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Towards a rationalisation of the EC-coordination regulations concerning social security ?

Promoter:	Prof. dr. Yves Jorens Financed Belgian partner
Scientific collaborators:	Mrs. Cindy Salamon Mrs. Barbara De Schuyter

Ghent University

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1. Introduction

Free movement of people and specifically that of workers, is one of the basic principles upon which the EU has been established. Art. 39 of the EC states the right to move about freely within the Community's Member States and to reside within the territory of a Member State in order to take up a job.

Although this right already exists for a considerable amount of time, the realisation of it seems to be hindered by an amount of obstacles. This makes it difficult to really exercise the right of free movement. In order to enhance cross-border free movement for workers, arrangements are required within Community Law. These arrangements are mainly situated in the field of social security. The fundamental right of free movement is complemented and secured by Community-level coordination of social security schemes. On the basis of Art. 42 of the EC Treaty, important measures were taken related to the arrangement of social security, necessary for the development of the free movement of workers. Regulation No 1408/71 and No 574/72, regarding the implementation of 1408/71, have been issued in order to coordinate the different social security schemes of the Members States. These regulations are the most important instruments in relation to cross-border employment.

These Regulations often had to be amended in line with changes and developments, as well on Community level, such as the judgments of the Court of Justice of the European Communities, as on national level, specifically changes to the social security systems of the Member States. Next to that the European migration trend has considerably changed since the Regulation was written. Where in earlier times workers used to migrate to another State with their whole family in order to start a new life, nowadays, people who migrate tend to be highly educated people who temporarily move to another State, yet mostly with the idea to move back to their home country of origin.

The profound changes the Regulation had undergone over the years made it to become a complex and difficultly readable document. The European coordination schemes are often too complex and too difficult to be interpreted by national governments, by social security agencies, by courts and even by the European Institutions themselves.

For this reason many initiatives were taken on the European level in order to simplify the Regulation. The debate was opened in 1998 by the Commission, who issued a first proposal for simplification of the Regulation. An important step was taken during the Belgian EU- Presidency in December 2001, when the Council adopted a few parameters, which include clear priorities and principles that create the political framework within which concrete changes related to the Regulation could be decided. The whole adjustment process finally resulted in the acceptance of Regulation No 883/2004 on 29 April 2004. However, acceptance did not result in the immediate entry into force of the new Regulation

because the effective date is linked to the date of effect of a new Application Regulation. A proposal for amendment of the current Application Regulation 574/72 still needs to be submitted and it is expected that the new Regulation will at the earliest come into force by 2008. In the meantime, the present Regulations Nos 1408/71 and 574/72 with all their amendments remain applicable.

2 Objective

From previous research (JORENS, Y. (ed.), "Grensoverschrijdende arbeid en Sociale Zekerheid: de relatie tussen België en zijn buurlanden: Duitsland, Frankrijk en Nederland", Rapport Sociale Cohesie, een voorbereidende studie, Fase I, auteurs: BUYSSE, S., JORENS, Y., KESSLER, F., KLOSSE, S. en SCHULTE, B., Gent, Academia Press, 2003, 217 p.) it became clear that many problems arose under the present Regulation 1408/71. This research indicates a few inconsistencies and practical (bilateral) application problems. The Regulation can be described as a patch-work with special measures for different categories to which insured persons belong and different principles to be applied for different risks. The abolition of these inconsistencies would be an important contribution to the further simplification of the Regulation. Rationalisation is the means par excellence to come to an adequate simplification and modernisation of the Regulation. As the Regulation will only come into force when the new Implementation Regulation comes into force, it is important to do further research and verify whether the existing problems will be solved and if there are still inconsistencies for which no solution was proposed. As the revision of the Implementation Regulation is now taking place, it is useful to verify where the biggest practical problems are situated.

The point of departure for the research are 12 parametres, which serve as a guideline for possible changes to the European coordination regulation. The parameters clearly indicate that a number of principles are open for discussion and further refinement. The present research wants to build further on the political agreement that was reached in Laken. We would like to have a look at the principles that are still discussable, scientifically support them and test them in a prospective way via 'best practice' models. We also would like to rule out inconsistencies within the regulation, depending on (according to) the risk.

