Mutual learning workshop on access to social protection for workers and self-employed: focus on health, sickness, accidents at work and occupational diseases

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Summary report

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Contact: Laurent Aujean

E-mail: empl-d2-unit@ec.europa.eu

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B-1049 Brussels

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1 Introduction

This report presents key findings from the Mutual learning workshop on access to social protection for workers and the self-employed: focus on health, sickness, accidents at work and occupational diseases held in Brussels on February 5-6, 2024. The workshop is part of a series of mutual learning events to support Member States, allow them to exchange information and contribute to the implementation of the Council Recommendation on access to social protection for workers and the self-employed.[1]

The purpose of the workshop was to facilitate mutual learning on access to social protection with a focus on three of the six branches covered by the Council Recommendation namely, healthcare benefits, sickness benefits as well as benefits with respect to accidents at work and occupational diseases. It provided participants the opportunity to discuss and exchange experiences on different aspects related to the focus areas such as (gaps in) access to social protection for employees and self-employed, ensuring adequacy of sickness benefits and benefits related to accidents at work and occupational diseases, and opportunities and risks related to voluntary and supplementary insurance schemes. A special focus was put on coverage for self-employed and non-standard workers who tend to face greater difficulty in accessing social protection – and are target groups in the Council Recommendation.

Examples of measures implemented in the Member States to improve access and adequacy of social protection were presented by the Thematic Expert, as well as by Austria, Cyprus, France, Germany, Ireland, Luxembourg, and Poland. The workshop was attended by representatives of 16 Member States (Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Slovakia, Spain and Sweden), academic experts, and representatives from the European Association of Paritarian Institutions (AEIP), the European Social Insurance Platform (ESIP), the International Social Security Association (ISSA), the World Health Organization (WHO), Force Ouvrière (FO), ACV-CSC United Freelancers, SOKA-BAU, Confederation of German Employers' Associations, SMEUnited, BusinessEurope, Eurofound, as well as representatives of the European Commission.

2 Policy context

Access to social protection is an important policy priority at European level and for the Member States. Social protection systems play a key role in enhancing income security and promoting social cohesion and economic stability. At the same time, the European Union (EU) is facing a series of long-standing and emerging challenges with major implications on the adequacy and sustainability of its social protection systems. The EU is witnessing an ageing of its population which challenges the sustainability of its social protection systems, as a higher proportion of citizens retires, combined with a shrinking workforce. There are also structural changes in the labour market such as the rise in new forms of employment with flexible labour or contractual arrangements. In 2022, almost 40% of the population in employment in the EU were in non-standard forms of work (temporary contracts, part-time work and/or self-employed).[2] These megatrends pose challenges as these categories are often less covered by social protection than standard employees. Notably, the dynamics of sharing responsibility for social protection between employers and employees has changed,

[1] Council of the European Union, 2019. *Council Recommendation on access to social protection for workers and the self-employed*. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32019H1115(01)

[2] Eurostat, EU-LFS. See more details in European Commission, 2023. Report on the implementation of the recommendation on access to social protection. Available at: https://ec.europa.eu/social/main.jsp?langId=en&catId=89&furtherNews=yes&newsId=10502

especially for digital platform workers and, consequently, they face higher economic uncertainty. These trends create new demands for social protection measures.

In November 2019, the Council adopted the Recommendation on access to social protection for workers and the self-employed[3] (hereafter the Council Recommendation) for six social protection branches including healthcare, sickness benefits and accidents at work and occupational diseases. Through the Council Recommendation Member States committed to provide access to all workers, including non-standard workers, and self-employed to social security schemes, to take measures to allow them to build up and take up adequate social benefits as members of a scheme and facilitate the transfer of social security benefits between schemes; as well as to increase transparency regarding social security systems and rights.

The Council Recommendation is structured around four pillars:

- **Formal coverage**: improve participation to social protection schemes for all including specific categories lacking access such as self-employed people or those in non-standard forms of contracts;
- **Effective coverage**: ensure that people participating in social protection schemes effectively receive benefits when facing a risk, by adapting the rules governing contributions and entitlements, while preserving the sustainability of the system and implementing safeguards to avoid abuse;
- **Adequacy**: provide individuals facing income loss with a sufficient and timely income replacement, maintaining their standard of living and protecting them from poverty;
- **Transparency**: ensure access to information and simplification of access to social protection schemes and administrative requirements, with a view to reducing the administrative burden.

Member States had 18 months (between November 2019 and May 2021) to prepare and submit plans setting out the corresponding measures to be taken at national level to address the issues identified by the Council Recommendation. The European Commission reviewed those national plans and more generally the implementation of the Council Recommendation in a report[4] to the Council in early 2023. This report noted the progress made by Member States in closing the gaps but also pointed out the remaining challenges and the need to further support the implementation of the Council Recommendation. A key conclusion is that a large number of workers and self-employed still do not have sufficient access to social protection; moreover, implementation efforts are mixed and the level of ambition of the plans varies among countries.

The observed limited access to social protection results in inequalities in access to healthcare, sickness benefits, and schemes for accidents and occupational diseases based on the type and duration of employment. In 2021, the share of people absent from work due to sick leave was higher for employees (2.5%) than for the self-employed (1.2%)[5], while self-employed (11.1%) were slightly more likely than employees (10.4%) to report work-related health problems.

