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Evidence review and trade union views

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Contents

Abstract

Work-related psychosocial risks (PSR) are a major contributor to the burden of disease in Europe. The stress mediated health impacts of PSR are evident in the healthcare and long-term care (LTC) sectors and were brought to everyone's line of sight by the Covid-19 pandemic. While the effects of these risks manifest at the individual level as physical and mental health problems, the sources and factors are found in work organisation and employment conditions. Consequently, effective prevention of PSR operates at the collective level. This report provides an evidence overview of PSR in the healthcare and LTC sectors as well as an analysis of interview data collected from trade unions on this critical issue during the pandemic. Based on the review and the data analysis, the paper outlines the main sources of PSR and illustrates them with the voice of worker representatives. The evidence shows the deterioration of working conditions in these sectors due to the use of New Public Management methods that are an ill-fit to the reality of care work and the continuing devaluation of the work done in these feminised sectors. A discussion is provided on some PSR prevention and mitigation measures and the critical issues that must be addressed in occupational safety and health, as well as in employment policies, to ensure the right of health and care workers to safe and healthy workplaces.

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Introduction

'PSR is the primary cause of unhappiness, demotivation and absenteeism from work. It is already and will continue to be the major battle to fight for trade unions in the 21st century; it is what is coming and we need to tackle it.' (UGT Galicia)

This report presents evidence on work-related psychosocial risks (PSR) and analyses the conditions and circumstances that give rise to these risks and which are associated with a wide range of adverse health effects. The reporting is based on a review of the scientific literature and on qualitative research which investigated the sources of PSR and prevention measures in the healthcare and residential long-term care (LTC) sectors in Germany, Spain and Sweden.

The qualitative study gives voice to trade union officials responsible for occupational safety and health and to those with responsibility for collective bargaining, in particular as regards safety and health at work. It provides clear evidence of the crisis in the healthcare and LTC sectors where years of disinvestment, monetisation and restructuring have had a severe impact on workers' safety and health, and have left only limited options for prevention and mitigation of the impacts.

To date, studies that have focused on the sources of psychosocial risks – that is, the relationships between labour management practices and the psychosocial work environment – and on prevention measures remain scarce. However, the value of targeting changes in work organisation in order to reduce psychosocial exposures and associated health problems cannot be denied (Schnall et al. 2016; Montano et al. 2014; LaMontagne et al. 2007). In the European context, this represents a priority since the EU occupational safety and health legal framework prioritises preventive actions at source in order to reduce risks in the workplace and to promote changes in working conditions with the participation of workers and worker representatives (Framework Directive 89/391/EEC).

Exposure to psychosocial risks among healthcare and long-term care workers is not intrinsic to their work and most of the factors are therefore modifiable. The evidence points to many sources of PSR in these sectors concerning, in particular: high levels of quantitative demands, work-life conflicts, job and working conditions insecurity and emotional demand; but low levels of control of work tasks and conditions, recognition and rewards, and social support. This report highlights that, at the organisational level, the prevention of PSR should focus on collective measures. It is also evident that developing and implementing primary prevention measures to eliminate the risks at source is essential.

The report is structured as follows: Section 1 describes the methodology and data on which the report is based and Section 2 frames the risks within their broader societal context. Section 3 introduces the concept of psychosocial risks and reviews the evidence on the health impacts of PSR in the healthcare and LTC sectors. Section 4 focuses on prevention and mitigation measures for PSR as described in the literature. Section 5 illustrates and enriches the evidence review with qualitative data from Germany, Spain and Sweden; and sections 6 and 7 bring together the findings of the study into conclusions and recommendations.

1. Methods and data

A review of the scientific literature, using PubMed and Scopus databases, was conducted between January 2021 and March 2021 by researchers at Instituto Sindical de Trabajo, Ambiente y Salud (ISTAS-CCOO): Clara Llorens Serrano, Claudia Narocki and Clara Gual, who are also the authors of sections 2 to 4. The evidence review investigated the broad societal context of PSR and summarised the specific sources of psychosocial risks, mitigating measures and interventions at organisational level in the healthcare and residential long-term care sectors.

The qualitative data collection was designed to supplement and expand the findings of the review by way of semi-structured online interviews. Barbara Helfferich conducted the qualitative study with data collection from trade union officials responsible for occupational safety and health (OSH) and those with responsibility for collective bargaining in Germany, Spain and Sweden. Paula Franklin coordinated and contributed to the research presented in this report.

For the qualitative data collection, the first contacts were made with unions that are members of the Sectoral Social Dialogue Committee for the Hospitals and Healthcare sector, in which the European Federation of Public Service Unions (EPSU) and the European Hospital and Healthcare Employers' Association (HOSPEEM) are the social partners at EU level. In Germany, contacts were made with ver.di which brings together a range of occupations in the public, private and not-for-profit health sectors. In Spain, initial contacts were made with the Sanidad y Sectores Sociosanitarios (Health and Socio-sanitary) federation within CCOO (FSS-CCOO) as well as the public service federation of the FeSP-UGT part of UGT. Subsequent contact was also made with Euskal Langileen Alkartasuna ELA – Basque Workers Solidarity and with UGT Catalunya. As for Sweden, interview requests were sent to the main unions in the care sectors: Kommunal (care workers, assistant nurses and other health workers); Vårdförbundet (nurses); Vision (white collar workers); and the ASSR union (academics, professionals and managers). Contact was also made with TCO – the Swedish Confederation for Professional Employees, as well as with LO – the Swedish Trade Union Confederation. Overall, 23 interviews were conducted between September 2021-January 2022 with trade union officials from the healthcare and LTC sectors: nine in Germany, eight in Sweden and six in Spain.

In Spain and Germany, interviews were first conducted with officials at country-wide level; thereafter, regional trade union structures were also approached in order to incorporate a particular regional perspective. The study participants included occupational safety and health representatives at various levels, staff at ombuds offices, collective bargaining officials, works councillors and trade union representatives. The research ethics protocol ensured that participants were provided with transparent information concerning the study and the implications of participation prior to providing their consent. Interviews were recorded where possible (with the agreement of the interviewee) then transcribed for further analysis. The number of interviews was limited due to potential interviewees being involved in addressing urgent matters related to the Covid-19 pandemic. Regardless, the information and materials that were obtained are of great relevance, giving insights into the ways that work-related psychosocial risk factors are addressed in these countries.

The interview schedule addressed the two major issues of the study: the sources of PSR and the measures to prevent them (Annex 1. Interview questionnaire in English, German, Spanish and Swedish). In order to verify the analysis of the interviews, two online focus groups were organised for Germany and Spain in January-February 2022 representing the two subsectors of healthcare and long-term care. As for Sweden, trade unions provided feedback on the findings in written form. The focus groups in Germany and Spain discussed the findings, based on the analysis of the interviews, as well as the conclusions and recommendations of the draft study report.

The three countries – Germany, Spain and Sweden – were chosen because they represent three of the six healthcare sector groups with similar features at European level, as classified by the European Agency for Safety and Health at Work (EU-OSHA) (2014). Germany is from the group of countries in which the healthcare system relies extensively on market mechanisms in regulating both insurance coverage and service provision (also in this group are the Netherlands, Slovakia and Switzerland). Germany has a mixed hospital system: public hospitals (Öffentliche Krankenhäuser); private hospitals (Privatkrankenhäuser); and non-profit hospitals (Frei gemeinnützige Krankenhäuser). Federal and local governments fund both public and university hospitals. Spain is among the majority of EU countries with heavily regulated public systems, separated by differing degrees of stringency of gatekeeping arrangements and of budget constraints (also in this group are Denmark, Finland, Portugal and Spain on the one hand; and Hungary, Ireland, Italy, Norway, Poland and the United Kingdom on the other). The sharp cuts in the Spanish healthcare sector following the 2008/09 economic crisis continue to haunt it today; these cuts resulted in contracts not being renewed and workers who left not being replaced (Healthcare in Europe 2013). As job insecurity abounds, nurses and other healthcare staff have been turning in large numbers to other European countries to find jobs. Sweden is from the group where rules provide patients with choice between providers, with no gatekeeping but an extremely limited private supply (also in this group are Iceland and Turkey).

Concerning residential long-term care, the choice is in line with the European Foundation for the Improvement of Living and Working Conditions report (Eurofound 2017) on European care homes. Regarding the providers of long-term residential care services: Germany is in the group of countries where the share of care homes is more private, with a predominance of non-profit provision; Spain is also in the group where the share is predominantly private and is also among those countries where demand exceeds supply; while Sweden is in the group where public provision constitutes more than half of the total number of care homes. Nordic countries have a long tradition of residential care, but the trend there is now for de-institutionalisation; while southern countries like Spain are increasing residential care by privatisation and the commercialisation of long-term care.

The Eurofound (2018) report on industrial relations in Europe locates Germany and Sweden in the cluster labelled 'organised corporatism'. These countries have strong traditions of regulation based on associational governance (high collective bargaining coverage). Nordic countries share coordinated and centralised collective bargaining systems. However, these systems have evolved – particularly in Sweden and Denmark – into a two-tier system of centralised-decentralised collective bargaining. National and sectoral framework agreements are supplemented by company agreements covering topics such as vocational training, work organisation, company-level social security and employability/workability. The state interferes the least in collective bargaining and wage setting in this cluster and trade unions are at their strongest (with the exception of Germany, where trade union density is much lower). A key defining feature of this cluster is the positive combination of collective autonomy and high associational governance. It includes countries that provide extensive rights to works councils, particularly Germany and Sweden, where co-determination rights are established by law. National and sectoral collective agreements in Nordic countries provide higher standards of information sharing and consultation than are set down in the legal provisions, as well as widespread participation rights to employees in terms of representation at board level. Spain is within the cluster of countries labelled 'state-centred associational governance' whose defining features are high collective bargaining coverage within centralised but quite uncoordinated collective bargaining, institutions that are dependent on state regulation, low trade union density and limited performance in social dialogue at company level. Mandatory works councils exist at company level but they are granted few wide-ranging legal rights and board-level employee representation rights are limited.

2. The context

2.1 Commercialisation of care, austerity and lack of staff

Tensions in healthcare organisations were felt during the last decade in the public sector. Countries that suffered reductions or very slow growth in financing public health systems experienced, among other issues, staffing reductions, increasing workloads for healthcare personnel and reductions in workers' remuneration. Austerity measures led also to hospital closures, restructuring of care delivery systems, privatisation and managerial reforms that introduced market-like mechanisms. These processes strained public health systems, affected the quality of service (e.g. through bed closures and service cancellations) and broadened the scope of two-speed medicine; as the number of health services not covered by the public system increased, the share of expenditure on private medicine, either private insurance or out-of-pocket payments, grew (OECD/European Union 2020).

The financing of the public sector was not only cut in this decade; it was also reshaped. A new way to allocate public funding to public healthcare institutions was introduced, switching from a global fixed budget based on the number of admissions or the number of beds occupied to a 'financing for service' model. Under this, care units are financed according to performance indicators based on diagnosis and therapeutic procedures or on flat fees based on national average stays. In long-term care, with much less public funding right across Europe although with enormous differences between Nordic countries and the rest, the main public policy question concerning public funding regards the relationship between service provision and costs. Advocates of the private provision of services state that competition between service providers increases the quality and efficiency of services at reduced cost to the public sector. This stance has been the norm for the majority of EU countries. Reforms in public sector funding thus put the emphasis on performance, contractualisation and the adoption of management practices from the private sector, particularly in LTC. Market mechanisms and quasi-markets were introduced so that different types of providers competed with one another. These reforms and market mechanisms resulted in competitive tendering, commissioning, user choice, user fees and vouchers in long-term care (Eurofound 2017). In a labour-intensive sector where activity has a low market value, like most feminised care activities, competitiveness is obtained by the majority of employers through the low road of making working conditions more precarious.

The New Public Management (NPM) approach was introduced in the healthcare and LTC sector, as in other fields of the public sector, as a way to increase efficiency and productivity and to cope with reduced budgets. It resulted in performance monitoring and metrics, as well as work intensification, rising quantitative demands and reduced job control (Schnall et al. 2016). In private healthcare companies, there was also a restructuring of the industry as a response to intensified market competition. New mottos appeared as in 'no empty beds', 'just-in-time' and 'lean management', characterised by last-minute changes in schedule, overtime and atypical hours. NPM standardised practices by removing (or rending invisible) difficult-to-quantify tasks connected with the building and maintaining of care relationships (the social care content of work), replacing it with a focus on medically linked, technical tasks and documented outcomes (Baines and Cunningham 2013).

Introducing the 'business model' into care work has had an impact on workloads. Under the new labour management practices, personnel became 'human resources' and human resources staff assumed roles in organising healthcare personnel according to numerical objectives. These management models are an ill-fit in a care context as they reduce the complexity of activities into graphs and tables and ignore the effects on the quality of care given to patients and on the quality of the working conditions of staff (Barnes and Armstrong 2019).

