MUTUAL LEARNING WORKSHOP ON ACCESS TO SOCIAL PROTECTION FOR WORKERS AND THE SELF-EMPLOYED: FOCUS ON HEALTH, SICKNESS, ACCIDENTS AT WORK AND OCCUPATIONAL DISEASES

Thematic discussion paper

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1 Introduction

Access to social protection and healthcare[1] are fundamental rights in the EU. In November 2017, the European Parliament, the Council of the European Union and the European Commission jointly proclaimed the European Pillar of Social Rights. **Principle 12 of the Pillar states that *'regardless of the type and duration of their employment relationship, workers, and, under comparable conditions, the self-employed have the right to adequate social protection*'**. To implement this principle, the Council adopted on 8 November 2019 a Recommendation on access to social protection for workers and the self-employed[2] (henceforth referred to as 'the Recommendation'), following a proposal that was put forward by the European Commission in March 2018.

While the Recommendation emphasises the importance of granting all workers and the self-employed in EU-27 the right to sufficient social protection, the January 2023 'Report on the implementation of the recommendation on access to social protection'[3] showed a mixed picture in the implementation efforts of the Recommendation, three years after its adoption by the Council. It concluded that further implementation efforts are needed to close existing gaps in working persons' access. The report also announced further EU support for these efforts, although Member States already make use of the Recovery and Resilience Fund to implement additional reforms. While gaps in social protection coverage are to be expected under conditions of the constantly evolving labour markets, it is important to continually monitor reform progress in Member States and to assess their challenges and successes when it comes to offering adequate access to social protection for different types of working persons. Leaving some people behind poses risks to the welfare of these individuals and their families, but also to the wider EU economy and society.

This thematic paper focuses specifically on three branches under the remit of the Council recommendation namely: a) healthcare, b) sickness, and c) accidents at work and occupational diseases, and examines how accessible these are for workers and the self-employed in EU Member States. Its aim is to support a mutual learning event taking place on 5-6 February 2024. Since Mutual learning workshops provide support for the implementation of the Recommendation in Member States, the aim of this event is to understand healthcare, sickness, and accidents at work and occupational diseases related gaps that are faced by those in non-standard forms of employment, rather than to explore the general functioning of the Member States' healthcare systems. The thematic paper serves to facilitate additional exchange of experiences on benefit design and to inspire further policy reforms and investments at national level, in line with the Recommendation.

The theme of health-related benefits is also enshrined in Principle 16 of the European Pillar of Social Rights which emphasises health by specifying that everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality. Apart from it being a fundamental right (see also Article 35 of the EU Charter of Fundamental Rights), access to healthcare also contributes to the overall well-being, productivity, and resilience of communities and societies. It helps maintain a healthy workforce, reduce absenteeism, and enhance overall economic productivity. Preventing and treating illnesses promptly can minimise the economic burden associated with long-term healthcare costs and loss of productivity. In addition, entitlement to social security benefits in the case of illness and industrial accidents was also explicitly recognised in Article 34 of the EU Charter of Fundamental Rights (2000). Income replacement in the form of cash benefits for sickness and/or accidents at work and occupational diseases contribute

[1] The EU Charter of Fundamental Rights (2000) stipulates that everyone has the right of access to healthcare (Article 35).
[2] EUR-Lex - 32019H1115(01) - EN - EUR-Lex (europa.eu).
[3] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043

to preventing poverty and enable the worker to properly recover before returning to work (ILO, 2020). Moreover, occupational diseases and accidents that are caused by working conditions are often regulated separately, and most existing national social security schemes provide more generous benefits than for sickness, since they follow the logic of additional employer compensation for work-related hazards. Their existence as a separate compensation scheme serves to also encourage employers to identify and mitigate work related hazards to reduce costs, which then also leads to lower worker absenteeism due to illness or injury and creates a safer and less stressful work environment.

The Council of the EU (following a proposal of the Commission in 2018) has recommended in 2019 Member States to extend and improve formal and effective coverage of social protection benefits (in six branches including those related to health covered in this paper) for all workers, regardless of their employment relationship, and for the self-employed. Moreover, adequacy of social protection entitlements should be ensured, as well as the transparency of the schemes. Since transparency aspects were previously addressed in a separate workshop (October 2023),[4] they are not re-examined in this thematic paper. Instead, emphasis is placed on the other three dimensions (formal coverage, effective coverage and adequacy). Moreover, the paper is informed by the Council Recommendation's acknowledgment that the same rules across all groups could lead to poorer outcomes for those who are in self-employment, warning that universal rules for all groups may not always lead to superior outcomes. In other words, countries where formal access to benefits is equivalent between employees and the self-employed can still have worse *de facto* outcomes for the self-employed in comparison to those Member States where the self-employed have rules that are tailored to their specific circumstances. It is therefore important to understand pros and cons of both universal and categorical approaches to regulating access to social protection for working persons. While regulating access to healthcare is more straightforward for all types of working persons, an area of particular concern is extending accidents at work and occupational diseases related insurance schemes to the self-employed, since there is no employer other than the self-employed individual who can take responsibility for their own occupational safety. At the same time, the COVID-19 pandemic made it very evident that he self-employed cannot bear full responsibility for their occupational safety, and that some risk factors are out of their control.

Following the COVID-19 pandemic, healthcare, sickness, accidents at work and occupational diseases related benefits drew renewed attention from policy makers. Ad hoc social policy adjustments and extensions were implemented with the intention of preventing the spread of disease and providing income protection for those who had to quarantine or who fell ill. As rightly pointed out in the 2021 ESPN Report on social protection and inclusion policy responses to the COVID-19 crisis,[5] the pandemic demonstrated how flexible and adaptable national healthcare systems across the EU can be when there is political will to provide essential healthcare benefits to the entire population. The post-pandemic context thus offers a good moment to place access to these benefits high on national policy agendas.

The present paper focuses on describing **gaps in formal and effective coverage, as well as adequacy of the schemes**. It also identifies relevant practices and actions taken by Member States to overcome some of the challenges faced by non-standard workers and the self-employed. Exchange of such practices is meant to generate reflections on how some of the existing gaps in coverage and adequacy can be closed. The paper is structured by the three branches of social protection covered in the mutual learning workshop:

[4] https://ec.europa.eu/social/main.jsp?langId=en&catId=88&eventsId=2144&furtherEvents=yes

[5] https://op.europa.eu/en/publication-detail/-/publication/38439d7c-24f7-11ec-bd8e-01aa75ed71a1/language-en/format-PDF/source-284732473

healthcare, sickness benefits, and coverage for accidents at work and occupational diseases. Section 2 which is on healthcare is structured somewhat differently from sections 3 and 4 which cover the other two benefits. This is because it focuses on access to, and affordability of, services, rather than cash branches, and because there are no significant differences between access to healthcare for employees and the self-employed in EU-27. Some of the themes that are reviewed in the section on healthcare can also offer additional insights for the other two schemes. Sections 3 and 4, provide a separate overview of access to the benefit for employees and the self-employed, since there are more significant differences between the two groups. They also provide an overview of relevant practices in some Member States, which can act as inspiration for others attempting to reform their systems of social protection. The final section provides an overview of the main themes and summarises relevant practices and the main takeaways.

2 Healthcare: Country cases and reform trajectories

Access to healthcare in the EU is substantially more likely than other branches of social protection to be universally accessible and tied to residence rather than employment status. There is residence-based access in at least 18 Member States, and there are also ongoing reforms in Estonia and Luxembourg intended to introduce universal healthcare coverage. In countries where health insurance is not mandatory for some working persons but where there is residence-based access via payment of contributions, as it is the case with Czechia and Romania, the key question is affordability rather than lack of formal access. Can low income working persons (and other residents) afford to pay for their healthcare insurance? Therefore, this paper also emphasises **the importance of understanding how countries are addressing the question of non-payment of contributions**. It asks whether ongoing efforts in some of the Member States to better support working persons in complying with their insurance obligations rather than only punishing them by withdrawing their access to benefits can be inspiring for other Member States (see section 2.4).

In the remaining nine Member States, many categories of persons beyond workers are eligible for health insurance based on some eligibility criterion (i.e. the unemployed, low-income individuals on social assistance), which means that a large portion of the population is included. These alternative ways of accessing healthcare insurance are particularly relevant for those in non-standard employment which are excluded from mandatory health insurance due to their low annual earnings, since such provisions offers them an opportunity to access healthcare by qualifying for social assistance. Particular attention, however, should be paid to the possibly large number of individuals in precarious working arrangements who are not mandatorily insured due to unstable income, but who do not qualify for social assistance.

When it comes to affordability of healthcare, another important concern is that of co-payments of health services in five Member States which are substantially higher than in other Member States (see Table 1 and section 2.2). Access to supplementary insurance, which can reduce waiting times and co-payments, or cover healthcare services that are not included in the basic packages, can also be unaffordable for non-standard workers and the self-employed who have to pay for it on their own instead of relying on their employers. This draws the attention to the question of inequality in healthcare and highlights further disadvantages that may be faced by those in non-standard work in comparison to standard employees.

2.1 Access to healthcare for employees and the self-employed

In addition to Denmark, Finland and Sweden, which generally guarantee residence based universal social rights to their inhabitants, access to healthcare is residence-based in at least additional 15 Member States (see Table 1). This means that **all working persons, including the self-employed, along with the rest of the population, are eligible to ensure themselves for healthcare**. In the majority of these Member States, working persons are still required to pay contributions towards healthcare, so healthcare is not free for residents, i.e. financed exclusively from indirect taxation. Yet, contributions towards healthcare insurance are not exclusively tied to their employment status, so people can insure themselves as long as they are residents, regardless of whether they are in gainful employment. Another important concern is that some countries which offer residence-based insurance offer it only to permanent and long-term residents (BG, CZ, CY, FR), while others offer it to temporary ones as well.