[3] Council of the European Union, 2019. *Council Recommendation on access to social protection for workers and the self-employed*. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32019H1115(01)

[4] European Commission, 2023. Report on the implementation of the recommendation on access to social protection. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52023DC0043&qid=1676473347749

[5] Eurostat, EU-LFS

As part of social protection, sickness and healthcare represented 30% of the total social benefits expenditures in the EU-27 in 2022[6]. It is widely recognised that access to healthcare and adequate benefits for sickness and accidents at work and occupational diseases help to maintain a healthy workforce, reduce absenteeism, reduce poverty and favours the conditions for a safe and healthy work environment and therefore enhance the overall economic productivity.

Yet, discrepancies can be seen between the formal and the effective access to social protection when it comes to healthcare, sickness benefits and accidents at work and occupational disease. There is a possibly large number of individuals in precarious working arrangements who are not mandatorily insured due to unstable income, while they may not qualify for social assistance. Affordability of coverage by social protection is also an important question, as some non-standard workers and the self-employed cannot pay a supplementary insurance on their own. Changes of employment status can also have an impact on the access to social protection, especially for persons in non-standard or unstable employment. Access to formal access to sickness benefits for some groups of non-standard employees is also challenging or conditions can be very strict, or with 'hidden' barriers.

The COVID-19 crisis also revealed gaps in access to adequate social protection. Member States implemented many measures to support groups that were not previously covered, including relaxing rules, extending the duration and/or increasing the amounts of benefits as well as providing specific support to the self-employed, persons working with precarious contracts and individuals working in certain sectors (e.g. culture, health, domestic workers). The pandemic showed that some risks factors are outside of the control of the self-employed, and that essential workers including those in the delivery sector faced more risks than other workers.

However, most measures implemented as a response to the COVID-19 pandemic and crisis were only temporary as confirmed by the 2021 ESPN Report on social protection and inclusion policy responses to the COVID-19 crisis[7]. While the post-pandemic context is appropriate to prioritise access to healthcare, sickness benefits and accidents at work and occupational diseases, in some cases, structural reforms were postponed.

The EU legal framework includes other key provisions regarding access to social protection and the rights related to the three branches. The EU Charter of Fundamental Rights, in its article 35 states the universal right to healthcare and, in its article 34, recognises the entitlement to social security benefits in the case of illness and industrial accidents. The European Pillar of Social Rights tackles social protection in many of its principles. In particular principle 10 ensures a healthy and safe work environment. Principle 12 states that workers should have social protection regardless of the type and duration of their employment and that self-employed should have the right to adequate social protection under comparable conditions. Lastly, principle 16 emphasises the right to timely access to affordable, preventive, and curative healthcare of good quality. The European Pillar of Social Rights Action Plan, which proposes concrete actions to achieve the principles will be reviewed in 2025 according to the results achieved, notably in terms of access to social protection.

[6] Eurostat, ESSPROS

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

The Council adopted in October 2023 under the Spanish Presidency the first set of conclusions on social protection focused exclusively on the self-employed.[8] These conclusions build on the Council recommendation and on the lessons learnt from its implementation. The conclusions call on the Commission and the Member States to take actions, where necessary, to tackle any remaining gaps in the four dimensions, and especially in branches with the largest gaps, including sickness benefits and accidents at work and occupational disease.

3 Access to healthcare benefits for workers and self-employed

Principle 16 of the European Pillar of Social Rights states that everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality. The economic impact of access to healthcare includes the maintenance of a healthy workforce; reduction of absenteeism in the workplace; and an enhancement of overall economic productivity.

Formal access to healthcare benefits for employees and self-employed

Most Member States offer widespread access to healthcare benefits. In 18 Member States (BG, CY, CZ, DE, DK, ES, FI, FR, IE, IT, LT, LV, MT, NL, PT, RO, SE, SK) healthcare access is linked to residency, which in principle means that all residents independent of their employment status can ensure themselves for healthcare. In the remaining Member States, all working individuals and registered unemployed have healthcare access. Furthermore, employees and self-employed tend to be insured in the same system.

While healthcare access tends to be broad in all Member States, a recent study[9] from the WHO showed that countries with entitlement to healthcare benefits based on contributions have lower coverage than countries with residency-based access (where individuals also need to pay a contribution, but independently from their employment status). However, residency-based systems are not necessarily universal as access can be linked to the duration of residency as it is the case in France, Ireland, and Malta. With respect to intra-EU mobile workers, it can be a challenge to determine by which countries system they are and should be covered.

Challenges and good practices regarding effective access and affordability

While most workers and self-employed enjoy formal healthcare access, there are some gaps with respect to non-standard workers and self-employed with fluctuating incomes. In addition, effective coverage can be limited by affordability as well as limited (public) financing and staff shortages.

Workers with non-standard employment and self-employment with fluctuating incomes

Challenges regarding coverage can result from moving between jobs and employment statuses. Non-standard workers, individuals in unstable employment as well as those working different jobs or combining work as employee and self-employed can be particularly at risk of losing coverage. For individuals experiencing frequent transitions, challenges

[8] Employment, Social Policy, Health and Consumer Affairs Council (Employment and social policy), 9 October 2023. Available at: https://www.consilium.europa.eu/en/meetings/epsco/2023/10/09/#:~:text=Ministers%20approved%20the%20first%2Dever,lessons%20learnt%20from%20its%20implementation.

