Work-related psychosocial risks in the healthcare and long-term care sectors

Sources, factors, and prevention measures

Barbara Helfferich and Paula Franklin

Introductory guide for trade unions

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european trade union institute

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Introduction

Work-related psychosocial risks (PSR) are a major contributor to the burden of disease in Europe. The health impacts of PSR are evident in the healthcare and long-term care sectors and were brought to everyone's attention by the Covid-19 pandemic. A significant body of evidence shows that work-related psychosocial risks correlate to labour management practices in different modifiable aspects of work.

This introductory guide presents the key aspects of PSR in the healthcare and long-term care sectors. It provides a brief outline of the context that gives rise to PSR in these sectors; an overview of specific PSR factors related to employment and working conditions; and an insight into some prevention and mitigation measures. This is followed by a discussion on legislation regarding work-related PSR in the EU, and descriptions of actions taken by trade unions to tackle this critical occupational safety and health (OSH) issue.

The contents are based on the results of an evidence review of scientific literature and analysis of interviews with trade union representatives in Germany, Spain, and Sweden, brought together in the ETUI report 'Psychosocial risks in the healthcare and long-term care sectors: evidence review and trade union views'. This guide aims to clarify what work-related PSR are, and to inspire further trade union actions on PSR to ensure safe and healthy workplaces for healthcare and care workers.

1. Commercialisation of care, austerity and lack of staff

Over the last 30 years, the world of work has undergone major economic and technological developments. Faced with the challenges of a globalised economy, in which financial markets are increasingly active, companies have adopted new modes of organisation with a view to increasing their profitability. Austerity measures have strained public healthcare systems, led to hospital closures, restructuring, the privatisation of long-term care facilities, and managerial reforms that have introduced market-like mechanisms. Evidence shows a deterioration of working conditions in these sectors due to the use of new public management (NPM) methods that are a poor fit for the reality of care work, and the continuing devaluation of the work done in these feminised sectors. These developments have had profound impacts on working conditions in the healthcare and long-term care sectors.

> '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 [an] eldercare home after only one week of training.' (DGB, Germany)

In parallel, the demand for care arising from chronic illnesses and longer life expectancy in most European countries increases the need for healthcare and long-term care. Combined with the lack of staff and resources, the increased workload can have severe impacts on workers' health.

> '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)

The Covid-19 pandemic has put a spotlight on the situation of workers in the healthcare and long-term care sectors, highlighting the importance of the work which, however, remains undervalued and under-paid. The healthcare and long-term care sectors are highly feminised, with low pay and frequent precarious working contracts. Women make up 86% of the total healthcare workforce in the EU.

> 'There is a wave of dismissals and elimination of posts that were created due to the [Covid-19] 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, Spain)

Job insecurity is experienced by unskilled women workers and migrant workers in particular as they are often unaware of their rights. The low unionisation of workers in the non-public healthcare and care sectors also means that workers' rights tend to be less respected than in other sectors. (Rogalewski 2018)

> '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 into danger.' (TCO, Sweden)

2. What are work-related psychosocial risks?

It is important to understand and acknowledge that psychosocial risks (PSR) are factors in the working environment. They are not intrinsic to an individual worker or related to their dispositions, attitudes or health status. In addition to mental health problems, workers exposed to PSR can go on to develop physical health problems such as cardiovascular disease or musculoskeletal problems. (Niedhammer et al. 2021, 2022)

While the effects of PSR manifest at the individual level as mental and physical health problems, the sources and factors are found in employment conditions and in the way that work is organised.

Definition: work organisation

Work organisation is about the division of labour, the coordination and control of work: how work is divided into job tasks, bundling of tasks into jobs and assignments, interdependencies between workers, and how work is coordinated and controlled to fulfil the goals of the organisation.

It encompasses the tasks performed, who performs them and how they are performed in the process of making a product or providing a service.