The reduction or removal of relationship-building practices (sitting and talking, reading, trips outside) has left many LTC staff with workloads consisting almost entirely of repetitive technical tasks to be accomplished in the shortest time possible. Most care work cannot be documented in these narrow metrics and thus it is rendered invisible in the documentary practices of the workplace. Under masculinist Taylorised New Public Management, work has become task-oriented. Furthermore, excluding care, the backbone of work in this sector, from the official 'job' of LTC workers results in them putting in extra unpaid overtime hours to complete their regular workloads because the time to provide care to residents is not being counted. Another source of unpaid overtime is entering work early to ease shift changes. This unpaid work goes officially unrecognised but management has come to rely on it to stretch resources in the context of underfunding (Baines and Armstrong 2019).

In the LTC system, the private sector has flourished as a result of privatisation and subcontracting with the public sector. Competitive tendering by price and market competition, beside weak institutional constraints, allows understaffing, very high workloads and other poor working conditions. As a result, working conditions in long-term care facilities across Europe fit in the 'low road model' of managerial methods (Ibañez and Narocki 2012; Findlay et al. 2017; Osterman 2017). Jobs are physically and mentally very demanding: half of LTC workers work shifts – a work mode associated with health risks such as anxiety, burnout and depression – but they earn much less than those working in similar occupations in hospitals. Non-standard employment, including part-time and temporary work, is common in the

sector: almost half (45 per cent) of LTC workers in OECD countries work part-time, which is over twice the share in the whole economy; while temporary employment is frequent – almost one in five LTC workers has a temporary contract compared to just over one in ten in hospitals (OECD 2020; Eurofound 2020; Eurofound 2017). As permanent personnel on fixed-term, full-time contracts are retiring, employers are increasingly recruiting by flexible arrangements not only to 'fill in' workforce gaps for short periods of time but to gain functional flexibility, temporal flexibility and workforce size flexibility (MacPhee and Svendsen Borra 2012).

Understaffing is found to be implicated in many working conditions that correlate with psychosocial risks; that is, low social support, low control and high work-life conflict (Cramer and Hunter 2019). The 'leanness' of staffing models also limits opportunities for skill development due to lack of time (Findlay et al. 2017; Lindsay et al. 2014). A mixed-methods intervention study in an emergency department found understaffing a barrier to the success of participative interventions to improve the working environment (Schneider et al. 2019). The evidence highlights that understaffing is not only a source of quantitative demands but that it compromises preventive measures devoted to increase job control or provide social support. A lean intervention study in a large US outpatient care system found that doctors and non-physician staff reported higher levels of control and social support; however, both described increased burnout in follow-up research alongside a higher workload than at the baseline (Hung et al. 2018).

There is an increased need for health and long-term care arising from chronic illnesses and rising life expectancy in most European countries but the needs are scarcely being met. In many countries there is a shortage of trained personnel, especially nurses, leading to staffing shortages (Franklin et al. 2020). Nurses are abandoning the profession before they reach official retirement age due to the physical, psychological and social demands. A major study with over 28 000 participants from ten European countries found that high psychological burdens were the strongest factor associated with an intention to leave the profession. Meanwhile, in some countries, budget cuts have led to a freezing of contracts thereby creating a large reserve of unemployed and under-employed healthcare staff, mainly nurses (Maatouk et al. 2018).

The Covid-19 pandemic underlined the already existing crisis and inequalities in the healthcare system. The dramatic rise in healthcare demand resulting from Covid-19 was concentrated in specialist acute care where the pre-existing shortage of nurses was exacerbated by many nurses becoming infected with the virus (Barrett and Heale 2021). The unpreparedness of the LTC sector was equally evident (see the evidence of the International Long-Term Care Policy Network). Meanwhile, just as the pandemic brought a precipitous decline in demand for some routine services, an upsurge is expected in the aftermath in terms of the healthcare needs associated with secondary diseases, the mental health impact on the population and with the multiplying effect of the delays in patients entering the system (Florek 2021).

2.2 Devaluing healthcare and LTC work: gender and intersecting inequalities

Two-thirds of healthcare workers worldwide are women (ILO 2018) and the share of women in the total healthcare workforce in the EU is 86 per cent (Franklin et al. 2021). Nurses find their profession devalued by gendered rules emerging from the care contents of their tasks. Representing nursing as a vocation results in a demand for aptitudes such as will, tenacity and self-sacrifice and for the personal traits of devotion, patience and availability. Such representations can be a source of PSR as they clash with strong professional definitions based on knowledge requirements, the complexity of tasks, technical training and labour rights. Adding to this, an emphasis on emotional, personal and therapeutic relationships with patients can lead to exaggerated expectations of what workers can and should do (Meseguer Gancedo 2018).

Nursing professionals with academic degrees describe nursing as offering broad horizons and the potential for advancement but, at the same time, express feelings that their expertise is undervalued as their pay does not equal the level of responsibility and autonomy they hold and that their skills, knowledge and experience are underused (Baines and Armstrong 2019; Hallin and Danielson 2008). The frequent subordination of nurses' knowledge and curtailments of their autonomy and status leads to nurse turnover and burnout (Schneider 2015).

Studies in LTC facilities show how the New Public Management approach has contributed to the deskilling of feminised care work and the shifting of power from frontline care workers to management. Workers would like to determine what tasks to undertake and in what order; what tasks to prioritise and which ones to downplay when they run short on time; and to have input into how care is planned for, funded and provided. However, they are left with workloads consisting almost entirely of standardised repetitive technical tasks (feeding, toileting, showering, dispensing medications and moving residents around the building) without autonomy on the job (Baines and Armstrong 2019; Moré 2016; Recio Cáceres et al. 2015). As the time spent on such tasks is not seen as 'profitable' from a managerial point of view, albeit being a central aspect of the role, they become sources of PSR for workers (mainly via low control and high demands). Further, healthcare and LTC organisations moving to 'customer-focused' care can heighten tensions between professional autonomy and service roles, reinforcing gender-work stereotypes, as female nurses are expected to fill a maid or waitressing role for patients or their families. Conflicts arise with some frequency in relations with patients and their families concerning requirements for availability or about demands for complete and rapid information, leading to aggressive or violent reactions becoming commonplace (Schneider 2016; Meseguer Gancedo 2018).

Research shows that nurses are less well-paid than those at the same level from a different professional background, especially those with an academic degree: they receive lower wages compared to other university graduates.

That difference becomes more noticeable over the years as salaries do not grow with specialisation. Some have attributed this to the notion that the intrinsic rewards justify inadequate wages (Clayton-Hathway 2020). In countries in which some occupational groups in the healthcare and LTC sector are receiving very low remuneration in terms of purchasing power, it is not unusual that part of their earnings is also irregular, subject to working unsocial hours (holidays, evenings and nights) and overtime; and that income can be radically reduced during periods of illness. In the case of Spain, low-paid personnel, both nurses and nursing assistants, and especially those working in eldercare in nursing homes, often combine more than one job to obtain an income which covers basic needs (Fité-Serra 2019). The lack of economic recognition is apparent in this situation.

Vertical differentiation between categories of workers has advanced during the last two decades as the result of the social contingencies that structure the professions in different countries (e.g. unionisation, educational requirements, the strength of professional associations and migration flows). The intersections of gender, ethnicity, race, class and migration status add further to the structural inequalities (Schneider 2016). A body of research highlights the inequalities in psychosocial risk exposure and health according to occupational class and gender (Niedhammer et al. 2017; Schütte et al. 2015; Nyberg et al. 2015; Campos-Serna et al. 2013; Landsbergis et al. 2014), while a recent cross-sectional study among registered nurses found that migrant status is associated with a higher risk of workplace discrimination and that lower levels of control over one's own job may partly contribute to the risk (Wesołowska et al. 2020).

Healthcare personnel work alongside nurses with various job titles, including nursing assistants, nursing aides and auxiliary nurses, while other job titles include healthcare assistants and 'caregivers', a category with low job entry hurdles and without externally recognised occupational training or education requirements. Caregiving is still considered a low-skill or a non-skilled job, as its area of competence references the domestic activities traditionally performed by women and it has very low levels of autonomy. For example, 28 per cent of Swedish practical nurses are on temporary hourly contracts, while one-fifth of those with a more permanent contract lack formal education or training (Szebehely 2020). In the LTC sector, untrained personnel predominate (Huupponen 2021).

Low levels of unionisation in the private sector increase the gap in status and salaries between 'proper nurses' and 'caregivers', especially in countries where the wage is negotiated individually and is dependent on candidates' profiles, qualifications and soft skills such as language proficiency (ETUI HesaMag 2015). Migrant care workers may be exposed to job insecurity, working for poor levels of remuneration or under substandard working conditions; that is, without being integrated into the host country's social systems, without work safety standards and without being covered by collective bargaining agreements (Rogalewski 2018; Burke and Wolpin 2015). Some companies use exploitative clauses including lower wages, longer hours

and even disclosure prohibition clauses; in some cases, contracts include clauses that forbid resignation or even include financial penalties for doing so. Such situations of the exploitation of migrants fit within the practices of social dumping and are found in private sectors in countries where there is weak or no collective agreements (Guzi and Kahanec 2015; Kuhlmann et al. 2019; ETUI HesaMag 2015). On the contrary, welfare regimes characterised by strong social protection and high union density moderate the association between job insecurity and negative outcomes for migrant workers (Sverke et al. 2019).

3. Work-related psychosocial risks: sources and factors

The scientific evidence in relation to the psychosocial work environment is extensive and documents a wide spectrum of adverse health effects. The psychosocial risk dimensions of Karasek-Theorell-Johnson-Hall's *demand-control-social support* (Karasek 1979; Johnson and Hall 1988; Karasek and Theorell 1990) and Siegrist's *effort-rewards* (1996) models have been the most used in the scientific literature to show this relationship. Recent systematic reviews associate these dimensions with highly prevalent problems (Niedhammer et al. 2021), such as anxiety and depression (Harvey et al. 2017; Theorell et al. 2015), myocardial infarction or strokes (Taouk et al. 2020; Theorell et al. 2016), based on longitudinal investigations with large databases that reliably rule out chance (Kivimäki et al. 2018). These risks are also considered one of the most relevant causes of absenteeism (Niedhammer et al. 2017) and sickness presenteeism (d'Errico et al. 2016) and are associated with a greater probability of suffering from musculo-skeletal disorders (Kraatz et al. 2013; Hauke et al. 2011). PSR has also been linked to suicide and the ideation of suicide (Milner et al. 2018). The relationship between exposure to psychosocial risks and the consumption of psychotropic drugs and painkillers has been established (Milner et al. 2019).

Demands or *efforts* in these two models consider the quantitative point of view; they refer to the workload in relation to the time available to perform it. From a qualitative perspective, demands are different if one is working with and for people, in which case reference is made to 'emotional demands' (Dormann and Zapf 2004; Vanroelen et al. 2009). *Control* is two-fold, referring to skill discretion and decision-making authority, meaning influence on how work is done and the possibilities for applying and developing skill in performing one's work. *Social support* refers basically to peer and supervisor functional support in performing tasks and not working in isolation. *Rewards* refer mainly to job security, remuneration, career progress and recognition, also known as esteem, which employees expect in return for their efforts at work.

Recently, research on job insecurity, a work-related psychosocial risk that reduces work-related health and wellbeing, has evolved (Virtanen et al. 2013; De Witte 2016). Consideration of work-life conflict as an occupational psychosocial risk deals with the possible consequences of employment for unpaid care and household work. This increases total work demands and working hours ('double work') and, at the same time, it implies the need to organise and manage the demands, which may be simultaneous, of the two different spaces. Both the 'double work' demands and their possible

synchronicity can lead to conflicts of time and energy for the mainly female workers (given the unequal gender distribution of unpaid work) affecting their health and wellbeing (Lunau et al. 2014; Cooklin et al. 2016; Franklin et al. 2022).

Based on European Working Conditions Survey (EWCS) data, Eurofound identified five working conditions profiles, two of which – 'under pressure' jobs (13 per cent of all jobs) and 'poor quality' jobs (20 per cent of all jobs) – are considered those most exposed to psychosocial risks. Most women profiled in 'under pressure' jobs worked in the healthcare and LTC sectors (Eurofound 2021). An EU-OSHA (2014) report on these same sectors outlined eight psychosocial risks as the most prevalent and serious: high workload and time pressures; lack of control regarding how work is carried out; multitask working in various departments within a hospital; poor organisational climate; lack of optimal working times leading to work-life conflicts; emotional demands; and a lack of financial support culminating in job insecurity.

The LTC sector scores below the healthcare sector for job prospects and monthly earnings (lower rewards) and discretion and skills development (lower control); it also scores higher than average and similar to healthcare for work intensity (similar quantitative demands) and below the healthcare sector for working time quality (higher work-life conflicts) and social environment (lower support from superiors and peers) (Eurofound 2020).

The negative impact of the Covid-19 pandemic further exacerbated quantitative demands and work-life conflicts because of the increasing numbers of patients and working hours, additional and short-notice shifts and staff shortages within healthcare systems. The scoping review conducted by Franklin and Gkiouleka (2021) of health workers' exposure to PSR during the pandemic showed that the risk factors concerned overtime working, excessive workloads and time pressures, an insufficient number of rest breaks and days away from work, and shift work. These working conditions lead to high quantitative demands and poor work-life balance further compounded by low rewards stemming from low wages and job insecurity.

