HUNGARIAN LABOUR LAW
E - J O U R N A L

Addressing Psychosocial Risks of Employed Persons in the Digital Age

Interaction between Labour Law and Social Law

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Abstract

The digital transformation and new labour patterns have led to additional or increased psychosocial risks and, as a consequence, to a significant rise in the number of mental disorders. These developments concern not only employees but also self-employed persons. Against this background, an analysis of the interaction between labour law regulations on the prevention of psychosocial risks on the one side and the social security law regulations on accidents at work and occupational diseases on the other side, is of particular importance, also from a comparative law perspective. In this regard, the question arises whether and to what extent the distribution of competences and responsibilities for the prevention of psychosocial risks between social security authorities and employers influences the effectiveness of the prevention of work-related mental disorders and the recognition of mental disorders as accidents at work/occupational diseases. In addition, it is questionable to what extent the recognition of mental disorders as occupational diseases influences the effectiveness of the prevention of psychosocial risks. Furthermore, in the changing world of work it is uncertain as to who should guarantee the right to mental health of atypical solo self-employed persons: they themselves, the state via social insurance institutions, or the clients/principals? Another issue is how the decoupling of labour law regulations from social security law regulations could influence the prevention of mental disorders. By answering these questions, this article is seeking to fill a gap in the analysis of psychosocial risks from an overall perspective of labour law and social security law. This analysis is based on a systematic legal comparison including different EU member states.

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1. Introduction

The digital transformation of the world of work and new labour patterns (working from home, mobile working, platform work) have a lot of advantages, not only for employees. At the same time, new labour patterns and new work instruments have changed the organisation and distribution of working time and rest time (often resulting in permanent availability, extended working hours); they have caused intensification of work; have increased workload; and have enabled new (non-personal) forms of supervision of working activity. As a consequence, these developments have often contributed to negative psychological health impacts, led to additional or increased psychosocial risks and to a significant rise in the number of work-related mental disorders. These developments do not only concern salaried employees but also atypical/dependent self-employed persons. In particular platform workers are exposed not only to the "traditional" psychosocial risks but also to different new psychosocial risks connected to algorithmic management, the latter of which leads to higher work intensity, dependence on good ratings, power asymmetries, depersonalisation of work, etc.

Against this background, an analysis of the interrelation between labour law regulations on the prevention of psychosocial risks on the one side and the social security law regulations on the prevention and the recognition of occupational diseases and accidents at work on the other side, is of particular importance, also from a comparative law perspective. Furthermore, the question arises whether and to what extent the distribution of competences and responsibilities for the prevention of psychosocial risks between social security authorities and employers influences the effectiveness of the prevention of work-related mental disorders and the recognition of mental disorders as accidents at work/occupational diseases. In addition, it is questionable to what extent the recognition of mental disorders as occupational diseases influences the effectiveness of the prevention of psychosocial risks.

In the changing world of work, it is unclear who should take care of the prevention of psychosocial risks of of atypical/dependent solo self-employed persons: they themselves, the state via social insurance institutions, or possibly their clients/principals? In other words: Who should be the one taking over the employer's duty of care for such persons? At the international and European level as well as in academia, universal social protection – regardless of employment status – has often been advocated. Another issue is how the decoupling of labour law protection from social security law regulations could influence the prevention of work-related mental diseases.

This paper is seeking to fill a gap in the analysis of psychosocial risks and the prevention of occupational diseases from an overall perspective of labour and social security law. This analysis is based on a systematic legal comparison including different EU member states.

2. Prevention of Psychosocial Risks in Labour Law and Social Law

It should be stressed that there is a lack of a uniform concept of "prevention" in law. The meaning of the term "prevention" becomes clear only if it is known *what circumstance/fact* is being prevented.[1] In social law, a distinction is made between primary prevention, secondary prevention and tertiary prevention.[2] Primary prevention takes place before the occurrence of a social risk and is directed at people not yet affected (by disease, invalidity, etc.). In contrary to primary prevention, secondary and tertiary prevention takes place when the social risk has already materialised and is aimed at preventing its exacerbation.[3] Secondary/tertiary prevention are more typical for social security law than for labour law.

The term "prevention" can be understood as an aim itself or as a set of measures (instrumental meaning)[4]; prevention can be a main or an ancillary concept. Prevention in labour law is always its central integral part.[5] The responsibility for primary prevention lies in the first place with the employers, while accident insurance institutions are in charge of governance and control with a view to the primary prevention measures of the employers.[6] The concept of (primary) prevention in labour law is, in this regard, broader than in social law. In accordance with his duty of care the employer shall organise the work process in such a way that hazards to life and physical and mental health are avoided as far as possible and the remaining hazards are kept as low as possible (e.g. par. 4 Act on Health and Safety at Work, Germany).[7] Nevertheless, the concept of prevention in social law has also been broadened in the course of time, and prevention has become one of the main functions in social

1 Minou Banafsche: Zielsetzung und Instrumente der Prävention im Sozialrecht. In: Judith Brockmann (ed.): *Prävention an der Schnittstelle von Arbeits- und Sozialrecht.* Münster, LIT Verlag, 2014. 8.