Work organisation refers to how work is planned, organised and managed within companies and to choices on a range of aspects such as work processes, job design, responsibilities, task allocation, work scheduling, work pace, rules and procedures, and decision-making processes. (Eurofound 2022)

For example, during the Covid-19 pandemic, exposure to psychosocial risks in healthcare has arisen from staff shortages, additional and unintended shifts, working overtime, work overload, time pressure, an insufficient number of rest breaks and days away from work, shift work, poor work-life balance, and inadequate rewards stemming from low wages and job insecurity. (Franklin and Gkiouleka 2021)

> 'The balance between [healthcare] 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 a crisis mode and employees' working hours were greatly increased to cope with the onslaught of patients with Covid-19.' (Vårdförbundet, Sweden)

The scientific evidence review (Llorens Serrano et al. 2022) identified the following sources of psychosocial risks in the healthcare and long-term care sectors:

- **High job and working conditions insecurity:** cost-cutting in personnel is often attained by layoffs and hiring freezes or the use of fixed-term contracts, reassessments, re-planning and reorganising of activites and days to respond to employers' demands for worker availability. Precarious contracting practices and demands for the availability of workers are part of a poor work organisation as the practices are associated with unpredictable income, work tasks, working hours, and workplace (e.g. hospital/care unit).
- **High quantitative demands:** arise from labour management practices that lead to understaffing, high patient-professional ratios, performance monitoring according to numerical goals vs. quality of care, and job redesign that increases routinised technical tasks, while leaving time spent on care work undocumented.
- **High emotional demands:** can be intrinsic to the nature of the work, but working conditions can both exaggerate or help reduce them. For example, understaffing entails elevated patient-professional ratios and long-working hours, thereby increasing exposure to emotional demands.
- **High work-life conflict:** can be intensified by unilateral programming of the working day by the employer (e.g. the length, scheduling), availability requirements related to the working day (changes with short or unannounced notice) and lack of staff.
- **Low control:** originates from labour management practices that deskill care jobs by routinising tasks, limit workers' decision authority, and support authoritarian organisational structures.
- **Low recognition and rewards:** sources include inadequate income, undervalued professional knowledge, lack of continuous training, and low promotion prospects.
- **Low social support:** risk increases when there is no scheduled time for peer support, no physical space to meet with colleagues, when a command and control management style is used, and with poor communication between management and workers.
- **Psychological and sexual harassment, third party violence:** lack of zero-tolerance culture regarding violence and harassment at the workplace is a clear risk factor.

The evidence review of scientific literature highlights the importance of focusing on collective primary prevention at source, in order to avoid and reduce occupational risks before illnesses or injuries occur, through changing working conditions. Secondary prevention includes mitigation measures that aim to reduce the impacts of a risk that cannot be avoided at source (for example, training in skills for managing emotional demands, and dealing with patient and family suffering or death, as well as therapeutic support) and tertiary prevention includes mitigation measures that address an illness or injury that has already occurred.

Figure 1 **Importance of collective primary prevention vs. interventions at the individual level**

Examples of major sources of work-related PSR in healthcare and long-term care sectors, and suggested measures to prevent them, are outlined in Table 1, below, based on the evidence review of scientific literature and the analysis of interview data (Llorens Serrano et al. 2022).

