

# Human health and social work activities – evidence from the European Survey of Enterprises on New and Emerging Risks (ESENER)

Report

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## Executive summary

The European human health and social work activities sector is a key sector in terms of ensuring the health and wellbeing of Europe's citizens, including its workforce. The human health and social work activities sector is one of the largest in Europe, employing around 11% of workers in the European Union according to 2020 figures from Eurostat<sup>1</sup>. A significant proportion of workers in the sector are employed in hospitals, although they also work in other workplaces, such as nursing and care homes, medical practices and in other health-related activity areas, as well as in patients' own homes.

Workers in this sector are exposed to a wide range of risks to their health and wellbeing. This diversity of risks for those working in this sector provides further justification for the selection of this sector for further analysis of the available ESENER data relating to this sector. The main risks include: biological risks, which include any form of exposure to biological agents such as blood-transmitted pathogens and infectious micro-organisms, and which also include risks related to COVID-19; chemical risks, including among others from drugs used in the treatment of cancer and from disinfectants; physical risks, such as from noise, slips, trips and falls, and ionising radiation; ergonomic risks, for example lifting during patient handling; and psychosocial risks, which include third-party violence and harassment, exposure to traumatic events, high workload, dealing with people at the end of their lives, the need to multitask, shift work, lone working, burnout, internal mobbing/bullying and lack of control over work.

Given the importance of this sector and the specific occupational safety and health (OSH) risks that its workers face, the main aims of this study were to analyse data from the three waves of the ESENER surveys (2009, 2014 and 2019) to gain an overview of trends over time in the areas of OSH management in general, psychosocial risks in particular, drivers and barriers to OSH management in the sector and worker participation in OSH. The overall objective of this study was to provide information that helps to explore the ways in which OSH management is organised in this sector and the reasons and motivations behind this. It also aimed to provide information about how OSH management is shaped by the context in which establishments in the sector operate.

In particular, the following research questions were addressed:

- **What are the main OSH risk factors faced by the human health and social work activities sector?** Have these risk factors significantly changed over the past decade, over the course of the three waves of ESENER from 2009 to 2019, and if so, how? Is there variance regarding the risk factors faced by country? How do the risk factors faced by this sector compare to those faced by other sectors?
- **How is OSH managed in the human health and social work activities sector?** What are the types/typologies of establishments in the sector regarding the way OSH is managed at the workplace? Has OSH management significantly changed over the past decade, and if so, how? Are there substantial differences regarding OSH management in this sector by country? Is OSH managed significantly differently in this sector than in other sectors?
- **What are the main factors influencing the management of OSH in the human health and social work activities sector?** What is the effect of, among other factors: national/sector context; size of establishment; management commitment; worker involvement; existence of procedures; and availability of expertise and support? Has this changed over time? Are there substantial differences at country and sector level?

To answer these research questions outlined, the study used a mixed-method approach. This comprised the following elements:

- Literature review;
- Interviews with nine key sector informants;
- Descriptive analysis of ESENER datasets;
- Advanced statistical analysis (latent class analysis) of ESENER datasets.

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<sup>1</sup> [https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa\\_egan2&lang=en](https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa_egan2&lang=en)

Overall, this study found that there is a **higher than average awareness of OSH** in the human health and social work activities sector, when compared with the average of all sectors.

In terms of the main OSH risks for the sector, the study focused on the two most common risks: ergonomic risks (including musculoskeletal disorders, MSDs) and psychosocial risks. The main reported **ergonomic risks** to those working in the human health and social work activities sector are repetitive hand and arm movements, prolonged sitting, and lifting or moving people or heavy loads. These risks can cause MSDs in general and back pains in particular. These factors are identified as risks for all sectors, but lifting or moving heavy loads is reported to be more of a risk for this sector than for other sectors. Risks from chemical or biological substances were also confirmed as higher for this sector than for other sectors.

In terms of **psychosocial risks**, having to deal with difficult patients is confirmed as the most significant reported risk for this sector. Time pressure is also identified as a significant risk. In line with this, according to a number of the experts interviewed for this study, harassment and violence in the workplace is a significant problem for the sector.

Overall, evidence from ESENER shows that risks related to the way the work is organised are much more often reported in establishments in the sector than in other sectors. Over time, all risks have increased in the sector, with the exception of fear of loss of job.

The **impact of COVID-19** has been significant for the sector in many different ways, a result that came out strongly from the interviews conducted for this research. Interviewees pointed to a huge rise in stress for those working in the sector, caused by factors such as overwork due to increases in the number of patients and staff shortages, lack of personal protective equipment (PPE) in the first wave of COVID-19, and general anxiety about their own health as a result of potential exposure to COVID-19 at work, and the health of their families during the pandemic. COVID-19 has also had an impact on workplace inspections, leading to reduced numbers of inspections taking place, due to factors such as shortages of labour and restrictions on entering workplaces due to biological risks.

Building on this, the proportion of establishments **visited by the labour inspectorate** in the past three years was reported to have decreased over time, both for all sectors and the human health and social work activities sector specifically. There are a number of reasons for this, such as the fact that labour inspectorates are under significant pressure in terms of number of personnel, and specialisation and training on specific risks. As pointed out above, the COVID-19 pandemic has also meant that labour inspectorates have on occasion not been allowed to enter workplaces due to biological risk factors.

The study found that human health and social work activities sector establishments, compared with establishments in all other sectors, are **most likely to have good OSH management and rely on internal support for OSH management**. Establishments have a range of **mitigation measures** in place to try to minimise both ergonomic and psychosocial risks in this sector. The sector performs better than the average of all sectors in terms of companies reporting that they have **action plans** in place to deal with workplace stress, and **procedures** in place to deal with bullying and harassment, and threats and abuse from external parties.

The provision of **specific ergonomic equipment, such as chairs or desks, was the most popular preventive measure**, followed by the provision of equipment to help with the lifting or moving of loads or other physically heavy work, and the possibility for people with health problems to reduce working hours. The most common measure taken to mitigate psychosocial risks in the sector in 2014 was **confidential counselling for employees**, but in 2019, a new ESENER item, on **allowing employees to take more decisions on how to do their job** was the most frequently reported one.

Overall, establishments in this sector, compared with establishments in all other sectors, are **most likely to have well-developed psychosocial risk management**. This was observed slightly more often in large and public sector establishments than in smaller and private sector establishments. Establishments in the sector were more likely than those in the other sectors to have a high uptake of measures to prevent psychosocial risks.

There is also a reported **higher use of health and safety services** in the sector than in other sectors across ESENER waves for almost all services.



The proportion of companies that reported carrying out **risk assessments** was higher in the sector than in all sectors, both in 2014 and 2019, although the trend is decreasing. There is **an increase over time in risk assessments being conducted internally** for the sector, in particular for micro/small and medium companies. Overall though, large companies more often have internal staff conducting risk assessments compared with micro/small or medium companies. There is also a substantial split between those companies that opt for internal and external OSH experts, and this is often associated with the level of human and financial resources. The most commonly reported reason for workplace assessments not being carried out in the sector in 2019 was that **no major problems were identified, or that the hazards and risks were already known**.

The major difficulties reported most often in terms of addressing OSH risks are the **complexity of legal obligations, a lack of time or staff, and paperwork**. In the case of psychosocial risks, the most commonly reported obstacle in the sector in 2019 was the reluctance to talk openly about the issues. This appears to be confirmed by the experts interviewed for the study, who pointed out the **stigma attached to mental health**.

The main drivers for addressing OSH risks include **fulfilling legal obligations, meeting expectations from employees or their representatives, maintaining or increasing productivity, organisational reputation and avoiding fines and sanctions**. The analysis found that human health and social work activities sector establishments, compared with establishments in all other sectors, are more likely to report these drivers for OSH management, with this effect stronger in the private sector and with a positive correlation according to company size. The interviews support these findings, the key identified drivers including **reputation** and **legal compliance**. Further, interviewees consider that **COVID-19** has resulted in higher levels of awareness of the importance of the human health and social work activities sector and the link between the quality of this sector and the quality of public health. Finally, **digitalisation** can also be seen as a key driver of OSH in that it can contribute to high-quality, effective and efficient OSH management, particularly in the area of automation. It is likely that artificial intelligence (AI)-based systems will increasingly be used in this sector in the future to automate tasks that are both cognitively and physically-based, due to factors such as an increase in demand for staff in this sector. The positive consequences of this include the fact that AI-based systems can perform strenuous tasks such as patient lifting, and also some routine tasks, such as reporting of scans or needle insertion. This will help to prevent MSDs and can also reduce psychosocial risks by removing some of the burden of routine work. However, AI-based systems may also create new and emerging risks linked to fear of job loss, deskilling and lack of appropriate skills. These themes have been discussed widely in the literature<sup>2</sup>.

In terms of worker participation in OSH, **health and safety representatives** are the most common form of employee representation, both in this sector and in all sectors. Overall, health and safety was discussed more regularly between employee representatives and the management in establishments in the human health and social work activities sector in 2019 than in all sectors. Health and safety representatives are also provided with **training during working time** slightly more often in the sector compared with all sectors, although the trend has been slightly downward since 2014.

For both the human health and social work activities sector and all other sectors, the vast majority of the companies that have regular risk assessments involve their employees in the design of the measures; this proportion is slightly higher for this sector than all sectors. Employees in the human health and social work activities sector are also much more often involved in **identifying possible causes for work-related stress and designing measures to deal with them** than in all sectors.

A number of key learning points emerge from this study, which may contribute to improving OSH in the human health and social work activities sector:

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<sup>2</sup> See, for example, European Commission (2019), AI, the future of work? Work of the future!: on how artificial intelligence, robotics and automation are transforming jobs and the economy in Europe: <https://op.europa.eu/en/publication-detail/-/publication/096526d7-17d8-11ea-8c1f-01aa75ed71a1>; and European Parliament (2021), Improving working conditions using Artificial Intelligence: [https://www.europarl.europa.eu/RegData/etudes/STUD/2021/662911/IPOL\\_STU\(2021\)662911\\_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2021/662911/IPOL_STU(2021)662911_EN.pdf)

- It is crucial to acknowledge psychosocial risks in the workplace, especially following the COVID-19 pandemic.
- Mechanisation and digitalisation can play an important role in mitigating ergonomic risks in the sector, and this role will doubtlessly increase in the future. Most specifically, the introduction and use of digital technologies such as wearable and AI devices is an opportunity to support OSH processes and procedures.
- This research has shown that this sector performs well in terms of having a range of OSH risk mitigation strategies in place, particularly in the case of stress, bullying and harassment and abuse and threats from external parties. This is a solid basis on which to encourage establishments to focus further on ensuring that their action plans and procedures respond to the evolving ergonomic and psychosocial risks.
- Training and awareness-raising is also a vital tool in reducing OSH risks in the workplace across the sector, both for employees and for managers, and the sector performs relatively well in this regard. This is particularly important in non-residential care and social care settings, where the work environment is less controlled.
- The sector also performs relatively well in terms of discussion of OSH issues, both among top management and with employee representatives. Given the paramount importance of communication, this should continue to be a focus for the sector.
- It is crucial that good practice examples that address the issues in the sector and within the different sub-sectors of the sector are available to all, which means that translation of good practice into more EU languages would be advisable.
- The involvement of employee representatives and employees in OSH management and risk assessment is an acknowledged advantage in terms of risk mitigation. The sector performs well in this area and should therefore continue to build on this.
- The human health and social work activities sector has undoubtedly suffered greatly from the COVID-19 pandemic in many respects. However, this could be used as a catalyst to improve OSH in the sector, based on the increased profile of the sector in the public eye and the strengthened links between this sector and public health policy. Future areas for focus include resolving staffing shortages, possibly linked to improvements in pay and conditions, and protecting the workforce from factors such as violence and harassment.