2 Banafsche op. cit. 9.

3 Ibid. 9.

4 Filip Dorssemont – Koen Naert – Anne Van Regenmortel: Well-Being at Work in Belgium: A Matter of Co-Operation. In: Edoardo Ales (ed.): *Health and Safety at Work.* Alphen aan den Rijn, Wolter Kluwer, 2013. 73.

5 Valerie Flohimont: Apprehension About Psychosocial Risks and Disorders in Social Security: A Comparison between the Approaches in Belgian and French Law. In: Loïc Lerouge (ed.): *Psychosocial Risks in Labour and Social Security Law. A Comparative Legal Overview from Europe, North America, Australia and Japan.* Cham, Springer, 2017. 305.

6 Claire-Kathrin Presting: *Die Erfassung psychischer Erkrankungen in der gesetzlichen Unfallversicherung.* Berlin, Duncker & Humblot, 2022. 160.

7 Compare: § 3 Workers' Protection Act in Austria: Employers are obliged to provide for the safety and health protection of workers in relation to all aspects concerning work; Art. L.4121-1 Labour Code in France: The employer shall take the necessary measures to ensure the safety and protect the physical and mental health of workers.

law. In particular, to the original goal of prevention of occupational diseases and accidents at work[8] later[9] the goal of prevention of work-related hazards was added.

Sometimes the opinion is expressed that the list system regarding occupational diseases narrows the concept of prevention in the statutory insurance against accidents at work and occupational diseases. In accordance with the main goal of prevention of occupational diseases and accidents at work, the statutory accident insurance should investigate the causes of work-related hazards to life and health. If mental disorders are not included in the list of occupational diseases, the investigation of causes of mental disorders will likely not be a priority task of the accident insurance. Furthermore, the interrelationship between labour law and social law is unduly limited if psychosocial risks are included in the risk assessment at the enterprise but not listed among occupational diseases, because "learning from incidents and accidents is one of the cornerstones of the dynamic risk management system"[10]. In addition, if mental disorders are not included in the list of occupational diseases/accidents, it is not possible to take into account the rate of mental disorders as occupational diseases via social insurance contributions. In other words, the lack of recognition of mental disorders as occupational diseases does more harm that the deficient list system.

As a general rule, employers enjoy liability privileges concerning accidents at work and occupational diseases. Such liability immunity reduces the preventive effect of the statutory accident insurance.[11] Nevertheless, for reasons of prevention, many jurisdictions provide social security institutions with a right of recourse against the employer if the employer has caused occupational accidents at work intentionally or through gross negligence.[12] However, this regulation cannot be applied suitably to occupational diseases.

At the same time, it is worth noting that often national occupational health and safety (OSH) legislation does not specify which psychosocial hazards must be taken into account and which protective measures the employer should take. Empirical evidence demonstrates that due to diffuse formulations in the legislation many hazards are largely ignored in the risk assessment, e.g. hazards arising from social relationships at work (e.g. destructive management behaviour, lack of social support), from interaction and emotional work (e.g. confrontation with events and situations at work that have a strong emotional impact), from excessive work intensity and/or from inadequate organisation of working and recovery times.[13] Studies show that most countries have not included or only insufficiently regulated mandatory psychosocial risk assessment and prevention in their national

8 Olaf Deinert: Occupational Health and Safety in Germany: A Dual System in Change. In: Ales (ed.) op. cit. 130.

9 E.g. in Germany since 1996.

10 Dorssemont–Naert–Regenmortel op. cit. 77.

11 Ernst Karner – Felix Kernbichler: Employers' Liability and Workers' Compensation: Austria. In: Ken Oliphant – Gerhard Wagner (eds.): *Employers' Liability and Workers' Compensation*. Berlin–Boston, De Gruyter, 2012. 106.

12 Compare §§ 104–107 SGB (Social Code Book) VII in Germany, § 333, 334 ASVG in Austria.

13 Bundesministerium für Arbeit und Soziales/Bundesamt für Arbeitsschutz und Arbeitsmedizin: Sicherheit und Gesundheit bei der Arbeit – Berichtsjahr 2021. Unfallverhütungsbericht Arbeit. 2021. 34.

occupational safety and health legislation.[14] For example, in Germany only 31% of the companies carry out a mental risk assessment.[15]

For many employees (due to the lack of prevention and management of psychosocial risks) the most widely used option to tackle chronic workplace stress as well as to cure work-related illnesses is a sick leave within the health insurance coverage (with high costs for the health insurance system as a consequence). Without mandatory and well-regulated psychosocial risk assessment and the recognition of mental disorders as occupational diseases, the burden of poor work organisation and precarious working conditions is shifted to the health insurance or the employees. Prevention is also part of the personal responsibility of the insured person. However, *poor work organisation* is not a responsibility of the employee. When an employers' liability is substituted by mere health insurance coverage, the link between risk prevention and the recognition of an accident at work/occupational disease is weakened or even absent. In order to reduce the number of long-term sick employees, some countries, e.g. Belgium, have introduced fines for heads of companies with too many long-term sick employees. However, this policy has not encouraged employers to a sufficient extent to introduce an effective prevention policy against depression and burnout at work.[16]