[9] WHO (2023) Can people afford to pay for healthcare? Evidence on financial protection in 40 countries in Europe. Available at: https://iris.who.int/bitstream/handle/10665/374814/WHO-EURO-2023-8969-48741-72485-eng.pdf?sequence=5

include determining the applicable system to which contributions must be made as well as to keep track of their contribution history. In this respect, it is important that rules governing contributions are transparent. Digital tools can increasingly also help individuals to check their contribution history and, linked to that, status of their healthcare coverage. Furthermore, given the increasing spread of non-standard work including digital platform work, it is important – and an important challenge – that social protection legislation is updated in line with changes in the labour market. Updated rules must then be communicated, in a timely manner, to administrations and workers on the ground, to ensure that both apply them correctly.

For example, Slovenia attempts to improve the social rights of those performing student work by implementing the "every job counts" concept, in which pension, disability and health insurance is provided for student workers. This concept aims to recognise the contributions of workers which are not regular employees and motivate individuals to contribute towards their healthcare coverage.

Box 1: Universal health protection in France

Since 2016, France has a compulsory health insurance (*Protection Universelle Maladie, PUMa*) that provides universal access to healthcare. Coverage under the system is an individual right attached to the person. Eligible for access are individuals working in France (from the first hour of work) or having resided in France on a stable and ongoing basis for three months or longer.

Workers remain covered when they change their employment status which ensures continuous coverage. Their data are transferred automatically from the tax authority to the organisation in charge of collecting social contribution when their employment changes. Furthermore, all adults over 18 years old have an individual right to healthcare – rights are not derived from a spouse or parent.

PUMa is a public system which partially (70-80%) reimburses of the costs of medical services. A second pillar are of the French healthcare system are voluntary, supplementary health insurance schemes covering the remaining costs as well as coverage for additional health services. To pay for supplementary health insurance, France offers solidarity supplementary health assistance (*Complémentaire santé solidaire*), which is a means-tested, state financed assistance offered to people with low income. The benefit covers the full cost of supplementary insurance for individuals with an income of less than EUR 809 per month and couples earning less than EUR 1 215, as of April 1, 2023. Individuals earning less than EUR 1 093 and couples earning less than EUR 1 640 per month can receive the assistance but must make monthly payment of between EUR 8-30 per month, depending on their age.

Source: Ministry of Solidarities and Health, France

An alternative approach is to decouple healthcare access from employment status as it is the case in residency-based systems. A more extensive version of this approach has been implemented in France (box 1) where healthcare access is an individual right, which remains with individuals even when changing jobs or losing employment.

Furthermore, it is important that the non-payment of contributions does not result in the loss of coverage. A recent WHO study[10] showed that linking the payment of contributions to coverage increase incidents of "catastrophic" health spending, i.e. health expenditures that

[10] WHO (2023) Can people afford to pay for healthcare? Evidence on financial protection in 40 countries in Europe. Available at: https://iris.who.int/bitstream/handle/10665/374814/WHO-EURO-2023-8969-48741-72485-eng.pdf?sequence=5

result in financial hardship for those involved. Catastrophic health spending tends to affect individuals with precarious work and, thereby, undermines equity.

Affordability, co-payments, and supplementary health insurance

Access rights – the right to buy health insurance – alone are not sufficient to ensure effective coverage. 11 Member States require co-payments for medical services and health insurance often does not cover all medical expenses. The biggest out-of-pocket payments are made for medications, equipment like wheelchairs and dental care.

The share of individuals in the EU with unmet healthcare needs due to affordability, is very low at only 1% of the working population.[11] The main reason for unmet healthcare needs in EU countries are waiting lists.[12] However, mostly poorer households and especially households in the so-called "twilight zone" – that cannot afford co-payments, supplementary insurance or even contributions for the basic insurance, but whose income is too high to qualify for social assistance – are affected by affordability problems. Furthermore, there is a strong correlation between out-of-pocket payments and financial hardship due to medical expenses.[13] For self-employed, declining business and fluctuations in income, may create problems to pay social insurance contributions as well as to pay for healthcare themselves. In addition, some individuals cannot afford to take time off from work to access services.

Supplementary (private) health insurance can improve access to adequate services. Specifically, they can reduce waiting times and provide additional and private services. However, supplementary health coverage can create equality and equity problems as those who can afford it receive better healthcare. With respect to self-employed, it is difficult to calculate a fair contribution level if their income fluctuates. In some countries, supplementary insurance is sometimes subsidised by professional associations (e.g. public employers in FR, occupational healthcare funds in IT for the self-employed). Furthermore, some countries like France (Box 2) offer financial support for lower-income individuals to buy complementary insurance. However, as several workshop participants pointed out, there is an inherent tension between expanding complementary insurance – and adequate healthcare for that matter – and financing the system.

Information and trust

As alluded to above, information problems can hinder healthcare access when (non-standard) workers do not know where and how to pay their contributions. Similarly, limited knowledge of how to register for healthcare or distrust towards public institutions can act as barriers to coverage. While digital tools can make it easier for some to access social protection, for others like older people with fewer digital skills the use of such tools may act as barrier. One example how to overcome these barriers is a pilot project on universal healthcare based on outreach to the most vulnerable implemented in Luxembourg (Box 2).

Box 2: Universal health coverage in Luxembourg

In April 2022, Luxemburg launched a pilot project called Universal Health Coverage to provide healthcare to the most vulnerable, including the homeless, those who do not have the right to remain in the country, and those who have insufficient means but cannot receive support through social assistance.

