SOCIAL SECURITY LAW IN TIMES OF COVID-19

HEALTH & VULNERABLE GROUPS

DAAD
Deutscher Akademischer Austauschdienst
German Academic Exchange Service

Hochschule Fulda
University of Applied Sciences

ARISTOTLE UNIVERSITY OF THESSALONIKI

Thanos Bourlos, Ad. L.L.M. (KU Leuven)

Kelly Anastasiadou, L.L.M. (AUTH)

PRESENTATION OUTLINE

- Introduction: Scope of the Presentation
- European Law/Policy Agenda & Health
- Entitlement & Coverage: Towards Universality(?)
- Organisation & Planning of Health Care Services
- Financing
- Healthcare Workforce
- COVID-19 as an Occupational Disease/Labour Accident
- Protection of Vulnerable Groups
- Amendments to Sickness Benefits
- Protection of Persons with Disabilities
- Conclusions

1. INTRODUCTION: SCOPE OF THE PRESENTATION

- **Disproportionately broad concept → Measures to address the pandemic combine various legal fields → Challenges to traditional social security law definitions**
- **Traditional approach: Benefits in cash for individuals who lost wages or face increased costs due to health problems (sickness/invalidity benefits) or benefits in kind for persons whose health condition requires medical attention (healthcare)**
- **<u>However</u>: '*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*' (WHO Constitution, 1946, Alma Ata, 1978), in light of increased risks posed by the pandemic**
- **→ Broader approach: incl. <u>preventive</u> measures and measures to cope w/ <u>family burden</u>**
- **Excluded: (a) Public health measures, (b) OSH measures, & (c) Long-term care**

2. EU LAW/POLICY AGENDA & HEALTH

- **State of the Art:**

A.1. Limited competence in social security: (a) Competence to ensure coordination of national social security systems (Article 21 and 48 TFEU), but (b) 'Deadlock' in the harmonisation of national systems → Limits in the adoption of legal measures, only measures that encourage cooperation (Article 153 TFEU)

A.2. Article 168 para. 1 TFEU (Public Health): '*A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, […], and monitoring, early warning of and combating serious cross-border threats to health*'

→ Supplementary competence to adopt measures to fight major cross-border health scourges (Article 168 para. 5)

→ Coordinates national policies to achieve the above objectives

2. EU LAW/POLICY AGENDA & HEALTH

B. Article 35 CFEU: '*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national law and practices [...]*'

→ Principle or right? Explanations to Charter: Principle → Interpretation instrument, no direct effect

C. European Pillar of Social Rights (Principle 16): '*Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality [...]*'.

→ Ambiguous legal nature: Soft – law, not legally binding, proclamatory nature.

D. Open Method of Coordination (OMC) & European Semester (CSRs): EU Member States should develop more cost-efficient and sustainable healthcare systems while maintaining universal access (quality and affordable services).

→ How is universal access understood?: No concrete minimum standards

→ Linkage with labour market: Focus on prevention/rehabilitation to ensure labour supply and productivity

2. EU LAW/POLICY AGENDA & HEALTH

- **Post-COVID-19 approach:**

A. European Semester (2020-2021): EU Member States should address the preparedness and resilience of national health and social protection systems → Equal access to affordable and high-quality healthcare that is fiscally sound.

→ **Use EU recovery and resilience plans/funds to implement healthcare reforms**

→ **Modernise and digitalise healthcare systems**

→ **Tax systems should contribute to healthcare (AGS 2020) → Increased solidarity**

B. Initiatives:

I. European Health Union → New roles for existing EU agencies (European Centre for Disease Prevention and Control and European Medicines Agency) and a new agency that will ensure, including through production, immediate additional goods/services in case of increased demand

II. Vaccination Strategy → EU Commission as a central negotiator of prices and for ensuring supply

3. ENTITLEMENT & COVERAGE: TOWARDS UNIVERSALITY?

- **Greece:**

A. State of the Art:

→ Art. 21 para. 3 of Constitution: '*The State shall care for the health of citizens and shall adopt measures for the protection of [...] disability [...]*' → Debate on the clause's personal scope

→ 'Mixed' model: (i) Beveridgean: National Health System (ESY) – Provision of health services, and (ii) Bismarckian: National Organization for the Provision of Health Services (EOPYY) – Central procurer of health services, negotiator of healthcare provision contracts and administrator of health insurance contributions

→ 2016: Step towards universality → including uninsured and vulnerable groups (incl. minors, pregnant women, people with disabilities, prisoners and non-legal third-country nationals and their family members, refugees, asylum seekers or persons residing in Greece for humanitarian reasons, even during periods of judicial dispute of status, etc.)