The present research focuses on 2 branches of social security , i.e. health care and employment. The branches to be researched are not chosen at random. Previous research demonstrated that in these 2 branches the inconsistencies and bilateral solutions found between Member States are clearly manifested. The focus on both branches allows a comparison of the various arguments pro or contra for a certain method.

The stipulations of the Regulation are not consistent.

The Regulations apply different rights to different categories to which insured persons belong. It is mostly the separate measures for frontier workers that evokes some questions.

In the application of the Regulation there exists a great inconsistency between the different risks and the rules that apply to them. With regard to sickness insurance integration in the country of residence is adopted, whereas for unemployment reference is made to the country where one was formerly employed. As regards health care a profound integration in the country of residence and control by the country of residence was adopted, whereas with regard to unemployment there is almost no reference to integration.

Moreover, in the field of sickness insurance, there are various bilateral initiatives which have been adopted as a result of problems that arise in practice when implementing the Regulations and which have the aim to allow a better and more simple application of the Regulations. Why a solution is chosen for a certain risk and for another risk yet another solution is not always clear. The export of unemployment benefits is limited to three months and moreover, frontier workers are completely on the account of the country of residence while they have paid no contribution in that country. Is there any ground of justification for this separate arrangement which differs from the general principle-of-the-work-State? Why do these differences exist? Need preference be given to the principle-of-the-work-State as the general basis for coordination of labour law, social security law and taxes? Could the system that is used for sickness insurance also be applied to unemployment? Is there a valid base for maintaining the different approaches according to the social risk at hand.

3 Working method

The selected risks are studied from 2 angles. First we identify and analyse the inconsistencies within the rules of the Regulation(s) according to the risk. Then we evaluate and analyse the bilateral initiatives that have been developed as a result of the application problems when implementing the Regulation.

The purpose of this research is to give an outline of the difference between both sectors and to record the difficulties, inconsistencies and bilateral initiatives.
People who are dealing with this issue have been interviewed and research was done to get statistical data so as to map out the migration that takes place with regard to health care and employment.

Because we want to approach the various dimensions of the health care branch, it was decided to draw up a survey concerning cross-border health care. This survey for patients focuses on the relation between Belgium and the Netherlands, because most initiatives with regard to cross-border health care were taken between these two Member States. Both countries are an important example for

the various experiments that exist in Europe. The survey only concerns Belgian patients who received care in the Netherlands.

For the survey-study, 7 target groups were selected which have been inquired via a survey by ordinary post :

1. Urgent care during a temporary residence
2. Planned care with preliminary approval
3. E112 + (IZOM)
4. Planned care without preliminary approval
5. Frontier workers
6. Frontier workers entitled to unemployment benefits
7. Frontier area residents

Per target group an adequate questionnaire was drawn up. A total of 5000 questionnaires was sent out, with a response rate of 28% (1383 questionnaires returned).

Next to the survey, many interviews took place with the different health care agents that are active in Flanders and who deal with cross-border care.

For the branch unemployment only interviews were done, because the group of persons who should be contacted is difficult to identify. The problems with which this group is confronted, only start to exist when the person is actually unemployed. Therefore only the related administrations were questioned. Also, the number of people who execute their right to receive health benefits is far greater than the number of people who uses the right to export unemployment benefits.

4 Structure of the final research report

In the first part of the report the basic principles of the Regulation are briefly highlighted. Then the focus is on the various articles which are applicable with regard to health care and unemployment.

In the second part, an outline is given of the problems which occur when applying and interpreting Regulation 1408/71. Additionally a selection was made of the most relevant problems which occur in practice.

In the third and conclusive part, a proposition is made for rationalisation of the Regulation, taking into account what exists today and which problems occur or not in practice.

5 Proposals for solutions of implementation problems

5.1 Health care

Regulation 1408/71 makes a difference between different kinds of insured persons and the different care one can obtain in another Member State.

A. Frontier worker

The frontier worker is differentiated from the usual migration worker or self-employed worker and because of this specific situation he gets a special kind of protection. The frontier worker gets the right of choice, therefore he can choose to get health care as well in the state of residence as in the state where he works, while the simple migrant worker or self-employed person only has the right to get health care in the country of residence.