Table 1. Healthcare access and qualifying periods for employees and the self-employed

Access	Country
Residence-based (18 MS)	BG, CY, CZ, DE, DK, ES, FI, FR, IE, IT, LT, LV, MT, NL, PT, RO, SE, SK
Not extended to all residents[b] (9 MS)	AT, BE, EL, EE[a], LU[a], HU, HR[b], PL, SI
Insurance not mandatory for some working persons	AT, CZ, LU, PL, RO
Qualifying periods	
Minor requirements	BG, EL
No qualifying period	All other MS
Residency-related requirements	FR, IE, MT
Co-payments for outpatient visits and inpatient care	
No fees (12 MS)	AT[c], BG, CZ, DK, EE, ES, DE, EL, HU, IE, LT, MT, PL
Small flat fees[e] (11 MS)	BE, CY, EE, FI, FR[d], IT, LV, NL, PT, SK, SE
Percentage of the cost	AT (for the self-employed), HR, LU, RO, SI
Amount ceilings	AT[f], CY, HR, FI, FR, LV, NL, PT
Income-related exemptions	BE, DE, IE, IT, PT

Source: MISSOC, 01 July 2023 update.

Notes: a) Reforms towards residence-based coverage have been announced. b) It is assumed that Croatia provides de facto universal access, since all social categories are covered through some insurance basis (including via insured family members). c) Except for the self-employed. d) With the exception of ambulatory treatment, where 30 % co-payment is required per visit. e) For example, in Cyprus a co-payment of 1-10 EUR per visit is required depending on the service, with an annual cap of 150 EUR. In Latvia, payments per visit are between 2-35 EUR, with an annual cap of 570 EUR. A minimal fee of up to 5 EUR per visit can be found in Estonia. f) In Austria, a ceiling is in place for hospital care for the self-employed.

In the nine Member States where healthcare is currently not formally and fully residence-based (see Table 1), all working persons still gain access by paying compulsory healthcare contributions. Moreover, if they become unemployed, they can be insured based on their registration with the national employment service in all nine of these Member States. They can also access healthcare by qualifying for low-income social benefits in Austria, Estonia, Hungary, Luxembourg, Poland and Slovenia, while this provision does not exist in Belgium, and Croatia[6] and Greece. At the same time, one should consider a finding by Eurofound (2020: 33), which shows a (couple of percentage points) higher instance of unmet need for healthcare among the unemployed than among employed individuals in EU-27. This difference, however, halved between 2010 and 2018, so significant progress can be observed in terms of convergence between the different groups, while there is also a significant reduction in the occurrence of unmet healthcare needs over time.

There is generally no distinction between employees and the self-employed when it comes to healthcare insurance, i.e. they are typically insured under the same conditions, so we do not distinguish between the two groups in Table 1. The latest reform towards removing this distinction between employees and the self-employed took place in Greece in 2020 (Theodoroulakis et al., 2020). Two minor exceptions are Austria[7] and Luxembourg[8], where non-standard employees and self-employed earning below a certain income level are not covered by compulsory healthcare insurance. At the same time, as mentioned previously, in both countries being registered as recipients of social benefits for people on low-income grants access to healthcare coverage. In case these individuals do not qualify for low-income receipts either, it is likely that they would have another job to provide them with a more substantial source of income and thus healthcare insurance. Moreover, in 2021, Luxembourg announced the introduction of universal healthcare coverage for anyone who has stayed for a minimum period on Luxembourg territory. A Universal Healthcare Coverage proposal was made by the government in October 2021 to offer access to healthcare through an affiliation to the health insurance to any vulnerable person residing in the country but not affiliated.[9] This led to a pilot project which was due for evaluation and amendment during 2023 (Baumann and Urbé, 2022).

Estonia is also implementing additional reforms to further improve coverage. While it currently has a compulsory health insurance scheme in place for all working persons (including the self-employed), and while large groups of the non-active population are covered on the basis of solidarity (e.g. all children and pensioners) or by contributions paid on their behalf by the State, the country's authorities aim to extend healthcare insurance to

[6] In Croatia, they can be insured via an insured family member.

[7] In Austria, non-standard employees, liberal professionals and 'new self-employed' with income below EUR 6,010.92 per year are not covered by statutory health insurance (nor pension and accident) on a mandatory basis.

[8] In Luxembourg, persons who carry out their profession occasionally and irregularly for a duration not exceeding three months per calendar year are exempted from compulsory insurance. Upon request from the concerned person, the activity performed on an incidental basis in the cultural or sport domain for an association without lucrative purpose is exempt from insurance if the occupational income therefrom does not exceed two thirds of the social wage minimum per year.

[9] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043

all its residents as a matter of priority, as stated in the country's National Health Plan 2020-2030 and in the national plan to implement the 2019 Council Recommendation. They expect this legislative change to raise healthcare coverage from 95 % of the population to 96.3 %.[10]

There is generally no qualifying period required for accessing healthcare benefits for working persons (see Table 1).[11] There are minor requirements in Bulgaria[12] and Greece[13] which are meant to tackle the issue of non-payment of contributions. There is a further, albeit minor, distinction between the self-employed and employees in Greece, with two months of insurance required during the previous year before the insurance risk occurs for the self-employed and 50 days of insurance for employees. There are also some special requirements for first time job holders in Estonia[14], which will likely be removed with the implementation of the envisaged residence-based insurance scheme.

When it comes to residency duration related requirements for access to healthcare, only France and Ireland have them, while other residence-based insurance systems do not. France requires a stable and regular residency of at least six months, while reimbursement of healthcare costs can be accessed from the third month of residence under certain conditions. Ireland requires one to have lived in Ireland for at least a year or to provide proof that they intend to live in Ireland for at least one year. In Malta, all nationals, as well as EU, UK and Australian nationals, have free access to healthcare when not in employment / not paying contributions, while third country residents also remain eligible when not in employment, but they have to pay an insurance fee.

2.2 Affordability: Co-payments for healthcare services

There are generally no co-payments for access to outpatient medical visits and inpatient care (hospitalisation) for insured individuals in 12 Member States, while there are small flat fee ones, often with amount ceilings, in further 11 Member States (see Table 1). Moreover, there are additional income-related exemptions and reductions on these small payments in Belgium, Germany, Ireland, Italy and Portugal, and for specific vulnerable social groups in many other Member States (unrelated to income).

In the remaining four Member States – Croatia, Luxembourg, Slovenia and Romania, the cost of these medical services for the insured is somewhat higher. In Luxembourg, co-payment for visits amounts to between 12-20 %, depending on the service, with an income-related ceiling (participation cannot exceed 2.5 % of the yearly income subject to contributions). Relative to the standard of living, co-payments in Croatia are more significant, with patients contributing to the costs of the healthcare with co-payments of 20 % of the costs, but no less than EUR 13 per day and with a ceiling of EUR 266 per issued

[10] https://ec.europa.eu/social/main.jsp?mode=advancedSubmit&catId=22&advSearchKey=socprotecnatplan-ee

[11] Note that in Belgium, which on paper could be seen as an exception as it requires 12 months of minimal contributions from working persons to open entitlement to healthcare for the following calendar year, those who have worked less than one year have other ways to access healthcare, so the coverage is de facto 99 % (ESPN study about access healthcare in Belgium: https://ec.europa.eu/social/BlobServlet?docId=20374&langId=en p.6).

[12] In Bulgaria, insured persons who have not made more than 3 contributions in the last 36 months will pay the provider for medical treatment. After the insured person pays all the due contributions for the last 60 months, their insurance rights are restored from the day of payment. The sums paid for the medical treatment previously received are not reimbursed.

[13] 50 days of paid contributions in one year are required.

[14] There is no qualifying period, except for those who were not insured and start working for the first time with an employment contract of at least one month or start self-employment as self-proprietor, for whom the qualifying period is of 14 days.

health bill.[15] In Slovenia, patients contribute between 10 % and 90 % of the price of services depending on the treatment or service received (except for a list of free services). In Romania, there are no limits to co-payments for a list of medical services beyond the basic package, with income related exemptions and reductions being in place for some social categories (e.g. low-income women).[16] Although less than 1 % of working persons in EU-27 report unmet healthcare needs due to affordability (Eurofound, 2020), capping healthcare costs in some form may make sense to consider in these four Member States. Capping for all residents becomes particularly important when we take into account the 'twilight zone' theory, according to which those in the second income quartile may experience more affordability challenges when accessing healthcare than the bottom quartile, since the lower income group is more likely to be in receipt of support (Eurofound, 2020). WHO (2023) also warns about financial hardship that is caused to low-income households due to out-of-pocket payments for healthcare related costs, including outpatient medicines and medical products, dental care, and even inpatient care.

If we zoom into the self-employed, differences with employees can be found in the case of Austria, where the self-employed pay 20 % of the cost of medical care themselves while the same is not required of employees. In the case of hospital care, there is a 28-day maximum to daily payments. Since the self-employed are slightly more likely (about 1pp) to have unmet healthcare needs due to lack of affordability than employees in EU-27 (Eurofound, 2020), the question of healthcare adequacy may be a particularly important concern for the lower income categories of the self-employed.