3. Recognition of Mental Disorders as Occupational Diseases

Because of the mentioned changes in the world of work and the increased number of mental disorders, the recognition of certain mental disorders as occupational diseases has been discussed in many EU member states and at the European level[17]. In this context, it is important to differentiate between work-related illnesses and occupational diseases. Work-related illnesses include illnesses that are caused by the working environment or influenced by unfavourable working conditions. The number of work-related illnesses that are recognised as occupational diseases depends on the legal requirements for the recognition of an illness as an occupational disease in the respective country. Only in few countries (e.g. Sweden) can a work-related disease of any sort theoretically be acknowledged as an occupational disease.

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14 Francesco Chirico – Tarja Heponiemi – Milena Pavlova – Salvatore Zaffina – Nicola Magnavita: Psychosocial Risk Prevention in a Global Occupational Health Perspective. A Descriptive Analysis. *International Journal of Environmental Research and Public Health*, Vol. 16, Iss. 14. (2019) 2470. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6678173/

15 Unternehmen sorgen sich zu wenig um das Wohlergehen ihrer Beschäftigten. *Haufe,* 07. 01. 2022. Available at: https://tinyurl.com/yf25jcwr

16 Depression or burnout cases in Belgium have almost doubled in five years. *The Brussels Times,* 27. 12. 2022. Available at: https://tinyurl.com/57jjy77t ; Belgium takes measures to get more long-term sick back to work. *The Brussels Times,* 29. 10. 2022. Available at: https://tinyurl.com/ycx3bnut

17 Mental Health in the Digital World of Work. European Parliament Resolution of 5 July 2022 on mental health in the digital world of work (2021/2098(INI)). OJ C 47/63. 7.2.2023. Available at: hhttps://tinyurl.com/yay5mmze

The recognition of mental disorders as occupational diseases can either be covered by the list system[18] or by a complementary system based on an individual case approach. In the majority of the EU member states (with the exception of Denmark and Latvia), mental disorders are still not included in the list of occupational diseases. In Latvia, two mental disorders (burnout and psychoneurosis) are included in the list of occupational diseases (under Section 5. Diseases Caused by Overload).[19] The best example for the regulation and operation of mental disorders as occupational diseases is given by Denmark. In Denmark, already on 23 December 1975 a law on OSH was passed in which the concept of occupational health and safety went far beyond the technical-medical concept and covered also psychological factors at the workplace.[20] It therefore comes as no surprise that in Denmark, in 2014, in comparison to other EU countries the largest number of claims in relation to mental disorders were recognised as occupational diseases (with Sweden taking second place).[21] The Danish Guide to occupational diseases (18th edition of 1 July 2023) includes post-traumatic stress disorder and depression after having taken part in acts of war[22]. In addition, several mental illnesses can be recognised as occupational diseases after a specific assessment.

In some countries, e.g. Belgium, Italy, France, Spain and Denmark[23], certain mental disorders are recognised as occupational diseases (e.g. depression, post-traumatic stress disorder, generalised anxiety) under a complementary system[24] that presupposes different conditions to be fulfilled for the recognition as an occupational disease. For example, the recognition of a mental disease as occupational can require a certain degree of permanent disability.[25] This requirement is rather typical for physical diseases and relatively incompatible with psychosocial disorders.[26] In Germany, where a mixed system is used (a list system in addition to a complementary system), mental disorders are not mentioned in the list of occupational diseases. Theoretically, a mental disorder could be classified "as quasi-occupational disease" (Wie-Berufskrankheit) in accordance with the complementary system (par. 9 sec. 2 of Book 7 of the Social Code). However, due to the strict conditions in par. 9 sec. 2 of

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18 There are no lists of occupational diseases in Sweden and in the Netherlands.

19 Annex 1 "Occupational Diseases" of Cabinet of Ministers Regulation No. 908 of 6 November 2006 "Procedure for Investigation and Registration of Occupational Diseases". [Hereinafter: Annex 1] Available at: https://tinyurl.com/3rzbfswj

20 Rolf Birk: Die Rahmenrichtlinie über die Sicherheit und den Gesundheitsschutz am Arbeitsplatz – Umorientierung des Arbeitsschutzes und bisherige Umsetzung in den Mitgliedstaaten der Europäischen Union. *Zeitschrift für ausländisches und internationales Arbeits- und Sozialrecht*, no. 1. (1999) 651–652.

21 Christine Kieffer: *What Recognition of Work-Related Mental Disorders? A Study on 10 European Countries: study report.* Paris, Eurogip, 2013. 7. https://tinyurl.com/4bhn2nbj

22 VEJ no. 10046 of 14/12/2021. Available at: https://www.retsinformation.dk/eli/retsinfo/2021/10046; Christine Kieffer: *Recognition and Compensation of Work-Related Mental Disorders in Europe.* Paris, Eurogip, 2023. 15.