This special protection originated from the aim to prevent long and needless work interruptions when a frontier worker would need medical care while he was working. It would be unfair that a frontier worker, who needs health care, would first have to go back to his country of residence in order to get the necessary health care. Yet, because of this regulation the frontier worker has received a privileged position with respect to the ordinary migrant worker. The frontier worker has an unconditional right of choice, whilst the migrant worker or self-employed person only has the right to receive health care on the territory of the work state, when he also resides in that work state or when he transfers his residence to that work state. Through this measure, the frontier worker has received a right that goes further than the original aim of the regulation.

One has to question whether this unequal regulation to the right of care is still justified. One could question this regulation by referring to the relevancy of it for a frontier worker in daily life. On the base of the survey it can be concluded that the regulation for the frontier worker is not really relevant. The right of choice is rarely used. When a frontier worker chooses to get care in the country of work then it usually concerns specialised care or hospital care. However, a frontier worker who is retired – a retired frontier worker looses indeed his right of choice upon his retirement – prefers to keep the right of choice after his retirement, although this right is hardly exercised. The results show a strong contradiction : one wants to keep the right of choice , but in practice it is rarely used.

This is proof that *in principle* there is no need for the right of choice and that the different treatment between various categories to which the insured persons belong can be abolished. There is no reason to allow a different treatment. Even more so because the right of choice is often used for care which should fall under

the preliminary approval procedure. The right of choice could therefore be abolished.

B. Entitlement to health care in another Member State

a) E111

With Regulation 631/2004 a new criterion was introduced to get benefits during a temporary stay in another Member State. The criterion to get care in another Member State is a medical necessity and no longer an immediate necessity. Because of the criterion non-urgent care is now also reimbursed. It suffices that care is medically necessary during a temporary stay on the territory of another Member State. The new article thus has a new point of departure. One can now even go abroad while being ill or when one needs certain care.

The new criterion's main purpose is to facilitate the introduction of the European Health Insurance Card. An equal treatment of rights became necessary because otherwise there would have to exist various European health insurance cards. The question, however, remains whether the introduction of this criterion is relevant for the practical execution of Art. 22 part 1a) of Regulation 1408/71, which regulates the right to medical care during a temporary stay in another Member State. The criterion indeed establishes an equal treatment between the various categories to which the insured persons belong.

Yet it is the medical doctor who will judge the necessity of the medical care. Seeing the way the Belgian health care institutions have implemented the old criterion and comparing it with how the new criterion is interpreted, it is clear that in practice not much will change. It can therefore be said that the equal treatment of rights implies an administrative simplification in practice.

The second aim, or more the consequence of it, is that the difference between planned and not planned care, as they were defined in the old Regulation, is abolished. In this way the Kohl & Decker procedure can be integrated in the Regulation. The difference between urgent care and planned care, as it was known under the old Regulation, is herewith done away with. The preliminary approval under the new Regulation does no longer have the function of effective approval (as a way to protect the system). The approval only has a function for the tariff system. When one has received approval then the reimbursement will happen on the base of the tariffs in the country where the care was obtained. If this is not the case then the tariffs of the country of affiliation apply. The words of the new regulation are however misleading. By including the preliminary approval in Art. 22 of Regulation 1408/71 and not in the stipulations concerning reimbursement, the illusion still exists that preliminary approval is necessary for planned care in another Member State. If the implementation of the new criterion can be considered as an implementation of *Kohll&Decker,* then it has to be pointed out that the difference between urgent and planned care is not relevant. After *Kohll&Decker* this difference is no longer necessary. Regardless of the fact

that care was urgent or not and regardless of the fact that car e was planned or not, the reimbursement will happen but on the base of the tariffs in the authorized Member State. Maintaining the difference would be a restrictive application of the judgment of the Court of Justice. But when integrating *Kohll&Decker* in the Regulation one did not go far enough, because the approval was maintained in the text, which leads to vagueness of the real function of it.