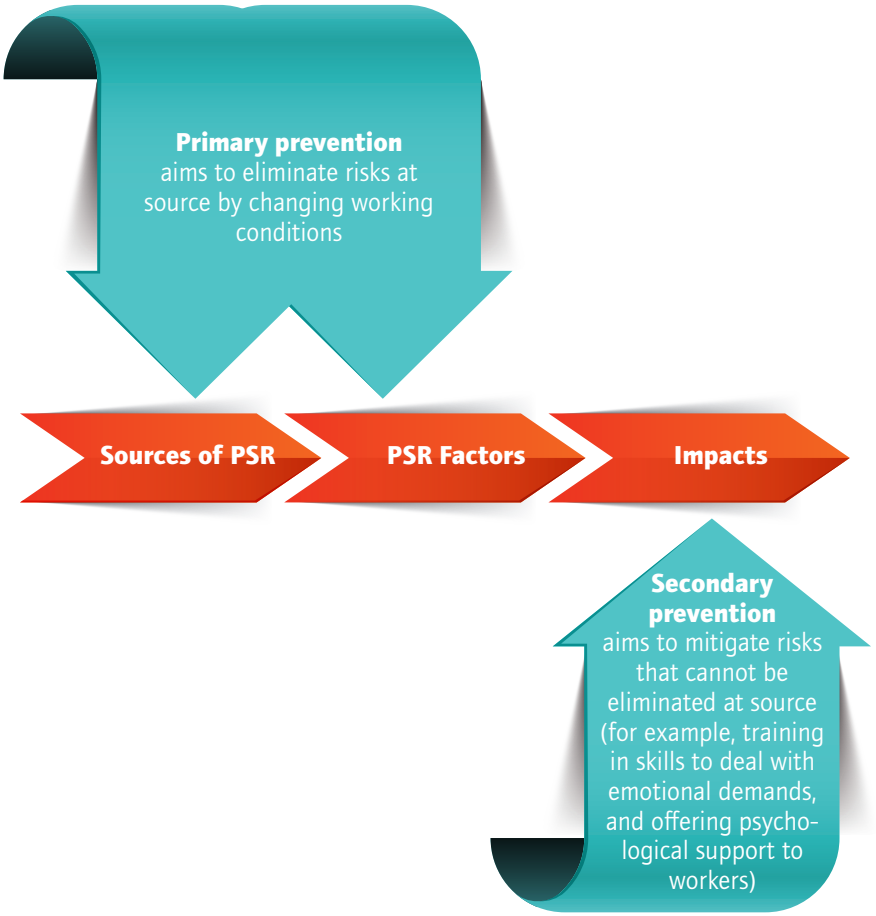

Table 1 **Examples of the sources and factors of work-related PSR and prevention measures in the healthcare and long-term care sectors**

Employment conditions		
Psychosocial risk factors	**Psychosocial risk sources**	**Prevention measures**
• High job insecurity	• 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	• 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	• 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)

* 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 emotional demands	• 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	Acknowledging the relational nature of care work (primary) Rotating high/low emotionally demanding tasks (primary)
	• Sense of powerlessness associated with not being able to fulfil tasks due to lack of resources	Adequate staffing and decreased patient ratios (primary)
	• Lack of psychological and therapeutical support	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)
• High work-life conflicts	• Understaffed facilities/hospitals • Long working hours • Changes in work schedules with short notice	Increasing the numbers of experienced and trained staff and decreasing patient ratios (primary)
	• Low influence on management of shifts • Lack of flexibility by management	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	• Lack of worker involvement and influence on decisions regarding how jobs are done	Practising participatory management style (primary) Transparent decision-making (primary)
	• Deskilling through job design that favours standardised tasks • Lack of influence over how the job is done	Developing direct group participation practices; enabling worker participation in work organisation through time and workload reduction (primary)

Working conditions		
Psychosocial risk factors	**Psychosocial risk sources**	**Prevention measures**
• Low recognition and rewards	• Low salaries	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)
	• Poor promotion opportunities • Undervalued/ unrecognised expertise	Valuing different care professions through recognition of professional competence derived from training and experience (primary) Job certificates (primary)
• Low social support	• Low quality leadership, e.g. authoritative management style	Developing participatory leadership procedures and direct group participation (primary), e.g. through training managers in participatory management and communication
	• Lack of support from management and/or colleagues in carrying out work; absence of shared workspace	Functional support from management in day-to-daywork; built-in opportunities for functional peer support during shfts; 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)

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

3. Legislation on work-related psychosocial risks in the EU

According to the EU Framework Directive on Occupational Safety and Health (Directive 89/391/EEC), employers are obliged to protect workers' health and safety in all aspects of work. Employers must consider how to avoid or eliminate any risks at their source; in terms of PSR this would mean, for example, optimal work organisation. The least effective level of prevention is the personal level, which in the case of PSR could for example concern an employer offering only anti-stress training to workers without changing the ways in which work is organised. (OSH Wiki)

European social partners have adopted two framework agreements covering certain specific PSR: European framework agreement on Stress (2004) and on *Workplace bullying and violence at work* (2007). However, these agreements are not legally binding, and their implementation has been inconsistent among the Member States.

Despite the common obligations laid out in the EU Framework Directive, Member States do not share common standards and principles regarding PSR. On the contrary, legislation on PSR differs widely between Member States, resulting in an unequal protection of workers. Some Member States have no specific regulation on the issue at all, others have regulated parts of the problem, and others still have a fairly sophisticated and complete regulatory system on the issue. For example, labour in central and eastern European countries can be characterised by a number of distinctive features, such as long working hours and low wages, high job insecurity, and a gender pay gap (Yarmolyuk-Kröck 2022), some of which may lead directly to increased psychological risks at work.

For specific information on the legal framework in your country see Cefaliello A. (2022) Comparison of the legal and policy regimes on PSR, Report, ETUI, [Forthcoming].

Figures 2-5: Countries in red have the legal provision.