23 Kieffer (2013) op. cit. 7.

24 Kieffer (2013) op. cit. 5.

25 In France, at least 25% permanent partial disability is required by law for the recognition. Maryse Badel: Psychosocial Risks in Social Security Law: Comparative Analyses of France and Northern Europe. In: Loïc Lerouge (ed.): *Psychosocial Risks in Labour and Social Security Law. A Comparative Legal Overview from Europe, North America, Australia and Japan.* Cham, Springer, 2017. 351.; Aurélie Bruère: Physical Effects of Psychosocial Risks: Opportunities and Limits of the Occupational Risks Compensation Legal Framework. In: Lerouge (ed.) op. cit. 366.

26 Bruère op. cit. 366.

Book 7 of the Social Code until recently almost all claims concerning the recognition of a mental disorder as an occupational disease were dismissed. In its decision of 22 June 2023, the Federal Social Court for the first time in Germany recognised a case of post-traumatic stress disorder (PTSD) of an ambulance driver as an occupational disease.[27]

Acknowledging the occupational origin of diseases also depends on whether courts take a stringent (narrow) or proactive approach and interpret the law creatively.[28] While in some countries (e.g. in Belgium[29]) in accordance with a stringent approach the respective disease must be directly, decisively and exclusively caused by work, in other countries (e.g. France) the conditions for a recognition are less stringent and work does not have to be the exclusive cause.[30] The main challenge for the recognition of mental diseases as occupational illness is the multicausality of mental disorders. Psychosocial risks are "at the interface between the individual and her/his work situation"[31]. In general, the more generous social security benefits are provided in case of a recognition of a disease as occupational, the more difficult is the procedure leading towards its recognition.

The digital transformation of work and new labour patterns have often led to additional or increased psychosocial risks and to a significant rise in the number of mental disorders that

often result from a long-time exposure to psychosocial risks originating in poor organisation of work and/or poor working conditions. For this reason, the analysis of the legislation of those EU member states in which such illnesses are recognised as occupational diseases are of particular importance.

In Italy, in accordance with INAIL Circular No. 71/2003, a disease will be recognised as an occupational disease if it has been caused by specific and particular conditions attributable to dysfunctions arising from work organisation ("costrittività organizzativa"). Such situations cover also prolonged assignment to overly heavy or excessive duties, including in relation to a possible mental or physical disability. However, organisational factors linked to the normal course of the employment relationship (dismissal, reassignment, etc.) and situations where the worker is exposed to a sudden, unexpected, short-term event are not covered.[32] Despite the fact that INAIL Circular No. 71/2003 was annulled by the Council of State via Decision No. 1576/2009, this decision does not appear to have slowed down the process of progressive extension of the scope of intervention of the social protection system or prevented a very broad interpretation of the link between the injury and the work activity.[33] In this view, the concept of "work-related cause" no longer appears so divergent from that of "work-

27 GERMANY: a first in terms of recognition of a work-related mental disorder. *Eurogip News,* 04/08/2023. Available at: https://tinyurl.com/2ekps3h2

28 Badel op. cit. 346.

29 Ibid. 348.

30 Ibid.

31 Bruère op. cit. 365.

32 Kieffer (2013) op. cit. 16–17.

33 Guglielmo Corsalini: Estensione della tutela INAIL. Questioni controverse. *Responsabilita' Civile e Previdenza*, no. 4. (2016) 1388.

related occasion", which occurs not only when the work activity was the cause of the injury, but also when it made the occurrence of the injury more likely.[34] It could also be argued that injuries which work has only facilitated or made possible are now also recognised.[35] Such an approach blurs the boundaries between work-related illnesses and occupational diseases and underlines the employer's responsibility for the organisation of work and the prevention of occupational diseases.

Due to the increased intensity of work and permanent availability of employees, in many countries cases of depression and burnout among employees have increased. In highly digitalised sectors, employees more often report high work intensity. In the service sector, almost half of the employees very often feel at the mercy of digital technology in their work.[36] In this context, in many countries the recognition of burnout as an occupational disease is discussed.