# 1 Introduction

The European human health and social work activities sector is a key sector in terms of ensuring the health and wellbeing of Europe's citizens, including its workforce. The human health and social work activities sector is one of the largest in Europe, employing around 11% of workers in the European Union, according to 2020 figures from Eurostat<sup>3</sup>. A significant proportion of workers in the sector are employed in hospitals, although they also work in other workplaces, including nursing and care homes, medical practices and in other health-related activity areas, as well as in patients' own homes.

In the future, the significance of this sector is likely to grow due to factors such as demographic change. Employers in this sector will not only be affected by the ageing population, which will lead to increased demand for the services of this sector, but will also face potential labour market shortages resulting from declining birth rates.

Given the importance of this sector and the specific occupational safety and health (OSH) risks that its workers face, the main aims of this study are to analyse data from the three waves of the ESENER survey (2009, 2014 and 2019) to gain an overview of trends over time in the areas of OSH management in general, psychosocial risks in particular, drivers and barriers to OSH management in the sector and worker participation in OSH.

The study also examines the new sections contained in the ESENER 2019 questionnaire, which are digitalisation and its impact on OSH, the quality of external preventive services and an assessment of accidents and sickness absence. This ESENER analysis is complemented with interviews with sector experts and stakeholders.

The overall objective of this study is to provide information that helps to explore the ways in which OSH management is organised in this sector and the reasons and motivations behind this. It also aims to provide information about how OSH management is shaped by the context in which establishments in the sector operate.

This report reflects the main findings of this study and is structured as follows:

- Section 2 gives some background and context for the study, based on a literature review.
- Section 3 sets out the conceptual framework for the study.
- Section 4 examines the main OSH risk factors faced by the human health and social work activities sector, focusing on MSDs and psychosocial risks. It looks at trends in these risk factors over the past decade, the variance to the risk factors by country, and a comparison of risk factors across sectors.
- Section 5 analyses the management of OSH in the sector, looking at types/typologies of establishments in relation to OSH management, trends in OSH management over the past decade, data on differences in OSH management in this sector by country, and a comparison of OSH management in the sector with other sectors.
- Section 6 looks at the main factors influencing the management of OSH in the sector, including the main drivers and barriers, trends over time and any differences at country and sector level.
- Section 7 analyses worker participation in OSH, looking at forms of worker participation in OSH, training of OSH worker representatives and the involvement of worker representatives in identifying risks and formulating action plans.
- Section 8 contains the main conclusions from this study.
- Section 9 sets out the main learning points resulting from this study.

Annex I contains the interview guide for the expert interviews. Annex II contains the results of the latent class analysis carried out as part of the statistical analyses of the ESENER datasets.

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<sup>3</sup> [https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa\\_eagan2&lang=en](https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa_eagan2&lang=en)

## 2 Background and context: occupational health and safety and its management in the human health and social work activities sector

The human health and social work activities sector in Europe makes a significant contribution to European society, both in terms of overall health and wellbeing and to society and the economy in general. This sector includes a wide range of activities, grouped into human health activities (NACE code Q86), residential care activities (NACE code Q87) and social work activities (NACE code Q88) as follows:

- Human health activities:
  - Hospital activities;
  - Medical and dental practice activities;
  - Other human health activities.
- Residential care activities:
  - Residential nursing activities;
  - Residential care activities for mental retardation, mental health and substance abuse;
  - Residential care activities for the elderly and disabled;
  - Other residential care activities.
- Social work activities:
  - Social work activities without accommodation;
  - Social work activities without accommodation for the elderly and disabled;
  - Other social work activities without accommodation.

Investments in healthcare systems can stimulate economic growth by improving the health of society's population and its workforce. Since March 2020, the COVID-19 pandemic has revealed how vulnerable our healthcare systems are and that building their resilience is urgent.

The human health and social work activities sector is an important employer, providing work for those in formal care settings, such as hospitals, nursing homes and care homes, and medical practices, in addition to care workers who provide care to individuals in their own homes. Throughout Europe, the human health and social work activities sector is one of the largest sectors, providing roughly 11% of all jobs (with women accounting for about 80% of the sector's workforce; Eurofound, 2020). In Scandinavian countries and the Netherlands, the sector even accounts for more than 17% of total employment. Since 2000, employment in the human health and social work activities sector has grown by 42%, outpacing the growth in most other sectors. As a result of its significance, employment in the sector is not directly aligned with general workforce trends, nor is it susceptible to cyclical employment fluctuations (OECD, 2020). The sector has grown steadily throughout the past decade and is likely to continue to grow in the near future given the ageing of the EU population (Eurofound, 2020).

Driven by this demographic shift, the type of work in the human health and social work activities sector is likely to change, which subsequently will demand a different skillset of its employees. With an ageing society, the distribution of the demand for health and social services will tilt towards greater demand for long-term care and related social services, which are particularly labour intensive. Long-term care typically requires more tailor-made services to meet the increasing variety of caring needs of the elderly. As such, countries are introducing new care delivery models which are more person-centred and better integrated with existing health and social services (OECD, 2020). Governments' healthcare policy focuses, for example, on an expansion of the roles of nurse practitioners, pharmacists and health workers, or the introduction of multi-professional teams.

However, contrary to earnings in the healthcare sector, which has a larger share of generally better-paid medical doctors, earnings in the social care sector are well below average throughout the EU. For over half of EU Member States, earnings in the social care sector are below 80% of average earnings (Eurofound, 2020). Compared with sectors requiring equivalent educational attainment, skills and training, remuneration for care workers is often relatively low. This, in turn, has led to an increase of worker mobility into other sectors, exacerbating labour shortages in the care sector.

In addition to low-paid work, working conditions in the human health and social work activities sector are often of a lower standard than those for workers in other sectors. According to the European Working Conditions Survey (EWCS), the health sector underperforms on all health and wellbeing dimensions when compared with other sectors in the EU. Typically, the health sector features high work intensity, high social and emotional demands, low health quality and health at work, negatively impacting workers' health and wellbeing (Eurofound, 2019).

In terms of OSH, health and care workers are exposed to a wide range of risks to their health and wellbeing. This diversity of risks for those working in this sector provides further justification for the selection of this sector for further analysis of the available ESENER data relating to this sector. The main risks include the following:

**Biological risks**, which include any form of exposure to biological agents such as blood-transmitted pathogens and infectious micro-organisms. There are four modes of transmission to which healthcare workers are most vulnerable. These modes are: 1) blood borne infections transmitted from blood to blood through penetrated or broken skin, for example through cuts or needlestick injuries; 2) airborne infection transmitted for example by a coughing or sneezing patient or through surgical smoke; 3) direct and indirect contact infections either transmitted directly through contact with contaminated skin of a patient or indirectly through contact with a contaminated surface (an intermediate carrier) (this could include cleaners who handle contaminated bedlinen or waste); and 4) special infections such as tubercular infections or scabies. A specific issue is also the nosocomial transmission of microorganisms who have become resistant to antibiotics, an increasingly complex issue in the healthcare environment (EU-OSHA, 2014, 2019 and 2020).

Although awareness of biological risks, more specifically of blood borne infections, has improved and precautionary measures have been implemented, thousands of healthcare workers incur needlestick or sharps injuries on a daily basis (King & Strony, 2020). EU Directive 2000/54/EC on biological agents at work<sup>4</sup> provides protection for workers in the area of biological risks, based on a social partner agreement concluded in 2009. This Directive aims to prevent workers' injuries caused by all medical sharps (including needlesticks), to protect workers at risk, and to set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring. Contact with biological agents, such as hepatitis and HIV, is also a risk.

Most recently, COVID-19 has emerged as a key biological risk, following the outbreak of the pandemic in early 2020. Accordingly, risk assessments now include COVID-19 as a specific biological risk, according to some of the experts interviewed for this study.

**Chemical risks**, including among others from drugs used in the treatment of cancer and from disinfectants. The daily use of hazardous chemicals poses a risk to those exposed to them, such as laboratory workers, doctors who treat patients daily with hazardous drugs or other medications, and cleaning staff. Exposure to hazardous chemicals can occur through inhalation or dermally (direct contact with skin). Workers in the human health and social work activities sector are specifically prone to chemical risks compared with workers in other sectors due to a lack of labelling provision of dangerous substances, high hygienic standards which require the use of chemical disinfectants, and the risk of neglected protection due to working sequences and high workloads (EU-OSHA, 2014). EU regulation in this area is contained in Directive 98/24/EC on risks related to chemical agents at work.

**Physical risks**, such as from noise, slips, trips and falls, and ionising radiation. Excessive noise stemming from for example laundries, orthotics areas, dental clinics and compressor rooms may lead workers to incur hearing loss as well as other forms of hearing impairment. The World Health Organization (WHO) recommends that sound levels should not exceed 35 dB in hospitals (Darbyshire & Young, 2013). However, it is not uncommon for hospital staff to be exposed to sound levels twice the maximum, especially those working in intensive care units where there is more heavy equipment. Among carers, ambulance staff, nurses and cleaners, the most common injuries are inflicted by slips,

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<sup>4</sup> <https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32000L0054>



trips and falls<sup>5</sup>. Mainly slippery, wet and uneven surfaces as well as obstructions are the cause of physical injuries. There are also risks relating to the safety of equipment used such as X-ray machines that require staff to follow principles of radiation protection. Overall, there are five EU Directives that provide protection in the area of physical risks. These relate to noise<sup>6</sup>, vibration<sup>7</sup>, artificial optical radiation<sup>8</sup>, protection against ionising radiation<sup>9</sup>, and electromagnetic fields<sup>10</sup>.

**Ergonomic risks**, for example lifting during patient handling. This includes lifting patients, pushing heavy equipment and other objects, working in awkward positions, performing repetitive movements, and work involving prolonged standing and sitting. This can be exacerbated by a lack of training; the growth in care work in individuals' homes, where specialist equipment may not be available and where the space is not adequately designed for care activities; and high workloads in the context of staff shortage, which may exacerbate risks. Among the nursing workforce, ergonomic hazards and MSDs form the leading OSH risks. The most common injury among nurses is lumbar back pain resulting from lifting and moving heavy equipment and patients<sup>11</sup>. EU regulation on lifting loads is contained in EU Directive 90/269/EEC on the manual handling of loads<sup>12</sup>.

**Psychosocial risks** may be defined as 'those aspects of the design and management of work, and its social and organisational contexts that have the potential for causing psychological or physical harm' (EU-OSHA, 2010). These risks include violence and harassment, exposure to traumatic events, high workload, dealing with people at the end of their lives, the need to multitask, shiftwork, lone working, burnout<sup>13</sup>, mobbing/bullying<sup>14</sup>, and lack of control over work, which is a known stress factor. According to the EWCS, workers in the sector hide their feelings to a greater extent, compared with workers in other sectors (Eurofound, 2019). They are also more exposed to adverse social behaviour, and they experience the most organisational change and job insecurity.

It is clear that the human health and social work activities workforce is exposed to a wide range of OSH risk factors. Workers providing care in individuals' homes are subject to a range of additional risks, apart from those mentioned above. These include the fact that home care work is not as controlled and supervised as work in institutional settings. Further, although patients' homes should be seen as a work site, not all workplace protections for workers can be put into place, making the environment potentially more hazardous for workers. Driving between individual homes to provide care creates extra stress and there have been issues concerning payment of care workers for the time that they spend travelling. On this issue, the Court of Justice of the European Union (CJEU) ruled in 2015 that, where workers do not have a fixed or habitual place of work, time spent travelling each day between their homes and the premises of the first and last customers does constitute working time<sup>15</sup>.