Figure 2 **Legal provisions with mentions of psychological or mental health**

Figure 3 **Legal provisions addressing psychosocial risk factors**

Figure 4 **Legal provisions addressing work-related stress**

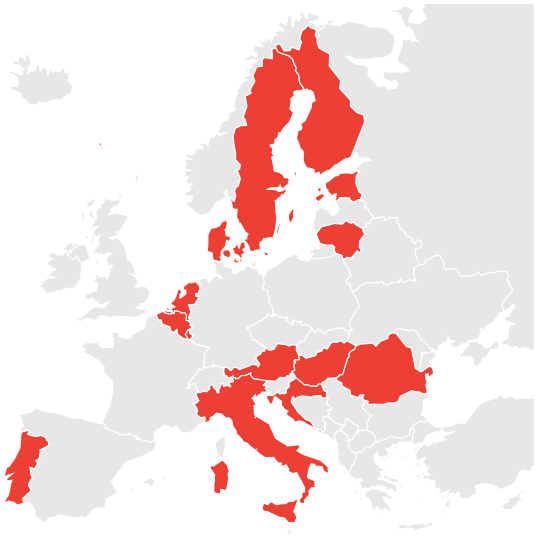

Figure 5 **Legal provisions addressing workplace bullying**

Interviews with trade union representatives show that where there is legislation, implementation is hampered by a lack of resources, such as in the form of labour inspectors, lack of political will and accountability and punitive measures to push reluctant employers to address PSR: 'Ultimately, it depends on the priority politicians make in terms of money for healthcare and how the employer distributes it in healthcare.' (Vårdförbundet, Sweden)

Research shows that jobs in which women are most exposed to psychosocial risks are in the healthcare sector (Eurofound 2021). In this specific context, gender blindness is expressed as a failure to recognise the roles and responsibilities imposed on women who work in this sector. 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 self-sacrifice and availability. Such representations clash with professional definitions based on knowledge requirements, the complexity of tasks, technical training and labour rights. Furthermore, low levels of unionisation hinder the prevention of PSR in the long-term care sector across the European Union. This creates widespread and deep inequalities, which themselves are sources of psychosocial risks. (Casse et al. 2020)

> '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. [Workers'] high ill-health rates, sick leaves and such are closely linked to an unhealthy work environment. This needs to be addressed as a serious problem.' (Kommunal, Sweden)

4. Trade union actions to prevent psychosocial risks

> '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, Spain)

The work of trade unions in the healthcare and long-term care sectors on PSR prevention is paramount to protect workers and mitigate the effects of adverse working conditions on their health. Trade unions can:

- protect the rights of workers;
- work towards sustainable structural and financial improvements in these sectors; and
- be a unique source of empowerment allowing for class action and proper OSH representation at the place of work.

While trade unions have been aware of the problem of work-related PSR for a long time, a lack of legislation has hampered the actions of trade unions to address PSR in the healthcare and long-term care sectors and beyond. Nevertheless, unions have developed a variety of strategies and actions to support workers. Actions have included, among others, lobbying, campaigns, strategic and practical support at the workplace level, and collective agreements.

4.1 Lobbying for an adequate legislative EU framework

There is a need for an EU directive on psychosocial health risks to clarify the employers' duty to prevent and deal with these risks and to organise work in such a way that creates good conditions for the employees (ETUC 2021).

Even though legislation is a strong driving force for employers to assume their responsibility for occupational health and safety, there is very little legislation, and in only few EU Member States, that addresses psychosocial risks directly. At the EU level there is no dedicated legislation, and in the Framework Directive on Occupational Safety and Health there is only one somewhat clear reference to work organisation.

The ETUC and its affiliates are campaigning for a directive that addresses psychosocial risks in the workplace. The ETUC addresses the need to expand the scope and definition so that social and relational aspects are included, such as the safe organisation of work (e.g. limiting the number of pace determinants a worker is subject to, measuring work pressure, time pressure, control/influence, monitoring and surveillance, performance management and change etc.) as well as the social aspects (management quality, support from management and peers, harassment and violence, bullying) are properly taken into account, along with physical factors such as noise, heat and levels of vibration.

The campaign *EndStress.EU* has been jointly set up by Eurocadres and ETUC and is advocating for the said directive. The campaign invites trade unions and employers alike to join the call for a European directive, working with an internet platform, webinars, and other multi-media tools.

4.2 Examples of action from Germany, Spain and Sweden

Unions are extremely well placed to provide information and to consult with their membership so that their actions on PSR are informed by bottom-up approaches. Although employers have a legal responsibility to ensure that workplace risks are properly assessed and controlled, it is essential that workers are also involved. Workers and their representatives have the best understanding of the risks in their workplace and involving them will ensure that the measures put in place are both appropriate and effective.

Trade unions in Germany, Spain and Sweden understand that PSR represents a serious issue that impacts workers' health, and they are taking action.