→ Non-legal residents from third-countries are provided urgent and necessary treatment

→ 'Law in Books versus Law in Action': Near universal (legal) coverage, yet 8.1% self-reported unmet need for medical care (Eurostat, 2019) → Poor performance and effectivity – Administrative obstacles

3. ENTITLEMENT & COVERAGE: TOWARDS UNIVERSALITY?

B. Post-COVID-19: No major changes in the personal scope of application

I. Entitltement:

IA. Consecutive extensions of dependent (family) members' entitlement to healthcare services ('health insurance capability') (current coverage until 28-02-2021), even if these entitlements had been forfeited or extended to self-employed persons' and farmers' entitlement to healthcare services, in case of contribution debts, and to other vulnerable groups (e.g. unemployed) until 28-02-2021 (L. 4764/ 2020)

IB. Easing of prior insurance conditions to unlock entitlements to sickness benefits in kind (L. 4722/2020)

IC. Extension of uninsured persons' (means-tested) entitlement to be excluded from co-payments for pharmaceuticals (1st phase of the pandemic) (L. 4690/2020)

ID. Elimination of co-payments for pharmaceuticals for low-income pensioners for 2021 (announced)

3. ENTITLEMENT & COVERAGE: TOWARDS UNIVERSALITY?

II. Access:

II.A. Provision of specific amounts, on a random basis, of rapid tests by the National Public Health Organization (EODY) (L. 4764/2020)

II.B. Setting an upper limit to the cost of PCR and rapid tests offered by private providers (Ministerial Decree 130022/07-12-2020) – Too late?

II.C. Creation of mobile healthcare units and nurse networks mandated to focus on preventive healthcare, especially in rural areas (L. 4715/2020)

II.D. Free delivery of pharmaceuticals to vulnerable groups and COVID-19 patients required to self-isolate at home (L. 4683/2020)

3. ENTITLEMENT & COVERAGE: TOWARDS UNIVERSALITY?

- **Examples from other EU Member States:**

I. Belgium: Contribution deferrals for indebted self-employed persons – Uninsured persons receive treatment at municipal level via social assistance – Measures facilitating care for undocumented migrants, as all care provided is deemed urgent (temporal)

II. Denmark: No out-of-pocket payments for COVID-19 care – Unclear situation for undocumented migrants (= Finland and Sweden → Payments for undocumented migrants)

III. France: Easing of conditions for migrants receiving care from State Medical Aid – Coverage of tele-consultation costs for vulnerable groups – Coverage by the National Health Insurance of the majority of COVID-19 treatment costs, including hospital fees

IV. Germany: Costs of intensive care of European patients, who cannot be treated at home due to insufficient capacity, are covered

V. Portugal: Entitlement to healthcare for migrants/asylum seekers who applied for residence by March 2020

4. ORGANISATION & PLANNING OF HEALTHCARE SERVICES

A. Greece

- **Efforts to strengthen primary healthcare contributions to manage the pandemic**
- **An online counseling network for COVID-19 patients, operated by health centres, has been under construction and is scheduled to be introduced within the year**
- **Medical staff make daily phone checks of patients, especially of vulnerable ones, to provide counselling and support**
- **COVID-19 online health services will be available to self-isolated/quarantined patients (self- and distance monitoring), patients with mild cases (distance monitoring and treatment), and patients after discharge (follow-ups)**
- **An electronic registry has been created to monitor patients diagnosed with COVID-19 and to ensure continuity of care.**

4. ORGANISATION & PLANNING OF HEALTHCARE SERVICES

A. Greece

- **Online appointments - a uniform appointment platform will be created which will include primary healthcare services, health centres and outpatient clinics. Citizens will be able to book an appointment with a doctor by phone or via a platform.**
- **The changes will take place in the context of a general digitalization of the health system, which includes online medical records, telemedicine, online appointments, online consultations, e-prescriptions, etc. It is expected that the digitalization of healthcare services in primary care will reach 50% for telemedicine and 100% for online consultation by the end of the year.**

4. ORGANISATION & PLANNING OF HEALTHCARE SERVICES

B. European Union

- **Teleconsultations as alternatives to face-to-face consultations have been implemented in many countries around Europe and are reimbursed by social health insurance. There are early indications of a growing number of tele- or video-consultations provided by physicians and psychotherapists.**
- **The case of 'Charité Berlin', which supports the treatment of ventilated COVID-19 patients through tele-visits with the help of a visiting robot that exchanges information with the treating doctors via a video communication platform. There are currently 25 visiting robots in use.**
- **The opening of a virtual hospital was proposed to support other departments and practices. 'The Charité Berlin' launched the 'CovApp', a web-based online tool to assess patients' medical condition, provide recommendations for action and inform about relevant contacts, healthcare services, access to hospitals or examination centres.**