[11] Eurofound (2020). Access to care services: Early childhood education and care, healthcare and long-term care, Luxembourg: Publications Office of the European Union.
[12] Eurofound (2020). Access to care services: Early childhood education and care, healthcare and long-term care, Luxembourg: Publications Office of the European Union.
[13] WHO (2023) Can people afford to pay for healthcare? Evidence on financial protection in 40 countries in Europe. Available at: https://iris.who.int/bitstream/handle/10665/374814/WHO-EURO-2023-8969-48741-72485-eng.pdf?sequence=5

To reach out to the target group, the Ministry of Health and Social Security cooperates with five local NGOs. Social workers working for the NGOs prepare healthcare access requests with beneficiaries, which means beneficiaries do not have to go to the social insurance office to make to apply for coverage. The requests are later validated by the ministry. The system is financed by the ministry, the NGOs act as link between the state and the target group. In addition to the initial outreach, the NGOs follow up regularly with beneficiaries. If beneficiaries' social insurance contributions are not directly paid for by the National Health Fund, they are paid by the NGOs (with financing from the ministry).

257 persons have benefited from the Universal Health Care Coverage from April 2022 until now. Currently, 165 individuals are covered. Coverage is extended to all family members (co-affiliation). The Coalition Agreement of the current government foresees that the measure will be made permanent.

Source: Ministry of Health and Social Security, Luxembourg

Financial sustainability and the quality of care

Finally, several participants raise concerns about the financial sustainability of healthcare systems and shortages of skilled (medical) staff. With respect to ensuring financing, one option is to develop new funding streams. For example, France introduced several levies, including on capital gains and income from lotteries and gambling, to diversify the financing of healthcare away from employee and employer contributions. This resulted in a reduction of the share of healthcare expenditure financed by social contributions from 70.8% in 1990 to 56.7% in 2022. In addition, several workshop participants emphasised the value of preventive care in the reducing overall healthcare costs in the longer term.

4 Access to sickness benefits for workers and self-employed

Sickness benefits provide individuals with an income while they are unable to work due to illness. While healthcare benefits are accessible to most employees and self-employed in most EU Member States, there are significant gaps in coverage of sickness benefits, especially with respect to non-standard workers and self-employed.[14]

Traditionally, paying individuals to not work while sick was thought to create a moral hazard problem and incentivise malingering. However, recent research and experiences during the COVID-19 pandemic have contributed to a rethinking of the value of such schemes. Sickness benefits stabilise incomes during healthcare crises and reduce pressure on workers to go to work while sick. As such, they can help prevent the spread of contagious diseases and prevent workers from developing chronic illnesses. On the contrary, limited sickness benefit coverage can result in "contagious presenteeism at work".[15]

Access to and adequacy of sickness benefits for workers

Employees in all EU 27 Member States have formal access to sickness benefits and benefits are usually paid from the first day of sickness (no waiting period). However, effective coverage can be limited through 'hidden' adequacy related barriers. About half of all Member States require several months of contributions until employees become eligible

[14] Avlijaš, S. (2023). Thematic discussion paper – Mutual learning workshop on social protection for workers and self-employed: focus on health, sickness, accidents at work and occupational diseases. Available at: https://ec.europa.eu/social/BlobServlet?docId=27349&langId=en

[15] Avlijaš, S. (2023). Thematic discussion paper – Mutual learning workshop on social protection for workers and self-employed: focus on health, sickness, accidents at work and occupational diseases. Available at: https://ec.europa.eu/social/BlobServlet?docId=27349&langId=en

for benefits. In addition to long qualifying periods, the reference wage for level of the benefit is crucial. In 15 Member States, the benefit is calculated based on the wage earned over the last six months or longer. As a result, the level of sickness benefits for employees who have not worked uninterrupted during the reference period tend to be inadequate.

Some types of non-standard workers lack formal coverage in nine Member States (CZ, DK, EL, HU, LV, PL, PT, SL). Non-standard workers with interrupted contribution histories such as seasonal workers are also likely to suffer from the hidden barriers described above. Shortening qualifying periods and waiting periods can improve coverage for non-standard workers and shortening the reference period for the benefit calculation can increase the adequacy of the benefit. For example, Ireland introduced a statutory sick pay scheme to be paid by employers to complement its existing social insurance-based system (see Box 3). The new benefit has a shorter qualifying period, is paid from day one and has a shorter reference period which should benefit non-standard workers.

However, workshop participants stressed that there are different rules across Member States and that there is no 'one-size fits all' approach to improving coverage for non-standard workers. Furthermore, several workshop participants raised the topic of financial sustainability and stressed the importance of a broad contribution base to pay for the benefits. Specifically, one should reconsider cases whereby higher-income groups like doctors and lawyers are exempted from financing the benefit, as it is the case in Austria. Similarly, exemptions for social insurance contributions, like they exist for employers of some low-wage workers in France, can stimulate employment but may negatively affect the financing of sickness benefits.

Box 3: Extension of sickness benefits to low-paid employees in Ireland

Ireland has a sick pay scheme called Illness Benefit for insured individuals. Eligibility is linked to the payment of Pay Related Social Insurance (PSRI) and a medial assessment. Furthermore, benefit recipients must follow their doctor's instructions, not behave in ways impeding their recovery and answer reasonable enquiries by the Department of Social Protection.

Low-paid employees could benefit from the scheme if they met the eligibility criteria. The Sick Leave Act of 2022 introduced statutory sick leave and extended coverage for this group. The scheme is currently being phased in. In 2023, workers received 3 statutory sick leave days per year, rising to 5 days as of January 2024. This will increase to 7 days in 2025 and 10 days in 2026 annually. Sick pay may be paid by an employer for 70% of a person's regular pay – the average pay over the preceding 13 weeks – but not more than €110 per day.