In ICD-10, burnout was not coded directly.[37] In ICD-11, which came into force on 1 January 2022, burnout (QD85) is defined as a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) a sense of ineffectiveness and lack of accomplishment. Burnout refers specifically to the phenomena in the occupational context and should not be applied to describe experiences in other areas of life.[38] The definition explicitly excludes *multifactual* causality of burnout. A part of the literature criticises that burnout is no longer be diagnosed if it is not related to a professional activity, e.g. in the case of family careers in the private sector[39] or students. The definition refers to chronic workplace stress without explaining its reasons. Some ILO standards[40] use the term "workplace stress" as a synonym for the term "external workload". In the European Social Partners' Framework Agreement on Work-Related Stress (2004) it is pointed out that work-related stress can be caused by different factors such as work content, work organisation, work environment, poor communication, etc. The ICD code does not differentiate between mild and severe burnout. For this reason, it could also be difficult to differentiate between severe burnout and depression, as well as define depression which can accompany burnout. In ICD-11 burnout is included as an *occupational phenomenon* and *not classified as a medical condition*, which means that burnout is not an occupational disease. Because of such classification, in many countries it is not possible to refer

34 Ibid.

35 Ibid.

36 Nadine Müller: Digitalisierung und psychische Belastungen – Bilanz und Handlungsperspektiven für Gute Arbeit. In: Lothar Schröder (ed.): *Arbeitsschutz und Digitalisierung – Impulse für eine modern Arbeitsgestaltung.* Frankfurt am Main, Bund Verlag, 2019. 39.

37 Wolfgang Spellbrink: Burn-out als Berufskrankheit? *Wege zur Sozialversicherung,* B. 9., 2012. 260.

38 ICD-11 for Mortality and Morbidity Statistics (Version: 01/2023). https://tinyurl.com/3ens784b

39 Definition des Burn-outs im ICD 11 ist unzureichend. *Median,* 07.06.2019. Available at: https://tinyurl.com/2kyu9ufn

40 ISO 6385; ISO 10075-1:2017.

to burnout as a cause for a sick leave or an occupational disease.[41] In case of burnout, physicians use other ICD codes (e.g. Z73) for the justification of a sick leave.

Burnout can trigger some mental or somatic illnesses, like depression or anxiety disorder.[42] This explains the *role of burnout prevention*. Also, the definition of burnout in ICD-11 stresses the role of burnout prevention and of OSH management because burnout is a result of chronic workplace stress that has not been successfully managed. This is consistent with the position of the burnout discoverer Herbert Freudenberg who was convinced "that people with burnout do not need a therapist but better working conditions".[43]

Latvia is the only country which explicitly lists the burnout syndrome in the list of occupational diseases.[44] In this context, the problem of multicausality was solved by linking psycho-emotional overload to job occupants like teachers, customs officers, surgeons, judges and some other categories.[45] However, the recognition of burnout as an occupational disease only helps to compensate harm when a disease has already taken the character of a chronic disease. Such regulation does not solve the main problem of precarious working conditions: extended working hours and low wages (lack of adequate remuneration). Research in Latvia has also shown that longer hours worked per week are associated with a higher prevalence rate of burnout. Anesthetists in intensive care tend to work 36 hours, for example. Because of low wages, nurses are often "forced" to take two successive shifts and as a result they are overworked.[46]

4. The Impact of the Form of Employment

The OSH regulations as well as the social security law regulations on occupational diseases/accidents at work are still envisaged primarily for employees. However, the new trends in today's labour markets are characterised by a changing structure in self-employment with a prevalence of self-employed workers without employees of their own, atypical self-employment and bogus self-employment; new forms of employment (e.g. platform work, zero hours contracts etc.) that combine features of dependent employment and of self-employment. Such new forms of employment call into question the salaried employment model both in labour law and in social security law. The following questions

41 For example, in Poland, a physician should not issue a certificate of inability to work which indicates professional burnout as its basis. See: Jarosław Karlikowski: Poland: Occupational Burnout. *NOERR,* 20.04.2022. Available at: https://tinyurl.com/mua5jhr5

42 Claudia Drechsel-Schlund: Burnout-Syndrom – aus Sicht der gesetzlichen Unfallversicherung. *Med Sach,* no. 4. (2014) 154–155.

43 Andreas Hillert – Arnd Albrecht – Ulrich Voderholzer: The Burnout Phenomenon: A Résumé After More Than 15,000 Scientific Publications. *Front Psychiatry*, no. 11. (2020). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7793987/ .

44 Annex 1 op. cit.

45 Edite Brikmane: Profesore Maija Eglīte: „Izdegšanas sindroms – šo diagnozi nosakām arvien biežāk". *LV Portals,* 27/07/2015. https://lvportals.lv/viedokli/272832-profesore-maija-eglite-izdegsanas-sindroms-so-diagnozi-nosakam-arvien-biezak-2015

46 Brikmane op. cit.

are arising: How should labour law and social security law (in particularly OSH regulations and mandatory accident insurance) respond to these developments? Who should guarantee the right to mental health at work of (atypical/dependent) self-employed persons and persons in atypical forms of employment? Who should take care of the prevention of psychosocial risks and occupational diseases/accidents at work of these persons: They themselves, their clients/principals or the state via social insurance institutions? In other words: Should a third person – and if so, who – should take over the employer's duty of care?

With respect to these changes is very important to clarify the legal nature of the statutory accident insurance on the one side and the employer's obligation to ensure the health and safety of workers on the other side.