3.1 PSR exposures and associated health impacts in the healthcare and LTC sectors

Healthcare workers experience high rates of mental ill-health such as burnout, stress, post-traumatic stress disorder, anxiety and depression due to psychosocial workplace conditions including excessive workloads (Gray et al. 2019; Bridgeman et al. 2018). A systematic review and meta-analysis of research studies on hospital nursing staff showed that an increase of one patient per registered nurse is consistently associated with a seven per cent increase in the odds of burnout among nurses and a five per cent rise in intention to leave the profession (Shin et al. 2018). Bae's (2021) systematic review of intensive care nurses found that, when the number of nursing staff

is low (i.e. a higher number of patients per nurse), levels of burnout, stress and fatigue are higher (increasing between 127 per cent and 178 per cent) (Bae 2021).

Exposure to traumatised individuals results in compassion fatigue among healthcare workers (Cocker and Joss 2016), while working in emotionally charged situations is an origin of stress and burnout (Adriaenssens et al. 2015; Zapf and Holz 2006). High emotional demands lie at the very heart of healthcare and LTC tasks and cannot be removed. However, the understaffing that characterises the healthcare and LTC sectors entails elevated patient-professional ratios and long working hours that increase exposure to emotional demands and cause higher emotional exhaustion leading, as a consequence, to longer recovery periods (Cramer and Hunter 2019; Bae 2021). Also directly related with emotional demands is frustration and the sense of powerlessness that occur when nursing professionals find themselves unable to provide the care their patients need as a result of understaffing, high workloads or a lack of resources (Angelos 2020; Franklin and Gkiouleka 2021).

PSR factors are associated with musculoskeletal disorders (Roquelaure 2018; Macdonald and Oakman 2022). Concerning nursing assistants in nursing homes, Ching et al. (2018) found a synergistic effect of long working hours without sufficient rest breaks because of staff shortages and an ageing workforce with a strong commitment to residential care, and that this played a crucial role in the development of work-related musculoskeletal disorders (see also Pelissier et al. 2014; Helgesson et al. 2020; Bernal et al. 2015).

A low level of communication between colleagues and neglected social relationships are associated with depressive symptoms linked with the perception of an imbalance between efforts and rewards (Jolivet et al. 2010). Lack of appropriate spaces and time for staff to share breaks or meet informally have a negative impact on the working environment (Pollock et al. 2020; Bridges et al. 2017; Cole-King and Dykes 2020; Teoh and Kinman 2020). Evidence also shows that a lack of strategies to partner inexperienced nurses with more experienced colleagues has a negative impact on social support (Billings et al. 2020; Maunder et al. 2006; World Health Organization 2020a).

In the residential long-term care sector, low possibilities for development and low influence have been shown to be the strongest predictors of high levels of depressive symptoms (Jakobsen et al. 2015) and long-term absenteeism (Clausen et al. 2012). High quantitative demands, low quality of leadership and excessive physical workloads (Januario et al. 2019), as well as emotional demand, high role conflict and a lack of support from colleagues and superiors (Clausen et al. 2012), have been linked to LTC workers experiencing long-term absenteeism due to illness.

Inadequate income, implying low and irregular pay and a lack of pensions and health insurance where these are not provided by the state, is highly stressful (Cramer and Hunter 2019). Burnout is associated with lower salaries in the UK National Health Service (Clayton-Hathway 2020) while frustration over

poor economic rewards is a major explanator of intent to leave the nursing profession (Jian 2011).

The literature records job and working conditions insecurity in the healthcare and LTC sectors stemming from cost-cutting in personnel, such as layoffs and hiring freezes or the use of fixed-term contracts; the reassessment, re-planning and reorganising of an activity; and understaffing. These factors pose demands for worker availability regarding working time and are associated with unpredictable income (financial stress) as well as the task and work rotation that are an intrinsic part of the creation of 'floating' staff; that is, the practice of 'assigning nurses to nursing units other than those they are regularly assigned to work' (Griffiths et al. 2021; Dall'Ora and Griffiths 2017).

Work-life conflict is associated with lower mental health among nursing assistants and licensed practical nurses than registered nurses (Zhang et al. 2016; Zhang et al. 2017) and with cardiometabolic risk among nursing assistants (Berkman et al. 2015). Work-life conflict arises from a low influence over shifts (e.g. the low possibility of swapping shifts, lack of control over shift patterns and having short notice of shifts), the number of weekend shifts, long working hours per week and high quantitative demands (Peter et al. 2021; Cramer and Hunter 2019; Zhang et al. 2017).

4. Overview of PSR prevention at organisational level

Many exposures to psychosocial risks among healthcare and LTC workers are not intrinsic to their work and are therefore modifiable. Workers are exposed to other psychosocial risks than those related to being involved in challenging or traumatic clinical situations and even the exposures regarding emotional demands seem to be affected by many other work variables which are modifiable.

4.1 Staffing

To reduce the high quantitative demands and work-life conflicts in the healthcare and LTC sectors, the literature points to higher numbers of staff as a necessary preventive measure: understaffing is the most prevalent source of PSR exposure among healthcare and LTC workers. Where public funding plays a role in LTC, public procurement requirements could be used by governments to improve ratios and general working conditions (Eurofound 2020).

The study in an acute care hospital by Bourbonnais et al. (2011) found that long-term significant improvements in working environment and worker health were achieved through the reduction of quantitative demands. Some measures included hiring more staff to replace personnel on extended leave, creating new work positions, revising and adapting workloads and ensuring the overlapping of shifts. Likewise, a thematic literature review by Cramer and Hunter (2019) on midwives' wellbeing concluded that efforts should prioritise improvements to staffing while White et al. (2019) found that the amelioration of the psychosocial work environment of registered nurses in nursing homes requires sufficient staff which, in turn, will enhance the retention of care and nursing staff. The same issue was identified by Kossek et al. (2016), whose qualitative study among work schedulers in healthcare facilities indicated understaffing as the main problem for work scheduling which would take into account employees' family care needs, and employee time control in general, in a round-the-clock eldercare facility.

4.2 Supportive working environment

A recent mixed-methods systematic review of the effectiveness of interventions for health and social care professionals (Pollock et al. 2020) highlighted the importance of the support of work colleagues in protection against mental health problems and the promotion of wellbeing. Studies have shown that workers appreciate having a workspace as a meeting point where they can offer help to each other (Adams and Walls 2020; Billings et al. 2020; Maben and Bridges 2020; Bridges et al. 2017; Cole-King and Dykes 2020). Built-in, scheduled opportunities for a team to check-in on each other's wellbeing and provide peer support during shifts has been highlighted as important in building a supportive work environment (Billings et al. 2020; Bridges et al. 2017). Likewise, reserved time for team meetings for small staff groups and weekly review meetings to resolve issues that are depleting wellbeing have been considered elements of a supportive working environment (Bridges et al. 2017; Cole-King and Dykes 2020; Groves 2020). A systematic review by Pollock et al. (2020) established that staff 'huddles' or handovers can be useful ways to check-in with each other, while shared break times also present opportunities for doing so. Social support is also built by making sure that other team members know if someone needs particular support during a shift (Bridges et al. 2017; Cole-King and Dykes 2020; Teoh and Kinman 2020).

In crisis or pandemic situations, it is important to implement regular meetings where staff can share experiences and obtain reassurance (Pollock et al. 2020; Adams and Walls 2020; Billings et al. 2020; Cole-King and Dykes 2020; Belfroid et al. 2018; Bridges et al. 2017). There is documentary evidence that communication is key to achieving social support at work, so training in communications and feedback skills can improve the social support given by supervisors and colleagues (Orgambídez and Almeida 2020). Being listened to and receiving functional support from colleagues and line management when performing tasks has a strong impact on wellbeing at work in hospitals (Roland-Lévy et al. 2014).

High role clarity has been found to help in the building of social support. Clearly defined expectations, tasks, functions and responsibilities reduce uncertainty and the unfair distribution of tasks (Orgambídez and Almeida 2020). A supportive and positive organisational culture can only be achieved when management carries a real concern about staff wellbeing. Leadership support can also be built by ensuring that staff have sufficient recovery time and work-life balance, allowing the organisation of short working shifts and support for flexible schedules to adapt to workers' needs where possible (Adams and Walls 2020; Dall'Ora et al. 2019; World Health Organization 2020b). On the contrary, a command-and-control management style – characterised by low social support from superiors and a lack of staff participation – may enable bullying in response to workers' concerns about their safety (Ananda-Rajah et al. 2020; Giorgi et al. 2020).

4.3 Direct participation

Direct participation practices are found to have positive impacts in psychosocial work environments and involving frontline staff in the design and implementation of interventions has been identified as a key success factor (Gray et al. 2019).

Although work processes in healthcare and LTC services are complex and governed by regulations, there is space for developing direct group participation practices that can mitigate low control and increase social support. Applying participatory continuous improvement can increase worker wellbeing (von Thiele Schwarz et al. 2017), while direct group participation mitigates low control and allows social support to be better than in an authoritarian or routinised work organisation. However, direct participation practices in lean and New Public Management processes, characterised by understaffing and work intensification, compromise such measures (Parker et al. 2017; Findlay et al. 2017).

Where there is unionised representation of workers with collective power, preventive action at source is more frequent and has been shown to have better results (Walters and Wadsworth 2017; Janetzke and Ertel 2017).

4.4 Scheduling which takes account of care work at home

Unilateral employer configuration of working time arrangements (i.e. a lack of employee scheduling control) has been proven to be harmful to workers' health. Scheduling control has been treated mainly as an individual job characteristic but it is, in fact, a key aspect of the employment relationship that plays a potentially critical role in employee wellbeing and in job and organisational effectiveness (Kossek et al. 2016).

The literature associates work-life balance with greater employee control regarding schedules, meaning increased influence on working hours and the possibility of adjusting working hours to family care needs. In the LTC sector, interventions designed to increase work-nonwork supervisor support and control over working time may benefit caregivers, especially those with 'double duty' elder caregiving at home and work, and 'triple duty' encompassing also childcare (Kossek et al. 2019). Cross-sectional studies note that facilitating employees to manage the work-life interface may improve staff retention since it influences workability (Weale et al. 2019) while also buffering emotional exhaustion and turnover intentions among 'double duty' and 'triple duty' caregivers (DePasquale et al. 2018).

4.5 Fair rewards

The devaluation of care work can be mitigated by fair rewards, including equal pay and decent remuneration (Meagher et al. 2016). Further measures to address the lack of recognition include acknowledgement of occupational competence, recognising experience and rewarding the diverse skills required in care work. More stable jobs and working conditions are also important measures that address the upstream sources of PSR. Fair rewards concern a combination of measures and interventions; for example, the benefits of scheduling LTC work with a consideration of care work at home, as a single measure, are limited unless they are also coupled with increased pay and staffing (Kossek et al. 2019).

4.6 Resources for coping with emotional demands

The work environment is an essential factor in understanding the management of emotion. While high emotional demands are intrinsic to the nature of both healthcare and LTC work, working conditions can either exaggerate or help to reduce them. Health and care professionals are expected continually to manipulate their emotions, with primary PSR prevention measures at the collective level including social support and job control, for example taking breaks and reserving sufficient time to attend to each client (Ybema and Smulders 2001; de Jonge et al. 1999, 2000). Emotional demands and emotionally demanding tasks can also be rotated with ones that are not so emotionally demanding, giving workers the opportunity to distance themselves from emotionally stressful work (Van Vegchel et al. 2004). In the Covid-19 pandemic, doing away with all non-urgent issues to alleviate the staff burden (Cole-King and Dykes 2020) and rotating nurses from high stress to low stress functions where possible were also recommended (Billings et al. 2020; World Health Organization 2020a).

Due to emotional demands and stressors, the concept of resilience has gained recognition in the field of healthcare (Hart et al. 2014; Jackson et al. 2007; McAllister 2009; McCann et al. 2013). Resilience is defined as personal resources or the static, positive personality characteristics that enhance individual adaptation (Block 1996; Nowack 1989; Wagnild and Young 1993). Evidence on the effectiveness of training and measures to increase and boost the resilience of healthcare workers remains inconclusive, however. The systematic review by Robertson et al. (2016) concluded that the resilience of healthcare professionals is multifaceted, so training and individual interventions must combine social and workplace features, while that by Kunzler et al. (2020) established that, for healthcare professionals, there is very low certainty of evidence that resilience training results in lower levels of depression or stress and higher levels of resilience factors post intervention.

Resilience promotion focuses on the individual level and does not mitigate systemic problems such as understaffing. Focusing on personal responsibility for psychological health and wellbeing, and treating resilience as an individual

trait, is seen to 'let organizations off the hook' (Traynor 2018) – yet this has often been the focus of organisational practices to date. This does not work at the best of times and certainly was not appropriate during the difficult circumstances of the Covid-19 pandemic (Maben and Bridges 2020).

As a secondary prevention measure, establishing an external support network, for example clinical psychologists or mental health support teams, and proactively offering this support is highly important in the mitigation of emotional demands (Shamia et al. 2015). Planning for long-term support programmes for post-traumatic stress recovery (Billings et al. 2020) and providing information on the range of confidential support options for trauma-exposed staff and their families can also help (Greenberg et al. 2015).