Employers have the option to offer sick leave schemes with more favourable terms – for example pay a higher amount or offer a longer period for which sick leave is payable – than the statutory sick leave. In this case, the more favourable scheme replaces the statutory scheme. Employees cannot receive payments from both.

The Illness Benefit entails a three-day waiting period, unlike statutory sick leave which is paid from day one. The days when sick leave is paid count as waiting days for the Illness Benefit. However, the Illness Benefit is only disbursed to qualified employees after exhausting statutory sick pay days. One aim of the reform is that extending the payment of sick pay to up to 10 days by 2026 will lead to a corresponding reduction in the payment of Illness Benefits.

Source: Department of Social Protection, Ireland

Access to and adequacy of sickness benefits for self-employed

21 Member States have compulsory sickness benefit schemes for self-employed, another five have voluntary schemes. However, qualifying periods for self-employed are longer than for employees in most Member States and, even more so than for employees, access to adequate benefits for self-employed with low earnings and short contribution records is impeded by long reference wage periods. In addition, the take-up rates for voluntary schemes vary strongly between countries.

Flat-rate benefits, as they exist in Austria (see Box 4), or benefit floors can improve benefit adequacy for self-employed with low incomes or short contributions histories. Alternatively, in countries like Luxembourg, Finland, and Sweden, benefits for self-employed individuals with inadequate contribution periods are determined by estimating their hypothetical income based on factors such as job type, education, and experience, akin to what an equivalent employee would earn. However, there should be some link between benefit levels and contributions to ensure that higher-income individuals can benefit proportionately as well. To this end, variable top-ups and graduate flat rates exist in Italy and Greece.

Purely voluntary sickness insurance schemes were considered unsatisfactory by most participants because low take up rates likely lead to coverage gaps and underinsurance among those who need it, while relieving higher income groups from the duty to contribute to a common scheme.

However, workshop participants showed strong interest for combining mandatory sickness benefit schemes to provide a minimum level of protection with voluntary schemes – either additional schemes or voluntary components of the mandatory system – to provide additional support for those who want or need it. Flexibility within such schemes can ensure that they fit the needs of different target groups. One recommendation was to organise voluntary schemes by occupational groups with the same risk profile. For example, Austria introduced a mandatory sickness benefit to protect self-employed and individuals running small businesses against long durations of incapacity for work (see Box 4). This mandatory scheme complements a voluntary sickness benefit system which has seen low take up. Malta has only a compulsory system but is open to the introduction of additional voluntary schemes, especially for higher risk groups like fishermen. Such a scheme could be organised by occupational organisations. In Sweden, self-employed can pay a premium to shorten the waiting period for sickness benefits from 7 days to 1 day.

To increase take-up, participants emphasised the importance of increasing the awareness of and trust in voluntary insurance schemes. Transparent rules and public information campaigns can be effective tools to communicate the risks and the benefits of (not) buying insurance. Specifically, self-employed should be informed that not declaring or under-declaring income will reduce the level of the sickness benefit they are entitled to. With respect to making it compulsory, different views exist. On the one hand, (solo) self-employed show little interest in paying additional contributions, as evidenced also by the low take up rate of voluntary sickness insurance schemes in several countries. Imposing additional costs on self-employed could also increase undeclared practices which would reduce coverage and, hence, be counterproductive. On the other hand, for reasons of fairness and financial sustainability, all employees and self-employed may be required to contribute to a basic sick pay scheme. Moreover, in voluntary schemes social insurance contributions could fall victim to cost competition between entrepreneurs and employees. Mandatory insurance schemes for all employees and self-employed would prevent this unhealthy from of competition and “race to the bottom” regarding social standards.

Box 4: Increase of sickness benefits for self-employed in Austria

Austria has a voluntary sickness benefit system for self-employed. Under this scheme, self-employed pay an additional monthly social insurance contribution of 2.5% of the contribution base, but at least 30.77€. The benefit amounts to 60% of the contribution

base and is paid for 26 weeks. However, there is a six-month waiting period and take-up is very low.

In 2013, a new **mandatory scheme** was introduced to protect self-employed running small or solo businesses against long durations or incapacity for work. The system covers self-employed persons whose business depends on their personal work performance and who regularly employ no or fewer than 25 employees. The benefit amount is fixed (2024: 37.28€/day) and paid after six weeks of incapacity for work for a duration of 20 weeks. Since mid-2018, the amount for the first six weeks is paid retroactively from week seven. This retroactive payment was introduced temporarily until 2027.

An evaluation comparing 2017 (before the introduction of retroactive payments) and 2019 showed a significant increase in costs (+60%) and recipients (about +24%). The evaluation showed that the scheme, as intended, benefits mostly solo-self-employed (62% of beneficiaries) and entrepreneurs with 1-5 employees (29% of beneficiaries), across various industries. In addition, there is evidence for a small increase in the number of individuals returning to their professional activity after incapacity, and a small decrease in the number of benefit recipients transitioning to invalidity pension. However, it also showed that beneficiaries aim to reach 43 days (6 weeks + 1 day) of incapacity for work to attain the retroactive payment.