Concerning the employer's obligation to ensure the safety and health of employees/workers it is important to investigate whether this obligation is based on the contractual relationship, or if this is (also) an obligation in accordance with OSH regulations. On the one side, the employer's duty of care is part of the contractual obligation and justified by the subordinate position of the employee. Initially, some categories of workers (e.g. home workers and domestic workers) were excluded from the scope of OSH regulations and accidents at work regulations.[47] This approach was relaxed in the past years. The case law in some countries (e.g. France) has already changed its focus away from the subordination relationship towards a "work-related approach" (not depending on working time and presence at the employer premises).[48] The COVID-19 pandemic (accompanied by the increasing digitalisation of work) has also contributed to such changes. In some EU countries (e.g. Germany, Austria[49]) work-related accidents of employees working from home were recognised as insured accidents at work; the employer's obligation to ensure safe and healthy working conditions were extended to working from home.

On the other side, the obligation to ensure the health and safety of workers and other persons can follow from public law obligations in the field of OSH. In some countries (e.g. in Germany) these obligations were transformed into contractual obligations with the result that health and safety provisions have a dual character:[50] "the employer is liable for health and safety from the point of contract law as well as of public law".[51] Furthermore, the employer is responsible for the effective functioning of the enterprise or business.[52] For these reasons the employer bears the responsibility for anyone who performs his/her activity within the employer's undertaking.

47 Edoardo Ales: Occupational Health and Safety: A Comparative Perspective. In: Ales (ed.) op. cit. 421.

48 Bruère op. cit. 370.

49 In Austria in accordance with amended Working from Home Act.

50 Deinert op. cit. 148.

51 Ibid. 128.

52 Karl Riesenhuber: *Europäisches Arbeitsrecht*. Heidelberg, Müller, 2021. 475.

At the international, European and national levels a universal approach concerning health and safety protection is promoted. The ILO has recognised safe and healthy working conditions as one of its fundamental principles and rights[53] at work.[54] Such recognition should strengthen the universal application of this right and its human rights nature, as well as protect all employed persons.[55] In accordance with the recent decision of the United Kingdom, the personal scope of Directive 89/391/EEC does not only cover employees, but also workers.[56] In Italy, the client of riders is also obligated to apply the rules applicable to health and safety at the workplace.[57] This approach is also supported in academic publications. In Davidov's opinion, the application of a purposive approach would justify the extension of the application of health and safety provisions to all those working for others.[58] Riesenhuber stresses that the type of employment should not make a difference in terms of health and safety.[59] "Should the right to safety not be recognised as a fundamental right for all?" Dorssemont, Naert and Regenmortel[60] asked this question already ten years ago.

Social insurance against accidents at work and occupational diseases is the branch of social security with the largest gaps in formal coverage of the self-employed. The latter are not covered by statutory accident insurance in Belgium, Bulgaria, Cyprus, the Czech Republic, Ireland, Latvia, Lithuania, the Netherlands and Slovakia (but they get other social benefits in the case of an accident at work or occupational disease).

Employer-financed accident insurance covers accidents at work and occupational diseases that are attributable to the employer's risk sphere. Accident insurance is targeted at employees, which is to be seen as an expression of the principle of third-party provision.[61] For this reason, the possibility of a voluntary insurance of self-employed persons in the mandatory accident insurance is an exception to this principle. Mandatory inclusion of all self-employed persons[62] in the accident insurance would mean a radical detachment from its basic principles and influence the foundations of the statutory accident insurance. For this reason, some countries are against the extension of the statutory accident insurance to self-employed persons. For example, Bulgaria considers the expansion of the scope of the formal coverage of self-employed persons for accident at work and occupational disease, even

53 It is a step forward from considering "safe and healthy workplaces" as one of basic working conditions (cf. ILO "Work for a Brighter Future", p. 38) to one of the fundamental workers' rights. Cf. Eva Kocher: *Digital Work Platforms at the Interface of Labour Law.* Oxford–New York, Hart, 2022.

54 Resolution on the inclusion of a safe and healthy working environment in the ILO's framework of fundamental principles and rights at work. Geneva, ILO, 10 June 2022. https://tinyurl.com/56t4vkcs

55 Verwaltungsrat. 341. Tagung. GB.341/INS/6. Geneva, IAO, March 2021. 6–7. Available at: https://tinyurl.com/y6z5hmbv

56 R (on the application of C) v Secretary of State for Work and Pensions and Others. https://tinyurl.com/368y9y8k

57 Ministry of Labour and Social Policy/INAPP: National plan for access to social protection by subordinate and autonomous workers. 2021. 12. Available at: https://ec.europa.eu/social/main.jsp?catId=1312&langId=en