As is evident, the sources, factors and prevention measures appropriate to work-related PSR are numerous in the healthcare and LTC sectors. The following sections illustrate these issues in three country contexts – Germany, Spain and Sweden – as described by our interviewees.[1]

1. Interviews were conducted in German in Germany and Spanish in Spain and translated into English.

5. Work-related PSR in different contexts: Germany, Spain, Sweden

Germany

German legislation remains rather uncommitted as regards PSR in the healthcare and LTC sectors while the range of prevention and mitigation measures is also relatively limited. While there is stringent legislation regarding the infrastructure of care homes, for example on the height of banisters, there is relatively little specific legislation that addresses working conditions. Issues such as violence in the workplace, long working hours, double shifts and poor management practices are often dealt with at company level and, in the best cases, through collective agreements. The quasi absence of works councils in many healthcare and LTC institutions does not make it easy for staff to claim their rights or improve their situation. Many workers have opted to leave the profession, and indeed are doing so, which makes it even more difficult for those who decide to stay in the job.

Almost 12 000 employees from hospitals, psychiatric clinics, eldercare facilities and other similar service sectors took part in a survey organised by ver.di, Germany's largest public service union. The survey revealed the extent of the problems that the industry is facing. There is a lack of time and staff while the quality of care is suffering and the health of employees is at stake. Of those who responded to the survey, a mere 18 per cent believed they will be able to hold out until statutory retirement (ver.di Versorgungsbarometer 2021).

> 'There is no doubt, in anyone's mind. Everyone knows that we have 'a care emergency', but nobody does anything about it.' (ver.di)

At floor or ward level, there are few prevention measures in place, if any. If a grievance arises, workers can approach supervisors but do not do so very often because they know there is little that they can do. Exhaustion and disillusion often keep healthcare and LTC workers from taking action. Workers can, of course, turn their complaints over to the trade union or OSH worker representative and ask for a risk assessment (Gefährdungsanalyse).

Works councils, too, can ask for a risk assessment which then needs to be followed up with a catalogue of measures although the implementation of these is, however, left to employers who do not have to fear sanctions or penalties should they fail to apply them. Works councils have been shown to be effective in addressing PSR, but their coverage remains poor. While it is difficult to

know how many there are, trade unionists estimate that they are present in around only 10 per cent of LTC care companies. One of the biggest companies running care institutions in Germany is Korian with 270 institutions and 25 000 employees. Only three of these institutions have in-house collective agreements as of November 2021; 20-25 per cent have works councils; and salaries are not negotiated but solely determined by the employer.

> 'If there is enough pressure from staff, works councils can be created, but we are facing a situation where staff are too overloaded, with many of the female staff also juggling family responsibilities. In these scenarios, it is hard to find activists who have the time and the energy to ask for the creation of a works council.' (ver.di)

Union representatives also report strong resistance by employers against the creation of work councils – ranging from spreading tales about workers' reps having beautiful offices to hiring detectives to collect information or forbidding union representatives to enter the premises.

Spain

In the healthcare and LTC sectors in Spain, attention to PSR first emerged due to the number of musculoskeletal disorders and injuries that workers reported. As part of their daily work, they had to lift on average 12 patients, often in less than one hour. When unions began to work on these health issues, they also found that many workers suffered major headaches and had some serious mental health issues, acknowledging the health problems related to PSR exposure.

> 'We clearly saw the need to integrate psychosocial risks and give them our priority.' (CCOO)

PSR is now recognised as the most important cause of ill-health in the Spanish healthcare and LTC sectors. There is a general understanding among union officials, particularly those in charge of issues of care, that PSR is significantly related to the health issues caused by poor work organisation.

> 'By law, employers are obliged to make a risk assessment that includes PSR, but the majority of companies or centres engaged in health services and LTC do not regularly assess the risks that each job position may entail. Those who do most often fail to include PSR; and only three per cent of Catalan companies have evaluated the psychosocial risks that affect their workers. Of this three per cent, only 70 per cent – that is to say, globally just over two per cent – have planned measures to confront this type of risk.' (FSS-CCOO)

> 'These are the 'forgotten risks' – always... There is a lot of difference between the public health services and big companies, and the smaller private companies, like private eldercare centres for example. The public

> and big companies usually have something done on PSR, but the private/ small ones do not; it is very rare to see a PSR assessment already having been done in these centres. Our job is to demand that employers first make this assessment; it is the first step to be able to take measures afterwards.' (ELA)

Since the principle of prevention at source is not being applied and working conditions are not improved, the negative health impacts of PSRs are reflected in growing prescription drug dependency among workers. Many workers need to take medication, such as diazepam, to survive working in this sector, taking pills before and after their shifts as a result of the emotional and physical demands being too heavy. There is also the use of so-called 'prevention pills' where workers know that, after their working day, they'll have a headache so they take ibuprofen at the start of their working day to prevent it. Workers are aware when their arm or leg aches because of their work but, when they cannot sleep at night or when they start to lose their appetite, it becomes more difficult to associate the health symptoms with PSR at work.

> 'The "wounds of the soul" are too often invisible, but they're there. At the end, when your mental health is not OK; you'll end up also having psychical health problems because your body tries to speak to you.' (CCOO)

> 'We're training our delegates on PSR. We've also done campaigns to create awareness on the issue; for example we launched a campaign about drug dependency and over-prescription. Many workers cannot afford to take medical leave and they take pills to be able to keep working.' (FSS-CCOO, Galicia)

> 'PSR is derived or linked to the organisation of the work, workload, tasks… These are the most important risks and are normally reflected as stress, anxiety, depression and, in extreme cases, if not addressed, could lead to suicide. It is also linked to cases of bullying and harassment.' (UGT Catalunya)

The Covid-19 pandemic finally convinced employers to start improving workers' safety in terms of making protective equipment available. However, discussions and reflections on what to consider in crisis conditions in terms of PSR have not yet really taken place and union officials noted that Covid-19 has not changed the rules and practices to address PSR. The law indicates that employers in the healthcare and LTC sectors are obliged to make contingency plans in which different aspects have to be covered – safety measures (e.g. personal protective equipment, masks and hydrogel); collective safety measures (e.g. seating spaces and teleworking); and identifying the risk of being infected by Covid-19 at work – but PSRs are not fully reflected in these plans.

Union officials lament poor management practices in both private and public healthcare and LTC facilities. The often-deliberate failure of employers

to match health and caring needs with an adequate number of workers, alongside the ever-increasing shortage of healthcare and LTC workers caused by mounting numbers of workers on sick leave, are factors that are raising PSR considerably.

> 'We need to consider that the private and public health and care sectors are very different. If in the public we're paying little attention to PSR, in the private the situation is worse.' (UGT)

Sweden

Trade unions observe that psychosocial risks in Sweden have steadily been on the increase as health and care workers have less and less time to reflect and recover on the job while many also struggle to reconcile private life with work. Moreover, the code of ethics in the healthcare and LTC sectors is also a risk factor in a profession where individuals want to do good but their experience is that they cannot do so in the way they have been trained because resources are too scarce. Trade unions refer to the loss of control over one's working schedule and of participation in structuring the work as important sources of PSR. The Covid-19 pandemic seems to have cast a critical light on these practices.

Unions report that Covid-19 did not really have an impact on the established practices of PSR prevention and mitigation at the workplace. However, they also note that the issues became more high profile as a result of the pandemic which caused stress reactions among their members.

> 'We think that the Covid-19 pandemic clarified the problem. For example, the government appointed a commission, 'the Corona Commission', that clarified all the different problem areas we have been pointing out for several years.' (Kommunal)

Unions point to important studies which show that people working in the healthcare and LTC sectors, as well as in teaching, had been among the healthiest of occupations in Sweden in the 1990s. With the slimming of the state sector in that decade, the remaining employees had to work the same but with fewer resources. It is therefore no surprise that recent figures show that the healthcare and LTC sectors now have the highest number of requests for sick leave (Huupponen 2021). Conversely, two municipalities which have abided by the old ways – neither did they cut staff, nor did they introduce NPM – have a sickness leave rate as low as it was in the 1970s (Klepke 2018; Karlsson 2013).

> 'Sick leave among women is almost twice as high as that of men. It remains true that pressures of work-life balance are unequally distributed between women and men, but there are also other health hazards that are particular for women such as having less opportunity to plan one's working day, less opportunity to carry out the tasks and fewer

> opportunities to take breaks at work, go to the toilet or have lunch. It is clear that the high rate of sickness leave is NOT the cause of having to attend to one's family, but to the unsustainable working conditions, lack of breaks and lack of opportunities to recover at work.' (TCO)

In a survey of Vision members, 10 000 workers highlighted workload at the top of the list of factors responsible for psychosocial risks, along with management issues. The same problems exist in public and private sector healthcare and LTC services; however, '[w]hat we find is that the private sector has the most work-related PSR.' (Vision)

Unions in Sweden have pushed for changes in working conditions over a long period in order to mitigate and prevent PSR. These include more staff to reduce high quantitative demands, worker participation to reduce low control and establishing a better ratio between workers and supervisors to increase management support.

> 'First, we pushed for many years to have those rules on PSRs in place... We started pushing already in 2004. Eurocadres also pushed for it at European level. It was clear that the nurses trade union wanted more than rhetoric: they wanted better working conditions; they wanted to get more staff – to focus on health factors including PSRs; and [they wanted] to be more involved in decisions and management. That professionals should decide more for themselves. We have argued that there must be a better ratio between staff and supervisors. We argued that the ratio should be 1 to 15-20 staff. We did this also because we found out that it was not uncommon that, in women-dominated sectors such as the care sector, there was one supervisor for 50 and more staff. This was not reflected in male-dominated sectors where the numbers were much lower.' (LO)

Sweden's legislation on psychosocial risks is quite advanced compared to other European countries. The work environment in care sectors is tightly regulated by the Arbetsmiljölagen, the Swedish Work Environment Act (1977). This contains a regulation on the organisational and social working environment (AFS 2015: 4) which stipulates that the employer must provide (and is responsible for) a good organisational and social environment in the workplace. However, despite what is in this regulation, trade unions have criticised in particular the provisions for handling many of the problems associated with stress, workloads, working time and bullying (abusive discrimination).

> 'We would like clearer legislation on staffing. But there is a problem because healthcare is regionally controlled and social care, for example eldercare, is controlled by the municipalities. That means that, even if you make priorities at state level, the municipalities can ignore it.' (Vårdförbundet)

> 'Legislation on PSRs is good in Sweden, but the problem is with implementation. The issue of fines is being discussed at this very moment, but we see from other sectors where fines are imposed that some employers prefer to pay the fines instead of making the required changes.' (LO)

Arbetsmiljöverket, the Swedish Work Environment Authority (SWEA), is tasked with monitoring compliance with the working environment rules. The Agency is currently evaluating, together with the social partners, how the organisational and social work environment regulation is being applied. The government is also showing great interest in the issue and is considering introducing fines if employers do not comply with what they are obliged to do. SWEA focuses every year on a particular sector where it suspects high risks.

> 'In 2021 they focused on eldercare and found that 89 per cent of care homes were not providing adequate working conditions to the extent that these were increasing PSR.' (TCO)

Current national policies are also guided by the work environment strategy for 2021-25. The strategy states that no-one should become sick at work or from work referring mainly to psychosocial risks. This is also an acknowledgment that it is very important to address those organisational and social issues that contribute to the high level of sickness leave, especially in female-dominated professions. A newly created government institution, the Myndigheten för arbetsmiljökunskap (Swedish Agency for Work Environment Expertise), has been assigned to obtain and compile data and information regarding work environment risks among healthcare and LTC staff.

> 'Ultimately, it depends on the priority politicians make in terms of money for healthcare and how the employer distributes it in healthcare.' (Vårdförbundet 2021)

5.1 Convergence in PSR sources and impacts

5.1.1 High quantitative demands

In Germany, the wave of privatisation that followed the Pflegeversicherung (long-term care insurance) legislation in the 1990s opened the healthcare and LTC sectors to foreign and national investment funds. Since then, many caring activities have been guided by the profit maximisation principle. As labour in these sectors constitutes the single largest expense, companies, whether private or public, have been reluctant to match personnel with actual demand. For example, rather than reduce the number of patients to whom one nurse attends, companies have introduced tight timetables for specific caring activities, putting additional strain on already pressured middle managers and employees. Union representatives have criticised the 'new' approach to care, which:

> '... aims to replace the more holistic way of caring by one trained carer attending to all the different needs of a person cared for, including washing, dressing and perhaps measuring blood pressure. Nowadays, professional carers, because they are more expensive than auxiliaries, spend their time in an office while different auxiliaries are assigned to attend to the different needs of residents according to an extremely tight timetable. In this context, again, auxiliaries may have to decide to perform tasks for which they weren't trained.' (ver.di)

ver.di's 2021 survey revealed that 53 per cent of long-term care and nursing workers said they could do their work 'only partly, mostly not or not at all' without rushing. Among eldercare, hospital and psychiatric employees, 46 per cent managed 'only partially, mostly not or not at all' to complete all the planned tasks. In the case of patient-related activities (in the hospital, psychiatric and eldercare sectors), taking the full length of a break without interruption is a major problem. On average, only one-third of all respondents were able to take most or all their breaks undisturbed and at their full length (ver.di Versorgungsbarometer 2021).