Source: Federal Ministry for Social Affairs, Health, Care and Consumer Protection, Austria

Partial sickness benefits

There seems to be an increasing interest – at least in parts driven by long COVID and increasing opportunities for remote work – for “partial sickness benefits”. They allow individuals who had their work capacity reduced through illness to return to work in a more limited role while continuing to receive a benefit to compensate for their reduced income. Partial sickness benefits can support rehabilitation and the return to full-time work but could also provide support during retraining for a different profession. As such, they can fill a gap between sickness benefits and disability related benefits, like disability pensions.

9 out of 18 EU Member States offer opportunities to combine work with partial sickness benefits. For example, Finland offers a partial sickness allowance to employees and self-employed who reduce their working time due to illness to between 40-60% for normal full-time hours. The partial sickness benefit can be claimed from nine days after the employee first fell sick and for up to a total of 150 working days.

To successfully reintegrate workers into their job, workshop participants stressed the importance of flexible rules and work arrangements to offer work opportunities in line with worker’s reduced capacities. In addition, several workshop participants stressed the importance of cooperation by employers. In the Netherlands, employers are obliged to support the reintegration of employees after sick leave. Other proposals to encourage employers to offer work opportunities for the partially incapacitated include subsidies and negotiated solutions based on social dialogue.

With respect to self-employed, some workshop participants voiced caution that small businesses may not survive an extended period of the owner only working with reduced capacity, or never returning to work full time. Against this background, it can be advantageous to introduce safeguards to ensure that partial sickness benefits are not used to subsidize and artificially keep alive an unprofitable business.

5 Access to benefits in case of accidents at work and occupational diseases for workers and self-employed

In this section, access to schemes for accidents at work and occupational diseases for workers and the self-employed are discussed. It is important to note, that there is a legal distinction between sickness benefits and work-related injury and illness benefits in most EU Member States. Sickness benefits provide income in case of illness-related inability to work. Work-related injury and illness benefits are usually more generous and provide income when the cause of injury or illness is work related. Since the pandemic there has been a renewal of interest in social insurance for occupational diseases.

Access to schemes for accidents at work and occupational diseases for employees

Benefits to compensate for accidents at work and occupational diseases are available to all employees in all Member States, except the Netherlands. Traditionally, accident and occupational disease schemes for workers should create financial incentives for employers to create safe working conditions. Some Member States explicitly recognise the need for additional compensation and entitlements for traumatic work-related events (e.g., AT, DK, IT, LU, SE) and encourage employers to identify and mitigate work-related hazards and provide a safer work environment. In the Netherlands, in contrast, insurance against injury and disability is viewed as a social risk regardless of whether it is of work-related origin or not. Thus, individuals can receive benefits if they experience injury at work, but also if they are injured in a different context. The prevention of dangerous working conditions in this context should be achieved through labour law.

Access to this benefit is substantially easier than sickness benefits since there is no qualifying period for access. And it is also quite adequate since it is typically more generous than sickness benefit. In most EU countries, the reference wage is calculated in the same way as for sickness benefits, except for Germany, France and Hungary that have shorter periods for the calculation of the reference wage than they do for sickness benefits. However, coverage gaps exist for some categories of non-standard workers in Latvia, Poland, Portugal and Romania.

Access to schemes for accidents at work and occupational diseases for self-employed

Access to schemes for accidents at work and occupational diseases for the self-employed varies among Member States. The scheme is compulsory in eleven Member States, namely AT, HR, HU, IT (no scheme for liberal professions and some tradespeople), LU, MT, PL, PT, SI, ES (voluntary for farmers), and SE. Other Member States have voluntary schemes: DK, FI, and DE, although it is compulsory for farmers in FI and DE, and in AT and LU the voluntary scheme is available to low-income categories. Two Member States have partial schemes, namely in Greece it is accessible only to craftsmen and in France, except for farmers for whom the scheme is compulsory. In these 14 Member States where the scheme exists, the self-employed have access to cash benefits under less stringent conditions than in the case of sickness and compensation is typically higher than in the case of non-work-related injury or illness.

Despite the various schemes available, the challenges of the self-employed persist. The data for the whole EU-27 are missing, but in nine reporting Member States, 4.4 million self-employed lack access to accident/occupational disease benefits completely[16]. Even in the countries where there is access, the principles of access are more complicated for the self-

[16] See COM-SPC 2023 Update of the monitoring framework, available here.

employed, who are traditionally considered responsible for their own working-conditions. In addition, due to the COVID-19 pandemic, it has become clear that they are exposed to hazards beyond their immediate control, and therefore in need of coverage that considers such occupational risks. The pandemic also drew the attention to preventative paid leave for the self-employed with chronical diseases that could be exposed to such hazards while performing essential jobs, such as services.

Several Member States have extended or are planning to extend coverage to the self-employed including Cyprus (Box 6) and Poland (Box 7).

Box 6: New draft-bill on the extension of coverage for accidents at work and occupational diseases to the self-employed in Cyprus

The Social Insurance Scheme of Cyprus is based on three principles: solidarity, universal coverage for all workers, and contribution to the Social Insurance Fund based on workers' level of earnings. **Currently**, the self-employed contribute at 22.1% of insurable earnings which is slightly less than the 23.1% by the employees. They are entitled to all benefits except coverage for employment accidents/occupational diseases benefits, parental leave benefits and unemployment benefit. They are, however, covered for sickness benefit and invalidity pension when they are incapacitated to work.

The provisions of the **new draft-bill** submitted to the national Parliament stipulate that the self-employed will be entitled to employment accidents/occupational diseases benefits and parental leave benefits. The employment accidents/occupational diseases benefits will include:

- Employment injury benefit for up to 12 months if there is incapacity to work.
- Disability benefits
    - In the form of a grant when the percentage of damage caused by the injury is below 20%, and
    - As a pension when the percentage of damage caused by the injury is 20% and above.
- Death benefit in the form of a pension for the spouse or dependent children of the deceased worker.