5. FINANCING

A. Greece

- **State finance to improve the national health system**
- **National health system supported by the state budget to address emergency needs**

  → increased wages, recruitment of staff, ICU support, medicine, medical supplies, extra cleaning costs, equipment, sample analysis, etc.
- **Intention to provide additional support to Intensive Care Units in 'reference hospitals' in the future**
- **So far, ICUs have been supported by donations from individuals or foundations**

5. FINANCING

B. European Union

- **In April 2020, the European Parliament mobilised EUR 3 billion to support health systems in EU regions hit hardest by the pandemic**
- **The initiative promotes the construction of field hospitals and the transportation of corona patients to hospitals with free capacity.**
- **The funds are used to purchase and distribute medical supplies**

  → respirators, personal protective equipment, reusable masks

In the long term, the funds will be used to improve medical research and testing capacities

Secondary source of funding donations and online crowdfunding platforms

6. HEALTHCARE WORKFORCE

A. Greece

- **Suspension and revocation of all regular leaves of absence of National Health System staff**
- **Initiatives for recruitment of additional staff – the Greek healthcare system has been strengthened with over 6,800 new recruits (medical, nursing, paramedical and other staff)**
- **Employment of private physicians in public hospitals to deal with emergencies for a specific period of time**
- **Establishment of a digital platform where individuals can register to volunteer in the fight against the pandemic**

  → doctors, nurses, paramedics, psychologists, medical students, retirees from the medical sector

  → anyone who wishes to provide administrative, technical and other forms of support to the healthcare system

6. HEALTHCARE WORKFORCE

B. Other EU countries have also implemented measures to increase the number of healthcare professionals.

- **Childcare facilities and schools remained open for children of healthcare workers**
- **The licensing and registration requirements of healthcare professionals were eased temporarily**
- **Medical and nursing students and physicians in training were involved in the fight against COVID-19**
- **Many countries also created volunteer programmes**
- **The mental well-being of healthcare workers was considered and support mechanisms were developed.**

6. HEALTHCARE WORKFORCE

B. Other EU countries have also implemented measures to increase the number of healthcare professionals.

- **Engagement of the Army to support and assist healthcare staff**
- **Financial support for healthcare workers (bonus, pay raise)**
- **Increase in maximum working hours, part-time workers requested to work full time, transfer of personnel**
- **Easing of mutual recognition procedures of foreign-trained health professionals**
- **Withdrawal of suspensions of early retirement pensions of healthcare professionals who were re-activated**

7. COVID-19 AS AN OCCUPATIONAL DISEASE/LABOUR ACCIDENT

- **Greece:**

→ Equally favourable schemes for disability and survivors' pensions

Occupational Disease: **Long-term exposure to hazardous conditions that gradually affect and deteriorate health conditions – 'List' system following the Commission's recommendation**

Labour Accident: **Sudden and violent accident, causing incapacity for work, which occurred in the context of occupational activities – 'Open' and dynamic concept, shaped by case law**

Does an infection with COVID-19 fit into this framework?

→ The government announced (18/01) that it is considering deeming deaths due to COVID-19 to be work accidents, if a sufficient causal link to professional activities is established

→ Case law?

7. COVID-19 AS AN OCCUPATIONAL DISEASE/LABOUR ACCIDENT

- **Examples from other EU Member States:**

I. Belgium: COVID-19 is an occupational disease: (a) assumption that COVID-19 is a work-related illness for healthcare staff, (b) other professionals may be potentially entitled, but bear the burden of proof

II. Denmark: Infection with COVID-19 can be considered an occupational illness – Law amended that if a probability of infection risk at the workplace is established, burden of proof is sufficient – Favourable first case law (= Italy & Finland)

III. France: Acute respiratory diseases linked to COVID-19 infections presumed to be of an occupational nature for healthcare staff, if in-person medical services are provided at the workplace

IV. Germany: COVID-19 is considered an occupational illness for healthcare workers who had contact with COVID patients, have relevant symptoms and a positive PCR test

8. PROTECTION OF VULNERABLE GROUPS

- **Greece:**

→ **During the first phase of pandemic: Only for certain public sector employees (special leave) – Private sector employees from vulnerable groups not formally covered**

→ **In August 2020: New scheme based on subsidiarity: (a) Teleworking, if an option, (b) If not, move to back office, (c) If that not an option → short-time work scheme (temporal unemployment) – How to prove vulnerability: Closed (?) list of conditions & medical certification – High sanctions for employers**

→ **Temporal (?) measure, until 31-01-2021 …….?**

→ **What about employees who live in the same household with vulnerable persons? Not formally covered**