> 'There is no other service sector in Germany where this is allowed.' (ver.di)

Much like in Germany, Spain has progressively opened up healthcare and, especially, long-term care to risk capital and investment funds. This has introduced to these sectors New Public Management strategies or the like, based on economic efficiency criteria and replacing the previously relational nature of caring with strictly timed task management. The result has been worsened working conditions and increased pressure as healthcare workers find themselves with too many patients to care for and a work rhythm that pushes them to their physical and mental limits. FSS-CCOO notes that trade unions have been repeatedly saying that the ratio between patients and health workers must be set at lower levels but, so far, they have seen little action on this.

> 'We're currently pressuring the consultative committee on 'dependency' [LTC] which is part of the social dialogue to change the order [type of regulation] about staff ratios, different categories and work shifts. This is important because companies say that they comply with the set regulation on ratios. The thing is that, legally, employers are also obliged to prevent [workers'] health issues and they're not complying with such obligations when it comes to risk prevention.' (CCOO, Sanidad)

During the Covid-19 pandemic, PSR rose exponentially in Spain as the lack of personnel was felt acutely while, simultaneously, management frequently failed to handle the crisis. What was particularly astounding to union representatives was the wave of dismissals and the suppression of vacancies that followed the first and second waves of the pandemic. Union representatives were also angered by the lack of attention to the rise of PSR during the pandemic as well as the consequences.

> 'People have been working under a lot of stress and many health interventions were postponed because of Covid-19. Now, this means that the things which had to be postponed due to the virus, non-urgent surgeries and many others, have to be addressed and dealt with and there is a lot of accumulated work. This is a huge source of stress for health workers.' (FSS-CCOO)

Quantitative demands also have a gender aspect, particularly in relation to part-time work. The use of part-time contracts in the care sector is a cause of many of the problems associated with PSR. Part-time work is often imposed on workers in this sector as employers use part-timers to help cover peak workload hours. The pace of work and workload are already very high during the regular working day, but there are some moments when there are even higher demands. This means that part-timers experience extreme stress over a very short period. This results not only in physical injuries but carries consequences for workers' mental health. Moreover, pay remains extremely low, often in Spain not reaching even 600 euros per month. This part-time strategy is described as:

> '[T]errible for the health and safety of our workers and specially PSR. This is happening because the sector is highly feminised; there is a gender aspect because employers take advantage of women workers. Exploitation is huge in the care sector.' (FSS-CCOO)

In the same vein, unions in Sweden report that lack of staff is one of the major issues associated with PSR. The lack of personnel means that the workload is greater for those who are in a job. Additionally, it creates stress because safe patient care is at risk when there is not enough time, raising the risk of making mistakes and thus increasing the psychological and physical pressure on staff. Swedish healthcare and LTC workers feel additional pressures when caring demands do not leave them sufficient time to reflect and recover; on the contrary, drinking coffee 'on-the-go' has become part of the job and breaks are far and few between.

> 'The balance between requirements and resources has been eliminated. It is not a new phenomenon but has been around for quite some years. During the pandemic it became particularly clear when public healthcare went into crisis mode and employees' working hours were greatly increased to cope with the onslaught of patients with Covid-19.' (Vårdförbundet)

Union representatives reported that, during the Covid-19 pandemic, managers were trying to fill the 'care gap' with untrained auxiliaries. This in turn put an additional burden on nurses and other healthcare professionals as they were the ones to ensure that untrained personnel were properly trained.

> 'During the pandemic, new staff was brought in, most less educated, leaving it also to nurses to train them, which created another type of stress.' (TCO, Sweden)

5.1.2 High job and working conditions insecurity

Fixed contracts or zero hour contracts make for precarious work which is considered a source of PSR in terms of job insecurity, working conditions insecurity and financial insecurity. In all three countries, the use of auxiliaries is common in the healthcare and LTC sectors.

German trade unionists report of incidences where auxiliary staff dispensed medicine or helped patients in ways that their training did not allow; in the LTC sector, the use of auxiliary staff has increased disproportionately and, with it, the instances in which they 'had to' act in order to help or save the person they cared for, even though they were only certified to wash or dress.

> 'It is not uncommon that "everybody does everything", which can put carers and auxiliaries at risk where legal boundaries are broken adding to the already high level of stress experienced.' (ver.di)

> 'I have the impression that most healthcare workers (...) fear the constant changes and many of them are not explained to them; what the next day will bring, perhaps yet again new staff, mostly auxiliaries, who come and go...' (ver.di)

In the Spanish healthcare sector, cost-cutting measures are often achieved by reducing the number of staff, particularly nurses, who are then replaced with temporary or part-time workers recruited via agencies. This practice was particularly pronounced in the context of the Covid-19 pandemic: while there was a hiring spree during the first and second waves of the pandemic, this was followed by a wave of dismissals.

> 'There is a wave of dismissals and the elimination of posts that were created due to the crisis. But we see that we need those workers. They have been working during the most difficult times and now they're being fired.' (FSS-CCOO)

In Sweden, staff shortages due to sickness leave and self-isolation during the Covid-19 pandemic have led to even greater use of temporary workers with varied levels of formal training (Socialstyrelsen 2020). Untrained care workers who come from a third country are often not aware of their rights, while 'many of them do not even know that they have rights at all' (Kommunal).

> 'Many registered nurses have left the job or looked for further opportunities in other EU countries. The gaps have been filled mostly with inexperienced or untrained staff who face high job insecurity because of zero hour or otherwise limited contracts. They never know when a restructuring or change in management puts their livelihood in danger.' (TCO)

5.1.3 High emotional demands

The transactional nature of the job – that is, the constant presence of a relationship between a nurse and patient and a carer and the person being cared for – can constitute a psychosocial risk. The nature of the relationship can be friendship, companionship or purely professional and the lines can become blurred. Healthcare workers may experience a multitude of emotions when attending to a patient, but they are also aware that showing these emotions may have a negative impact on patients. This means that emotions may have to be repressed.

> 'The different PSRs that workers in this sector experience are related to the issue of not being able to disconnect from your work because you work with people and not machines, so you're exposed to emotional charges, to social relations – with patients, family and other workers – and you also create bonds with the people who need you there, who need your care. This is a big psychological burden that counts as PSR in these sectors. You have to deal with patients who can be aggressive towards you or have severe and chronic pain which makes them suffer a lot… And you need to deal with that emotionally and psychologically as part of your job. It is not easy as you're not working with a machine but with human beings.' (Euskal Langileen Alkartasuna ELA)

Interpersonal conflicts may develop between carers and elderly residents; an example from Germany is the excessive expectations of LTC residents as to what carers should do for them given that they may have to contribute up to 20 per cent of the cost of care, housing and additional living expenses.

> '[T]hey [the workers] very often find themselves sandwiched between the needs of their patients and their own physical and emotional limits. Many of them overstep these limits again and again.' (ver.di 2021)

> 'There are some theories, made from the point of view of the health of the patient, that say that it is better if older people are always cared for by the same person, but for us and for workers it is better to have rotation, otherwise the emotional dependency gets very heavy and it becomes a huge source of PSR for workers.' (CCOO)

The healthcare and LTC professions place many emotional demands on staff, particularly when the working environment is unsustainable among other reasons due to a lack of staff, profit-oriented management practices and job insecurities. Many tasks demand decisions which may have considerable impact on clients' health and wellbeing, often adding to the pressures on workers. Resources, such as staff access to a therapist, to cope with the emotional demands are often lacking: 'Women's health is all about resources.' (TCO)

5.1.4 High work-life conflicts

Women workers in the healthcare and LTC sectors experience work-life conflicts very intensely. These often leave them stressed, over-worked, exhausted and without the options that would improve their situation as they also have little influence over the design and planning of their working days, for example by swapping shifts and deciding on the number of shifts, their weekly working hours and their time off. Rosters may be frequently changed at the last minute and shifts can be excessively long.

> 'The majority of management practices do not take work-life conflicts into consideration. They just ignore that most women working in the care sector shoulder many additional responsibilities including childcare, household responsibilities and care for their in-laws. There is little sympathy for a woman who cannot come to work because her child is sick. The pressure on these women is enormous, but few care about it, least of all the middle managers.' (ver.di)

In Germany, healthcare and LTC workers can be required to work long and/or double shifts. Working time is mostly regulated by company agreements. A comparison with the transport sector reveals that employers and lorry drivers can face heavy fines (up to 15 000 euros) if working time and rest periods are not respected.

In Spain, the worker has little or no control over the planning of the work, including shifts and working hours. Additionally, poor management practices leading to short-term scheduling changes, long working hours and understaffing have the potential to worsen work-life conflicts and, with it, PSR. Additionally, the healthcare and LTC sectors are highly feminised and, in Spain, as in all EU countries, it is mostly women who are responsible for unpaid care and domestic work. Having to respond simultaneously both to demands from work and from domestic and family life can put a continuous strain on workers.

> '[I]t is very frustrating to see how your male colleagues do not need to adjust their working life to the reconciliation of work and family life… and even more devastating seeing these colleagues have a greater chance of promotion than the female worker. This feeling of getting 'stuck', but also the fact that income suffers when reconciling [things], are also sources leading to PSR.' (FSS-CCOO)

Many union officials are very aware and understand the psychosocial risks that women in the sectors experience, but they also acknowledge that this issue has not taken the priority it deserves. Women are on the frontlines when it comes to confronting the difficulties of balancing work and family responsibilities. In addition, they are the first to have to deal with deskilling and the loss of control through new labour management practices. In this regard, structural gender inequalities are apparent in the healthcare and LTC sectors.

> 'It is no secret that, the higher you go up in the hierarchy, the less likely it is to find women. Men are louder; women are exhausted, often from triple burdens; and yes, women know that their issues take second or third place; never the first. It is very disheartening having no voice.' (ver.di)

5.1.5 Low control

Worker participation in the planning and execution of work activities has been shown to promote job satisfaction and a healthy work environment. However, the introduction of New Public Management strategies has resulted in feelings of loss of control as workers have fewer opportunities to determine their work priorities.

> 'Everybody knows that the planning of health and care work is only a theoretical thing and has little to do with what happens in the real world. That creates stress for managers and for the staff. Bad planning means that work is less predictable and thus stressful. And because of the inability to plan, middle management will delegate responsibilities downward. So, everybody is trying to do their best and take care of the residents.' (ver.di)

> 'They [the workers] are not heard, they do not participate in the organisation, but these are things that would improve the organisation of the work… You feel you're treated like a number and that your voice doesn't count at all where you work.' (FSS-CCOO)

Until very recently no training at all was required in Spain in respect of eldercare. Workers entering this sector were (and still are) mainly women who were seen and supposed to be 'good at caring' as something 'innate' or 'natural' to them. Many women entered this work as their first experience of the formal job market, having previously been housewives or working in the informal sector. Women's lack of experience of the formal labour market was often accompanied by a lack of knowledge about their rights as a worker or where to turn to enforce them.

> 'Some feel like they owe them [the employer] something because 'he has given me a job'. Even if they earn only a tiny amount, this is something for them. This is linked to PSR; often many workers do not ask for improvements, for better working conditions… because of a lack of information about their basic rights.' (CCOO 2021)

PSR is also related to the understanding that the job of a healthcare worker or carer is 'vocational', implying a specific emotional engagement which goes beyond the call of duty. In Spain, union representatives describe instances where workers skip lunches, work longer than required and take on extra shifts and so forth to accommodate the needs of those for whom they provide care. The expectations that are attached to the performance of the work can cause considerable stress for those who do it.

> 'In the care sector, you are working with people, not with shoes, so you cannot leave the person unattended there; for example, you cannot leave an old person without food because you do not have time to do all your tasks, so you end up doing more hours, leaving later than your established schedule and so on. You also have the burden of not having done your work well because you do not have time, too much work, too many tasks… Not being able to perform your job properly is a PSR too. All this is part of PSR.' (FSS-CCOO)

5.1.6 Low recognition and rewards

The Covid-19 pandemic led to a public re-evaluation of the importance of health and eldercare. Yet, despite the public outpouring of support for these sectors, workers in them continue to experience low recognition.

> 'It was hard and it was catastrophic; carers had to stand by and watch 20 per cent of their residents die; they did not have proper PPE and mostly arranged for such equipment themselves or made their own masks and reduced their personal and family contacts out of fear of bringing the virus home. Carers who got sick but only showed mild symptoms were asked to continue to work. There was clapping, there was acknowledgment, there were promises, but there weren't any measures to alleviate the stress.' (ver.di 2021)

The LTC sector in Germany is among those with the lowest incomes; it is also highly feminised with female participation amounting to 85 per cent. There is also a great difference between regions in Germany, amounting to a pay gap of 800 euros for the same job in the LTC sector in Saxony-Anhalt and Baden-Württemberg.

> 'There is the assumption that care work can be done by anyone. This impression is reinforced when employers hire people who have never worked in the care sector but are expected to work completely on their own in senior care homes after only one week of training.' (DGB)

In Sweden, LO pointed to the lack of resources or, rather, the unavailability of funds to support the work of the healthcare and LTC sectors as a direct and indirect cause of workplace stress. It was also underlined that the distribution of budgetary resources is heavily gendered, affecting care jobs in particular which are under-resourced and where the issues are less recognised than in male-dominated jobs.