58 Guy Davidov: *A Purposive Approach to Labour Law.* Oxford, Oxford University Press, 2016. 121.

59 Riesenhuber op. cit. 475.

60 Dorssemont–Naert–Regenmortel op. cit. 73.

61 Stefan Muckel – Markus Ogorek: *Sozialrecht.* Munich, C. H. Beck, [4]2011. 221.

62 Ulrich Becker: *Soziales Entschädigungsrecht.* Baden-Baden, Nomos, 2018. 39.

on a voluntary basis, as incompatible with the core principles of the Bulgarian insurance model. At the same time self-employed persons who insure themselves against general diseases have the opportunity to receive cash benefits at the occurrence of temporary inability to work, including in the workplace. [63] In the Czech Republic self-employed persons can join a commercial (civil law) insurance with one of the private insurance companies when assessing a work risk. The reason for such regulation is that these persons are not subject to labour law.[64] A similar situation can be seen in Slovakia where the accident insurance in the case of an accident at work and/or occupational disease is "exclusively connected with the status of worker. Employer is in turn responsible for the working conditions, including the health and safety of an individual particularly in line with Labour Code. The accidents at work and occupational disease branch of the social protection system that is constructed as an insurance of an employer against accidents at work/occupational disease of the employee".[65]

Furthermore, the statutory accident insurance is characterised by the principle of causality as a necessary consequence of the attributability to employer-related risks. A reason for exclusion of self-employed person from the statutory accident insurance is also seen in the nature of the activity of self-employed persons, that makes it difficult to determine whether a risk occurred in a private life of the self-employed person or whether it is related to performing his/her professional activity.[66] This is also a reason why in Belgium occupational risks of self-employed persons are not insured via the accident insurance but via an alternative to the accident insurance within the occupational incapacity insurance and pension insurance. The situation is quite similar in other countries: in Greece self-employed persons are granted sickness benefits and rehabilitation benefits; in Lithuania benefits from pension social insurance, health social insurance and sickness social insurance. In some countries (e.g. in Portugal) self-employed can be insured in a private insurance against accidents at work.

Nevertheless, not only in the Scandinavian countries, but also in some other European countries (e.g. in Austria, Italy, Luxembourg, Spain), in accordance with the general tendency towards a universalisation of social protection, benefit systems against accidents at work and occupational diseases were extended to self-employed persons[67] or dependent self-employed persons ("para-subordinate workers" in Italy[68]). In many countries, self-employed persons may voluntarily join the insurance against accidents at work (e.g. in France, Denmark). In most cases, the self-employed are insured in accordance within the general scheme (together with employees). An insurance exclusively

63 Information on the Implementation of the Council Recommendation on Access to Social Protection for Workers and the Self-Employed in Bulgaria. 2021. 3. Available at: https://ec.europa.eu/social/main.jsp?catId=1312&langId=en

64 Council Recommendation on Access to Social Protection for Workers and the Self-Employed (2019/C 387/01). Report of the Czech Republic. 2021. 20. Available at: https://ec.europa.eu/social/main.jsp?catId=1312&langId=en

65 National Plan of the Slovak Republic under the Council Recommendation on Access to Social Protection for Workers and the Self-Employed. 2021. 2. Available at: https://ec.europa.eu/social/main.jsp?catId=1312&langId=en

66 Federal Public Service: Access to Social Protection for Workers and the Self-Employed. Belgian Action Plan. Available at: https://ec.europa.eu/social/main.jsp?catId=1312&langId=en

67 MISSOC: Gegenseitiges Informationssystem für soziale Sicherheit. Sozialschutz von Selbstständigen. Available at: https://www.missoc.org/?lang=de

68 Ministry of Labour and Social Policy/INAPP op. cit. 4.

within a special scheme for self-employed workers is rather the exception (e.g. in Spain). For many self-employed freelancers the scheme for accidents at work and occupational diseases is often structured around an appropriate professional group, regardless of employment status.[69] Some countries have already extended social insurance against accidents at work to all or certain categories of platform workers (e.g. riders), not depending on their employment status (e.g. in France, Italy, Belgium). Such regulations confirm the logic of extension of social protection in accordance with affiliation to the same professional group.

However, such extensions change the nature of the accident insurance since self-employed persons[70] have to pay social insurance contributions themselves. In the context of the changing structure of self-employment with a prevalence of atypical self-employment and dependent self-employment it could be considered to impose an employers' duty to pay social contributions on the principals, clients or the counterpart of a civil law contract. The justification of such imposition is based on the recognition of a broader category of economic and social dependence/subordination of atypical/dependent self-employed persons who are in need of social protection /in a vulnerable position. For example, in Italy, social insurance for accidents at work for "para-subordinate work" (Legislative Decree No. 38/2000) has been provided for since 2000. In doing so, two thirds of the social contributions are to be paid by the client and one third by the dependent self-employed, paying tribute to the economic vulnerability of these workers.

It may be the case that in certain countries and under certain circumstances genuinely self-employed persons are included into the social insurance scheme but not into the scope of labour law. In such cases, the prevention of psychosocial risks and mental disorders is, first and foremost, the responsibility of the self-employed persons themselves (and only secondarily that of the health/accident insurance). The psychosocial risk factors facing the genuinely self-employed differ significantly from those facing employees. Empirical evidence has shown that there is a very high correlation between job satisfaction and a person's economic situation. The COVID-19 pandemic has confirmed these findings. Many workers in small businesses in tourism and hospitality have experienced existential anxiety. Due to the economic crisis, many of them did not take vacations during the pandemic.[71] At the same time, the economic situation cannot be seen as an excuse for genuinely self-employed persons to not take action and prevent the OSH risks themselves and to bear responsibility for their mental health. They have the decision-making discretion to organise their work in a healthier way (e.g. to take fixed rest breaks or to have fewer clients).