Finally, this analysis does not include out-of-pocket payments for outpatient prescribed medicines, dental care and medical products, which are subject to almost universal co-payments in all MS, except for some vulnerable groups (e.g. pensioners, those with invalidity, etc). According to WHO (2023), out-of-pocket payments for these services are the most significant drivers of financial hardship and catastrophic healthcare spending for poorer households.

2.3 Access to voluntary and/or supplementary health insurance

While access to voluntary basic health insurance is not so relevant for working persons since it is mandatory for them to have health insurance in every Member State (with only a few exceptions such as some categories of non-standard workers in Austria, Czechia, Luxembourg, Poland and Romania, and some self-employed in Luxembourg; see Table 1)[17] Eurofound (2020) highlights the importance of supplementary health insurance for employees, notably to reduce co-payments or cover healthcare services that are not included in the basic packages. They also report that waiting times, shortages of medical staff and residents' access to private sector care alternatives and their affordability are some of the main concerns for many EU citizens. Therefore, access to healthcare can be of lower quality and thus leading to unmet health needs for those who cannot afford supplementary insurance packages themselves nor have employers who offer them, such as those in non-standard work and self-employment. From the perspective of equality of access to quality healthcare, it may be beneficial to place more efforts into

[15] In contrast, some Member States have annual caps on costs, rather than caps per visit.

[16] Eurofound (2020: 29) indicates that 7% of the population in Romania reported unmet needs due reasons of affordability in 2018 (source: EU-SILC).

[17] Some Member States' governments also offer voluntary insurance to individuals who have no other basis for healthcare insurance (Croatia, Estonia, Germany, Greece, Hungary, Luxembourg, Poland, and Spain).

encouraging the self-employed to voluntarily join supplementary (private or mutual fund based) insurance schemes to complement their existing mandatory schemes (also see discussion in section 2.4). However, those who are unable to afford basic insurance are unlikely to be able to afford supplementary insurance premiums (WHO, 2023: 79). Moreover, even those who pay for supplementary insurance on their own may choose to terminate it when faced with declining incomes (Eurofound, 2020). WHO (2023) generally warns that voluntary health insurance increases inequality in access to healthcare and that countries should lower their expectations that such schemes can boost universal access. This is why it is also important to consider whether the State or other organisations are able to subsidise the cost of additional healthcare insurance for low-income individuals in particular. While France recently decided that public employers will fund 50 % of the complementary health insurance for public sector employees, this may not be fiscally sustainable for larger parts of the population. There are also occupational healthcare funds available in some countries, most notably in Italy. For example, the healthcare fund San.Arti covers craftsmen who employ workers, offering different forms of supplementary medical provision (from diagnostics to rehabilitation). Also, for self-employed professionals, there are several schemes that offer extra healthcare coverage based on membership in a 'professional fund'. Often such occupational welfare provision is supported by the state through fiscal incentives: for example, employers can apply for tax reductions if they prove they have paid premiums and provided resources to healthcare funds.[18] Scalability and fiscal sustainability of such schemes are, however, questionable.

2.4 Labour market transitions and non-payment of contributions

While formal and effective coverage of working persons by healthcare appears satisfactory across most MS, with however some affordability related concerns (see section 2.2), two additional challenges should be considered, as embodied in the following questions:

1. Even when insurance is residence based, how are working persons (and other residents) practically maintaining access to healthcare while switching between different employment statuses, or from employment to non-employment (the latter being less relevant for this report as it focuses on working persons)? Do these individuals experience temporary loss of coverage while switching between administrative statuses?
2. How do Member States address non-payment of mandatory contributions by working persons and other residents (which happens even when payments are mandatory)?

While residence-based access indicates full formal coverage by healthcare, in practice there can be transaction costs when switching from one labour market status to another, especially in systems that are financed by contributions rather than taxes (which are a majority of EU residence-based healthcare systems). With work arrangements becoming increasingly diversified across the EU and the switching of legal status more frequent than before, this can particularly affect people who are in non-standard or unstable employment. They could be temporarily losing health coverage due to the bureaucratic cost of transitioning from one type of insurance basis to another. While more information should be collected on how the switching between different work statuses functions in Member States and whether such labour market transitions cause temporary disruptions in social protection coverage, some national measures to tackle this challenge

[18] ESPN, 2017. Country report on Italy. Accessible at: https://ec.europa.eu/social/main.jsp?advSearchKey=ESPNsensw&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0

have been recorded. This administrative question on labour market transitions is also intricately linked to the second question posed above, that of how a country handles non-payment of contributions by those who are obliged to pay them to stay insured. Improving the monitoring of types of jobs not only helps individuals to maintain their social rights, but also helps the government to continually collect due social security payments from their residents.

As shown in Box 1, France offers a good practice on how to resolve the problem of temporary loss of coverage when switching between different labour market statuses. Slovenia has also made effort to administratively account for every job an individual holds, thus allowing social protection entitlements to be fully preserved when people change jobs or employment status (European Union, 2018). Another example of a monitoring strategy which ensures both that people pay contributions when they are in the situation to do so, and that they remain insured under different circumstances, can be found in Germany. Since early 2022, German employers must report if short-term contract employees are not covered by health insurance. Employers are required to report the existence of health insurance coverage to the *Minijobzentrale*. In addition, the employer will in future receive feedback from the *Minijobzentrale* as to whether the employee has already had other short-term employment in the calendar year. This will make it easier for employers to check whether the employee is employed on a short-term basis without paying contributions or whether he or she is subject to social insurance contributions. Since 2015, Bulgaria has undertaken efforts to make the employment of seasonal day-labourers simpler in order to provide incentives for employers to stop informal contracting and start paying social and health contributions. This type of contracts contributes to the access to healthcare benefits, benefits in relation to accidents at work and occupational diseases and old-age benefits: the employee has the relevant social security and health insurance contributions paid for the period of the contract. When it comes to ensuring compliance from the perspective of affordability, an interesting example comes from Greece, where graduated flat rate contributions for different income branches of the self-employed were introduced since 2020, to tackle the challenge of prior non-compliance (Theodoroulakis et al., 2020). Designing contribution bases and rates so that they are reflective of equality and solidarity when it comes to accessing healthcare rights for the self-employed, however, remains a challenge for some Member States.

The more passive approach can be found in some Member States, where workers and the self-employed are simply excluded from healthcare access when they fail to pay their contributions. This is the case in Croatia, Hungary, Romania, and in Slovenia for the self-employed, but not for employees.[19] While this sanctioning approach can be linked to these countries' efforts to clamp down on undeclared work, Slovenia's approach seems fairer, since employees have little influence over whether their employers regularly pay their social security contributions. There are other ways for the government to fine employers for lack of compliance, while at the same not harming their workers' access to healthcare. The same logic cannot be extended to the self-employed, since they are directly responsible for their own compliance.

Therefore, we can identify two general strategies. **While some Member States exclusively rely on the *ex post* punishment-oriented strategy of benefit loss for non-compliers, others also make proactive efforts to ensure higher collection of social security contributions, rather than (exclusively) relying on catching and penalising those who fail to comply**. The more proactive strategies indicate that social protection systems can adapt to the continually evolving world of work, while also benefiting from digital tools that can ease some of the existing administrative procedures. This is important because due to

[19] This distinction is likely because employers should be the ones who are sanctioned if they fail to pay their employees' contributions, rather than the employees themselves.

the increasing prevalence of non-standard employment contracts, the dynamics of sharing responsibility for social protection between employers and employees has changed. This is a particular concern for the so-called "new self-employed", such as independent professionals and/or platform workers. As pointed out by Beuker et al. (2019), this population of working persons is heterogeneous, due to their multiple activities, many of them combining different legal statuses, which usually results in more complexity and fragmentation of rights. Moreover, their circumstances often prevent self-employed professionals from developing membership of organisations that could grant them the power of collective bargaining or offer legal services to them (Semenza and Pichault, 2019). In a world where people often have to navigate their own access to social insurance, while switching or juggling multiple jobs, governments need to make it easier for people to comply with regulations. It is also part of the provisions of the 2019 Council Recommendation on access to social protection to ensure transparency and simplification of these procedures, and the October 2023 mutual learning event[20] discussed this subject in greater detail. Therefore, a seemingly good approach is to increase the provision of needs-based healthcare for all residents, while in parallel facilitating and monitoring individuals' compliance with the payment of healthcare contributions.

Another question relates to the (dis)continuation of coverage for those who lose their job or for the self-employed facing financial difficulties. In Member States where healthcare coverage is residence-based (see Table 1), the unemployed and those with low income generally remain covered. In systems where coverage is based on employment-related contributions (see Table 1 and discussion in section 2.1), those who register as unemployed with the public employment service continue to have access to healthcare. Their healthcare insurance is therefore connected to how long they can be registered as unemployed, and in receipt of the unemployment benefit. Moreover, as already explained in section 2.1, those who are facing financial difficulties can become insured for healthcare if they qualify for social benefits for those on low income.

There is evidence that unemployed persons are more likely report unmet needs (especially for the reason of unaffordability), while employees are least likely to do so (source: EU-SILC and Eurofound, 2020).

Box 1: France: Continuous health coverage for all residents

The problem

France has had a universal healthcare system since the turn of the millennium. Until recently, however, the system required that citizens obtain a new health insurance policy in the event of unemployment or a change in family situation or administrative region. Each year, as many as two million people in France had to ask to have their file transferred to a new policy due to a change in employment. Some residents would even be asked to provide proof of their right to health insurance every year. This resulted in temporary losses of healthcare coverage for citizens, as well as unnecessary bureaucracy.