> 'Here is an example of what happens much too often. I am talking about a comparison of the resources that a municipality made available to the mostly female nursing staff of a home for the elderly and the resources it made available to the maintenance crew and the building superintendent of the same home. While the superintendent and his crew were provided with bigger and safer cars and aids to carry heavier objects, nursing staff

had smaller cars (some of them only a bicycle) and there was no money made available to purchase badly needed lifting equipment.' (LO)

Vision also noted that municipalities and local councils value sectors differently. Indicators are not only the differing amounts of budgets, with lesser amounts available in sectors dominated by women, but also the staffing levels.

'It is a fact that managers in male dominated sectors have better access to the political level and thus better access to resources than those in female dominated sectors. It is not uncommon that managers in the health sector, when they ask for badly needed additional resources, are told that there is no room in the budget whereas there is much greater budgetary flexibility for needs in a male dominated sector.' (TCO)

'Working in an [unhealthy] psychosocial work environment is a gender equality issue as the workload is, socially and psychologically, to a large extent in occupations that are dominated by women. It is the contact professions that place extremely high demands on the employee to be able to meet people in different life situations here and now with a professional approach. Ill-health rates, sick leave and such are closely linked to an unhealthy work environment. This needs to be addressed as a serious problem.' (Kommunal)

5.1.7 Low social support

Unions in Germany note that there is evidence of a lack of responsiveness on the part of employers in cases of grievances. This lack of responsiveness is often combined with a lack of strategic management as there are no real positive incentives or negative repercussions. Rosters are frequently changed at the last minute, shifts tend to be excessively long and healthcare workers and carers are often assigned nightshifts alone, having to attend to one or sometimes two entire floors or wards by themselves, which carries great responsibility. In many cases, senior management representatives are aware of the situation but do not act on it, thus leaving middle management without resources or guidance except for 'staying within the budget'.

'It is not unusual that the same complaints are made over and over again with no results. Those who have complained often find it easier to stop complaining or look for another job.' (ver.di)

In Sweden, managers working in the healthcare and LTC professions often have to supervise too many workers, making it difficult to support them.

'Floor managers in the eldercare sector have sometimes more than 60 employees to supervise, making it difficult to follow issues and problems at work.' (Vision)

Interviews in Spain also report that workers are mostly left to their own devices while the strategy of the employer tends to reinforce the notion of PSR being an individual level problem and having little or nothing to do with working conditions or the place of work.

> 'The employer's strategy is to individualise workers' demands and problems. They would say to workers things like "the problem is that you're too sensitive"; "you shouldn't take your job home with you, you should disconnect"; "you're too emotional"; "the problem is that you get angry easily". By placing the responsibility on the shoulders of workers, they avoid having to make structural changes or even take specific measures.' (ELA)

> 'I am the responsible union representative in the general works council which oversees the work of 21 eldercare homes. I have not seen a major change away from this [New Public] Management style in any of them. And it is precisely this kind of style that is a source of PSR.' (ver.di)

The ver.di representative pointed out that the sick leave rate at these 21 homes had reached 15 per cent but that management was unwilling to react as long as the work was done. They also explained that 50 per cent of staff were trained professionals while the other 50 per cent were auxiliaries.

Spanish union representatives underline that care workers truly suffered psychologically during the Covid-19 pandemic. Many, they say, improvised their own protective clothing using, for example, plastic rubbish bags because there was no protective equipment available to protect them from infection.

> 'They were completely left alone and the emotional and psychological pressure was huge on all these workers. And, despite their efforts, many of those who they cared for died. What we see is that those actions have been framed as "personal or individual heroic actions". Their employers didn't take care of them, didn't protect their workers. They left them completely alone.' (ELA)

They also noted that the economic crisis and the subsequent restructuring and reforms in the healthcare and LTC sectors explain the reductions in the level of social support that they used to enjoy.

> 'As a result [of privatisation], there is a less welcoming, team building, good atmosphere among workers in this sector. Before, carers used to support each other more, and at least they had the support of their peers, but the changes of ownership and market-based profit-oriented work strategies have created a very negative work atmosphere and, with it, the increase in PSR.' (FSS-CCOO)

Moreover, several Spanish interviewees note that companies in the healthcare and LTC sectors purposely provoke competition between workers, causing stress and distrust.

> 'The company instigated a lot of competition among workers. They announced that, "on this floor you have achieved everything in 1 hour 30 minutes, but on that floor the team needed 2 hours". Such comparisons cause a strained atmosphere among workers and produce further PSR.' (FSS-CCOO)

5.1.8 Violence and harassment

Interviewees in Germany noted that current management practices do not reflect sufficiently that workers in the healthcare and LTC sectors are at risk of violence, sexualised violence and harassment, and other acts of ill-will. Preventive measures are few and far between and too often fail those who take the step to complain.

In a 2018 survey by Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege and the University Medical Centre Hamburg-Eppendorf, 76 per cent of the hospital nursing staff surveyed stated that they had experienced physical violence at work within the previous twelve months. Among nurses in inpatient care for the elderly, the figure was 73 per cent and it was 51 per cent among nurses in outpatient care. And 97 per cent of the hospital nurses surveyed had experienced verbal violence in the same period (94 per cent in inpatient care for the elderly and 90 per cent in outpatient care) (Bieler 2018).

> 'I know of this recent case where a carer was beaten up by the family members because the carer, following the rules, did not allow them to see their relative. This is shocking, but what is equally shocking and unacceptable is the fact that there was no protocol that could have prevented this in the first place.' (ver.di)

Violence against healthcare workers in hospitals is a preventable problem; for example, mandatory training that focuses on recognising and responding to abusive patients and family members would better prepare healthcare workers to avoid escalation and to respond to violent individuals. However, training courses for staff and managers are few and infrequent and are often not attended because of a lack of time and understaffing.

In Sweden, the safety and health representatives affiliated to Vision have expressed a particular need to be better trained in issues related to PSR. Under the current legislation, supervisors are obliged to have sufficient knowledge to prevent an unhealthy workload and to tackle harassment, while employers are required to provide training so that safety representatives can carry out their work. However, training is frequently short (usually lasting one or two days) and covers only the basics, leading to them not always being fully informed. Moreover, the representatives may also lack the time to deal with PSR.

In the community of Catalunya, employers have started progressively to adopt mediation when there are conflicts, including interpersonal ones.

While mediation is a technique that can successfully resolve conflicts, it has also come to be applied in cases of harassment. This is deemed to be a real problem by trade unions on the grounds of the inequality between the parties.

> 'Cases of harassment are pretty often very serious and we should not be dealing with them in mediation processes because from our experience the results are often detrimental to the worker. Therefore, we are very cautious about mediation. The problem is also that if a conflict goes through mediation, we are not informed of anything, we're just informed that a process has started and has been closed. But we have no information of what happened in between, and what the consequences for the worker have been.' (UGT Catalunya)

When a case of harassment is referred to the 'mediation support unit', the union loses control over the process and is excluded from participating in or managing the case.

> 'It is our experience that mediation has been applied in cases where it should never have been applied at all. But there are also other issues that make us worry, starting from the question of what kind of training these mediators have undergone.' (ELA)

5.2 Trade union action on PSR prevention

Several trade union actions towards preventing PSR emerge from the qualitative data, including the use of legislation, collective bargaining, industrial action, health and safety representatives, risk assessments that account for worker experience, having a work environment strategy and toolbox, arguing for training in PSR and taking on grievance cases.

5.2.1 Legislation

In Spain, unions address PSR by means of the gender equality plans[2] that companies are required to establish and implement.

> 'We're tackling more PSR with gender equality plans. In collective bargaining [and on] work councils, PSR is not discussed in detail but it does finds expression in the "prevention councils".' (UGT, Catalunya)

> 'So, we try to address PSR related issues through gender equality plans. For example, our expert on gender equality insists on adopting measures to decrease part-time work in this sector in equality plans. In her words:

2. Public administrations require companies to have gender equality plans if they want to have a chance of winning a public contract (companies in the care sector in Spain depend heavily on the contracts they win with government administrations).

> "I'm not signing any other gender equality plan which doesn't contain specific actions and a compromise to reduce part-time work; I will not sign it. It's enough." We believe this can help indirectly to reduce the sources of PSR for our workers. Because often, as explained, part-time work is imposed though not necessary; it is a strategy to increase their benefits through the massive exploitation of workers in this sector.' (CCOO)

Asking for the application of legislation is an important trade union tool; company level protocols, for example, usually refer to the laws that exist, for example Ley de prevención de riesgos laborales (the law regarding the prevention of risks in the workplace) and Ley de igualdad (the gender equality law).

> 'It would be great if these laws, especially the one on risk prevention, would be more concrete so that employers cannot interpret them to their benefit or in a dishonest way.' (Union representative, UGT, Catalunya)

In Spain, unions are also engaged in improving the tools listed in the Notas Técnicas de Prevención (NTP) which are agreed and published by Instituto Nacional de Seguridad y Salud en el Trabajo (the National Institute of Safety and Health at Work); an official body of the Spanish Ministry of Employment and Social Security.

> 'So, we use those tools to say that it's not us who say that employers should take this or that measure but it is the NTPs that demand it. These NTPs are not law but they nevertheless have some kind of authority. They are summaries of key issues on prevention. Such tools help us in our negotiations.' (ELA)

5.2.2 Collective bargaining and industrial action

It is common practice in the hospital sector to have in-house agreements between staff and management that regulate PSR, working time/time off and salaries. Ver.di has negotiated several such agreements. Union representatives refer to the importance of responding and supporting the demands of their membership; however, demands for action do not arise very often because workers in the healthcare and LTC sector face strong resistance from employers. Further obstacles are work overload and the stress that workers experience.

In Germany, strikes are not particularly common and constitute not only a financial burden but also an emotional one as workers would have to forgo their role in helping and caring for people. However, recent strikes in the hospital sector in Berlin at the Charité and Vivantes hospitals have made headway towards some improvements as regards PSR. The strikes, which started in September 2021 and lasted more than a month, were followed by a series of individually negotiated collective agreements across Germany.

Some 98 per cent of more than 2000 employees had voted to go on strike and 96 per cent supported the collective agreements (Berliner Zeitung 2021). The collective agreements between ver.di and the Charité and Vivantes hospitals stipulate how many staff the clinics must deploy on the wards and in specific departments. If employees work multiple times in understaffed shifts or in otherwise stressful situations, they receive additional days off; this is an immediate relief for those affected. At the same time, clinics are being given time to build up the staff they need in order to secure agreed-upon staffing targets. Now it is a matter of consistently implementing the regulations in everyday life. They offer the opportunity to improve working conditions substantially (Ver.di 2021b).

German unions reported that the Covid-19 pandemic shed light on problems in the healthcare and LTC sectors and the conditions under which personnel have to work. Hospital nurses and carers for the elderly are leaving the profession in droves. The rate of dropouts among trainees is also high, reaching 20 per cent. Many of them are leaving because of Überlastung ('excessive pressure').[3] Deutsche Gewerkschaftsbund (DGB, the German Trade Union Confederation) conducted a survey of 18 000 workers in the healthcare and LTC sectors, the great majority of whom reported that they wanted to leave their jobs because of 'excessive pressure' (DGB 2018).

> 'At a recent professional gathering, representatives of 90 works councils in the care sector expressed a common sentiment "We're fed up!" We can't take it anymore. Nothing concrete comes out of it. We need proper finances and sanctions for employers.' (ver.di)

> 'As there are no common regulations regarding staff:patient ratios, each hospital has different rules and, if those rules are not kept, middle management needs to know that there are sanctions if they are not adequately enforced. It should also be the aim to ensure enough free time for staff and for that we need to have an instrument that forces employers to ensure, for example, enough staff, better pay and better working conditions.' (ver.di)

In Sweden, union officials report that the issue of PSR is not specifically referred to in collective agreements; what is regulated, however, are working hours and the general conditions of employment; that is, the primary sources of PSR.

> 'We have annexes in collective agreements where the parties agree to work on work environment issues; PSRs are somehow included, but not explicitly. However, these annexes do not have collective agreement status.' (Vårdförbundet)

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3. The concept of psychosocial risk is not particularly common in Germany although Überlastung is an effective translation.

5.2.3 Risk assessments and inspections

In Spain, companies often prefer a risk assessment methodology in which representative participation is not necessary (FPSICO 4.0) and employers can carry out the assessment on their own, without the participation of trade unions at company level.

> '[We] always push for the ISTAS21 method which ensures the participation of the person responsible for prevention; it is developed in a participative task group and ensures more participation and information to trade unions.' (ELA)

It has been suggested that employers should avoid presenting risk assessment results by different units of analysis which could reveal that certain jobs, departments or floors face tremendous work overloads. With an overall assessment of the company (regarding all type of risks across the company), the results could look advantageous in general but this will not help alleviate problems where work overload predominates:

> 'Employers will always try to make large scale assessments so that we cannot see the details of the working conditions of workers and their PSR.' (ELA)

It was also pointed out that, should an assessment report capture the extent of PSR, the employer is obliged to plan and issue prevention and mitigation measures. But in the end these measures have no binding force, frequently they are not applied and they always fall short of what is really required: a change in working conditions.