- **Examples from other EU Member States: (a) Persons at risk of complications from COVID-19 infection covered by sickness benefit (Denmark), (b) Vulnerable employees and those who share a household with a vulnerable person, if not teleworking → Partial activity (= short-time work scheme with high income replacement) (France), (c) Consultation with employer about alternative work arrangements – If not an option, discussion about furlough (CJRS) → If not, Universal SSP (UK)**

9. AMENDMENTS TO SICKNESS BENEFITS

- **Greece**:

→ Sickness benefits in cash (restricted income replacement) granted following a waiting period of 3 days, conditional on prior insurance periods – Wage continuation by employer for the first month, topping-up sickness benefit to reach salary level

No changes to the general scheme for COVID-19 – Easing of administrative formalities:

I. Health Evaluation Committees, in principle, assess cases remotely and not in person

II. Medical certifications can be produced at a later stage

III. Trial launch of digital platform for application of sickness benefits (22/01)

→ New special leave schemes for parents with childcare responsibilities – Tripartite financing by state budget, employers and employees (except when child contracts COVID)

→ If the employee has received an order from the health authorities to self-isolate and teleworking is not an option: wage continuation paid by the employer for 7-14 days, obligation to work for an extra hour without remuneration until half of the self-isolation time is covered (L. 4722/ 2020)

9. AMENDMENTS TO SICKNESS BENEFITS

- **Examples from other EU Member States:**

I. Belgium: (a) Elimination of waiting periods, incl. for self-employed, (b) Benefits can be received prior to doctor's attestation

II. Denmark: (a) Elimination of 2-week waiting period, (b) Extension to self-employed, (c) From 22 weeks to 3 months → work-assessment (temporal), (d) Covers quarantine period

III. France: (a) Sickness benefits for workers in quarantine or self-isolation due to COVID-19, independent of previous health insurance, (b) Elimination of waiting periods, (c) In case of childcare responsibilities as well (for children under 16, no age limit in case of disability)

IV. Spain: Special sick leave if individual contracted COVID-19: (a) no prior social security contributions, (b) maximum benefit prescribed by law, (c) also for those in quarantine and (d) does not affect future rights – Consideration of extending it to parents of children who are infected with the virus

10. PROTECTION OF PERSONS WITH DISABILITIES

- **Greece:**

→ **Suspension of authorities' assessments of applications for disability benefits during periods of strict lockdowns (temporal – recently re-activated) (L. 4682/2020 & L. 4690/2020)**

→ **Automatic extension of fixed-period disability pensions and social assistance disability benefits, while re-assessment is pending due to above suspension (temporal, until 30-04-2021) (L. 4682/2020 & L. 4690/2020**

→ **Extension of entitlements for healthcare services for beneficiaries of disability benefits for isochronous as above, time periods (L. 4682/2020 & L. 4690/2020)**

→ **General clause: Authorities shall ensure that persons with disabilities are provided with all possible conveniences to meet their needs (L. 4690/2020)**

- **Similar examples from other EU Member States: (e.g. Austria & United Kingdom)**

11. CONCLUSIONS – PART 1

- **EU principally advocates in favour of universality, yet does not delineate limits of solidarity or provide concrete minimum standards for quality and access, while focussing more on ad hoc ways and measures to achieve cost effectiveness and fiscal sustainability - New-found impetus for public health systems and support for investments and reforms in public healthcare – Strengthened role of EU in public health affairs**
- **Equivalent responses observed in different health and social protection systems**
- **Right to healthcare should be universal – Everyone should have access to fundamental healthcare services to fight the viscitudes of life, especially during a pandemic – Strict prior insurance conditions and residency criteria should be reconsidered, if not waived – Necessary both from a human rights and a public health perspective**
- **The pandemic has led to a mass and rapid digitalization of the healthcare system - The digitalization of healthcare is here to stay – How to ensure quality?**
- **Health emergencies of this extent can only be dealt with by a state-financed public healthcare system**
- **Healthcare workers are crucial for the operation of public healthcare systems – They must be protected (adequate medical equipment) and rewarded (financially)**

11. CONCLUSIONS – PART 2

- **COVID-19 is gradually being recognised as an occupational disease or labour accident, if causality conditions are met, granting access to more favourable schemes**
- **Is it time to consider broadening the concept of incapacity for work to include persons from vulnerable groups during periods of increased risk by contagious diseases? → Preventive sickness benefits in cash? How to prevent abuse? Role of employers?**
- **Universal use of sickness benefits for loss of earnings caused by COVID-19, ordered quarantine or childcare responsibilities → (i) elimination of waiting periods, (ii) extension of payment periods, (iii) increase of benefit levels, (iv) administrative facilitation**
- **Suspension of work capacity re-assessments and isochronous extension of disability benefits and entitlements to healthcare services**
- **How temporary is temporary? When does temporary become structural?**
- **What about allocation of increased costs? Need for new ways of financing?**

Thank you for your attention!