There are also a range of factors that have an influence on the health and safety of workers in the health and care sector. EU-OSHA has collected these drivers from its examination of literature and questionnaire responses in this area (EU-OSHA, 2014). These are principally:

- **Demographic changes**, in terms of the ageing of the general population and of the workforce, the implications for the health and care sector are twofold: 1) the number of patients likely to need care will increase, increasing labour demand, and 2) the health and care workforce is increasingly made up of older workers, diminishing labour supply. These older workers have

<sup>5</sup> European Commission (2010). Occupational Health and Safety Risks in the Health Care Sector: Guide to Prevention and Good Practice. Available at: <http://bookshop.europa.eu/en/occupational-health-and-safety-risks-in-the-healthcare-sectorpbKE3111047/>. European Commission (2010b).

<sup>6</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02003L0010-20190726>

<sup>7</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02002L0044-20190726>

<sup>8</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02006L0025-20190726>

<sup>9</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02013L0059-20140117>

<sup>10</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02013L0035-20130629>

<sup>11</sup> EU-OSHA 2000, Risk assessment in health care. E-facts No 18: <https://osha.europa.eu/en/publications/e-facts/efact18>

<sup>12</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A31990L0269>

<sup>13</sup> For more information on burnout, see: [https://oshwiki.eu/wiki/Understanding\\_and\\_Preventing\\_Worker\\_Burnout](https://oshwiki.eu/wiki/Understanding_and_Preventing_Worker_Burnout)

<sup>14</sup> See EU-OSHA (2009): Workplace Violence and Harassment: a European Picture.

<https://osha.europa.eu/en/publications/workplace-violence-and-harassment-european-picture>

<sup>15</sup> Case C-266/14 of 10 September 2015:

<https://curia.europa.eu/juris/document/document.jsf?doclang=EN&text=&pageIndex=0&part=1&mode=DOC&docid=167291&occ=first&dir=&cid=746970>

increased OSH risks and needs, most specifically in terms of needing a longer recovery period from illness and injury. It is estimated that the gap between labour supply and demand is likely to grow as the average age of the workforce in the healthcare sector rises (Geyer & Schultz, 2015).

- **Changes in family patterns.** Older people are increasingly not living with their families, which means that they have less support from family members and will therefore increasingly rely on formal care provision. For many countries in the EU, attracting enough workers to the long-term care sector is challenging and in addition, care workers experience difficult working conditions.
- **Lifestyle factors,** such as increasing obesity, diabetes and coronary heart disease will increase the likelihood of the need for care among the general population. Lifestyle-related diseases can be well avoided by improving the awareness on these type of diseases and their prevention and stimulating physical activity.
- **Levels of migration of health workers.** Due to a lack of healthcare personnel, many employees have been recruited from mainly less developed countries over the past decades. This can cause issues in terms of ensuring that patient safety is maintained in a multilingual environment in the countries to which these workers migrated. There may also be implications for the health and safety of these workers, for example if they are not familiar with the environment in which they are operating or do not understand safety information. They may also be at risk of being exploited in terms of their working conditions. On the other hand, the countries from which migrants leave may experience difficulties in providing proper healthcare. Taking into account the fact that a diverse workforce requires special attention to maintain patient safety is of key importance.
- **Economic factors.** The economic crisis that began in 2008 led to a lack of investment in many sectors, including healthcare. This has had a range of impacts on health and care workers in terms of increasing job intensity and stress for staff as a result of organisations not replacing workers who left. Further, globalisation is resulting in increasing competition, which means higher levels of restructuring and an increase in precarious work and job insecurity.

To this list can be added the **risk of COVID-19**, which has been a major cause of illness among the general population since early 2020. Further, COVID-19 has contributed to increasing stress levels among staff working in the human health and social work activities sector through increasing workload. Other factors, such as concerns about transmitting COVID-19 to relatives and friends, having to deal with negative attitudes from those seeing healthcare workers as sources of infection, having to work long hours wearing high-protection and uncomfortable PPE, dealing with high patient mortality, and inexperienced staff working in intensive care, also contributed to increased stress levels for staff in this sector. Staff must try to cope with an increased number of patients, cover for colleagues off sick, and cope with issues around a scarcity of PPE, particularly at the outset of the pandemic. It is likely that COVID-19 will be a continuing driver for change in the sector over the medium term.

Apart from regulation at EU level, the social partners have been active in trying to address OSH concerns for health and home care workers. The EU-level social partners have concluded agreements in the areas of violence and harassment in the workplace<sup>16</sup> (2007) and stress in the workplace<sup>17</sup> (2004). The existence of these risks has significant implications for the management of OSH in the health and care sector. These may be summarised as including the following:

- The need for more practical initiatives at national level to improve the working conditions of home care workers, in the case of both formal and informal caregivers;
- The need for more exchange of knowledge and good practice in this area;

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<sup>16</sup> <https://osha.europa.eu/es/legislation/guidelines/framework-agreement-on-harassment-and-violence-at-work>

<sup>17</sup> <https://osha.europa.eu/es/legislation/guidelines/framework-agreement-on-work-related-stress>

- In the context of an ageing workforce, the need for OSH interventions that take into account the impact of risks on older workers, and also policies that help to improve work-life balance for all workers;
- Given the significant number of workers in the human health and social work activities sector who are migrants, attention should be paid to reducing language and cultural barriers, and especially to establish clear communication around OSH issues;
- Training is vital in the context of the increased use of new technologies, as is assessment of the risks posed by these technologies. These new technologies could also be used to improve working conditions in a home care setting (for example, the use of robotics and exoskeletons).

### 3 Conceptual framework

This section sets out the conceptual framework that defines the core issues covered in this study. It also sets out the project's research questions to enable the study to address these core issues. This section also gives an overview of the methodological tools that were used to answer the research questions. These are essentially the initial literature review, topic guides for the expert interviews and the framework for the descriptive analysis of data.

#### 3.1 Core issues covered in the study

This study examines three main issues that affect the human health and social work activities sector: 1) OSH risk factors, 2) OSH management, and 3) drivers and barriers to OSH management. For each of these, the study focuses on the current situation, changes and trends over the past 10 years and a comparison across countries and with other sectors.

#### 3.2 Key research questions

These research questions have informed the development of the discussion guides for the expert interviews and the design of the descriptive statistical analysis.

1. What are the main OSH risk factors faced by the human health and social work activities sector?
  - a. Have these risk factors significantly changed over the past decade, over the course of the three waves of ESENER from 2009 to 2019, and if so, how?
  - b. Is there variance regarding the risk factors faced by country?
  - c. How do the risk factors faced by this sector compare to those faced by other sectors?
2. How is OSH managed in the human health and social work activities sector?
  - a. What are the types/typologies of establishments in the sector regarding the way OSH is managed at the workplace?
  - b. Has OSH management significantly changed over the past decade, and if so, how?
  - c. Are there substantial differences regarding OSH management in this sector by country?
  - d. Is OSH managed significantly differently in this sector than in other sectors?
3. What are the main factors influencing the management of OSH in the human health and social work activities sector?
  - a. What is the effect of, among other factors: national/sector context; size of establishment; management commitment; worker involvement; existence of procedures; and availability of expertise and support?
  - b. Has this changed over time?
  - c. Are there substantial differences at country and sector level?

#### 3.3 Study methodology

To answer the research questions outlined above and meet the study objectives, the study used a mixed-method approach. This comprised the following elements:



- Literature review;
- Interviews with nine key informants;
- Descriptive analysis of ESENER datasets;
- Advanced statistical analysis of ESENER datasets.

### **Literature review and desk-based research**

The study used desk-based research throughout several stages of the project and the analysis. Most importantly, researchers carried out desk-based research at the inception phase of this study, as set out in the Background and context section above. The study also used the findings of the desk-based research when deciding on model specifications in the statistical analyses (see below). A further review of the relevant, available literature was conducted after the statistical analyses were finalised to allow the study team to gain further understanding of the results obtained and aid the interpretation of results.

### **Key informant interviews**

The aim of the interviews with EU key informants, experts and policy-makers across Member States was to achieve qualitative in-depth insights and reflection on the survey results, as well as a reflection on current and required policy measures.

A list of potential respondents was established and individuals were then invited by email for an interview. The email was accompanied by an introduction to the study as well as an invitation letter signed by EU-OSHA.

An interview guide was developed, structured according to the four main areas of the survey: 1) OSH management in general; 2) psychosocial risks; 3) drivers and barriers; and 4) worker participation. The interview guide is contained in Annex I.

During the interviews, respondents were asked to reflect on relevant findings from the descriptive analysis and complement them where relevant. They were also asked to reflect on related policy measures that are currently implemented, as well as policy measures that seem to be required to improve aspects related to workers' workload, working conditions and the psychosocial risks to which they are exposed.

Although the situation relating to COVID-19 has influenced several aspects regarding this topic, the interviewers tried to primarily focus on the situation as it was before the pandemic during the interviews. The reason for this was because ESENER 2019 was carried out before the outbreak of COVID-19 and the qualitative research aimed to complement that survey. Nevertheless, it was necessary to include the impact of the pandemic in the study. Therefore, a section dedicated to the impact of COVID-19 on the OSH risks and management was also included in the guide, dealing with issues such as how OSH management will change in the sector post-COVID.

A total of nine individuals were interviewed, as set out in Table 1. The interviews took place either by video call or by telephone and lasted between 45 minutes and an hour. They were conducted in English and interview notes were taken during the interview. The information collected during these interviews has been included in this final report on a thematic basis, complementing the data analysis results.

**Table 1: List of key informant interviews**

Organisation	Interview date
HOPE - European Hospital & Healthcare Federation	3 February 2021
DG EMPL. C.2 Unit, Health, Safety and Hygiene at Work	8 February 2021
ETUI - European Trade Union Institute	12 February 2021

Organisation	Interview date
HOSPEEM - European Hospital & Healthcare Employers' Association	12 February 2021
Federation of European Social Employers	16 February 2021
Irish Health and Safety Authority	18 March 2021
Faculty of Medicine, University of Thessaly	19 March 2021
EPSU – European Federation of Public Service Unions	26 March 2021

### **Descriptive analysis of ESENER data**

Following data cleaning and data preparation, the main descriptive analysis of the ESENER data was undertaken between late January and mid-February 2021. The analysis covered the following areas:

- A comparative analysis of the 2019 and 2014 findings for the sector, to the extent that this was possible.
- Examination of ESENER 2009 aimed at providing an overview of the evolution of OSH management practices in the sector over the past decade.
- Comparison of the findings with those from other sectors.
- Analysis of the four main areas of the ESENER survey: 1) OSH management in general, 2) psychosocial risks, 3) drivers and barriers, and 4) worker participation.
- A focus on the new sections included in the ESENER 2019 questionnaire, such as digitalisation and its impact on OSH, as well as the quality of external preventive services and the evaluation of accidents/sickness absence.

The key variables of interest included those related to day-to-day OSH management, new and 'traditional' health and safety risks, and employee participation in OSH issues.

This descriptive analysis also took into account the national sample boost (+1,250 interviews) in Ireland, where human health and social work activities was one of the two sectors that was deliberately over-represented

This descriptive analysis enabled the researchers to gain a more in-depth understanding of the information that the ESENER data provides and how it could be used to answer the research questions of the project.

#### **Sample size**

The sample size for the ESENER survey responses is contained in Table 2. This forms the basis for the figures contained in this report.