Also Regulation 883/2004 which has not yet come into force, does not or not completely follow the ruling of the Court of Justice. The new Regulation does not consider all situations in which cross-border care occurs, especially when people, who have a serious health problem and who want to get ambulant care abroad in line with the Regulation , still need to get approval. This is clear against judgment of the Court of Justice. If *Kohll&Dec*ker is to be implemented correctly, then the difference between planned and urgent care needs to be abolished. It has to questioned what the impact of that decision would be on the health care system of the Member States. Would the abolition of this difference cause an increase in mobility of patients, which would put a strain on the own health care system? Referring to the data which are available concerning cross-border cooperation agreements and referring to the data of our own research, the above-mentioned question can be answered negatively. It is only in rare cases that one chooses care in another Member State. All this proves that the fear for social tourism is not really funded and that the *Kohll&Decker*-principle should be extended towards all care.

If this option is going too far, then one could opt for maintaining the difference between de urgent care procedure and the *Kohll&Decker*-regulation. Then two parallel procedures with two different payment systems : the urgent care procedure on the one hand and the Kohll&Decker procedure on the other hand, which include planned care as well as not-planned care. If this option is chosen, then the problem, namely what is to be understood under urgent care, remains.

b) E112

If one wants to get treatment in another Member State than in the country of residence for a certain existing medical condition, then this is hardly possible following art. 22, part1 C of Regulation No 1408/71. Art 22, part 1 C, Regulation 1408/71 limits the possibility to get health care which is appropriate to the health condition of the insured person and health care needs to be preliminary approved by the authorized instance. When approving or disapproving, the qualified organisation has an ample discretionary authority. It is then the insurance instance of the competent country that determines if the mentioned condition has been fulfilled. Research has shown that every Member State decides for itself how this article needs to be implemented, which leads to different interpretations. A big problem with article 22 is that it only says when approval can definitely not be refused. It does however not determine anything for other cases. The

consequence is that the insured person is fully dependant on the interpretation, which the competent service will give to this article 22.

As many uncertainties continue to exist and as the case law of the Court of Justice is not always implemented in the same way , it would be useful to introduce international standards in this branch so as to determine when approval has to be given and when approval has to be refused. In this way a more uniform approach can be obtained within the different Member States.

C. Evaluation of administrative measures and cooperation agreements

With regard to cross border health care, different kinds of cooperation agreements were concluded. Their implementation differs greatly and also the categories that are involved can differ greatly. However, they have one common aim, which is to simplify the mobility of the patient, this by introducing administrative simplification and by making the approval procedures more flexible.

Considering the content of these agreements, it is clear that each of these agreements simplify the approval procedure and in most of the cases this procedure is even abolished. The issue of the E112 form does no longer depend on the preliminary medical approval. The approval does not depend on the approval of an advising medical doctor. The E112 form fulfils a pure administrative function, which allows to take charge of the costs.

The conclusion of these cooperation agreements is actually an implementation of the *Kohll&Decker* judgment of the Court of Justice. These simplified procedures actually mean that *Kohll&Decker* is applied, without copying the way reimbursement. Reimbursement in the framework of these cooperation agreements does not happen on the basis of the tariffs in the competent country, but on the basis of the tariffs of the country where care is applied. The consequence of this is that in certain regions, where agreements of this kind exist, there is no more difference between urgent and planned care. It is not important to the insured persons who wish to take advantage of these agreements whether the care in the other Member State is urgent or planned. The different procedure is only noticeable because of the kind of E-form that is used. It is thus only the administrative procedure that differs when one goes to another Member State.

D. Proposition for rationalisation of the Regulation

Taking into account the above mentioned situations, one could ask himself in which way the case law of the Court of Justice should be implemented best and in which way the access to care in another Member State could be simplified.

The ideal scenario would be to combine the best of both systems. The application of the *Kohl&Decker* procedure as provided by the Court of Justice, but where the reimbursement would happen on the basis of the tariffs of the Member State where the care is supplied and not on the basis of the tariffs of the competent Member State. The care in another Member State would then no longer depend on a preliminary approval and the reimbursement of the costs on the basis of the tariffs which were guaranteed, would be insured in this way. This systems exist today in all regions where cooperation agreements were concluded. The question is thus whether this system can be generalised and would no longer only be applied within the border regions. Taking into account the various possibilities that exist to simplify access to care, one could conclude that in reality there is a need for a definitive, by law supported application of E112. In order to counter the judicial inequality, the amplified application of the E112-procedure has to be applied to everybody, irrespective of the geographical position of the insured person.