The solution

Since January 2016, a new universal healthcare system has been in place: the *Protection Universelle Maladie* (known as 'PUMa' for short). The PUMa – introduced by the government's Social Security Financing Act for 2016 after examination by the National Assembly and Senate – automatically provides individual access to healthcare for all adult workers, including those who are self-employed, non-standard workers or platform workers.

[20] https://ec.europa.eu/social/main.jsp?langId=en&catId=88&eventsId=2144&furtherEvents=yes

It also covers anyone legally resident in France for at least three months. Workers pay a healthcare contribution proportionate to their income, while unemployed residents pay a subsidised contribution. The reforms mean residents are entitled to health insurance even when unemployed and are no longer obliged to set up a new policy due to a change in employment.

How it works

PUMa grants an automatic and continuous right to healthcare in France to those who are legally resident in the country, and without the need for any administrative formalities upon a change in circumstances. The determination of the charge for affiliation to PUMa, called the *Cotisation Subsidaire Maladie (CSM)* is simply extracted from the person's income tax return, although few households actually pay the charge, due to the exemptions that apply. The former *CMU-Complémentaire*, for those on a low income who pay no charge remains in place, although it is now called the *Complémentaire Santé Solidaire (CSS)*.

People who have annual earnings from employment or professional activity greater than a modest level, currently EUR 8 800 (equal to 20 % of the PASS, or *Plafond Annuel de la Sécurité Sociale*, an amount revised annually) are considered to have contributed sufficiently to the national health system via payroll deductions paid by them and their employers, or by direct charges. They do not have to pay the CSM. This category also includes married or PACSed individuals (partners recognised legally) whose income is not sufficient, but whose partners earn sufficient income; and minors. In summary, people who pay the CSM are generally those who have little to no employment income and significant passive income.

The impact

This new universal healthcare system makes it possible for workers to remain in their health insurance scheme when their employment status changes, as they are automatically covered thanks to their resident status. This ensures continuous coverage, avoiding the temporary gaps in coverage that used to arise under the previous system.

As well as guaranteeing continuous and effective coverage, the reforms have simplified the administration of healthcare – the number of phone calls to the Health Insurance Network fell by 16 % in 2016 – a change that should improve efficiency and save money.

*Source: European Commission (2018) (*Access to social protection for workers and the self-employed: Best practice examples from EU Member States) and other websites.

3 Sickness benefits: Country cases and reform trajectories

In 2023, sickness benefits were not accessible to some categories of non-standard workers in Czechia, Denmark, Greece, Hungary, Latvia, Poland, Portugal, Romania and Slovenia and they were only accessible on a voluntary basis for other categories of non-standard workers in Austria, Luxembourg, Poland, Portugal and Slovakia. Regarding the self-employed, they were without access to sickness benefits in Ireland and for some categories in Italy, Germany and Greece – and were only covered on a voluntary basis in Bulgaria, Czechia, Germany (compulsory for artists), the Netherlands, and Poland (compulsory for farmers), and for specific categories of self-employed in Austria, Estonia, Spain, Slovakia, Lithuania, and Luxembourg. Therefore, **formal coverage of non-standard workers and the self-employed by sickness benefits is a lot more significant concern for Member**

States than access to healthcare. Effective coverage is also an additional concern, especially when it comes to the self-employed. While in some reports countries such as Romania and Sweden are grouped together because they both have compulsory formal social insurance coverage of the self-employed Romania has a much lower social insurance effective coverage rates for the self-employed (see Avlijaš, 2021).

According to the 2023 Report from the Commission to the Council,[21] based on the data available in a limited number of Member States, it is estimated that 366 000 non-standard workers have no access to sickness benefits (in six Member States). These numbers should be seen as lower-bound estimates, since not all Member States report such gaps where they exist. Moreover, 5.3 million self-employed lack access to sickness benefits (based on data available in three Member States).

One of the key 'older' concerns related to sickness benefits was that guaranteed sick pay may induce workers to be absent from work without actually being sick. Johansson & Palme (2005) found such a moral hazard problem in Sweden, while Ziebarth (2009) estimated that a reduction in the replacement rate for sick workers in Germany from 100 % to 80 % led to some 12 fewer days of sick leave per year (Böheim & Leoni, 2011). Austria also reformed its system of sickness insurance in 2000 to tackle this problem. Yet, more recent research emphasises that lack of coverage by sickness benefits and/or low-income replacement rates in case of sickness may induce working persons to go to work when they are sick (Adams-Prassl et al., 2020) and that poor coverage may spur "contagious presenteeism at work" (Pichler & Ziebarth, 2017; Pichler et al., 2020).

Moreover, the COVID-19 crisis drew further attention to the relevance of sickness benefits. **Reviews of policy adaptations to the pandemic show that sickness cash benefits have been among the measures most widely used by governments to address the impact of COVID-19 on workers and their families** (ILO, 2020). The sickness benefits served to slow down and delay the spread of the virus while protecting household income. These benefits also served to compensate the side effects of society-wide restrictions, while preserving household consumption/supporting aggregate demand. These benefits also helped companies by partially compensating their financial obligations to employees during an exogenous shock, while allowing workers to rest and recover when sick, so that they can resume their activities more rapidly.

Pre-COVID-19 needs for sickness benefits were therefore exacerbated by the pandemic during which, many countries waived their waiting periods for access to benefits (e.g. France, Denmark, Sweden), while extending statutory coverage to many categories of working persons, including those who had to care for sick children. In Sweden, the State rather than employers covered the cost since the first day of leave. These measures contributed to increasing the take-up of benefits amongst flexible mobile workforce, including platform workers and the self-employed (ILO, 2020). This was particularly relevant since the COVID-19 outbreak had severe consequences for platform workers relying on voluntary employer initiatives for protection, in light of forced work stoppages due to self-isolation and lack of sick pay in many cases.

Moreover, when there are no State schemes for sickness that employers can rely on, the cost of loss of productivity for them, due to epidemics such as influenza, can be very high. There is also evidence that belonging to a scheme reduces staff turnover for companies, and that paid sick leave may even enhance productivity of workers and reduce their chances of developing chronic illnesses. Moreover, temporary workers are more likely to go to work sick (Reuter et al., 2019), and there are also even costs related to work-based accidents and injuries when sick workers work (ILO, 2020).

[21] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043, p.11-13

Therefore, **there is growing evidence that even financially, it is more beneficial for socio-economic actors (employers and the state) to offer paid sick leave to workers**. This research helps us to deter concerns related to the moral hazard of benefit abuse, especially since people who are not in permanent employment are probably even more likely to display productivity and hard work to their temporary employers and clients, to ensure future opportunities. Moreover, there is already a clear distinction in the way Member States approach this question. In some, sickness is treated as a random social risk which should be covered for anyone who is insured, regardless of the length their contributions record and their working history. Others have stricter eligibility requirements that are tied to personal insurance records, although there is no indication that those with longer contribution records would have less incentive for moral hazard (the opposite is in fact more likely). Member States diverge with regard to their policy attitudes on this matter.

3.1 Access and adequacy for employees

Although all EU-27 employees have formal access to sickness benefits, since they have to belong to a compulsory social insurance scheme, there are some exceptions for non-standard categories in nine Member States: – Czechia, Denmark, Greece, Hungary, Latvia, Poland, Portugal and Slovenia[22].

Beyond lack of formal access that is faced by some groups of the legally excluded non-standard workers, the main challenge for employees, when it comes to accessing sickness benefits, comes from their inability to fulfil the qualifying conditions to de facto access the benefits, and/or the inadequacy of income replacement amounts, often due to irregular income or shorter than required contribution records. Table 2 summarises the conditions which can impede effective coverage by (and adequacy of) sickness benefits for employees. Ten Member States have a requirement of at least six months of contributions to qualify for accessing the benefit (left panel, Table 2), while ten others have no qualifying period in place, and further seven Member States are in between. The strictest qualification requirements can be found in Croatia, Ireland and Malta.

Table 2. Qualifying periods and reference wage for calculation of benefits for employees

Qualifying period	Country
No qualifying period	AT, CZ, EE[2], FI, HU, IT, LU, SK, SI, NL
1 month	DK, FR, DE, PL
3-4 months	LV, LT, EL

Benefit calculation basis / Reference wage[1]	Country
based on current income	AT, **FI[1], SE**
1 month	DK[3], IT, **EL, LU**[4], ES
3 months	**LT**, FR, DE

[22] See Tables about lack of formal coverage in the update of the Monitoring framework on access to social protection available here. Gaps regarding **sickness benefits** relate notably to workers employed in simplified contracts in Hungary and Portugal and casual workers in Romania, seasonal workers (in HU, LV, PT and RO), trainees (in DK, EL, HU and PL) and other specific national contracts such as agreements to perform a job in Czechia, some civil law contracts in Poland and Slovenia. Moreover, sickness benefits were only accessible on a voluntary basis for other categories of non-standard workers in AT, LU, PL, PT and SK.

6 months	BE, BG, CY, RO, ES, SE, PT	6 months	BE[5], EE (short term), HU, **HR**, **PT**, RO
9 months	HR	12 months	CZ, LV, EE (longer term), CY, PL, SK, **SI**, NL
12 months	MT	18 months	BG
24 months	IE	(graduated) flat rate	MT, **IE**

Source: MISSOC, 01 July 2023 update.

Notes: 1) Countries in bold in column 4 have a benefit floor (minimum amount) in place. 2) EE – there is a qualification period only for those who were not insured and start working with an employment contract of at least one month. 3) DK – More precisely, 74 hours in the past 8 weeks. 4) LU – the highest wage during one of the last 3 months. 5) BE – More precisely, gross salary on the last day of second calendar quarter preceding the materialisation of the risk.