**Table 2: Sample sizes in ESENER survey waves**

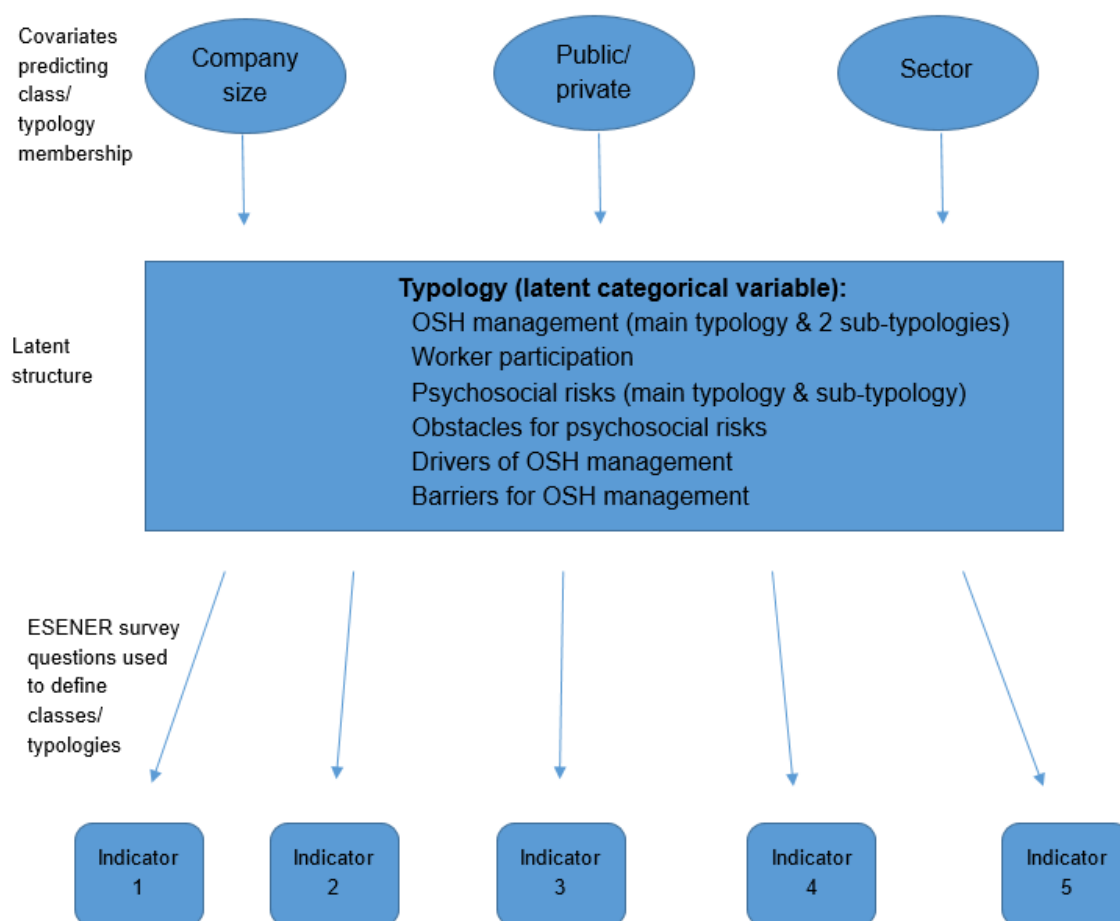
Sample size (EU-27)	Q - Human health and social work activities	All sectors
ESENER 1 (2009)	1,698	23,679
ESENER 2 (2014)	3,186	36,334
ESENER 3 (2019)	3,964	37,460

## Advanced statistical analysis

Latent class analysis (LCA) was then run on the 2019 ESENER to find nine different typologies with regards to OSH management, worker involvement in OSH, psychosocial risks as well as barriers and drivers for OSH management. Each of the nine typologies included three predictors of class membership. More specifically, each of the typologies includes a sector dummy variable, a dummy variable indicating whether an establishment is in the public or private sector, and establishment size dummy variables. The sector dummy was of particular importance as it was used to investigate whether companies in the human health and social work activities sector are more/less likely to report certain types of OSH management and so on than companies in other sectors. This enabled researchers to directly compare companies in the human health and social work activities sector to those in other sectors. For details of this methodology, see Annex II.

Figure 1 below illustrates the conceptual model of the latent class models.

Figure 1: Conceptual model for LCA analysis



## 4 The main OSH risk factors in the sector: MSDs and psychosocial risks

As highlighted in Section 2 of this report, in terms of OSH, health and care workers are exposed to a wide range of risks to their health and wellbeing. This section of the report will focus on the two most common risks: ergonomic risks (including MSDs) and psychosocial risks.

As evidenced in the literature review, which is set out in Section 2 of this report, **ergonomic risks** include lifting patients, pushing heavy equipment and other objects, working in awkward positions, performing repetitive movements, and work involving prolonged standing and sitting. This can be exacerbated by a lack of training, the growth in care work in individuals' homes, where specialist equipment may not be available, and where the space is not adequately designed for care activities, and high workloads in the context of staff shortage, which may exacerbate risks. Among the nursing workforce, ergonomic hazards and MSDs form the leading OSH risks. The most common injury among nurses is lumbar back pain resulting from lifting and moving heavy equipment and patients<sup>18</sup>. EU regulation on lifting loads is contained in EU Directive 90/269/EEC on the manual handling of loads<sup>19</sup>.

**Psychosocial risks** may be defined as 'those aspects of the design and management of work, and its social and organisational contexts that have the potential for causing psychological or physical harm'.<sup>20</sup> These risks include violence and harassment, exposure to traumatic events, high workload, dealing with people at the end of their lives, the need to multitask, shiftwork, lone working and lack of control over work, which is a known stress factor. According to the European Working Conditions Survey (EWCS), workers in the healthcare sector hide their feelings to a greater extent compared with workers in other sectors.<sup>21</sup> They are also more exposed to adverse social behaviour and experience high levels of organisational change and job insecurity.

In this section of the report, we present the most commonly identified trends for both ergonomic and psychosocial risks across European Union Member States in 2014 and 2019, based on the ESENER waves for these years. We then move on to discuss the measures that have been adopted throughout the EU to mitigate these risks. Finally, we also discuss the main obstacles to mitigating psychosocial risks.

### 4.1 Ergonomic risks

As noted above, the most commonly reported risks in the human health and social work activities sector (the Q sector as defined by NACE) as well as for all sectors were MSD risk factors (**ergonomic risks**). More specifically, as demonstrated in Figure 2 and Figure 3, in 2019 the most reported risk factor in the sector and for all sectors was repetitive hand or arm movements. The second most reported risk was prolonged sitting and the third was lifting or moving people or heavy loads.

Looking at trends between 2014 and 2019, in the human health and social work activities sector, there was a significant increase in the number of establishments reporting repetitive hand or arm movements as a risk, up from 51% in 2014 to 66% in 2019. The number of establishments reporting lifting or moving people or heavy loads also increased in the sector, from 54% in 2014 to 57% in 2019, and those reporting an increased risk of slips, trips and falls increased from 26.5% in 2014 to 30.5% in 2019. The risk of tiring and painful positions, including sitting, was split into two categories in the 2019 ESENER survey and therefore this question is not comparable between 2014 and 2019. For details, see Figure 2.

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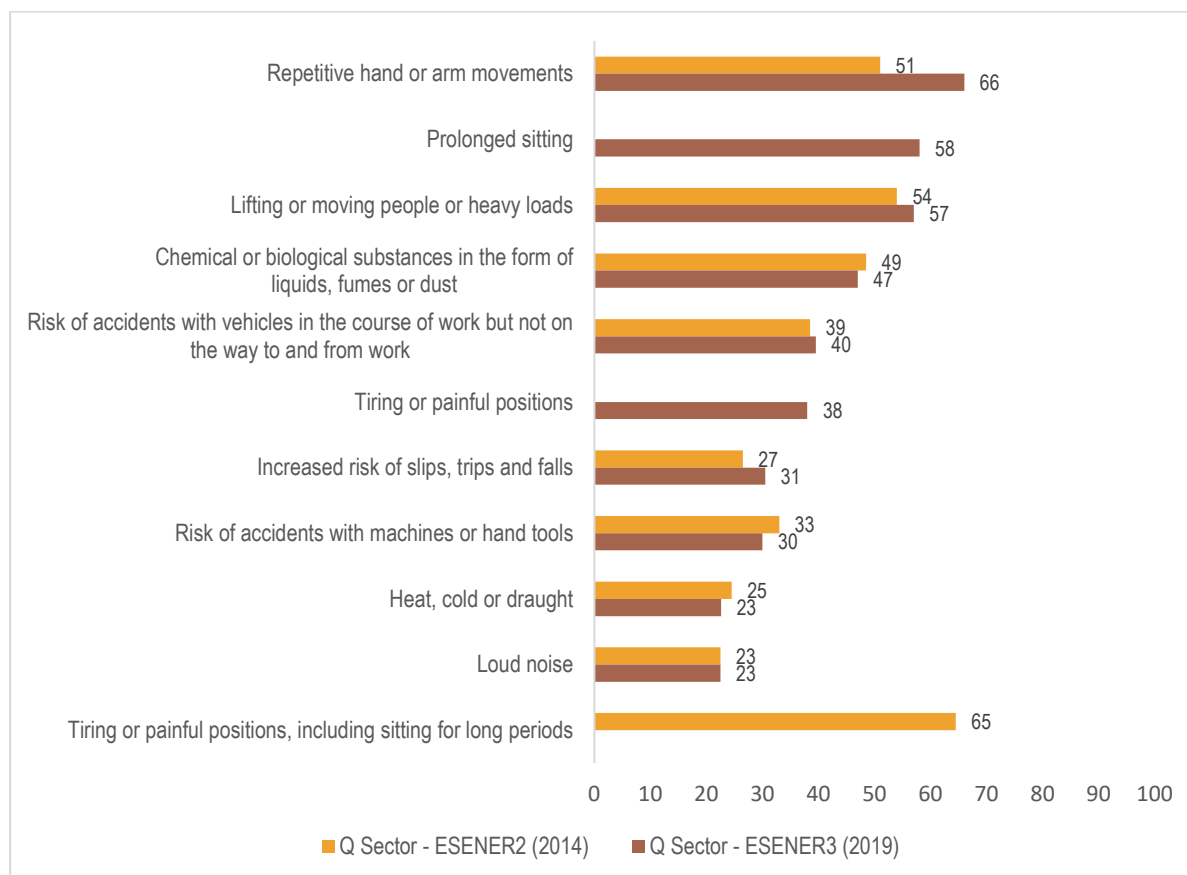
<sup>18</sup> EU-OSHA 2000, Risk assessment in health care. E-facts No 18: <https://osha.europa.eu/en/publications/e-facts/efact18>

<sup>19</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A31990L0269>

<sup>20</sup> EU-OSHA (2010). European Survey of Enterprises on New and Emerging Risks (ESENER): Managing Safety and Health at Work. Luxembourg: Publications Office of the European Union.

<sup>21</sup> Eurofound (2019). Working conditions and workers' health. Luxembourg: Publications Office of the European Union.