If this would be the case, it would mean a high level of simplification. This system would provide a solution for the fragmented approach that exists today. Between and within the Member States there exist differences concerning cross border care, which could give rise to judicial inequality between EU-citizens. Insured persons who can use possibilities which are offered to them through cooperation agreements, have more freedom with regard to cross border health care than somewhere else. The same is true for frontier workers. The new system makes sure that no insured person can be treated better than another insured person. Another advantage of this system is that all problems which are confronted with the *Kohll&Decker* procedure (such as the possible financial burden of the patient, who has to advance all costs, and the uncertainty that these costs will be reimbursed) would in this way be solved. The existing duality between a system based on the EC-Regulation and a system directly based on the EC-Treaty is not good for the patient. Next to that it also implies lots of administrative problems. As already said, the difference between needed and planned care should be abolished, which would lead to administrative simplification.

The proposed combination between both existing procedures for care in another Member State implies a simplification of the current system and follows as well the case law of the Court of Justice, as the current text of Article 22 of the Regulation. Many will however argue that this system hold financial risks for the Member States and the organisation of access and the quality of the care for the nationals. It is of course difficult to estimate how a patient will react, when an unlimited possibility is offered to get care in another Member State. However, in reality it is clear that the mobility of the patient is limited and that there is definitely no systematic use of the possibility to obtain care in another Member State. From the survey we held, it became clear that persons who do use this possibility, are mostly people who have used the possibility of cross border care in the past and who had a positive experience with it or that they are persons who migrated and go back to their country of origin in order to receive care. One

can however not exclude that the behaviour of the patient might change in the future. What would then be the influence on the system and how can this be solved? The financial organisation of the system could be influenced, systems would have to be reorganised because of the overcapacity which would start to exist, etc. How can this be dealt with? It is of course an impossible task to harmonise the national tariffs of the Member States and the problem of differences between the tariffs will continue to exist. A possible solution would be to create a European solidarity fund as a compensation for the financial consequences resulting from an increasing mobility of patients.

An alternative should however be provided in case the new system would have negative consequences. The objective of the case law of the Court of Justice is to realise an optimal allocation of production means with freedom of choice for the patient consumer. For that reason cross border cooperation has to be stimulated. The conclusion of agreements allowing access to care should be promoted. This is already happened in certain regions where a kind of automatic authorisation is given to be treated abroad. This implies to a certain extend that care provided for, in another Member State, is integrated in the own system of a Member State and that this medical care will form part of the offer in the State concerned. Integration of medical care of another Member State in its own system, however, pre-supposes that one has sufficient confidence in the fact that the care provided for abroad offers the same quality and is of the same level as the care provided in the own Member State. The case law of the Court of Justice however does not give sufficient guarantees for this question. This is however necessary. When agreements are concluded that abolish the condition of authorization, it should not be forgotten that this implies the necessity when planning a health care system to take into account in this system foreign care that will be given to its insured people. When authorisation falls away, integration has to be obtained by focussing the planning of health care on this issue. Intrinsically this is linked to the need for quality norms.

As long as no European framework is foreseen, Member States will have to investigate each others quality through cooperation agreements and to come to a mutual recognition of each others control mechanism. For that reason we believe that it is important that together with agreements that abolish preliminary authorisation as foreseen in the regulation, agreements would be concluded on a mutual recognition of control mechanisms in the other Member State. Control on the quality of the medical service as on the medical provider (doctor) in general, and this as long as no harmonisation of quality standards exists. Linked to that there is a great need for a clear definition of the rights of the patient. There is also a need for a definition for a kind of health care basket on European level and what has to be understood under medical care. Defining a health care basket will undoubtedly lead to the creation of a kind of European service package where all national care together with supplementary care of other Member States will form part. Under this alternative mechanism however price differences will continue to exist. This is as such not problematic, as differences in price in health care

systems could also be useful. It guarantees and improves the quality of the care and leads to competition in the heath care system. As long as no harmonisation of quality norms and of a European service package exists, it is sufficient that agreements would be concluded dealing with the abolishment of authorisation and with the mutual recognition of control mechanism. The results would be that the reimbursement of provided care could happen on the basis of the tariffs of the country where care was given, as the competent State agrees that the care of the other Member State would have the same quality as in its own system. This implies that we accept that our system is based on the principle of the State where care is received. This would definitely be a simplification of the actual system.