The definition of an occupational accident in the draft bill is that of an accident occurring due to employment and during its course. Coverage in the new draft-bill also includes when the self-employed are in transit to or from a client's location where they will or have already provided services, as well as in transit from one client to another. The qualifying coverage criteria include:

- The accident must have occurred during the exercise of the specific occupation for which the self-employed individual is insured.
- The accident must have been reported to the Department of Labor Inspection of the Ministry of Labor and Social Insurance.
- The self-employed must have been insured on the day of the accident.
- The self-employed must have worked for the immediately preceding 13 weeks before the day of the accident.
- The self-employed must have paid the contributions due in the 2 preceding periods to the accident (2 quarters).

Source: Social Insurance Services, Ministry of Labour and Social Security, Cyprus

The Polish reform is interesting since access to benefits for accidents at work and occupational diseases is provided to some, but not all self-employed while achieving a very high coverage rate. Among the two types of civil law contracts, which are the legal contractual arrangements available to the self-employed and other non-standard workers in Poland, access to benefits for accidents at work and occupational diseases is extended to the contracts of mandate, but not to contracts for specific work. The distinction lies in the amount of work: specific work contracts are used for small jobs that provide supplementary income and therefore are considered legally non-contributory, whereas the contracts of mandate are the main means of income since their performance is extended in tasks and period, therefore contributory. Although the number of persons performing specific work contracts in Poland in 2022 was 342,600; only 0.41% (1417 persons) were not subject to social insurance for any other reason, which means that in the current system only a small share of non-standard workers remains uncovered by any social insurance schemes (for more details in the Polish system see Box 6).

Box 7: The extension of benefits in respect of accidents at work and occupational diseases to people working under civil-law contracts in Poland.

Non-standard employment in Poland is regulated through civil law contracts that fall under two main categories: contracts of mandate and contracts for specific work. The subject of contracts of mandate is the obligation to perform specific activities repetitively regardless of the result of these activities, whereas the subject of contracts for specific work is the obligation to perform a specific work or task understood as the achievement of a specific individualised result in a tangible or intangible form.

Contracts of mandate (*Umoja zlecenie*) include managerial contracts, agency agreements, mandate contracts and contracts for the provision of services, as well as ‘activating’ agreements for nannies. These contracts fall under the compulsory insurance scheme regarding health insurance, old-age pension, disability pension. Whereas sickness insurance is voluntary.

The extension of compulsory insurance for accidents for contracts of mandate has several benefits. Firstly, there is no waiting period and the right to accident benefits is activated from the first day of insurance. Sickness allowances related to incapacity for work due to an accident at work or occupational disease are covered 100%, granted regardless of the period of being covered by this insurance and from the first day of incapacity. Rehabilitation benefit is also payable at 100%, but it is granted to those covered by sickness insurance who have already used up the entire sickness allowance and are still incapable of work due to an accident at work or occupational disease. In addition, there are also lump-sum compensations for permanent or long-term bodily injuries due to an accident at work or occupational disease. The lump sum is calculated at PLN 1133 for each percent of the injury.

Accidents pensions are granted irrespective of the duration of the accident insurance period and irrespective of the date of occurrence. They are calculated as the amount of the disability pension, but cannot be lower than 60% of the pension assessment basis for a person with a partial incapacity, 80% of the pension assessment basis for a person fully incapable of work, and 100% for a person eligible for the training pension. The training pension is paid at 100% and is granted to a person who fulfils the conditions required for the award of the disability pension, if a certifying doctor or medical board of the Social Insurance Institution (ZUS) have stated that the person needs to retrain because they are incapable of work in the current profession due to the injury suffered through an accident at work or occupational disease. The training pension can be paid up to 30 months, although it is usually granted for six months.

Contracts for specific work (*Umoja o dzieło*) are non-contributory because they are not the main source of income but additional small-scale earnings. There is no compulsory social security insurance, only a voluntary old-age pension and disability pension insurance and persons performing such contracts cannot join a voluntary sickness insurance or the compulsory accident insurance.

Source: Department of Social Insurance, Ministry of Family, Labour and Social Policy, Poland

Apart from access, it is equally important to assess the adequacy of the existing schemes whether they are benefits for accidents at work or occupational disease or other schemes of invalidity/disability. Yet, the assessment of the adequacy of health-related coverage for the self-employed is difficult without understanding how the different schemes, such as sickness, accidents at work and invalidity interact with each-other within the same social security system.

The workshop participants noted several challenges regarding extending coverage for accidents at work and occupational diseases to the self-employed. For example, the definition of accident at work is an important one, especially regarding travel to and from the place of work for the self-employed or for platform workers, which has been further complicated by the increase in remote work since the pandemic and the work might be done in third places other than their home or workplace. In addition, proving that the accident did occur in the course of work is more difficult for certain categories of self-employed. Better monitoring practices should be complemented with measures to prevent fraud and abuse of the social security system.

Differences in procedure were also reported. In Malta, for example, there is no difference to the law except for the way the accident is reported: self-employed must report the accident to the police. Other accidents at work are reported to the police only when there has been criminal intent identified by labour authorities. While this procedure aims to deter abusive practices from the self-employed, it can also have the opposite effect since both the injured and the police are reluctant to engage in the process. Shifting the responsibility to the labour inspectorate might make it easier for self-employed to report accidents at work and for public authorities to monitor and inspect them.