Figure 2: Risk factors present in establishments, Q sector 2014 and 2019 (%)

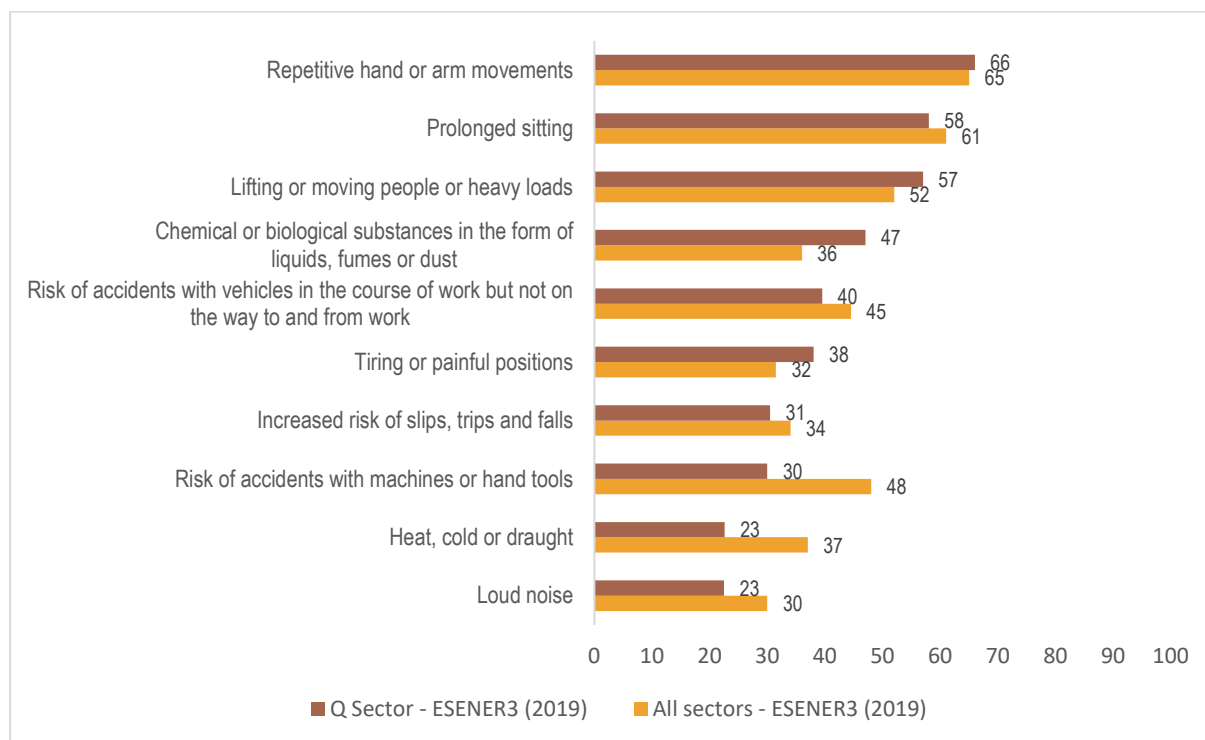


Base: all establishments in Q sector in the EU-27

Looking at risk factors in the sector compared with all sectors in 2019, more establishments in the sector reported chemical and biological risks than the average of all sectors (47% of establishments in the sector compared with 36% of establishments in all sectors). Similarly, the risk of lifting or moving people or heavy loads was reported more often in the sector (57% of establishments in the sector compared with 53% of establishments in all sectors), in addition to the risk of tiring or painful positions (38% in the sector compared with 31.5% in all sectors).

In the case of some other factors, fewer establishments in the sector reported these as risk factors, compared with all sectors. These risks are risk of accidents with machines or hand tools (30% in the sector compared with 48% in all sectors), heat, cold or draught (22.6% in the sector, compared with 37% in all sectors), and loud noise (22.5% in the sector, compared with 30% for all sectors). This is to be expected, as it reflects the work environment in the human health and social work activities sector, where workers are more likely to come into contact with chemical or biological risks or face issues around lifting or moving patients. Issues around lifting were also raised in the interviews carried out for this study, particularly in the care sector, where patients are often in their own homes and the work environment is therefore less controlled and specialist equipment not available. Workers in this sector are also less likely to encounter risks around machines or temperature, compared with workers in sectors such as manufacturing. For details, see Figure 3.

**Figure 3: Risk factors present in establishments, Q sector and all sectors 2019 (%)**

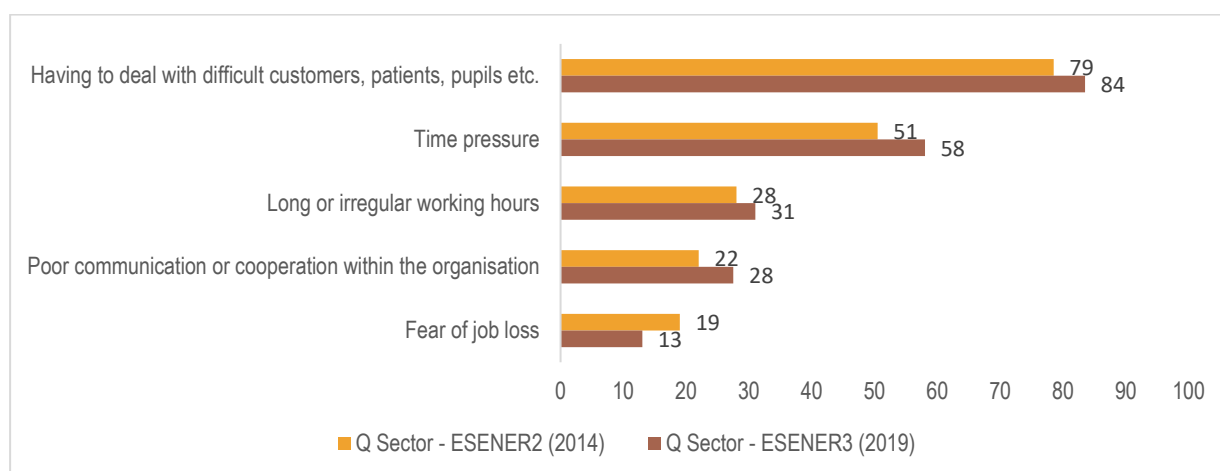


Base: all establishments in the EU-27

## 4.2 Psychosocial risks

In terms of psychosocial risks, as can be seen in Figure 4, risks related to having to deal with difficult customers/patients are particularly common in the human health and social work activities sector (78.5% in 2014 and 83.5% in 2019). Over time, the reporting of most risks (with the one exception of fear of job loss) increased between 2014 and 2019. This could in part be explained by the fact that workloads have increased in recent years, as noted by one of the experts interviewed for this study.

**Figure 4: Risks resulting from the way work is organised, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

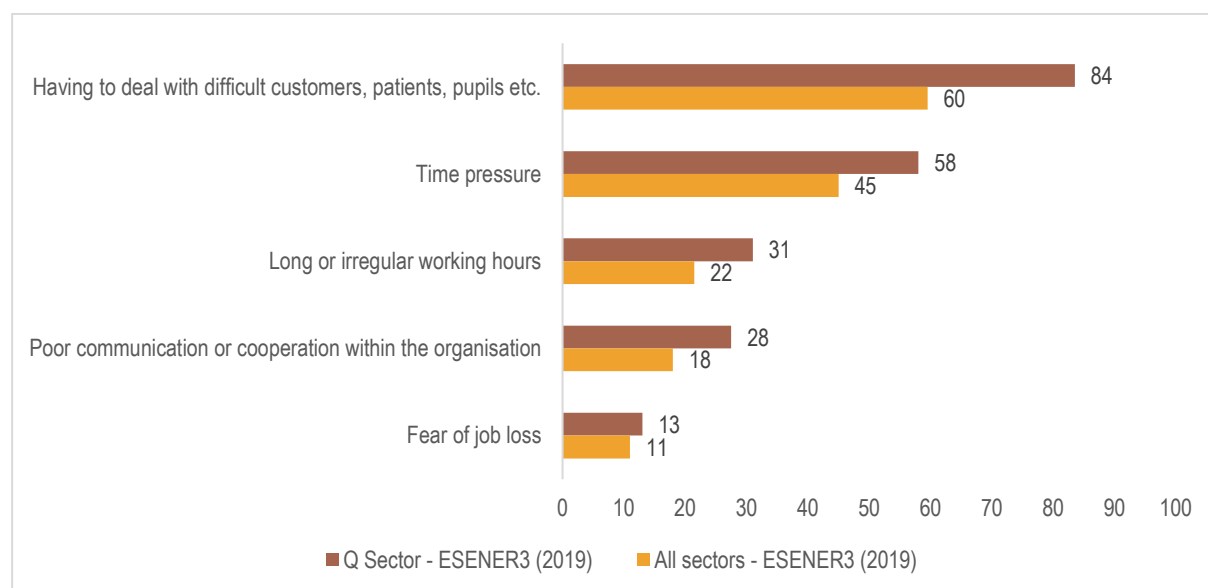
According to a number of experts interviewed for this study, harassment and violence in the workplace is a significant problem. For example, one interviewee noted that physical assaults represent 21% of all incidents causing harm, 48% are related to nurses and 7.8% to mental health workers. Another important issue highlighted by the interviewees is the precariousness of the sector, with one expert stating that ‘a lot of social care workers are precarious – lots of migrant workers with short-term contracts, zero hours contracts. This is in particular for long-term care and elderly care, and this adds a layer to stress which is financial stress, income insecurity’.

Interviewees noted that it is incredibly important to acknowledge psychosocial risks in the workplace, especially following the COVID-19 pandemic that has caused many of those working in the sector to suffer from post-traumatic stress due to the high-levels of illness and death in the workplace. There was also the added stress of potentially contracting the virus most prominently during the first wave of COVID-19 due to a lack of effective PPE. One interviewee stated that ‘the big problem is how to stay safe psychologically after a year in such bad working conditions, with the fear of passing the virus to your family’. This view was also echoed by other interviewees, who found that stress and burnout have increased due to the pandemic and staff shortages.

Interviewees also found that one of the determinants associated with the risk of burnout was medical supply shortages, which had a profound impact on the medical care. One interviewee confirmed the psychosocial risks of COVID-19: ‘workforce shortages that lead to busy schedules, long working days, no possibility to take time off, issues with work-life balance – the majority of workers are women and if they are also in a caring role, it becomes difficult and this creates stress’. Other interviewees confirmed that COVID-19 is still seen as a huge risk as there is an ongoing problem with healthcare staff either on sick leave or isolating – estimates are that this number is around 1 in 10 staff in the United Kingdom, for example. Lack of staff leads to increases in workload and stress for those in the workplace.

Evidence from ESENER shows that overall, risks related to the way the work is organised are much more often reported in establishments in the sector than in other sectors. This can be seen in Figure 5, which indicates that having to deal with difficult customers, patients, pupils, etc. is the most reported risk according to companies.

**Figure 5 : Risks resulting from the way work is organised, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27

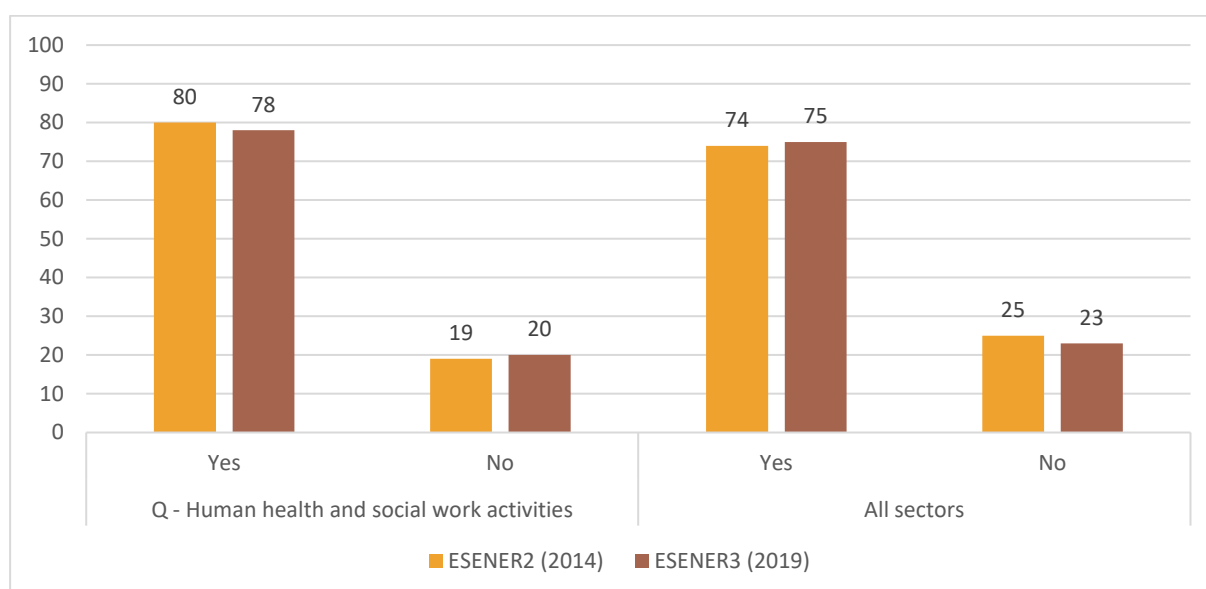
## 5 Management of OSH in the sector

This section examines the ways in which OSH is managed in the human health and social work activities sector. It begins with an analysis of the findings on risk assessments and then examines the main measures taken to mitigate ergonomic and psychosocial risks. It also looks at practices such as regular medical examinations, use of health and safety services, the use of health promotion measures and management training on health and safety, and enforcement activities – that is visits by the labour inspectorate. This section also looks into measures to mitigate both ergonomic and psychosocial risks. Chi-square tests were performed on some of the descriptive analysis data where results appeared to be particularly interesting or significant. It concludes with the results from the latent class analysis, which reveal three different types of establishments in terms of OSH management.

