (2003: 14-17). They did not follow the opinion that a simple 2-paragraph adjustment would suffice. This view is based on two grounds. The first is of minor importance for this paper. Namely, that a full reform of the care insurance is necessary to preserve its financial health. The second ground on which the minority of experts found that a simple adjustment of the care insurance would not do, goes to the heart of our subject. Namely, these experts state that the European regulations also apply within Belgium. So according to these experts, the simple adjustment to the European regulations implicates that also 'within Belgian migration' falls under the free movement of persons and services regulations. This is not because Europe enforces this, which would imply a violation of the subsidiarity principle, but because Belgium itself enforced the free movement principles upon its laws. In the special law by which Belgium, 25 years ago, empowered its defederalized state structure, article 6, §1, VI states that the principles of free movement of capital, goods, persons and services also apply in domestic situations.³⁵ If this holds, and previously the Court of

³³ See footnote 29.

³⁴ Court of Arbitration, case-number 3194 and 3195; no verdict yet.

³⁵ See footnote 3.

Arbitration followed this rule³⁶, then the scope of the simple adjustment to the European regulations is wider than was initially meant. In Belgium, with its precarious communitarian balance, this can create a politically tense situation.

The alternative proposal of the minority of experts radically alters the organisation of the care insurance. The chief two alterations are that benefits would no longer be in cash but in kind, namely via a system of service cheques, and that the funding of the care insurance would be based on income related contributions instead of flat rate premiums.

However, with respect to the European regulations, the alternative organisation of the care insurance would imply no difference with the existing system. The funding would remain contribution based, and in that case regulation 1408/71 treats benefits in kind just the same as benefits in cash. The only possibility to be treated differently under regulation 1408/71 would be to make the care insurance funded by general government revenues. With a general revenue funding, two new situations are possible.

Firstly, the care insurance would be exempted from the scope of regulation 1408/71, because the Flemish care insurance only applies on a part of the Belgian territory (see 2.1.d). Secondly, in the hypothetical case where a care insurance applies to the entire territory of a member state, another exemption ground arises. Namely, one could argue that a care insurance is not directly related to the social security branch of 'sickness benefits', but is supplementary to it.

In the Molenaar-case, the ECJ classified the *Pflegeversicherung*, which is the German care insurance, as a 'sickness benefit'. Despite the fact that the ECJ recognizes that the *Pflegeversicherung* is "intended to *supplement* sickness insurance benefits"³⁷, it classifies the *Pflegeversicherung* as a clear 'sickness benefit', not as supplementary or ancillary. One of the reasons for this is that non-medical care is a prevention mechanism, and therefore related with health and sickness. However, this is not the only ground on which the ECJ classifies the care insurance as a clear 'sickness benefit'. The ECJ connects the first motive with a second one, namely that the *Pflegeversicherung* is "linked at the organisational level" with sickness insurance

³⁶ A.o. cases 69/2004, 128/2001, 34/97 and 55/96.

benefits. This is not the case for the Flemish care insurance, because in Belgium sickness benefits are a competence of the federal government, and the care insurance are a communal competence (see 1.2). So, perhaps one could argue that the Flemish care insurance is not a clear ‘sickness benefit’, but a supplement to it.

If this would be the case, and if the funding of the care insurance would be based on general revenues instead of premium based, then the exportability of regulation 1408/71 would not apply to the Flemish care insurance.

However, the attempt to restrict the Flemish care insurance to the Flemish borders rests upon vain hope. Firstly, but actually of minor importance, because of the fact that the alteration from a premium based funding to a funding based upon general revenues is politically not possible. But the second reason is far more important. Even when the Flemish care insurance could be expelled from the scope of regulation 1408/71, or from parts of it, the regulations on the free movement of services would still apply. This is the far-reaching conclusion from the Decker and Kohl-case.

Only exceptional reasons, such as serious threats to public health, can exempt a social scheme from the free movement of services (see 2.1.f). Such exceptional reasons are extremely rare. I already mentioned that the ECJ is of the opinion that the financial balance is not threatened when exported benefits are rated the same as inland benefits. Additionally, the Dutch Ministry of Public Health (2000: 21) points out that the impossibility of a quality inspection abroad is neither accepted to stay out of the scope of the free movement of services.

To conclude, even when the Flemish care insurance is in need of an alteration concerning its content, such an alteration cannot avoid that the Flemish care insurance would fall under Europe’s principles of free movement.

2.3 The modernisation of regulation 1408/71

I cannot finish this paper without discussing the modernisation of regulation 1408/71. The present legislation is utmost complex, especially because of the continuous incremental changes to adapt regulation 1408/71 to today’s labour market,

³⁷ See footnote 24, my italics.

international mobility and social protection. Furthermore, it is also to be recommended that the regulation be adapted to the developed jurisprudence. Before discussing the content, I briefly summarise the history of this modernisation (see De Nys 2001).

At the summit of Edinburgh (1992) a first call was made to simplify the regulation. This call was picked up at the summit of Stockholm (1996) and included in the overall SLIM-project: Simpler Legislation for the Integrated Market (see EC 1996). From the first Commission proposal (COM(98) 779) to a replacing regulation (883/2004), it took five and a half years.³⁸ And if it was not for the enlargement of the Union – the new regulation was signed on 29 April 2004, two days before the enlargement took place – the procedure would possibly still be ongoing (Kvist 2004: 304). A new resolution in the field of social security requires unanimity³⁹, and such unanimity is reached more easily with 15 than with 25 member states. However, it will still take some time – probably some years – before the new regulation comes into effect. First a regulation of application needs to be established. But the EC has not even yet submitted a proposal for such a regulation of application.

a) Comparison of regulation 1408/71 and 883/2004

An article by article comparison between the old and the new regulation clearly shows the simplification of wording. The content which applies to the Flemish care insurance – Title I, II, and the first chapter of III – did not change that much, and I certainly cannot report of a modernisation.