> 'They typically list the following recommendations: to put a suggestions box in the workplace; to conduct periodical collective meetings to discuss PSR issues; and to engage in activities outside the workplace and outside working hours to create a better atmosphere among workers – like "team-building activities" – it's terrible [it does not change working conditions]!' (ELA)

Trade unions in Spain have developed specific ways to respond to such assessment reports by drafting counter reports stating that the prevention and mitigation measures fall short of what is really required. This has, from time-to-time, produced good results; for example, greater flexibility in terms of coming to work and leaving work, developing better rotation routines, accessing more and specific training, or even making sure one more person is hired. All these are measures to address psychosocial risks such as work-life conflict, emotional and quantitative demands.

Unions underscore that there are not enough safety and health inspectors – the ratio in Spain is one of the lowest in the EU (1 per 15 000 workers or more) – and many of them do not pay much attention to PSR or ask employers to apply preventive or mitigation measures. Therefore, it would be very

important to increase the number of labour inspectors and to train more of them specifically on PSR.

> 'They do not monitor further. In the best case they just ask for measures but then there is no follow-up, no monitoring. We need more resources and budget for inspection and on measures to ensure the effective implementation of prevention measures, including PSR.' (ELA)

In Sweden, the Covid-19 pandemic also affected the work of the union in preventing and mitigating PSR because this was a period when union officials and labour inspectors were completely shut out of workplaces, not being allowed to enter to assist and support their members or do their jobs. Overall, LO estimates that there was a 34 per cent reduction in workplace visits by labour inspectors during this period, adding to the feelings of insecurity that care staff experienced.

The use of sanctions has often been cited as a powerful tool to convince employers of the usefulness of both prevention and mitigation measures to address psychosocial risks. In the case of Spain, unions have pointed out that neither sanctions (or only very small ones) nor any other corrective measures are used by labour inspectors or the labour courts.

> 'We would like employers to be forced to implement the measures that are proposed in the "prevention plan"; they should have some sort of obligation to apply the measures. Now, the recommendations are dead letters because employers use the excuse that they do not have the tools and the necessary money to implement them. That is not true.' (UGT Catalunya)

5.2.4 Other trade union tools and approaches to support workers

In Sweden, the more specific rules on PSR which came into effect on 31 March 2016 have helped to support the work of safety and health representatives who are usually affiliated to unions and who can be found in almost all workplaces. Elected representatives/safety representatives raise issues at workplace meetings or at safety committee meetings.

> 'Eighty per cent of the work that our safety and health representatives do is finding ways to prevent PSR. Things may look good on paper, but it is another thing to implement preventive measures.' (Vision)

The Swedish law gives safety and health representatives far-reaching powers. They can, for example, 'suspend' a job that they believe creates a risk of ill-health for workers and do so without the consent of the employer. Follow-up is carried out by the SWEA which assesses whether or not the suspension can be lifted.

> 'After we got those rules six years ago, it was the nurses trade union which sent a majority of the complaints about excessive workloads to the SWEA.' (TCO)

Kommunal, in Sweden, has created its own work environment strategy. The guidelines are industry-specific, featuring a toolbox to use when there are particular situations or problems at work. In general, the strategy covers issues like the organisation of work, staffing, working time, threats/violence and victimisation/sexual harassment.

In Spain, unions conduct training on PSR and take on grievance cases but most employers, companies and workplaces are not sensitive to the issue and leadership training on the topic remains insufficient. Often, it is risk prevention delegates, i.e. unionised OSH representatives, who work on PSR prevention.

5.3 Main findings on PSR sources, factors and prevention measures

Based on the evidence review of scientific literature and the qualitative data analysis, the major sources of work-related PSR in the healthcare and long-term care sectors, and suggested measures to prevent them, are outlined in Table 1. Many of the sources of PSR are connected to the New Public Management model in the public sector and 'lean management', or competition, that gives rise to precarious working conditions specifically in the private sector. The findings highlight the importance of focusing on collective *primary prevention* which aims to prevent disease or injury before it occurs. *Secondary prevention*, on the other hand, includes mitigation measures that aim to reduce the impact of the risk exposure that has already occurred. The sources and factors are interrelated and prevention measures should thus be considered in conjunction with each other. For example legislation, labour inspections and industrial action on the sources of PSR are upstream measures that can enable or strengthen the workplace level protection of workers.

Table 1 **Examples of the sources and factors of work-related PSR and prevention measures in the healthcare and long-term care sectors**

Employment conditions		
Psychosocial risk factors	**Psychosocial risk sources**	**Prevention measures**
• High job insecurity Arises from cost-cutting in personnel attained by lay-offs and hiring freezes or the use of fixed-term contracts	• Zero hour contracts • Involuntary part-time work • Unpredictability of salary • Uncertainty of renewal of temporary contract	Minimising the use of the temporary contracts (primary) Eliminating zero hour contracts (primary)

Working conditions		
Psychosocial risk factors	**Psychosocial risk sources**	**Prevention measures**
• High quantitative demands Arises from labour management practices leading to understaffing; high patient-professional ratios; performance monitoring according to numerical goals as opposed to quality of care; job redesign that increases routinised repetitive technical tasks; undocumented care work	• Excessive workloads • High number of 'floating' staff reassigned from one unit to another/hiring untrained staff	Safe staffing levels (primary) Hiring more and adequately trained staff (primary) Ensuring recovery time (primary)
• High insecurity about working conditions Arises from reorganisation of tasks by the employer; understaffing which requires inflexible/unplanned worker availability and task and working unit rotation (e.g. 'floating' staff)	• Conflicting demands and lack of role clarity • Frequent changes in the content of work • Frequent changes in work schedules, tasks, the number of hours worked, and salaries	Providing clear and detailed description of roles and responsibilities (primary) Eliminating, or if not possible, limiting changes in working conditions that are not initiated by the worker (primary) Establishing procedures to negotiate changes in working conditions, which are based on fair criteria, with sufficient notice, and that facilitate workers' adaptation tothe new situation. Monitoring the application of the procedures periodically (primary).
	• Poorly managed organisational change • Ineffective communication	Involving workers and their representatives in decision-making processes (primary) Promoting training on participative management* (primary)
• High emotional demands While high emotional demands are intrinsic to the nature of the work, working conditions can either exaggerate or help reduce them	• High expectations from clients, patients and their relatives • Stereotypical expectations that women are destined to be carers and must 'give their all' when doing so • Sense of powerlessness associated with not being able to fulfil tasks due to lack of resources • Lack of psychological and therapeutical support	Acknowledging the relational nature of care work (primary) Rotating high/low emotionally demanding tasks (primary) Adequate staffing and decreased patient ratios (primary) Resources to cope with emotional demands, such as offering psychological group and individual therapy support during working time, offering professional mental health support and time off (secondary) Providing confidential support options for trauma-exposed staff (secondary)

* Workplaces that use participative management seek to integrate the expertise of their employees into company decision-making. A participative management structure enables employees at all levels to have an impact on company operations and goals.

Working conditions		
Psychosocial risk factors	**Psychosocial risk sources**	**Prevention measures**
• High work-life conflicts Arises from scheduling that is used as a short-term labour cost-reduction transaction; management unilateralism about different scheduling details (e.g. a lengthening of the working day and changed starting/finishing times and patterns); understaffing	• Understaffed facilities/hospitals • Long working hours • Changes in work schedules with short notice • Low influence on management of shifts • Lack of flexibility by management	Increasing the numbers of experienced and trained staff and decreasing patient ratios (primary) Participatory management and decision-making (primary) Gender training to understand the inequalities that women experience as a result of work-life conflicts (primary) Scheduling to consider care work at home, e.g. using self-rostering or being consulted on the number of working hours and working time organisation and distribution (primary)
• Low control Arises from the shifting of power from frontline health and care workers to management; job redesign and working methods that deskill care work into routinised technical tasks; limited decision-making authority; authoritarian hierarchical organisational structures related to professions and gender; understaffing which compromises measures aimed at job control	• Lack of worker involvement and influence on decisions regarding how jobs are done • Deskilling through job design that favours standardised tasks • Lack of influence over how the job is done	Practising participatory management styles (primary) Transparent decision-making (primary) Developing direct group participation practices; enabling worker participation in work organisation through time and workload reduction (primary)
• Low recognition and rewards Arises from inadequate income; labour management practices aimed at lowering wages, wage freezes and wage increases below inflation; undervaluing of professional knowledge (e.g. low professional grades); low promotion prospects	• Low salaries • Poor promotion opportunities • Undervalued/ unrecognised expertise	Fairness of remuneration in relation to needs, allowing purchasing power to be maintained or improved (primary) Income that recognises qualifications, experience and job requirements (primary) Valuing different care professions through recognition of professional competence (primary) Job certificates (primary)
• Low social support Arises from the lack of scheduled time for peer support and the lack of appropriate spaces for workers to meet; a command and control style management; poor communication culture	• Low quality leadership, e.g. authoritative management style • Lack of support from management and/ or colleagues in carrying out work; absence of shared workspace	Developing participatory leadership procedures and direct group participation (primary), e.g. through training managers in participatory management and communication Functional support from management in day-to-daywork; built-in opportunities for functional peer support during shifts; reserving time for weekly review meetings to resolve issues (primary and secondary)
• Psychological and sexual harassment; • Third party violence	• Lack of zero tolerance culture regarding harassment and violence at the workplace	Establising a clear policy for the prevention of psychological and sexual harassment and developing specific procedures (primary). Training directors and managers on harassment and violence prevention (secondary) Provision of reporting mechanisms and psychological support at the workplace (secondary)

Note: Collective agreements, PSR risk assessment, and training OSH representatives on PSR are primary preventive measures for all the risks described in the table.

6. Discussion

A significant body of literature shows that psychosocial risks and related health problems, staff turnover and care quality are not due to the nature of healthcare and long-term care work but correlate with labour management practices regarding, among others, work process design, working methods, job design, working time, hiring arrangements, staffing, task assignment and pay. These can be modified so the issues can be prevented at source. Further, a lack of resources and insecure employment give rise to specific PSR factors while simultaneously limiting the effectiveness of workplace level preventive measures.

Inequalities are clear in this context and they regard gender, health, OSH and intersecting factors. The study findings highlight that the healthcare and LTC sectors need to be valued more while gender segregation needs to be addressed in both. Working in this challenging psychosocial work environment is a gender equality issue as these occupations are largely female dominated. Ill-health and sickness leave are directly related to an unhealthy work environment which needs to be tackle via measures which include increased staff levels, decent pay, family-friendly working time, more direct participation by workers on how to carry out their jobs, greater contractual security, more management support and better rules regarding the prevention and mitigation of violence and harassment. Discrimination against migrant care workers is a critical issue that requires urgent measures, as is the differing protection of workers from PSR between countries, sub-sectors and workplaces.

Legislation does support focusing on PSR at source, as the data from Sweden and Spain show. However, the implementation of legislation is raised as a problem. Making legislation more tangible would be an improvement; this would enable the proper application of prevention and mitigation measures. There is also a need for common criteria regarding PSR prevention at source, which means identifying the dimensions of working conditions that need to be changed and which require sanctions, as well as establishing binding safety and health management standards. A specific measure that was highlighted in all three countries concerned regulations on staffing and it was also stated that collective agreements should be used to address PSR. Furthermore, there is a clear need for more safety and health inspectors and it is very important that inspectors are trained in addressing PSR at source.

Dealing with staff shortages is a key measure in preventing PSR regarding the demands (both quantitative and emotional) placed on workers as it mediates the support received from colleagues and management, work-life conflicts and possibilities for participation. There is also the issue of the differential and poorer treatment of workers in private companies which requires greater transparency and closer attention in terms of monitoring and general supervision. Adequate funding and resources have also been pointed to as an important way of ensuring PSR is tackled. Budgetary cuts or restricted budgets due to the commercialisation of the sectors are felt directly by workers. Cutting costs in these sectors has meant cutting personnel costs, dismissing trained staff and hiring untrained staff. As is the case with Sweden, female-dominated sectors experience less flexibility regarding budgetary largesse.

Trade unions understand that PSR is a serious issue that has an impact on workers' health and they are taking action. For example, before the Covid-19 pandemic, LO started to work with 290 municipalities in Sweden to help them address staff shortages, bringing in a team of experts to investigate those places with the highest rates of reported sickness leave. Kommunal has also created its work environment strategy with industry-specific guidelines, establishing a toolbox to use in problem situations. In Spain, trade unions have developed specific ways to respond to obligatory company risk assessment reports by drafting counter reports which have, on occasion, produced good outcomes. Furthermore, unions have also taken on grievance cases and conducted awareness campaigns on psychosocial risks. In Germany, trade unions have concentrated on supporting the creation of works councils in healthcare and LTC organisations; they have also concluded important collective agreements in the hospital sector.

Training and awareness raising were two specific tools that were flagged up as important. Employers should be educated on PSR to show that it is also to their benefit that preventive measures are undertaken. Middle management was pointed out to be in particular need of training on PSR even though decisions to change labour management practices lie not in its hands but in those of senior management. Moreover, health and safety representatives also need to be properly trained with the costs being borne by employers.

Ultimately, prevention and mitigation measures should seek to change labour management practices regarding staffing, payment and worker participation in scheduling. Importantly, workers and their representatives should be involved in designing robust risk assessments, changes to work practices and the implementation of these and the subsequent monitoring.