### 5.1 Regular risk assessments

The proportion of companies that reported carrying out risk assessments was higher in the sector than in all sectors, both in 2014 and 2019. However, there was a two percentage-point decrease in the sector (80% in 2014 and 78% in 2019) and a one percentage-point increase in all sectors (74% in 2014 and 75% in 2019). As a result, the gap in favour of the sector has shrunk from six to three percentage points.<sup>22</sup>

**Figure 6 : Regular risk assessments, Q sector and all sectors 2014 and 2019 (%)**



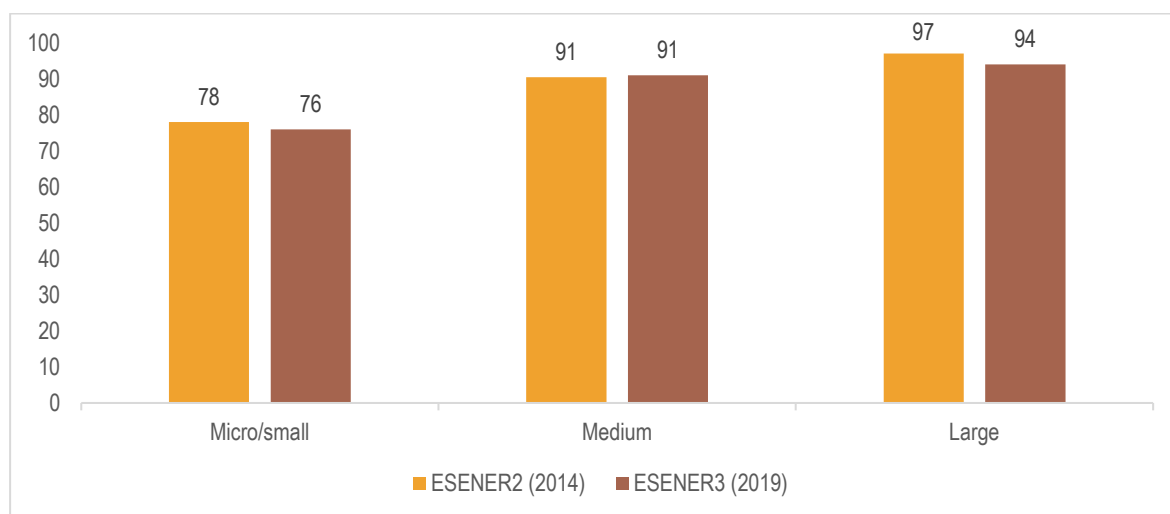
Base: all establishments in the EU-27

In the human health and social work activities sector and in all sectors, carrying out regular risk assessments is positively associated with establishment size – larger companies report carrying out risk assessments more frequently. Over time, the rate of companies reporting to be carrying out regular assessments dropped for micro/small establishments, while it stayed roughly the same for medium and large companies.

<sup>22</sup> The wording in ESENER 2009 was not exactly the same and data is not presented.



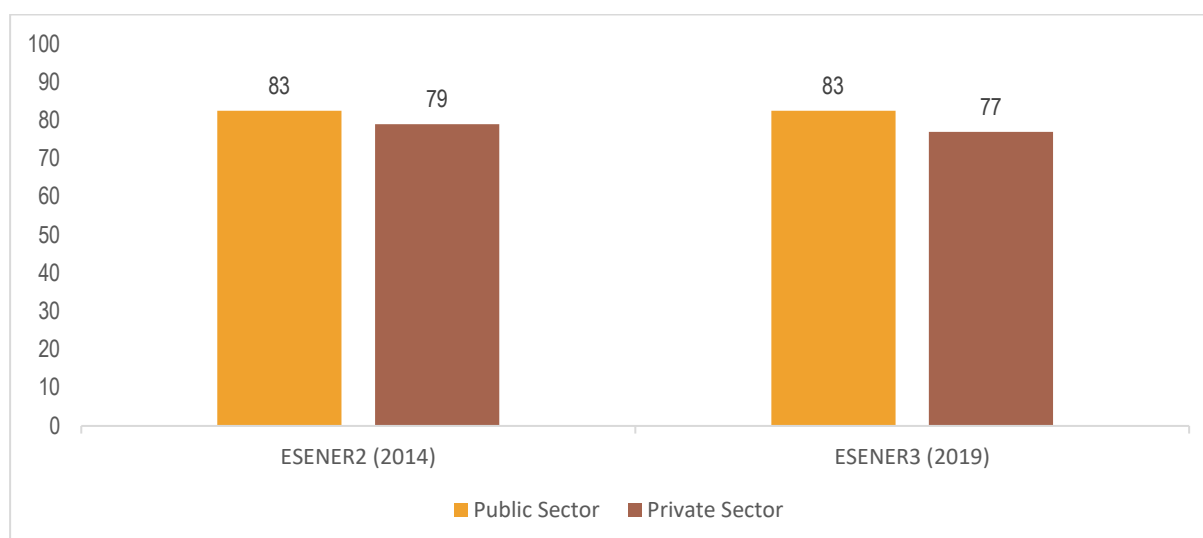
**Figure 7 : Regular risk assessments by company size, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

Over time, there has been a decrease in the rate of companies in the human health and social work activities sector that report performing regular risk assessments, which applies to both the public and private sectors. Overall, establishments in the public sector report carrying out regular risk assessments more often than those in the private sector.

**Figure 8 : Regular risk assessments by public/private sector, Q sector 2014 and 2019 (%)**

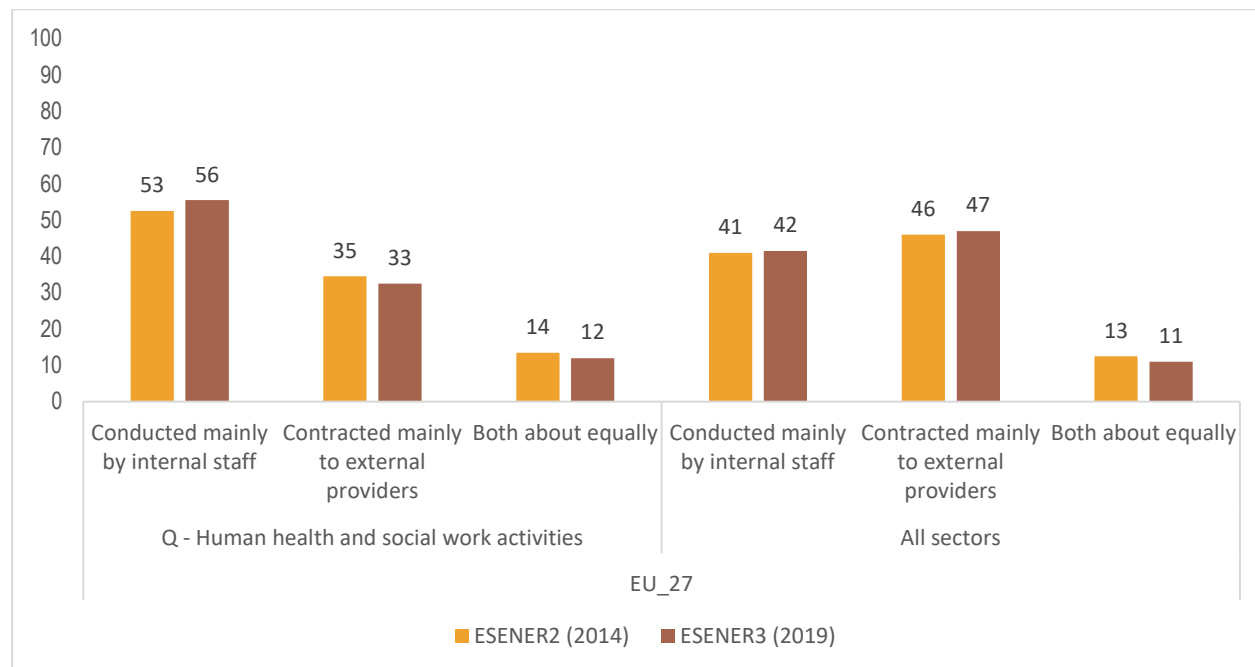


Base: all establishments in the Q sector in the EU-27

Risk assessments are more often reported to be conducted mainly by internal staff in the human health and social work activities sector than in all sectors, and this percentage increased slightly, from 53% in 2014 to 55.5% in 2019. The average for all sectors in terms of reported internal risk assessments was 41% in 2014, rising very slightly to 41.5% in 2019. Accordingly, risk assessments are less likely to be contracted to external providers in the sector, when compared with the average of all sectors (32.5% compared with 47% in 2019). The trend in terms of external risk assessments is a slight decrease in the sector between 2014 and 2019 (from 35% to 32.5%) and a very slight increase in all sectors (from 41% to 41.5%). A minority of companies in both this sector and all sectors reported that risk assessments

were carried out equally internally and externally, and this proportion fell in the sector and in all sectors between 2014 and 2019. For details, see Figure 9.