The three main changes concern:

- the *ratione personae* (art. 2 in both regulations): instead of relating to, in the main, employed and self-employed persons, the new regulation relates to all ‘nationals of a Member State’.
- the *ratione materiae* (art. 4 in both regulations): two small additions are added. To ‘maternity benefits’ ‘equivalent paternity benefits’ are added,

³⁸ See http://europa.eu.int/prelex/detail_dossier_real.cfm?CL=en&DosId=141180 for details on the procedure.

³⁹ Art. 42, §2, EC-Treaty.

and ‘pre-retirement benefits’ are introduced as a new branch⁴⁰. Non-medical care is not specifically mentioned.

- benefits in kind which apply only to a part of a member state’s territory (art. 4, 2b in regulation 1408/71): these special benefits, which were exempted from the scope of regulation 1408/71, are not restrained in the new regulation.

Because the jurisprudence relating to the free movement of services has in no respect had any influence on the new regulation, two standards remain. Cross-border cases will firstly be judged from the free movement of persons (in the future regulation 883/2004), but also a second judgment criterion remains, namely the free movement of services. The tendency by which the jurisdiction on the free movement of services predominates the free movement of persons – especially with regard to sickness policy – persists. Thus, Europe has missed the opportunity of a thorough modernisation of the free movement regulations (Palm 2005), whereas a tuning of the principles of free movement with the principles of the European health policy urges itself (Mossialos & McKee 2002: 191, 209).

b) The impact of regulation 883/2004 on the Flemish care insurance.

The new regulation 883/2004 has no direct impact on the Flemish care insurance. The only change is that one of the hypothetical alternatives for the Flemish care insurance to avoid falling under the regulation is ruled out. Namely, when the funding of the care insurance would be general revenue based instead of premium based, then the fact that the Flemish care insurance only applies to a part of the Belgian territory is no longer accepted as an exemption. But even this has little to no influence, because, as I stated earlier, next to the fact that an alteration of the funding of the Flemish care insurance seems unfeasible, the Flemish care insurance would still fall under the freedom of services. Thus, any real impact of the new regulation, even all hypothetical alternatives included, is eventually nonexistent.

Conclusion

⁴⁰ Pre-retirement benefits were already covered in regulation 1408/71, but not as a separate branch (cf art. 12).

The European regulations concerning the principles of free movement redesign the Flemish care insurance into a structure difficult to sustain – especially with regard to the Belgian sensitivities.

In a society where the supply of private care dwindles and the demand for care increases, the Flemish care insurance wants to maintain the non-medical care affordable for everyone. For this purpose, a Beveridgean insurance scheme was set up. The initial rules strongly tried to restrict the Flemish care insurance to the Flemish territory. However, these rules were in conflict with the European regulations.

On the subject of social policy, Europe applies the principle of subsidiarity: the national states remain competent. Only to settle cross-border conflicts of law, Europe enforces a system of coordination. However, despite the fact that the mechanism of coordination formally does not intrude in national law, the real consequences seem to be more far-reaching.

The restriction of social security schemes to the national territory is as old as social security itself, and has a strong budgetary rationale. The European rules on the free movement, however, both the work state principle and the exportability of benefits, limit “national capacities to contain transfers ‘by territory’” (Leibfried & Pierson 1996: 169). Furthermore, practically all welfare states are partly developed on the basis of market services. Certainly when one uses Europe’s broad definition of ‘economic services’. Therefore, the dividing line between the free market of services and autonomous welfare states, two principles of the European Treaties, becomes hard to draw (Leibfried and Pierson 1996: 199). These conclusions emerged clearly from the analysis of the Flemish care insurance: care benefits must be exportable, from both the freedom of persons regulations and the freedom of services principle.

The uncertainty about the exact financial consequences of the exportability leaves space for further research. But, even when it turns out that the exportability has a minor financial impact, the remaining uncertainty can prevent politicians from implementing new social policy. Namely, control of the government budget is of major importance for politicians, and so uncertainty can lead to inertia.

Whereas the impact of cross-border cases will probably remain rather limited, the impact of Europe’s regulation can be more profound on the Belgian communitarian

situation. For the moment, it seems that foreigners who work in Flanders can join the Flemish care insurance, but Walloons cannot. Foreigners can also receive benefits for care in Wallonia, while Flemings cannot. If it is true, as the minority of the commission of experts claims, that the European regulations also apply within Belgium itself, the situation will obviously change, but will not become less disputed. A considerable number of Walloon people work on the territory of the Flemish Community, mainly in Brussels. As a consequence of the European regulations, the Flemish care insurance will be open to them. In other words, means from one community will flow to the other community. In the knowledge that cash-flows from Flanders to Wallonia already cause considerable disputes in Belgium, the consequences of this case study can only fuel these disputes. Thus, the final conclusion of this paper is that, despite of Europe's principle of subsidiarity, its regulations have a clear and large impact on national, and certainly regional, social policy.

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