The participants reported differences in access between employees and the self-employed. While the participants had different country experience with compulsory and voluntary schemes, they tended to agree that for the most vulnerable, such as the economically dependent solo self-employed a compulsory scheme should be enforced. At the same time, the tension between cost-competitiveness and comprehensive social protection insurance packages remains. The inclusion in additional schemes for accidents at work, especially compulsory ones, might not always be appealing to all self-employed. Research on Belgium presented in a mutual learning event in September 2020[17] indicated that the self-employed were reluctant to pay additional contributions. In other country contexts, such as Romania, the removal of some schemes, including the one on accidents at work, was used as a strategy to encourage the self-employed to formalise their employment by reducing their labour costs.

The participants also discussed the adequacy of the existing schemes clarifying how invalidity/disability schemes are combined with accidents/occupational disease benefits in various country contexts. One important point raised relates to the assessment of psycho-social risks and compensation for occupational diseases that are caused by these risks.

[17] Mutual learning workshops on access to social protection for non-standard workers and self-employed, September 2020, report available at: https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8357&furtherPubs=yes

Another point raised relates to sector-specific risks and adequate compensation in high-risk sectors. In this case, voluntary and complementary sector-specific schemes managed at the sectoral level were proposed. In addition, awareness campaigns on the importance of participating in voluntary schemes should be implemented, since workers might lean towards cost-saving approaches that might turn counterproductive in case of accidents at work or occupational diseases.

6 Main takeaways and recommendations

The following main takeaways and recommendations emerged from the workshop:

- **Healthcare** insurance should ideally **guarantee uninterrupted coverage for workers** transitioning frequently between jobs, working status, as well as between employment and unemployment or those with intermittent income. To this end, residence-based systems seem better equipped to guarantee access to healthcare benefits. Workers with intermittent employment and self-employed should be proactively supported in accessing healthcare benefits and paying contributions, including through technical and legal solutions. In this respect, the use of digital tools can be helpful. To avoid coverage gaps, it is crucial that the non-payment of contributions does not result automatically in a loss of coverage. Especially for individuals with intermittent income, financial and bureaucratic challenges can result in the (accidental) non-payment of contributions and the resulting loss of coverage increases the risk of “catastrophic” healthcare expenses.
- Ensuring the **financial sustainability** of healthcare insurance is an important concern in many Member States and there is an inherent tension between ensuring effective coverage for all on the one hand and affordability on the other. In several Member States, healthcare systems are also strained by staff shortages which result in longer waiting periods. Diversifying financing away from employer and employee contributions can be one approach to ensure financial sustainability. Furthermore, ensuring that no societal groups are exempted from financing a common system can support financial sustainability and increase fairness.
- With respect to **sickness benefits**, the combination of a compulsory insurance guaranteeing minimum benefits with voluntary schemes for self-employed who want extended coverage was seen as advantageous by many participants. Voluntary programmes can be organised for example by occupational groups so that the insurance fits the risk profile of individuals within the specific profession.
- There seems to be an increasing interest for **partially sickness benefits**. While in most systems individuals can either be healthy or sick, there is no reason why this dichotomous approach must be continued. New work modalities like remote work allow for more flexibility and partial sickness benefits can allow employees with partial incapacity (e.g., those suffering from long COVID) to return to work on a part-time basis.
- About half of all Member States offer no or only partial **accident at work and occupational diseases** related benefits to self-employed. And there is evidence in some countries that demand for such schemes among entrepreneurs is limited. However, those without coverage may ultimately fall in tax-funded social insurance schemes. Challenges to extending coverage to self-employed include defining what counts as work accident for self-employed, preventing fraud while ensuring low administrative burdens for self-employed and public officials, and reluctance among self-employed to pay (additional) contributions.
- **Mandating** (solo) self-employed to buy social protection **coverage is contentious**. On the one hand, opponents of mandates argue that there is little appetite among

solo self-employed to pay higher contributions. Furthermore, imposing additional costs on self-employed could increase undeclared practices which would further reduce their coverage. On the other hand, participation in voluntary schemes can fall victim to cost competition among entrepreneurs as well as between entrepreneurs and employees and, hence, a 'race to the bottom' regarding social protection coverage. Making insurance mandatory could prevent this unhealthy form of competition.

- The workshop highlighted the importance of **transparency** and the potential of digital tools – one of the four pillars of the Council Recommendation discussed in a previous workshop[18] and highlighted in a recent ESPN Report[19] – with respect to health, sickness benefits and insurance against accidents at work and occupational diseases. Transparency is important to inform workers and self-employed about the benefits of voluntary insurance schemes and the risks of not or underinsuring. In this way, increasing transparency and proactively informing workers and self-employed can be an alternative to mandating insurance coverage. Furthermore, transparency is important to facilitate the payment of contributions to ensure that workers and self-employed maintain coverage.

[18] Mutual learning workshop on access to social protection for workers and self-employed: focus on transparency. 16-17 October 2023. Summary report. Available at: https://ec.europa.eu/social/BlobServlet?docId=27248&langId=en

[19] Spasova, S., Atanasova A., Sabato, S. and Moja, F. (2023), Making access to social protection for workers and the self-employed more transparent through information and simplification: An analysis of policies in 35 countries, European Social Policy Network (ESPN), Luxembourg: Publications Office of the European Union. Available at: https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8530&furtherPubs=yes

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