In Germany trade unions have concentrated on supporting the creation of work councils in healthcare and eldercare organisations; they also have recent successes with concluding several important collective agreements in the hospital sector. It is estimated that only 10 per cent of long-term care institutions have work councils; union representatives support care workers if they wish to push for the establishment of one in their institution.

While recent research indicates that workers in the health and care sectors are more reluctant to strike than other sectors, strikes can be an effective means of bringing about positive tangible changes in these sectors.

The result of the strike action in hospitals in Berlin, Germany, October 2021

The collective agreements in the healthcare sector between Ver.di, Charité, and Vivantes stipulate how many clinical staff must be deployed 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.

'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 Spain, the law obliges employers to undertake a risk assessment that includes PSR, but the majority of companies/centres engaged in providing health services and long-term care do not regularly assess the risks that each job position may entail. Those who do most often fail to include PSR. Unions can address these failures by referring to the law and ensuring monitoring and follow-up. Spanish trade unions have opted to address this via the obligatory Equality Plan; Spanish law requires companies with over 50 workers to draw up and apply an equality plan aimed at achieving equal treatment for women and men. Equality plans are subject to negotiation with workers' representatives.

> '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)

Trade unions have also developed specific ways of responding to obligatory company risk assessment reports by drafting counter reports stating that the mitigation measures fall short of what is really needed. From time to time, this has produced good results in terms of greater flexibility in arriving at work and leaving work and developing better rotation routines to reduce work-life conflict; getting more and specific training to cope with emotional demands, and even hiring another person to reduce high quantitative demands. Unions have also taken on grievance cases and conducted awareness campaigns on psychosocial risks.

In Sweden, the Trade Union Confederation (LO) started to work with 290 municipalities (before the Covid-19 pandemic) to help them address staff shortages directly linked to PSR by bringing in a team of experts to investigate those places where the highest rates of sick leave were reported. The Swedish Municipal Workers' Union (Kommunal) has created its own work environment strategy that covers issues such as the organisation of work, staffing, working time, threats/violence and victimisation/sexual harassment. They also have guidelines that take account of the specificity of a sectoral work environment and feature a toolbox for particular situations or problems at work.

4.3 Key takeaways

- PSR arise from poor organisation of work and poor employment conditions.
- PSR can translate into emotional, behavioural and/or physical symptoms such as stress, absenteeism, sleep disorders, drug abuse, back pain, migraine, depression, conflicts, burnout, aggression, harassment, parasuicide and suicide.
- PSR are evident in the healthcare and long-term care sectors. Sick-leave rates, which are high in these sectors, can be reduced by tackling the sources of psychosocial risks.
- PSR prevention is effective when carried out at the collective level. Priority must be given to primary prevention actions, i.e. actions designed to eliminate the sources that give rise to the PSR factors.
- Workplaces should regularly conduct proper assessments of PSR and involve workers in the process.
- Workers are not equally protected from PSR across EU Member States. The situation is critical in the highly feminised healthcare and long-term care sectors.
- In order to address the sources of PSR in these sectors, it is paramount to apply a gender lens to the drivers of inequality, including in leadership and the gender pay gap.
- Unionisation and the promotion of quality collective bargaining around health and safety at work with a focus on PSR is crucial in the healthcare and long-term care sectors.
- The EU should take advantage of the momentum created by Covid-19; there is more awareness now about recognising and addressing PSR. Having EU legislation on this issue would help equalise how Member States tackle what is already recognised as major contributor to the burden of disease in Europe.

5. Further resources and references

European Trade Union Confederation (ETUC)

An ETUC resolution on actions for combatting stress and eliminating psychosocial risks in the workplace: putting an EU Directive on the agenda (2018) https://www.etuc.org/en/document/etuc-resolution-actions-combatting-stress-and-eliminating-psychosocial-risks-workplace

ETUC Resolution on the upcoming EU Occupational Safety and Health strategy in light of Covid-19 (2021) https://www.etuc.org/en/circular/etuc-resolution-upcoming-eu-occupational-safety-and-health-strategy-light-covid-19-0

EndStress.EU campaign: https://endstress.eu/

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European Public Services Union (EPSU)

No to commercialisation of care – yes to right to quality care, decent pay and safe staffing. https://www.epsu.org/newsletter/no-commercialisation-care-yes-right-quality-care-decent-pay-and-safe-staffing

European Agency for Safety and Health at Work (EU-OSHA)

ESENER shows how health and safety is managed in human health and social work. https://osha.europa.eu/en/highlights/esener-shows-how-health-and-safety-managed-human-health-and-social-work

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