**Figure 9 : Risk assessments mainly conducted by internal/external staff, Q sector and all sectors 2014 and 2019 (%)**



Base: establishments in the EU-27 reporting carrying out regular risk assessments

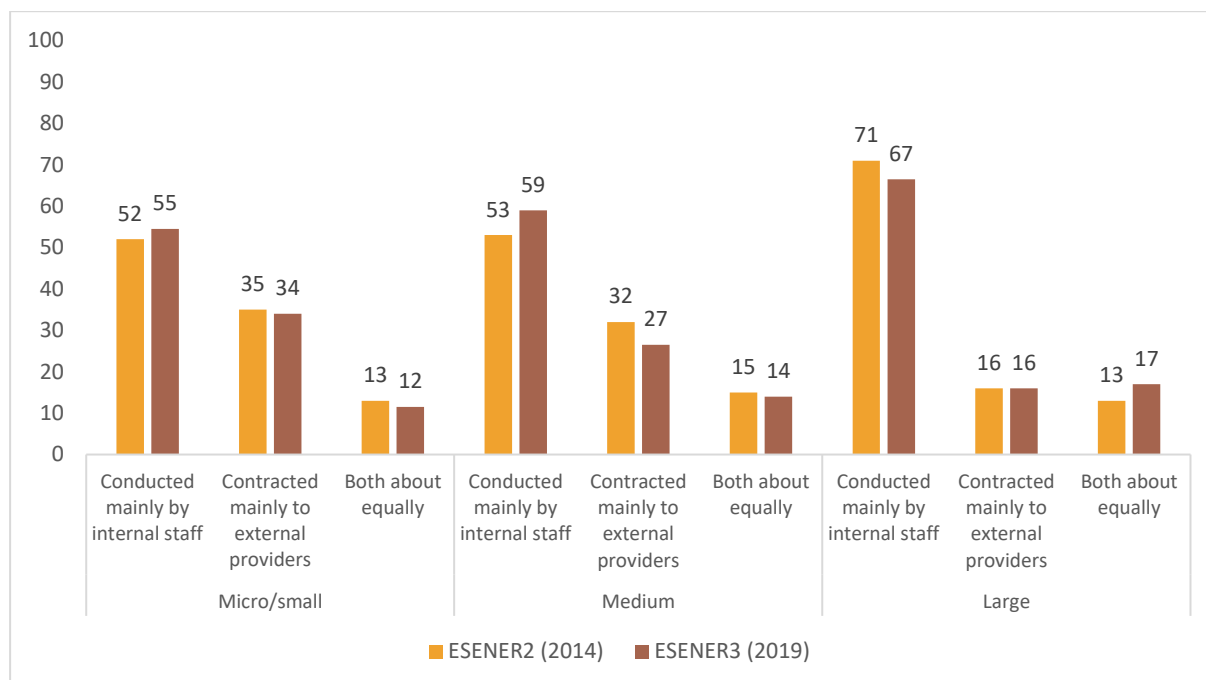
As mentioned above, there is an increase over time in risk assessments being conducted internally in the sector, and this is particularly the case for micro/small and medium companies. In any case, overall, large companies more often have internal staff conducting risk assessments than micro/small or medium companies.

The split between organisations that opt for in-house or external experts, in relation to risk assessments but also broader OSH-related tasks, is important and was further investigated by conducting interviews in the sector. According to research participants, while there are many factors that play a role, the size of the establishment is clearly perceived as key – with larger companies having the financial and human resources to opt for internal experts, as they have a larger pool of employees to choose from and can also train their staff for these roles. This would apply both to organisations in the health sector and the social care sectors, for example in large university hospitals and long-term care facilities. However, it can be challenging to find human resources to fulfil these roles in-house because employees may have little to no incentive; for example, there would be little financial incentive for in-house occupational physicians to become occupational medicine consultants in the hospital where they work.

Interviewees also expressed a view that there is a tendency to think of internal experts as being more qualified, for example because the organisation has the financial and organisational capacity to fund training and specialisations. However, this is not always the case, and one should not underestimate the value of external experts.

Despite this, it is also useful to consider how in-house experts have the advantage of knowing the establishment in which they work. This is not the case for external experts, who have limited knowledge and little opportunity to improve on it, given the irregularity of sporadic meetings for them to assess risks and measures and re-assess them after some time has elapsed. Therefore, one challenge of relying on external experts is that there may in certain cases be a substantial gap between what is on paper and what happens in practice.

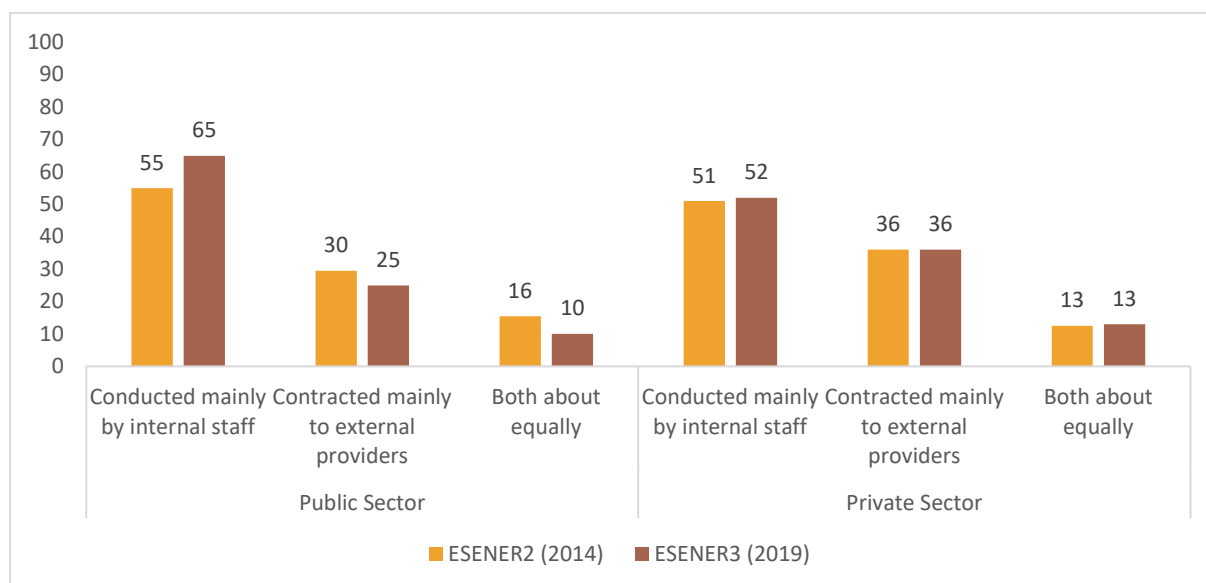
**Figure 10 : Risk assessments mainly conducted by internal/external staff by company size, Q sector 2014 and 2019 (%)**



Base: establishments in the Q sector in the EU-27 reporting carrying out regular risk assessments

Over time, there has been an increase in the rate of companies in the sector in which risk assessments are performed by internal staff in both the public and private sectors. Overall, risk assessments are performed by internal staff more often in the public than the private sector.

**Figure 11 : Risk assessments mainly conducted by internal/external staff, Q sector by public/private sector 2014 and 2019 (%)**



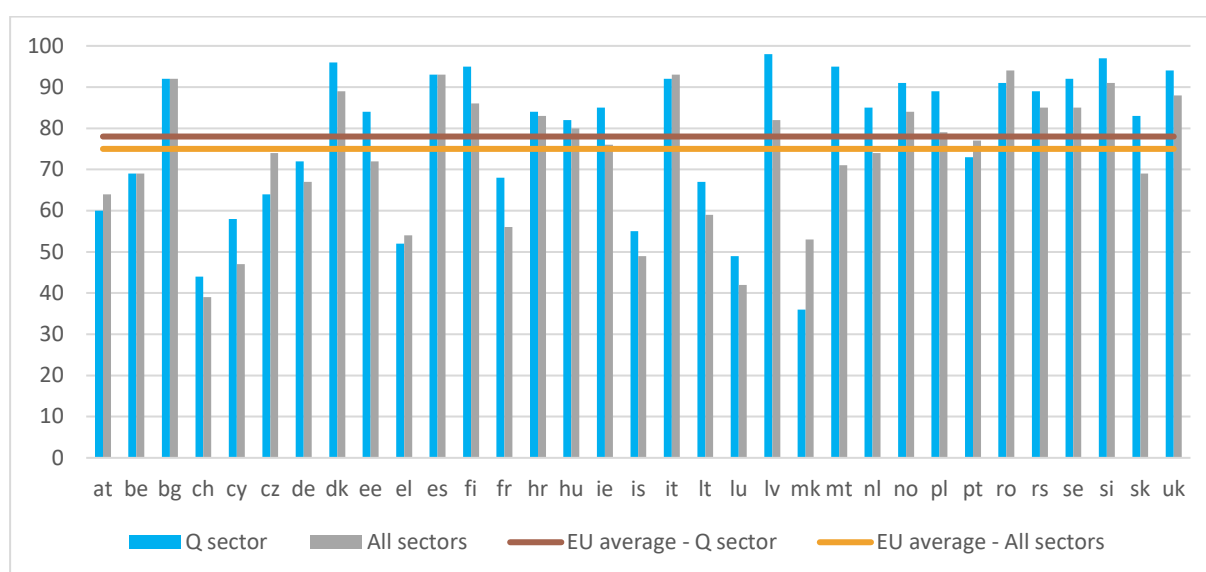
Base: establishments in the Q sector in the EU-27 reporting carrying out regular risk assessments

## Differences between countries

The EU-27 averages for regular risk assessments in the sector and in all sectors are quite similar: 78% and 75% respectively. There are 12 countries that have a national average in the sector that is higher than 90%, which is very high. However, this is not the case for all sectors, with only five countries (Bulgaria, Spain, Italy, Romania and Slovenia) having an average higher than this threshold (seven countries, if Denmark at 89% and the United Kingdom at 88% are included). It should be noted that these five countries have averages higher than 90% both for the sector and all sectors.

Czechia and North Macedonia do particularly poorly in this case. They have averages that are lower than the EU-27 for both the sector and all sectors, together with Austria, Belgium, Switzerland, Cyprus, Greece, France, Iceland, Italy and Luxembourg. Further, their national average for the sector is considerably lower than the one for all sectors: 64% and 74%, respectively for Czechia; and 36% and 53% for North Macedonia, whereas the reverse is true for France (68% and 56%, respectively).

Figure 12 : Regular risk assessments by country, Q sector and all sectors 2019 (%)

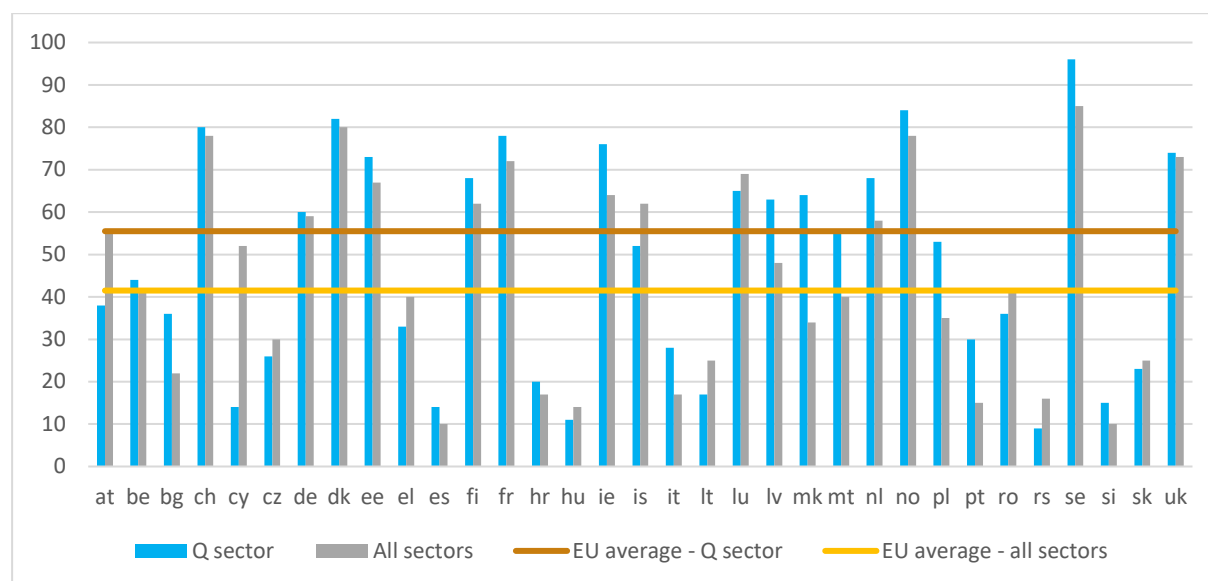


Base: all establishments

The EU-27 average for risk assessments mainly conducted by internal staff is 55.5% in the human health and social work activities sector and 41.5% in all sectors. There are 15 countries with an average for the sector that is higher than the EU-27 sector average, particularly Sweden (96%). There are 18 countries with a lower average, particularly Serbia (9%), Hungary (11%), Cyprus and Spain (14%), and Slovenia (15%).