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69 Paul Schoukens: *The Social Security Systems for Self-Employed People in the Applicant EU Countries of Central and Eastern Europe.* Antwerp–Oxford–New York, Intersentia, 2002. 236.

70 With the exception of platform workers.

71 Michelle Winner: Existenzängste und psychische Belastung: So leiden Kleinunternehmen und Selbstständige unter der Pandemie. *Online Marketing,* 02. 03. 2022. Available at: https://tinyurl.com/3cnuvt4y

However, some hazards of a psychosocial nature concerning social factors at work (especially concerning interpersonal relationships with clients, patients, etc.) are similar for employed and self-employed persons due to the character of the activity performed. For example, not only salaried employed social workers, but also self-employed persons providing outpatient care services could have everyday contact with clients with mental illnesses and be available for their clients around the clock[72] and develop a depression. The nature of the hazard is the reason why genuine self-employed persons should be protected against mental disorders as occupational diseases in a way like employees. However, this would not justify imposing the social security burden (for self-employed persons) on the contractual counterpart since the former are not economically/organizationally dependent on the latter. The right to health of the genuine self-employed persons is guaranteed within the health insurance and can also be guaranteed within accident insurance for which they pay contributions themselves.

Last, but not least, the legislative trends demonstrate that countries which are open to the extension of the scope of labour law are often simultaneously ready to extend the scope of social security schemes (e.g. Italy, France), while countries that apply a strict approach related to the dependent employment model are rather reluctant to extend the scope of labour law as well as social security law (e.g. Bulgaria, Czech Republic).

5. Conclusion

Whereas the main challenge in the field of OSH in the 19th century was the issue of physical health, a new major concern of the 21st century is mental health. In many countries, a significant increase in the number of mental disorders can be observed. Many of such disorders relate to poor work organisation, excessive workload or unfavourable social factors at work. That is why the prevention of psychosocial hazards and work-related mental disorders is so important. Empirical evidence demonstrates that without specific legislation that provides an employer's obligation to include psychosocial risk factors into the risk assessment or other instruments of this sort, many psychosocial hazards will continue to be widely ignored. For example, burnout is a result of chronic workplace stress that has not been successfully managed. Without mandatory (and well regulated) psychosocial risk assessment and the recognition of mental disorders as occupational diseases, the price for poor work organisation, unfavourable working conditions and human misbehavior has to be paid by the employees and their health insurances.

The prevention of psychosocial risks and occupational diseases (or at least mental disorders recognised as work-related diseases) presupposes that measures of prevention provided through social

[72] This is an example from Danish practice. Available at: https://www.retsinformation.dk/eli/retsinfo/2020/9968 (Example 10).

law (externalising measures) and labour law (internalising measures) stand side by side.[73] There is clear evidence that the recognition of mental disorders as occupational diseases in social security law influences the effectiveness of the prevention of psychosocial risks at the enterprise level.

Due to the changes in the world of work accompanied by an increased number of mental disorders, the recognition of mental disorders as occupational diseases has been discussed in many EU member states and at the European level. Up to date, it is only in Denmark and Latvia that several diseases are included in the list of occupational diseases. In some countries (e.g. Belgium, Germany, Italy, France, Spain, Denmark) mental disorders are recognised as occupational diseases under the complementary system. The effectiveness of the recognition of mental disorders as occupational diseases depends on: whether the legislator and courts follow a strict or a proactive/broad approach concerning the term 'occupational disease'; on the personal scope of occupational disease law; and on the respective regulation of the principle of causality.

OSH regulations as well as social security law regulations on occupational diseases/accidents at work are still guided by the salaried employment model. The employer-financed accident insurance covers accidents at work and occupational diseases that are attributable to the employer's risk sphere. New trends in today's labour markets with atypical and dependent self-employment, as well as delimitation between employees and self-employed persons call into question the established foundation for OSH and occupational diseases/accidents at work regulations. Some countries (e.g. Bulgaria, Czech Republic) continue to follow a strict approach and are against the extension of the accidents at work insurance scheme to self-employed persons, because this would be incompatible with the core principles of their insurance model. Some other countries have already extended this scheme to self-employed persons imposing the obligation to pay social insurance contributions on the self-employed themselves and, in this way, changing the character of the accident insurance scheme. The answer to the problem of atypical/dependent self-employment could be the imposition of a social responsibility on third persons in cases in which self-employed persons are comparable to employees in their need of social protection. The problem of new forms of employment/self-employment can be solved in the most effective way if both labour law and social security law follow a proactive approach, extending the personal scope to anyone who is in need of social protection.

73 Raimund Waltermann: *Sozialrecht*. Heidelberg, Müller, [14]2020. 131.