Although it may be logical that non-standard employees are better covered in Member States where there are no qualifying conditions in place for accessing the benefit, **these conditions should be looked at jointly with the reference wage that is being used for calculating the benefits (as well as minimal benefit amounts), to be able to also account for the adequacy of the benefits**. It is commonly the case that even though there are no formal qualifying conditions, the actual coverage is inadequate until the person has worked for at least 12 months due to the income base used for the calculation of the benefit. For example, in Czechia, although there is no qualifying period for the benefit, the assessment base is calculated as a percentage of gross earnings over the last 12 months preceding the temporary incapacity to work. This means that the benefit amount will be low until a sufficiently large number of months of received salaries is accumulated by the worker. The same goes for several other countries with minimal qualifying periods, such as Estonia, Hungary, Slovakia, Slovenia and the Netherlands. Thus, out of ten MS without a qualifying period condition, 6 have a reference wage condition that is at least six months long. We find a similar situation in several other countries with the more lenient qualifying periods. In Latvia, while the qualifying period is three months, the 12 months average wage is the basis for benefit calculation. In Bulgaria, the reference income is 18 months of earnings preceding the illness, while one can formally access the benefit with 6 months of insurance. On the other hand, there are nine Member States with qualification periods below six months and where the reference wage period (used for the benefit calculation) is also short (Austria, Denmark, Finland, France, Germany, Greece, Italy, Lithuania, Luxembourg; see Table 2).

Besides the reference wage used for calculating the benefit, it is important to look whether there are benefit floors (i.e. minimum amounts that can be paid out) which can correct some of the challenges associated with long reference wage periods. Such benefit floors exist in nine Member States (they are marked in bold in column 4 of Table 2). Nonetheless, Table 2 also shows that more than half of the countries with benefit floors also have less stringent conditions of access in the first place. We can thus conclude that benefit floors are generally not meant to compensate for the inadequacy of the calculation basis for the benefit amount, but that countries with more inclusive schemes tend to have both less stringent income calculation bases and benefit floors in place. Benefit floors seem to be particularly useful in Croatia, Portugal and Slovenia, since they can set off some of the other more stringent criteria that are in place.

The qualifying period conditions are especially challenging in Ireland, Malta and Croatia (see Table 2). In Malta, access to the sickness benefit requires quite a lengthy contributions record, equivalent to the record required to access unemployment insurance, although the benefit on offer is flat rate. This is rather unusual as in most countries relatively long insurance records are required to access unemployment benefits due to the bigger potential for moral hazard, but not when it comes to sickness. Moreover, in Romania the qualifying period for sickness benefits was increased from one to six months for both employees and the self-employed in 2020, so there are instances where access to social protection is becoming more rather than less stringent.

Efforts to improve the current situation have been taking place in Ireland, where the 'Sick Leave Act 2022' introduced from January 2023 a statutory right to sick pay, providing employees (notably those with low pay and without entitlement to a company sick pay scheme) the right to a minimum period of paid leave if they become sick or sustain an injury that makes them unfit for work. The duration of paid sick leave will be increased on a gradual basis over the next three years to avoid placing excessive financial burden on employers. Another example can be found in Czechia which, in its national plan to implement the 2019 Council recommendation, explained that it does not intend to turn its 'agreements to perform a job' into an employment relationship but does consider amending criteria for access to insurance and to improve access to coverage for sickness and related risks (including maternity) for non-standard workers.[23]

When it comes to accessing the benefit, in general most Member States do not have a waiting period for employees, although in many instances the benefit comprises of continued payment by the employer for at least an initial period. For example, there is a waiting period for up to three days in eight Member States (Czechia, Estonia, France, Ireland, Italy, Malta, Portugal and Spain), but this period includes continuation of payment of wages by the employer. Finland has an additional provision: if there is no employer or the employer does not pay wages (e.g. if the employee has been employed for less than a month), the waiting period is nine working days from the onset of the sickness. Moreover, in Sweden, there is no waiting period but a qualifying deduction of 20 % of the average weekly sickness benefit is applied during the first 14 days. This indicates that those employees which do not qualify for continued payment off wages by the employer, typically because they are in non-standard employment, are more vulnerable to losing income when becoming sick in those countries which have waiting periods in place.

Employees also have access to supplementary sickness benefits, such as taking paid leave in order to take care of a sick child or family member, in 20 Member States.[24] Some of the remaining Member States offer supplementary amounts for beneficiaries with dependants, but do not provide sickness leave in the case of sick children (e.g. Cyprus and Malta). In addition, Box 3 provides an overview of access to partial sickness benefits across Member States, which have gained particular policy prominence due to the phenomenon of 'Long-COVID'. These additional sickness schemes offer greater flexibility and support to working persons when it comes to balancing their working lives with care responsibilities towards dependents with illness. Ensuring access to these schemes for non-standard employees should also be high on the policy agenda, together with ensuring their access to basic paid sick leave.

In summary, there are challenges related to formal access for some groups of non-standard employees in nine Member States. Apart from that, qualifying conditions for accessing the benefit are quite stringent in ten Member States (six months and above), while there are also 'hidden' adequacy related barriers in place in several MS with laxer

[23] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043, p.14

[24] BG, HR, CZ, DK, EE, EL (unpaid), ES (a similar benefit in place only for cancer), DE, FR, HU, IT, LV, LT, LU, PL, RO, SK, SI, SE (sorted via maternity/paternity benefits), and NL.

qualifying conditions. This issue is often compounded by the absence of legally prescribed minimal benefit amounts, rendering the theme of benefit inadequacy extremely relevant for those with shorter contribution records. There are, however, instances of MS where these formal rules are more aligned and thus more inclusive for non-standard workers. Examples that stand out are Austria, Finland, Denmark, Italy, and Luxembourg. Further policy attention should also be drawn towards reviewing waiting periods for non-standard employees (and the self-employed) who do not qualify for the employer paid days of sick leave, and towards examining their access to supplementary and partial sickness benefits.

3.2 Access and adequacy for the self-employed

When it comes to formal access to sickness benefits for the self-employed, 21 Member States provide compulsory sickness coverage to them (though some specific categories of the self-employed in these countries have voluntary or no coverage, see Box 2). Voluntary sickness schemes for all self-employed exist in five Member States, while Ireland does not have any sickness scheme for the self-employed, except for fishermen/women[25] (see Box 2).

Box 2: Formal coverage of the self-employed by sickness cash benefits in EU-27

- *Compulsory sickness scheme*: Austria, Belgium, Croatia, Cyprus, Denmark, Estonia, Finland, France, Greece, Hungary, Latvia, Lithuania, Luxembourg, Malta, Portugal, Romania, Slovenia, Slovakia, Spain, Sweden, and Italy for the 'new' self-employed.
- *Voluntary sickness scheme*: Bulgaria, Czechia, Denmark, Germany (compulsory for artists), Italy, the Netherlands, and Poland (compulsory for farmers) and Slovakia; and for specific categories of self-employed in Austria, Estonia, Spain, Slovakia, Lithuania, Luxembourg, Netherlands.
- *No sickness scheme*: Ireland (except fishermen/women), and some categories of self-employed in Italy, Germany and Greece.

There are also some countries where certain groups of the self-employed are not mandatorily insured for sickness although general sickness insurance is compulsory for the self-employed. For example, farmers in Spain are offered voluntary schemes,[26] while other self-employed are mandatorily insured. There is also no cash benefit scheme for farmers in Austria or Greece, although other self-employed have mandatory sickness insurance. In Italy traditional self-employed are not covered by sickness benefits, while specific categories of 'new' self-employed (i.e. the economically dependent self-employed) are. This means that 1.5 million of the self-employed are insured, while 3.5 million are not. The situation in Germany is also fragmented, with voluntary opt-in for self-employed/liberal professions, compulsory for self-employed artists and publicists and others with statutory pensions insurance, and no scheme for farmers. In an effort to offer more inclusive access to sickness benefits, France extended sickness benefits to the liberal professions in 2020, thus covering all types of self-employed persons.[27]

In Member States with voluntary sickness insurance schemes, we see significant variations in benefit take-up among the self-employed, which indicates that providing voluntary access does not generate the same level of risk of non-coverage in all countries. In Czechia, only

[25] The Partial Capacity Benefit discussed in the previous section offers voluntary access for the self-employed. Moreover, in the case of sickness of the self-employed, Ireland has other provisions in place through the general social assistance system (see Guaranteed Minimum Resources).
[26] In June 2023, 90% of agriculture workers in Spain were covered by sickness benefits.
[27] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043, p.13.

about 13 % of the self-employed were covered by voluntary sickness insurance (99,913 out of 744,067 persons, according to data computed in March 2023). In the Netherlands, the voluntary sickness scheme is only extended to those self-employed with a previous compulsory insurance record of at least one year, i.e. a history of wage employment prior to self-employment. According to the most recent update of the monitoring framework (2022), there were 17 673 self-employed opting in among 1 292 000, which amounts to an almost negligible take up rate of 1.4 % (note: data from 2021). In Lithuania, the take up of sickness benefits by self-employed was only by around 20 persons, therefore close to 0 %. When it comes to Poland, EUROMOD assumes that all self-employed minimise their social security contributions by declaring the minimum income base and *by opting out of the sickness insurance*. On the other hand, in Bulgaria, 69 % of the self-employed opt in, while this figure is estimated to be around 43 % in Slovakia (voluntary coverage for self-employed below a certain income threshold). Where the take up is low, further efforts should be made to motivate the self-employed to join voluntary schemes or to ease their administrative access to these schemes, while at the same time keeping in mind possible resistance since many entrepreneurs prefer to keep their labour costs low.