The new system would imply that someone has the right to care which is the best for the person concerned. The patient would not have to worry anymore whether the care forms part , yes or no, of the national medical care package. The proposed system also respects the will of the patient once he goes abroad for medical care for social reasons. This is not possible in the actual system. Only medical reasons are taken into account. Another result would be that there is no need anymore under the system, to have different provisions for different categories of insured people as all persons have right the best medical care. Every insured person has now the possibility to choose regardless additional conditions. Result would be that the possibility of choice of the frontier worker would be abolished.

5.2 Unemployment

A. Frontier workers

Notwithstanding the fact that Regulation 1408/71 has as basic principle the country of employment, the provisions on unemployment benefits are an exception at least for the fully unemployed frontier worker. This last person receives unemployment benefits according to and on behalf of the country of residence. A principle of fiction is herewith introduced, on the basis of the assumption that a frontier worker has more possibilities of integration into his country of residence. This presumption is however not conform with reality. Different reasons would plead for the principle of working place instead of principle of residence. The principle of employment would in practice not only better fit with reality, also many other reasons are in favour of this principle. With respect to the division of financial burden, it would be fairer, as according to the principle of residence, the country of residence has to pay the benefits without ever having received any contributions. It would also be fair with respect to the unemployed person himself. Under the principle of residence the amount of benefits and the durations are determined by the country of residence. It is very well possible that the benefit received is lower than the benefit one should have received in the country of employment. The amount of benefits could for that reason be unequal with respect to the amount of paid contributions. This is

considered as problematic by frontier workers and could be solved if one should introduce the principle of employment.

Introduction of the principle of employment would also imply a simplification as the question which legislation is applicable and which is the competent state would not be dependant anymore of the fact of the unemployment is only partially or fully unemployed. The difference between both concepts is very difficult as this concept is not in all Member States related to the labour agreement. Introduction of the country of employment principle would also abolish the difference between frontier workers and other migrant persons. The different categories would now be treated in the same way.

B. Export

Unemployment benefits are in principle not exportable. Article 69 of the Regulation is an exception allowing the unemployed person to look for a job during three months in another Member State while keeping his unemployment benefits. Research has shown that the period unemployment benefits may be exported is much too short in order to allow an unemployed person to find a new job in another Member State. Extending this limited possibility of the exportability of employment benefits is therefore recommended. A lot of Member States are however afraid that this would lead to social tourism, as the amount of benefits is determined by the legislation of the competent state. Unemployed persons from Member States with higher unemployment benefits would for example be in the possibility to move to other Member States where for example climate is better and staying there during many months while keeping their unemployment benefits although they would only have rights to few days of holiday in the competent state. However this is already the case today. Everything has to do with the control exercised on unemployed persons coming from another Member State and looking for a job. If one would introduce an unlimited right to export unemployment benefits, close cooperation between the concerned Member States is necessary. As such this is also not new and fits perfectly within the duty of cooperation as it exists today in the Regulation. However, the provision as foreseen in a new regulation would make this cooperation less evident as the competent state is obliged to pay out unemployment benefits while the unemployed person is looking for a job in another Member State. There would hardly any incentive to exercise real control. That is the reason why this duty of cooperation should be clearly described in the chapter of unemployment, so that abuse of an unlimited possibility of export would be as much as possible avoided.

Member States are afraid of social tourism. However, the opposite situation may not be forgotten either. A lot of unemployed persons coming from a Member State where the benefits are low and which are going to (richer) Member States to find a job would have difficulties to survive in a State where the standard of living and prices are in principle much higher. One could even say that the

system valid under the Regulation, where benefits are determined by the country of the competent state is limiting the free movement of these unemployed people. Unemployed people of (poorer) Member States would be less inclined to look for a job in (richer) Member States. Would this plead for a modification of the principle of employment? Would it be better to translate the system which is applicable in health care to unemployment?