7. Conclusions

According to European Framework Directive 89/391 on Occupational Safety and Health, if a risk assessment proves that working conditions derived from work organisation are hazardous to health, such working conditions must be changed at source and with the participation of workers' representatives. This report has highlighted the importance of eliminating and reducing exposure to work-related psychosocial risks and promoting effective and lasting workplace preventive actions at source that address the way work is organised. The aim is to support healthcare and LTC workers' representatives and occupational health professionals to develop policies for primary preventive measures. However, it is acknowledged that the remit of the prevention and mitigation measures that are available to unions is limited due to the broader context of the devaluation of care work and the structural inadequacies concerning work organisation.

The care sector in Europe has undergone dramatic changes since the 1990s and, while expenditure in the healthcare and LTC sectors has grown, the accessibility, affordability and quality of care have all come under strain, particularly during and after the 2008 financial crisis (Eurofound 2017). The academic literature clearly points out that understaffing is the source of high quantitative and emotional demands and that it may also compromise preventive measures devoted to increase job control or social support.

New labour management practices are a common source of unhealthy psychosocial exposure and speak to a broader context of austerity measures including health and social care budget cuts, downsizing, privatisation and the implementation of new management methods. These practices aim to increase worker flexibility, productive performance and profitability and, as such, are factors that can lead to PSR which, in turn, may lead to ill-health. It is documented that this harmful work environment is associated with the higher intention to leave work among eldercare professionals (Rahnfeld et al. 2016). This creates a vicious circle in which the lack of personnel causes adverse working conditions that push professionals to leave their jobs in even greater proportion. In the case of the healthcare and LTC sectors, labour management practices have reproduced and reinforce inequalities (Holland et al. 2018).

The literature review identified several research gaps that remain despite the important volume of academic evidence on the relationship between psychosocial risk exposures and health and wellbeing indicators. Concurrently,

however, studies on the relationship between exposure to psychosocial risks and their sources, and on the primary prevention measures, remain scarce; and it should also be noted that there are many more articles and studies relating to health than to the long-term care sector. Further studies are needed into the knowledge gaps regarding the differences between public and private subsectors (primary care, hospitals and eldercare facilities) as well as the occupational groups and professions exploring class, gender and ethnic inequalities. Studies should examine the sources of quantitative demands such as downsizing, incorrect time measurement, under-resourced work (poor tools, materials, poor working process, etc.); while there remains a gap regarding studies into availability demands regarding schedules (coming into work at short notice, modification of shift schedules, etc.) and its relationship with work-life conflicts. There is an important need for research to be carried out on workplace flexibility through a gender lens in order better to understand the social dynamics involved in the matching of employer, patient and worker working time demands in the context of healthcare and long-term care facilities. Development of primary prevention measures is important as well as strengthening the knowledge base on how the different levels of prevention measures interact. Finally, specific attention should be paid to the developments in platform-based care work in Europe and the related PSR such as lack of social support, high job and working conditions insecurity and low control. The gender division in platform work is particularly stark; women represent a large majority (64 per cent) of on-location workers that find work through platforms, a category which is dominated by young women performing care services (Piasna et al. 2022).

The contribution of this study to the evidence base stems from the identification of commonalities across heterogenous contexts. The academic literature review, accompanied by the qualitative data analysis, shows that, while work contexts and places are highly diverse, the sources of PSR as well as the negative health outcomes are convergent. High quantitative demands, low control over one's job, the lack of work-life balance, job insecurity, low recognition and rewards, and low social support, as well as high emotional demands due to organisational pressures, were all identified in the data across the three studied countries. This indicates that there are common elements to the sources of work-related PSR that should be subjected to harmonised prevention as per the principle of an equal level of safety and health for the benefit of all workers set down in the EU Framework Directive on Occupational Safety and Health.

Psychosocial risks are among the most challenging concerns facing policymakers in the area of occupational safety and health today (ETUC et al. 2019; European Commission 2017; ILO 2016; Leka et al. 2015). The risks are not covered by a specific EU directive despite clear evidence that the ill-health attributable to such risks is a significant problem and that exposure to psychosocial risks is increasing. Even though the overall provisions of the Framework Directive apply in this case, the absence of any significant legislative measures must be seen as a lacuna in the EU OSH acquis. It reflects an important gap in the legislative protection of workers and, at the same time,

represents a clear indication of a potential area for improvement in the safety and health of workers since legislative requirements are the main driver for preventive action by many employers (European Commission 2015).

> 'The EU should take advantage of the momentum created by Covid-19. There's more sensitivity now to recognise and tackle PSRs. Having legislation from the EU on this issue would help. Something that equalises the whole Union for the better, that no member states are left behind.' (UGT)

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All links were checked on 24.03.2022.

Annex
Template for semi-structured interviews on psychosocial risks and prevention measures in the healthcare and long-term care sectors (EN, DE, ES, SE)

Interview outline in English

Part I Personal details
Name of interviewee:
Email:
Country:
Union affiliation:
Position:

Part II Interview Questions
Conducted by: phone/zoom/skype/in person/other

1. **Awareness of psychosocial risks (PSR)**
a) What do you consider/understand psychosocial risks to be in your work context?
b) Are psychosocial risks considered an issue in your organisation? If yes, please explain how and by whom.
2. **Description of a situation/case**
a) Could you describe a situation in which PSR has been evident for workers?
b) How did the management react?
c) What was the outcome?
3. **Prevention and mitigation measures to address psychosocial risks at organisational level**
a) Do you consider current management practices and work organisation to be responsive to PSR?
b) Has the Covid-19 pandemic changed the rules and practices of your union to address PSR? How? Do these changes affect how PSR is perceived in your working environment?
c) What could be done to promote awareness and responsiveness to PSR in your organisation?
4. **Polices and legislation to prevent work-related psychosocial risks**
a) Do you consider current national policies sufficient to address work-related PSR as you understand them? Why yes/why no?
b) Are you aware of any specific initiative, legal and otherwise, which tries to address PSR? Please elaborate.
c) Are you aware of collective agreements – relating to your union/social partner agreement or otherwise – that address PSR? If yes, is there any monitoring of the results (e.g. indicators)? Please elaborate.
d) Which recommendations would you give to EU institutions, Member States, unions and other stakeholders better to promote the awareness of PSR and possible prevention measures?

Is there anything you would like to add on the topic?

Interview outline in German

Fragebogen zu psychosozialen Risiken und Präventionsmaßnahmen im Gesundheits- und Pflegebereich

Teil I Persönliche Daten
Durchgeführt von: Barbara Helfferich
Mit:
Titel/Position:

Teil II Interviewfragen
Mit: Telefon/Email/Zoom/Skype/Persönlich/Andere: ?

1. **Bewusstsein für psychosoziale Risiken (PSR)**
a) Welche psychosozialen Risiken sehen/verstehen Sie in Ihrem Arbeitskontext?
b) Werden psychosoziale Risiken in Ihrer Organisation als Thema betrachtet? Wenn ja, erläutern Sie bitte wie und von wem.
2. **Beschreibung einer Situation/eines Falls**
a) Können Sie eine Situation beschreiben, in der PSR für Arbeitnehmer offensichtlich waren?
b) Wie hat das Management reagiert?
c) Was war das Ergebnis?
3. **Präventions- und Minderungsmaßnahmen zur Bewältigung psychosozialer Risiken (PSR) auf Organisationsebene**
a) Sind Ihrer Meinung nach die aktuellen Managementpraktiken und die Arbeitsorganisation der PSR angemessen?
b) Hat die COVID-19-Pandemie die Regeln und Praktiken Ihrer Gewerkschaft geändert, um PSR zu bekämpfen? Wie? Beeinflussen diese Veränderungen die Wahrnehmung von PSR in Ihrem Arbeitsumfeld?
c) Was könnte getan werden, um das Bewusstsein und die Reaktionsfähigkeit für PSR in Ihrer Organisation zu fördern?
4. **Richtlinien und Gesetze zur Prävention arbeitsbedingter psychosozialer Risiken (PSR)**
a) Halten Sie die derzeitige nationale Politik für ausreichend, um die arbeitsbezogene PSR so anzugehen, wie Sie sie verstehen? Warum ja/warum nicht?
b) Ist Ihnen eine spezifische Initiative, rechtlich oder anderweitig, bekannt, die versucht, PSR anzugehen? Bitte erläutern.
c) Sind Ihnen Tarifverträge – in Bezug auf Ihre Gewerkschafts-/Sozialpartnervereinbarung oder anderweitig – bekannt, die sich mit PSR befassen? Wenn ja, gibt es ein Monitoring der Ergebnisse (z. B. Indikatoren)? Bitte erläutern.
d) Welche Empfehlungen würden Sie den EU-Institutionen, Mitgliedstaaten, Gewerkschaften und anderen Interessengruppen geben, um das Bewusstsein für PSR und mögliche Präventionsmaßnahmen besser zu fördern?

Möchten Sie etwas zum Thema hinzufügen?

Interview outline in Spanish

Guión sobre riesgos psicosociales y medidas preventivas en el sector sanitario y sociosanitario

Parte 1 Datos personales
Nombre de la persona entrevistada:
Correo electrónico:
País:
Afiliación sindical:
Cargo en la organización:

Parte II Preguntas de la entrevista
Realizada por: teléfono/zoom/Skype/en persona/otro

1. **Conciencia de los riesgos psicosociales (RPS)**
a) ¿Qué considera / entiende como riesgos psicosociales en su contexto laboral?
b) ¿Se consideran los riesgos psicosociales un problema en su organización sindical? En caso afirmativo, explique en qué sentido y por quién.
2. **Descripción de una situación/caso**
a) ¿Podría describir una situación en la que los RPS hayan sido evidentes para las trabajadoras y los trabajadores?
b) ¿Cómo reaccionó la dirección de la empresa?
c) ¿Cuál fue el resultado?
3. **Medidas de prevención y mitigación para abordar los riesgos psicosociales (RPS) a nivel organizativo**
a) ¿Considera que las prácticas de gestión laboral y la organización del trabajo actuales responden a los RPS?
b) ¿La pandemia de COVID-19 ha cambiado las reglas y prácticas de su sindicato en el abordaje de los RPS? ¿Cómo? ¿Afectan estos cambios a cómo se percibe los RPS en su entorno de trabajo?
c) ¿Qué se podría hacer para promover la conciencia y la capacidad de respuesta a los RPS en su organización?
4. **Políticas y legislación para prevenir los riesgos psicosociales relacionados con el trabajo (PSR)**
a) ¿Considera que las políticas nacionales actuales son suficientes para abordar los RPS relacionado con el trabajo tal como usted los entiende? ¿Por qué sí / por qué no?
b) ¿Conoce alguna iniciativa específica, legal o de otro tipo, que intente abordar la RPS? Por favor elabore.
c) ¿Conoce convenios colectivos que aborden los RPS? En caso afirmativo, ¿hay seguimiento de los resultados (por ejemplo, indicadores)? Por favor elabora.
d) ¿Qué recomendaciones daría a las instituciones de la UE, los Estados miembros, los sindicatos y otras partes interesadas para promover mejor la concienciación sobre los RPS y las posibles medidas de prevención?

¿ Le gustaría agregar algo más sobre el tema?

Interview outline in Swedish

Enkät om psykosociala risker och förebyggande åtgärder inom vård- och omsorgssektorn
Frågeformulär

Del 1 Personuppgifter
Namn på intervjupersonen:
E-post:
Land:
Facklig tillhörighet:
Placera:

Del II Intervjufrågor
Genomförs av: telefon/zoom/skype/personligen/annan

1. **Medvetenhet om psykosociala risker (PSR)**
a) Vad anser/uppfattar du som psykosociala risker i ditt arbetssammanhang?
b) Anses psykosociala risker vara ett problem i din organisation? Om ja, förklara hur och av vem.
2. **Beskrivning av en situation/fall**
a) Kan du beskriva en situation där PSR har varit uppenbara för arbetare?
b) Hur reagerade ledningen?
c) Vad blev resultatet?
3. **Förebyggande och begränsningsåtgärder för att hantera psykosociala risker (PSR) på organisationsnivå**
a) Anser du att nuvarande ledningspraxis och arbetsorganisation är lyhörd för PSR?
b) Har covid-19-pandemin ändrat regler och praxis för ditt fackförbund för att ta itu med PSR? Hur? Påverkar dessa förändringar hur PSR uppfattas i din arbetsmiljö?
c) Vad kan göras för att främja medvetenheten och lyhördheten för PSR i din organisation?
4. **Poliser och lagstiftning för att förebygga arbetsrelaterade psykosociala risker (PSR)**
a) Anser du att den nuvarande nationella policyn är tillräcklig för att hantera arbetsrelaterad PSR som du förstår dem? Varför ja/varför inte?
b) Känner du till något specifikt initiativ, lagligt och på annat sätt, som försöker ta itu med PSR? Vänligen utveckla.
c) Känner du till kollektivavtal – relaterade till ditt fackliga/arbetspartnersavtal eller på annat sätt – som tar upp PSR? Om ja, finns det en övervakning av resultaten (t.ex. indikatorer)? Vänligen utveckla.
d) Vilka rekommendationer skulle du ge till EU-institutionerna, medlemsstaterna, fackföreningarna och andra intressenter för att bättre främja medvetenheten om PSR och möjliga förebyggande åtgärder?

Något du vill tillägga i ämnet?

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