Some Member States which require mandatory sickness coverage for the self-employed have certain voluntary components built into their compulsory schemes where they distinguish between short-term and long-term illnesses, while others cover all types of illnesses for the insured self-employed by default. The more flexible benefit design could offer alternative solutions on how to offer greater flexibility to the self-employed without making the entire scheme based on voluntary opt-in. These examples can also serve as inspirations for countries with voluntary schemes that are considering to make them compulsory. For example, some Member States offer a voluntary choice to the self-employed to choose the waiting period that they deem the most adequate for their circumstances. In Luxembourg, Austria, Denmark and Sweden, coverage in cases of the more serious illnesses of longer duration is automatically included, whereas the self-employed are given a choice whether to insure for short term sickness. In other words, the default waiting period for sickness benefits is three months in Luxembourg but those self-employed who voluntarily opt for employers' mutual insurance can receive compensation from the first day of work incapacity. In Sweden the default is 7 days but a different waiting period between 1 and 90 days can be chosen instead. In Austria the waiting period is 42 days (following which they can be paid retroactively from the 4th day), but the self-employed can also choose to insure themselves additionally for shorter spells of illness. Denmark has a default two-week waiting period for the self-employed, but they can voluntarily opt into an additional insurance, in which case they can get paid from either day 3 or day 1 of sickness. In Portugal, we see a substantially shorter waiting period (10 days), and also gradually higher compensation for illnesses that last longer than 30 days. In Croatia the default waiting time is 42 days for the self-employed, without an option for insurance against short term illness.

Table 3 provides a summary of conditions which influence effective coverage by (or adequacy of) sickness benefits for the self-employed. Countries in bold are those where qualifying periods are the same for self-employed and employees. Greece had a recent reform following which self-employed and independent professionals should have paid their social security contributions and be insured on the day when the illness occurs, while 120 days of work are required for employees. In the rest of the countries, qualifying periods are longer for the self-employed than for employees, except for Portugal where it is the other way around.

A particularly striking difference between the qualifying period for employees and the self-employed can be found in France which has minimal requirements for employees but a 12-month qualifying period for the self-employed. Denmark also stands out with a 6-month requirement for employed while having a one-month requirement for employees (also see

Table 2 for comparison). The Netherlands has a peculiar criterion for the self-employed to join the voluntary sickness insurance scheme. To qualify, they must have participated in a compulsory sickness scheme (as employee or unemployed) for at least one year prior to the voluntary scheme and have to opt-in within 13 weeks after the compulsory scheme has ended.

Table 3. Qualifying periods and reference wage for calculation of benefits for the self-employed

Qualifying period[1]	Country
No qualifying period	**AT**[1], **FI, HU, EE,** EL, **LU,** PT[2], **SI**, **SK**
1 month	**DE**, RO
3-4 months	CZ, **EL**, IT, **LT**, **LV**, PL
6 months	**BE**, **BG**, **CY**, DK, **ES**, **SE**
9 months	**HR**
12 months	FR, **MT**, NL (in the employee scheme)
24 months	n/a

Benefit calculation basis / Reference wage[3]	Country
based on current income	**FI**[4]**, SE**[5]
1 month	**ES**
3 months	**CZ, LT**
6 months	DK, **HR**, **HU**, **EE**, PT, RO
12 months	**CY, LV, PL, SI, NL**
18 months	**BG**
24 months +	SK, FR (36m)
(graduated) flat rate	AT, BE (linked to prior income), **EL,** **MT** (linked to contributions), IT (linked to contributions), FR (for farmers)

Source: MISSOC, 01 July 2023 update.

Notes: 1) Countries in bold in Column 2 (left panel) are those where qualifying periods are the same for self-employed and employees. In the rest of the countries, qualifying periods are longer for the self-employed than for employees, except for Portugal where it is the other way around. 2) PT – The qualifying period is longer for employees. 3) Countries in bold in Column 4 (right panel) use the same calculation basis for the self-employed and employees. 4) FI – Income is based on hypothetical annual earnings, based on occupation. 5) SE – If self-employed less than 24 months, their sickness benefit is determined based on what an employee with the same work, education and experience is likely to earn.

Several Member States have very 'light' formal eligibility criteria to access sickness benefits for the self-employed. There are either very short or non-existent contributions requirements in place (see Table 3). Yet, similarly to the conditions set out for employees (see section 3.1), the amount of sickness benefit is calculated as a percentage of the recipient's average monthly gross income over a given period. Therefore, average reference wages are calculated over longer time periods than is required to qualify for the benefit in 11 Member States (Bulgaria, Cyprus, France, Hungary, Estonia, Latvia, Portugal, Poland, Romania, Slovakia and Slovenia), with benefit floors in place only in Slovenia and a very low one in Portugal. Some countries without the benefit floor have minimum insurable income (e.g. Poland), but this is often inadequate (see Avlijaš, 2021 for further details). This severely hinders benefit adequacy for the self-employed with low earnings and/or short contribution records.

This policy inclination towards inadequate benefit levels for those with shorter contribution records is further pronounced in Slovakia and France, where the calculation basis for the self-employed is substantially longer than for employees (24 months in SK, and 36 months in FR). This makes it much more difficult for them than for employees to access adequate benefits without rather long continuous contribution records. This tension is particularly pronounced in Slovakia, where there is no contributions length requirement to qualify, but where average income over the past 24 months is used to determine the amount of benefit.

Flat rate benefits can offer an alternative way to ensure a certain level of adequacy of benefits for those with low income and short contribution records, as they ensure a social minimum for every recipient, regardless of their contributions record. Also, it is likely that due to fluctuating monthly income in the case of self-employment, it may be easier to administer flat benefits (see the example of Greece which recently reformed its system) or graduated flat benefits which are linked to contribution records (see the case of Italy). These can, however, be unfair for the higher earners, so they may have to be combined with a variable top-up when possible, or at least by way of graduated flat rates, as seen in Italy, and to some extent in Belgium and Greece. Austria's plans to increase its flat rate benefits for the self-employed should also be taken into account.

On the other hand, not all flat rate benefit designs offer inclusivity for those with lower earnings. In Malta, which offers flat rate benefits for sickness, their duration is limited by the beneficiary's contributions record, rather than based on need. For comparison purposes, in Italy the level of the flat rate benefit is dependent on the recipient's contributions record, but the duration of the benefit is not limited by it like in Malta. On the other side of the spectrum, we find Luxembourg, Finland and Sweden which use hypothetical income levels which guarantee adequate benefits for those with lower contributions records. For example, in Sweden if one is self-employed less than 24 months, the sickness benefit is determined based on what an employee with the same work, education and experience is likely to earn.

In summary, the self-employed are faced with even greater obstacles to accessing sickness benefits than non-standard employees. Apart from some categories not having formal access to any sickness scheme, even in systems which generally provide compulsory insurance to the self-employed, there is also the challenge of low take up of voluntary sickness insurance among the self-employed in some Member States. It is, however, encouraging that higher voluntary take-up rates have been recorded among the self-employed in Spain (among farmers), Bulgaria and Slovakia. Moreover, some countries that offer compulsory insurance have voluntary components built into the design of their schemes, which makes them more flexible and more affordable for the self-employed. Apart from inadequacies in formal access to sickness benefits for all types of self-employed, there are also significant challenges in effective coverage for the self-employed in some MS, where they either have high qualifying period requirements, or where, in instances of laxer qualifying conditions, they cannot receive benefits of adequate levels because of the very

long period over which their reference wage is calculated. Benefit floors (minimal benefit amounts) and/or flat rate benefits, however, have allowed some MS to overcome such challenges, as their design in some cases facilitates greater inclusion of the self-employed.

Box 3: Availability of partial sickness benefits

Partial sickness benefits (i.e. Benefit for reduced working time because of sickness) have gained public attention due to the phenomenon of "Long-COVID", which has left people incapacitated for full-time work for prolonged periods of recovery, but perhaps not long enough to qualify for disability related benefits. While there is no particularly obvious reason why people should be either full-time employed or full-time sick (especially when it comes to people who can work from home, or for people who have to be absent due to receiving regular therapy in a hospital, but can otherwise work, etc), two thirds of the MS do not currently offer such flexibility when it comes to sick pay (9 do and 18 do not).

The most notable exception are the three Nordic EU MS, which have specific provisions[28] for partial return to work and training activities for all working persons as part of their active labour market policy oriented features of the social security system.

Belgium, France, Ireland, Luxembourg, the Netherlands and Slovenia also have provisions in place for partial sickness benefits. In terms of hours of absence, Belgium offers significant flexibility for employees, while the self-employed only have access to graduated flat rate benefits which are linked to the composition of the person's household (single, cohabiting, dependants) and their previous income. The self-employed, however, have access to a caregiver allowance, which allows them to partially (or fully) interrupt their independent activity (at least 50 %) to care for a sick relative or disabled child.

In France, continuing or resuming work part time for therapeutic reason has to be discussed with the occupational doctor, while its duration and the scheduling have to be negotiated with the employer, which makes this option non-extendable to the self-employed. In the Netherlands, a partial sickness benefit is possible in the context of re-integration into work, while the number of hours that the employee is able to work is determined by the occupational doctor (continued payment by the employer) or the insurance company medical advisers and labour experts at the Institute for Employee Benefit Schemes (sickness benefit). Luxembourg offers a partial sickness benefit for gradual return to work for therapeutic reasons when the return to work is likely to improve the health condition of the person. The same scheme covers employees and the self-employed. In Slovenia, a partial sickness benefit is paid for the hours the insured person is unable to work, and the same scheme covers both employees and the self-employed.