The system of health care is characterised by a complete integration of the person receiving medical care in another Member State into the system of the receiving state as if the person concerned was insured there. The tariffs of the receiving state would be applicable. The competent state would therefore have to reimburse the medical care on the basis of the tariffs applicable for national citizens of the Member State where the medical services are provided. Applying this system on unemployment would imply that the amount and the duration of unemployment benefits would be determined by the legislation of the country where the person is looking for a job and not by the competent state. By following this method, the benefit would be linked to the control exercised as is the case for the national citizens of that Member State. The competent state would therefore have to reimburse the benefits up to that amount. In case the possibility of exports would be unlimited, this could lead to a financial risk for (poorer) member states, as they have to risk that during this period determined by the country of the receiving state, benefits have to be paid back than the contributions received. One could perhaps insert a limitation for cases where unemployed persons are coming from Member States with lower benefits than the country where the unemployed is going to. This should however lead to a discrimination on the basis of the country of origin and the choice of a Member State where one is looking for work. For that reason it can not be recommended to fully apply the system of integration. The system of full integration as it exists for sickness benefits is not preferable for unemployment benefits. The fact that in the framework of cross border medical care higher tariffs have to reimbursed than those applicable in the competent state, is different from the risk that would apply in case of unemployment benefits. Cross border medical care remains marginal and is most of the time only dealing with single occasion treatments. Financial risks would be much higher in case of unemployment, as an unemployed person could for much longer time look for a job in another Member State. The integration principle is therefore less preferable for benefits of longer duration.

A solution could be found by applying the difference between benefits in kind and cash benefits on the other hand also in case of unemployment benefits as it exists for the moment for sickness benefits. Concerning benefits in kind as control methods and reintegration methods, full integration into the system of the receiving country would be possible. For cash benefits however, the principle of the country of employment would be applicable and the amount and duration of benefits would be determined by the legislation of the competent state. The problem of the unemployed person coming from a poor country would continue to exist but this is a result of the coordination by the Regulation. One should

however not forget that the possibility for exporting unemployment benefits is a right and not a duty. It is the own decision of the person concerned to look for a job abroad. So, he should also bear the consequences. It is however necessary that the unemployed person for that reason is well informed of the consequences.

C. Proposal for rationalisation of the Regulation

In the chapter of unemployment the distinction is made between cash benefits and benefits in kind as the services for employment provision. Starting point for the cash benefits is the principle of the country of employment, regardless if one is a frontier worker or not. The legislation of the competent state determines the right to unemployment benefits, what would lead to less administrative problems. Unemployment benefits may now be exported unlimited. Control would however be exercised by the country where work is looked for. Concerning, the services for employment provision, one is now fully integrated in the system of the receiving state. Within the framework of the cooperation duty between Member States, agreements could be concluded dealing with the mutual recognition of control mechanisms of the Member States. This recognition could also limit abuse up to a minimum.

6. General conclusion

The starting point for the new system for sickness benefits and employment, is the difference between 'benefits in kind' , i.e. care provision and the services for employment provision, on the one hand and cash benefits, i.e. sickness cash benefits and unemployment benefits on the other hand. For these services a full integration is aimed at in the country where the service is provided. For medical care this implies that the tariffs of the member state where care is provided is applicable and this as a result of the mutual recognition of each others control mechanisms. For unemployment this means that it is the Member State where work is looked for that will control the unemployed persons efforts. Also in this last case, the competent state will accept the controls exercised by the other Member State. For the service providing a mutual recognition of the control mechanisms of the country where the service is provided for, is introduced. In both cases, export is unlimited. For medical care, it is sufficient that agreements are concluded on the recognition of each others quality norms and the control mechanisms linked to that as well that international standards are determined for defining quality together with criteria for defining the health care basket and what should be understood under medical care. For unemployment it is sufficient that Member States are collaborating with regard to the control of the unemployed.