The Partial Capacity Benefit in Ireland is based on the assessment of the restriction on capacity for work as moderate, severe, or profound, while there is no restriction on earnings or number of hours the person can work. One can work in a self-employed capacity while getting the Partial Capacity Benefit. Since there are no sickness benefits for the self-employed in Ireland (except for fishermen/women), this is most probably a separate (voluntary) social insurance scheme which in some cases may act as a replacement for the absence of sickness benefits for the self-employed in Ireland.

[28] In Finland, the reduction of the holder's capacity to work must still be at least 50% in medical terms, and this equally extends to the employed and self-employed. In Sweden, where sickness benefits can also be combined with income from work, the partial benefit is more flexible than in Finland, and is payable according to the reduction in capacity to work ¾, ½ or ¼. In Denmark, the minimum absence to access the partial benefit is 4 hours per week.

4 Accidents at work and occupational diseases: Country cases and reform trajectories

All Member States (except Netherlands) offer benefits related to accidents at work and occupational diseases to employees. In 2023 these benefits were however not accessible to some categories of non-standard workers in Latvia, Poland, Portugal and Romania, and they were only accessible on a voluntary basis for other categories of non-standard workers in Portugal. [29] The self-employed were without access to benefits related to accidents at work and occupational diseases in Belgium, Bulgaria, Cyprus, Czechia, Estonia, Ireland, Lithuania, Latvia, Netherlands, Romania and Slovakia and were only covered on a voluntary basis in Denmark and only for some categories in Austria, Germany, France, Finland and Luxembourg. In the 9 Member States reporting data, 3.9 million self-employed lack access to benefits relating to accidents at work and occupational diseases.[30]

The ILO underlines that sickness benefits should not be confused either with employment or work injury benefits which cover occupational accidents and diseases contracted in relation to work (ILO, 2020). While most such schemes, where they exist, follow the same principles as sickness (and invalidity) schemes, **they are often more generous in terms of income replacement rates, to compensate for the additional fact that the disease or accident was work-related.**

On the other hand, some countries do not see the need to recognise employer related injuries or diseases as something that should be regulated by the social security act, but rather by labour law. For example, the Netherlands does not treat the work-related origin of disability differently (for employees or the self-employed) from the perspective of social insurance, although employees can get compensated by the employer in case an inadequate working environment led to an accident or illness (this is regulated via labour law, rather than the social security act). In other words, the Netherlands regards injury/disability as a social risk regardless of whether it takes place at work or not for all types of working persons, and other residents. Instead, they treat it as general disability. Since this type of social insurance was historically conceptualised around the idea of placing the cost of accidents at work and/or occupational diseases, and the resulting economic loss, on the industry and/or employer (Witte, 1930), the question can be raised whether it is still a legitimate approach in the new era of work, and/or for the self-employed in particular. This is one way to resolve the issue of who bears responsibility and pays for costs when it comes to accidents at work and occupational diseases that incur to the self-employed, since it is not always legally clear who the compensating party should be, nor how allocation of costs should take place.

There are also countries which recognise compensation for injury at work as an important entitlement. For example, Luxembourg even offers additional payments and compensation for different grievances (e.g. allowance for physiological or aesthetic damage, pain endured until healing, and loss of amenities of life in order to compensate for the loss of quality of life and the loss of value on the job market). Italy explicitly recognises any form of exposure to violence or traumatic event while at work as eligible for compensation. In some cases, additional in-kind healthcare benefits where no co-payments are asked for any type of health products or services are also offered (pharmaceuticals included). In countries like Denmark, Sweden, Luxembourg and Austria (albeit less generously), where sickness

[29] See Tables about lack of formal coverage in the 2022 update of the Monitoring framework on access to social protection available here. Gaps regarding accidents at work and occupational diseases relate to workers employed in simplified contracts in Portugal and casual workers in Romania, seasonal workers (in Latvia, Portugal and Romania), trainees and some civil law contracts in Poland.

[30] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043

benefits are already very generous, the logic of this additional insurance is not (only) about income smoothing, but about compensating the person for the traumatic event that is work-related, and accounting for their additional grievances.

The COVID-19 pandemic also renewed public and policy interest in adequate insurance against occupational diseases. Many essential workers such as those working in delivery (including platform workers) were more at risk than the average worker during COVID-19 and without possibility to telework. Germany's statutory accident insurance system, for example, declared COVID-19 infections in the occupational environment as an occupational accident or disease. The question of recognising COVID-19 infections as an occupational risk even for the self-employed became prominent because this cohort of working persons were also found among essential workers such as small shop owners and taxi drivers. Therefore, the issue of occupational exposure to the coronavirus became recognised as something that is largely out of the self-employed person's control rather than a question of arranging adequate working conditions for oneself. Preventative paid sick leave for the self-employed with chronic illnesses who are more vulnerable to the coronavirus was also debated. On the other hand, many of those in new forms of self-employment, and particularly those with higher skills and white-collar tasks, have not been as impacted due to their ability to telework.

4.1 Access and adequacy for employees

Almost all Member States[31] have formal provisions in place for employees when it comes to accidents at work and occupational diseases. At the same time, in 2023, benefits relating to accidents at work and occupational diseases were not accessible to some categories of non-standard workers in Latvia, Poland, Portugal and Romania, and they were only accessible on a voluntary basis for other categories of non-standard workers in Portugal. [32]

There are no conditions for qualifying to access these benefits, so they can be obtained regardless of the length of the employees' insurance record. This rule makes this benefit substantially easier to access than the sickness one in most Member States. Moreover, the benefit is typically more generous than the sickness benefit. In the case of work-related illnesses or injuries, eligible workers usually receive compensation at 100 % of their reference wage, although in most Member States, the reference wage is calculated in the same way as for sickness (see Table 2). For example, in Croatia, the average net wage over the 6 months preceding the month in which the contingency occurred is used, while in Bulgaria it is the average of 18 months on which contributions have been paid (the same as for sickness benefits). There are also instances in which the required reference wage covers a longer period than for sickness (Austria, Belgium and Portugal). Therefore, workers can sometimes face the same or even worse benefit inadequacy for this scheme than for sickness benefits, since employees with contribution records shorter than the period used to calculate the reference wage are likely to get inadequate compensation.[33] A more inclusive practice for workers with shorter contribution records can be found in Germany which legally requires employers to continue paying wages to the concerned employee for up to 6 weeks before they get state benefits, following which the benefit amounts to the

[31] All Member States except the Netherlands.

[32] See Tables about lack of formal coverage in the 2022 update of the Monitoring framework on access to social protection available here. Gaps regarding accidents at work and occupational diseases relate to workers employed in simplified contracts in Portugal and casual workers in Romania, seasonal workers (in LV, PT and RO), trainees in PL and some civil law contracts in Poland.

[33] In addition, the benefit calculation formula in many Member States is also linked to the level of the worker's incapacity, which often makes its adequacy difficult to assess beyond a case-by-case basis.

gross remuneration of last month before beginning of inability to work. While employers are also required to pay full salary in the case of sickness for up to 6 weeks, the reference wage for sickness benefits is based on a three-month average (subject to contributions). France and Hungary also use the salary from the past month as reference income, which is a lower requirement than they have for sickness.

4.2 Access and adequacy for the self-employed

The self-employed are generally covered by the scheme for accidents at work and occupational diseases in 14 Member States, although there may be exceptions for certain types of self-employed (e.g. in Italy there is no scheme for liberal professions and some tradespeople). More precisely, the scheme is generally compulsory in 11 Member States and generally voluntary in 3 Member States: Denmark, Finland (compulsory for farmers, and athletes due to the nature of risk they face) and Germany (compulsory for farmers). Greece and France have partial insurance mechanisms for the self-employed in case of accidents at work and occupational diseases, while there is no insurance against this risk for the self-employed in the remaining 11 Member States.

Box 4: Formal coverage of the self-employed by accidents at work and occupational diseases benefits in EU-27

- *Compulsory scheme*: Austria, Croatia, Hungary, Italy (no scheme for liberal professions and some tradespeople), Luxembourg, Malta, Poland[1], Portugal, Slovenia, Spain (voluntary for farmers), and Sweden.
- *Voluntary scheme*: Denmark, Finland (compulsory for farmers) and Germany (compulsory for farmers); and for some categories in Austria and Luxembourg.
- *Partial scheme*: Greece (only craftsmen), France (compulsory scheme for farmers).
- *No scheme*: Belgium (only exists for asbestos exposure), Bulgaria, Cyprus, Czechia, Estonia, Ireland, Latvia, Lithuania, Romania, Slovakia and the Netherlands.

Note: 1) With the support of the Recovery and Resilience Facility (RRF), at the end of 2021, Poland initiated a reform to extend mandatory insurance and improve coverage.

In the 14 Member States where the scheme exists, in the case of work-related injury or occupational disease**, the beneficiary generally receives cash benefits under less stringent conditions than in the case of sickness**. For example, in Austria waiting period is 3 days if the illness is work-related, instead of 42 for general sickness. There are in some cases also additional provisions. For example, in Croatia there is no benefit ceiling for accidents at work and occupational diseases, while there is one in case of sickness.

Similarly to employees, **levels of compensation are typically higher than in the case of non-work-related injury or illness** (e.g. in Slovenia it goes up from 90 % to 100 % of reference earnings). At the same time, the income basis for accidents at work and occupational diseases related benefits are the same as for sickness in most Member States (see Table 3), which can pose a problem to those self-employed with shorter contribution records, in countries where their reference income is based on long time frames (e.g. Bulgaria with an 18 months of reference income requirement, Slovakia with a 24 month one, or France with 36 months). The income basis is adjusted to increase benefit adequacy for accidents at work and occupational diseases for the self-employed only in Germany (from 3 months to 1 month of income).

Schemes in countries with partial insurance have the following characteristics: a) in Greece craftsmen, who are traditionally self-employed, are covered by the scheme because they belong to the list of hazardous occupations. They qualify after one day of coverage, in the same way as employees, and can receive a flat monthly allowance for 4 months. b) in France, insurance is compulsory for farmers, while other self-employed can only receive in kind benefits (no cash insurance).

In the 11 Member States where there is no insurance scheme for the self-employed, work-related injuries or illnesses are generally recognised for employees while the self-employed rely on invalidity/disability insurance. In Denmark, Estonia and Finland, invalidity is a residence-based benefit rather than an employment based one. In Ireland, disability insurance was only extended to the self-employed in 2017, but with much more stringent conditions for accessing the invalidity pension. It is therefore difficult to assess the adequacy of health-related coverage of the self-employed, but also of other working persons, without getting into the gist of how sickness, accidents at work and invalidity schemes interact. Future research should thus explore the relationship between accidents at work and occupational diseases related benefits to disability and invalidity pensions and other forms of insurance and compensation.

At the same time, **it is also important to keep in mind that invalidity insurance is not a functional equivalent of accidents at work and occupational diseases insurance**. This is because invalidity insurance also exists in countries which offer accidents at work and occupational diseases coverage to their self-employed. As explained previously, accidents at work and occupational diseases insurance should act as an extension (top-up) for those illnesses and injuries that are work related, so its primary function is not coverage for sickness or invalidity, but additional compensation for those who experience it due to work. This principle, however, is not adhered to in most Member States, since the self-employed are traditionally considered as solely responsible for their own working conditions.

To address some of these concerns related to protection from hazards related to self-employment, Belgium has a special *droit passerelle (‘bridging right’)* benefits for the self-employed which, under some conditions, could be related to accidents at work and occupational diseases. There are five legally prescribed situations of forced interruption of business beyond control of the self-employed that can be covered by *droit passerelle*. Yet, this scheme is effectively closer to insurance against loss of business than accidents at work and occupational diseases.[34]

Moreover, we have to keep in mind the sometimes-conflicting goals of allowing the self-employed to make ends meet in contexts where labour costs are a key determinant of their competitiveness, or where the self-employed earn less than wage employees and where overburdening them reduces their disposable income to a significant extent, with the goal of ensuring that their quality of work and social protection are satisfactory. For example, Romania, characterised by a large share of persons working in the informal economy, recently opted to reduce the contributions burden for the self-employed and remove some of the schemes such as accidents at work in order to reduce their labour costs and incentivise them to formalise their activities (Pop, 2019). Moreover, the self-employed in Belgium have shown unwillingness to pay additional contributions for any ‘new’ coverage. Therefore, we should not always assume that there is demand for insurance against occupational accidents and diseases, especially among the self-employed.

On the other hand, new social risks, such as the ones experienced with the coronavirus pandemic have illustrated very well that even the self-employed can be exposed to

[34] In its national plan to implement the 2019 Council recommendation, Belgium announced its intention to improve formal coverage for specific categories (artists, platform workers, informal carers, evaluate and adapt *droit passerelle* that provide income support to the self-employed).

occupational hazards that are beyond their immediate control, and that their better coverage by social insurance against such occurrences might be a question of policy fairness.

5 Main takeaways and recommendations

The findings presented in the report offer insights on how countries are approaching challenges related to ensuring access to and adequacy of healthcare, sickness benefits, and benefits for accidents at work and occupational diseases.

Healthcare access in Member States is considerably and increasingly more likely to be universally available and linked to residency rather than employment status compared to the other two branches of social protection covered in the paper. In countries without formal residence-based healthcare, compulsory contributions still grant access, while unemployment or receipt of social assistance may also qualify individuals. When it comes to affordability, most Member States have either no co-payments or small flat rate ones for access to medical services and hospitalisation for insured individuals. Additional income-related exemptions and reductions on these small payments can be found for example in Belgium, Germany, Ireland, Italy and Portugal, while there are also caps to total annual expenditures in many Member States.

While formal coverage by healthcare is generally suitable across EU-27, the report raises concerns regarding practical access to healthcare insurance during transitions between different employment statuses or from employment to non-employment. Switching between administrative statuses can result in temporary loss of coverage, especially in systems financed by contributions. The report underscores proactive strategies by Member States that focus on developing transparent and simplified procedures to facilitate compliance with healthcare insurance related regulations for those in non-standard employment, leading both to larger collection of social security contributions and to a larger number of insured individuals. Development of effective digital tools of e-governance can increase the prevalence of such strategies across EU-27. The case of France is highlighted in Box 1, while other relevant practices from Slovenia, Bulgaria, Germany and Greece are also presented. These cases are contrasted to the more passive approaches that ‘simply’ exclude non-compliant individuals from healthcare access. They show the potential of developing more flexible and proactive social protection systems that can adapt to the dynamic world of work.

Supplementary health insurance is also highlighted as crucial for employees to mitigate co-payments and cover services not included in basic packages, addressing concerns such as waiting times and shortages of medical staff. The report suggests that individuals in non-standard work and self-employment, who mostly lack employer-sponsored supplementary coverage, may face lower-quality healthcare and unmet needs. The report also emphasises the potential benefits of encouraging non-standard workers and the self-employed to join voluntary supplementary insurance schemes, which can top-up their basic benefits.

When it comes to **sickness benefits**, the report highlights a substantial switch in policy discourse away from moral hazard issues related to work absenteeism without genuine illness which characterised the 2000s, and towards an improved understanding of the risks of insufficient sickness benefit coverage or low replacement rates, which may prompt individuals to work while sick, leading to "contagious presenteeism". The report also underscores the financial advantages for both employers and the state in providing paid sick leave, as it reduces staff turnover, enhances productivity, and mitigates costs associated with work-related accidents.

Despite the growing awareness that extending sickness benefits coverage to all working persons can be beneficial for the economy, substantial challenges remain when it comes to offering such insurance to non-standard workers and the self-employed. The report outlines

the challenges faced by certain groups of non-standard employees, some of which include stringent qualifying conditions. There are also "hidden" adequacy-related barriers in some countries, referring to the calculation of benefit amounts based on longer time periods of contributions than those that are required for formal access. Austria, Finland, Denmark, Italy, and Luxembourg, on the other hand, are highlighted as examples where rules are more inclusive for non-standard workers. The self-employed encounter even greater obstacles, including limited formal access, low voluntary insurance uptake, and challenges in effective coverage due to long qualifying period requirements or lengthy reference wage calculation periods in some Member States. However, positive instances of higher voluntary uptake are noted in Spain, Bulgaria, and Slovakia, while other countries overcome some of the challenges through benefit floors or flat rate benefits.

Several Member States with mandatory sickness coverage for the self-employed incorporate voluntary components into their compulsory schemes, providing flexibility in distinguishing between short-term and long-term illnesses. Examples from Luxembourg, Austria, Denmark, and Sweden illustrate that coverage for more serious, longer-duration illnesses is automatically included, while self-employed individuals can choose whether to insure for short-term sickness. The waiting periods for sickness benefits vary across countries, with Luxembourg having a default waiting period of three months, Sweden offering flexibility between 1 and 90 days, and Austria allowing self-employed individuals to choose additional coverage for shorter spells of illness. These flexible benefit designs could offer alternative solutions for providing greater flexibility to the self-employed without relying solely on voluntary opt-in, therefore serving as potentially inspiring practices for countries with voluntary schemes which are considering a shift to mandatory coverage.

While all Member States (except Netherlands) offer **benefits related to accidents at work and occupational diseases** to employees, coverage of the self-employed by such schemes is a lot sparser across the EU. In the Member States where the scheme exists, there are generally no conditions for qualification, which makes it easier to access than sickness benefits. The compensation for work-related illnesses or injuries is also typically more generous (than for sickness benefits), often at 100% of the reference wage. However, the reference wage for the calculation of these benefits is often based on the same or even longer period of contributions than for sickness, potentially offering inadequate compensation for working persons with shorter contribution records. More inclusive rules for accidents at work and occupational diseases than for sickness benefits can be found in Germany, France and Hungary which use the salary from the past month as reference income for employees, while they have longer reference periods for sickness benefits.

The report also highlights that most Member States treat work related injuries and diseases as events that merit higher compensation than such non-work-related events, especially for employees. The situation is more complicated when it comes to the self-employed, since conflicting goals can arise in balancing self-employed individuals' competitiveness with social protection needs, as seen in Romania's removal of some schemes, including the accidents at work one, to reduce labour costs and thus encourage formalisation of self-employment. The report thus emphasises that the assumption of demand for insurance against occupational hazards among the self-employed may not always hold, as also illustrated by Belgium's self-employed population's reluctance to pay additional contributions. Nevertheless, the COVID-19 pandemic has underscored that even the self-employed can be exposed to occupational hazards beyond their immediate control. Therefore, arguing that, due to the absence of an employer, the self-employed are solely responsible for all occupational hazards they may experience, may even infringe on their fundamental rights.

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