Figure 13 also compares the national average in the sector with the national average across all sectors to check if and how the sector differs. In 22 countries the human health and social work activities sector 'outperforms' all sectors, particularly in North Macedonia (64% Q sector, 34% all sectors, although this country reports a relatively low share of establishments in the sector carrying out regular risk assessments), and by as little as one percentage point in Denmark and the United Kingdom. By contrast, in 11 countries the national average for the sector is lower, particularly in Cyprus – with a 38 percentage-point gap (14% Q sector, 52% all sectors).

**Figure 13 : Risk assessments mainly conducted by internal staff by country, Q sector and all sectors 2019 (%)**



Base: establishments reporting carrying out regular risk assessments

## 5.2 Risk mitigation measures

### Ergonomic risks

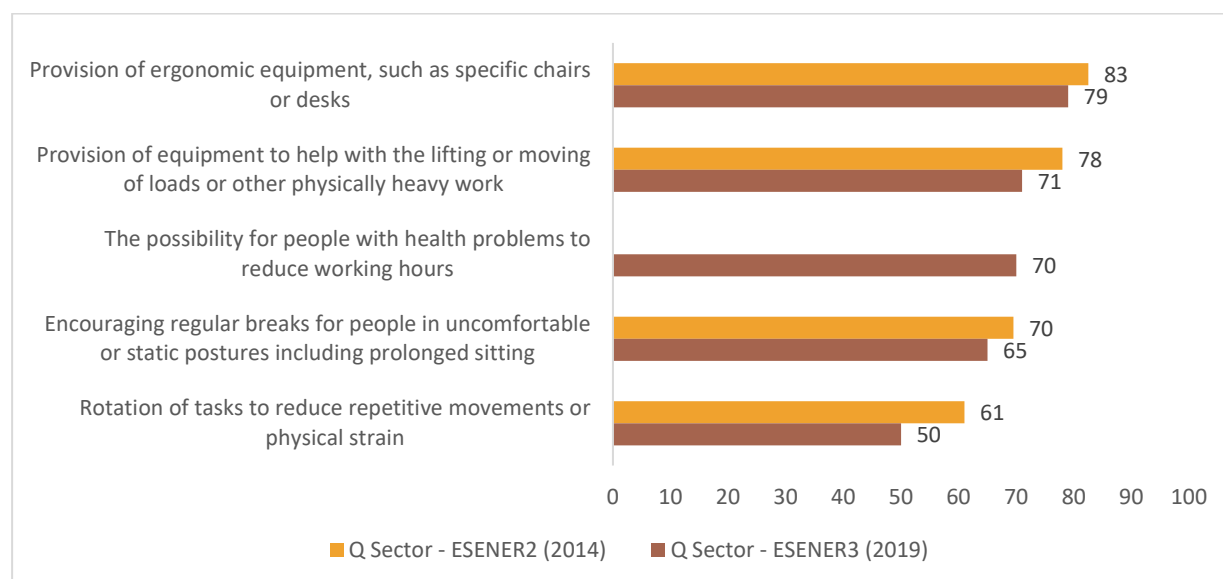
In terms of preventive measures taken to mitigate ergonomic risks, in 2019 the provision of ergonomic equipment was the most commonly reported measure (79%), closely followed by the provision of equipment to help with the lifting or moving of loads or other physically heavy work (71%), and by the possibility for workers with health problems to reduce working hours (70%), which was asked for the first time in 2019. Encouraging regular breaks (65%) and, particularly, rotating tasks (50%) were used less often.

Between 2014 and 2019, the reported adoption of such measures in the sector decreased. For example, the provision of equipment to help with the lifting or moving of loads or other physically heavy work decreased by 7 percentage points (from 78% in 2014) and the rotation of tasks, which is important to mitigate the risks of repetitive strain injuries (RSI), decreased by 11 percentage points (from 61% in 2014). However, when looking at the results at country level, there were some increases in the reported adoption of these measures in the sector. For example, in the case of the reported provision of equipment to help with the lifting or moving of loads or other physically heavy work, this increased by 20 percentage points between 2014 and 2019 in Slovakia, by 11 percentage points in Hungary and by 10 percentage points in Luxembourg and Belgium. In the case of the reported rotation of tasks to reduce repetitive movements or physical strain, this increased by 52 percentage points in Slovakia, by 14 percentage points in North Macedonia and by 11 percentage points in Finland. In the case of encouraging regular breaks for people in uncomfortable or static postures, including prolonged sitting, this was reported to have increased by 15 percentage points in Austria and 14 percentage points in Hungary. Finally, in the case of the reported provision of ergonomic equipment, such as specific chairs or desks, this increased by 14 percentage points in Bulgaria and by 5 percentage points in Czechia and Finland.

When comparing the sector with all sectors, all measures, with the exception of the provision of equipment to help with the lifting or moving of loads or other physically heavy work (77% for all sectors; 71% for the sector), are reported to be used more often in the former than in the latter. Lastly, as in the sector, an over-time drop in the reported adoption of ergonomic risk mitigation measures can also be seen

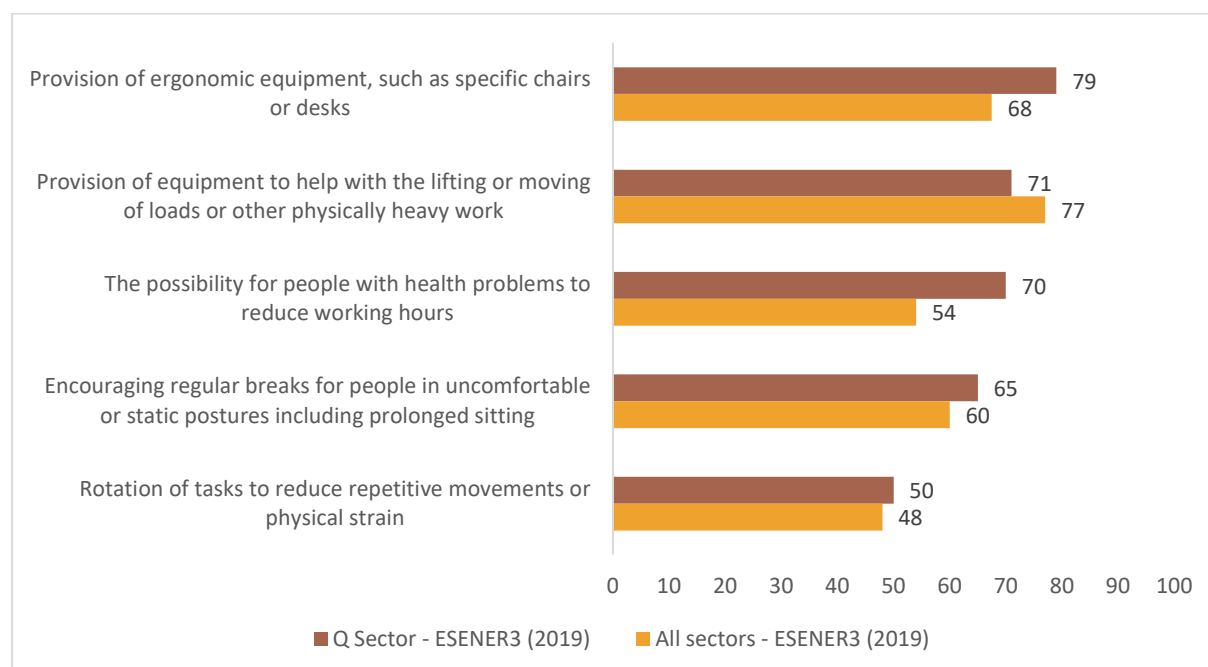
seen in all sectors – with the main drop in the provision of equipment to help with lifting or moving loads (85% in 2014, falling to 77% in 2019).

**Figure 14 : Measures taken to mitigate ergonomic risks, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27. In the case of the provision of equipment to help with lifting, and encouraging regular breaks, only those enterprises reporting that this is a risk.

**Figure 15 : Measures taken to mitigate ergonomic risks, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27. In the case of the provision of equipment to help with lifting, and encouraging regular breaks, only those enterprises reporting that this is a risk.

The experts interviewed for this study noted that mechanisation is an important measure to mitigate ergonomic risks. Training is also important and should be adopted and incentivised in the workplace: for example, one interviewee noted that ‘there are gaps in the education of personnel on the prevention of MSDs and the proper handling of loads’. Another interviewee found that risk assessments are a useful tool in mitigating ergonomic risks.

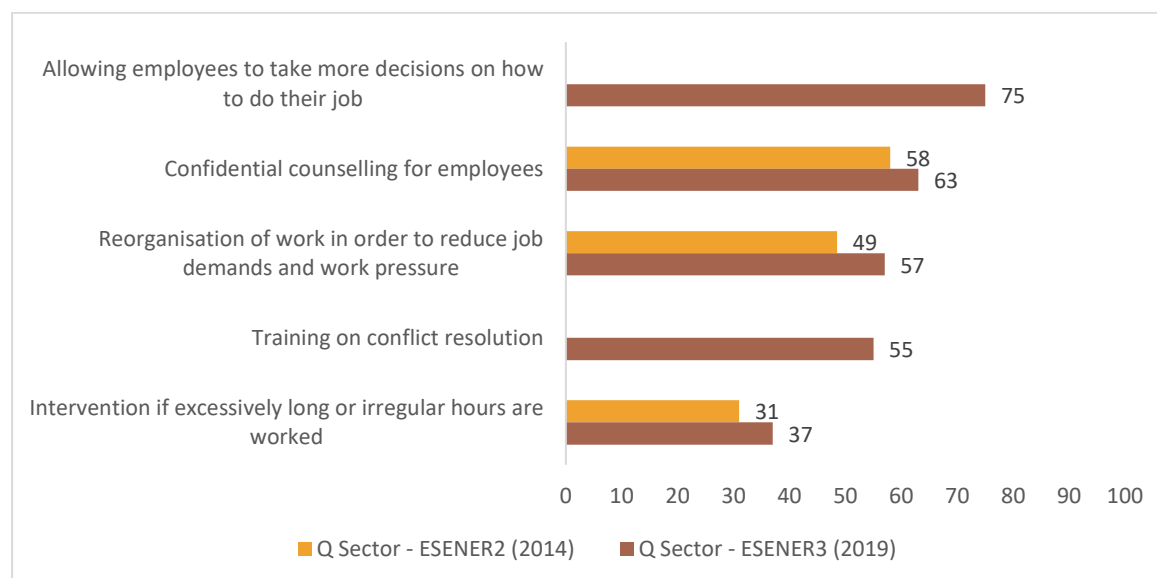
Further, another interviewee found that more could be done in terms of mitigating ergonomic risks, stating that ‘more visibility of the issue is critical and so is identifying good practices and sharing them’. Despite this, one challenge when sharing best practices is that they are often not translated into English or the national language, which limits dissemination to other European Member States. The point concerning awareness was also raised by another interviewee, who felt that occupational risks should be further discussed and awareness on the topic should be pursued further. The qualitative research strand also found that more could be done regarding the availability of mitigation measures, which remain quite unevenly spread.

## Psychosocial risks

In terms of measures to mitigate psychosocial risks, in 2019 the most popular reported measure in the sector was allowing employees to take more decisions on how to do their job, reported by 75% of establishments. This was a new item in the ESENER 2019 questionnaire. By contrast, the measure taken less often was intervention if excessively long or irregular hours are worked (37%). The full breakdown can be found in Figure 16.

Contrary to the decreasing trend in the case of ergonomic risks, psychosocial risks mitigation measures were reported to be adopted more often in 2019 than in 2014, with the biggest increase of 8.5 percentage points in the reorganisation of work to reduce job demands and work pressure, followed by intervention if excessively long or irregular hours are worked (increase of 6 percentage points), and confidential counselling for employees (increase of 5 percentage points).

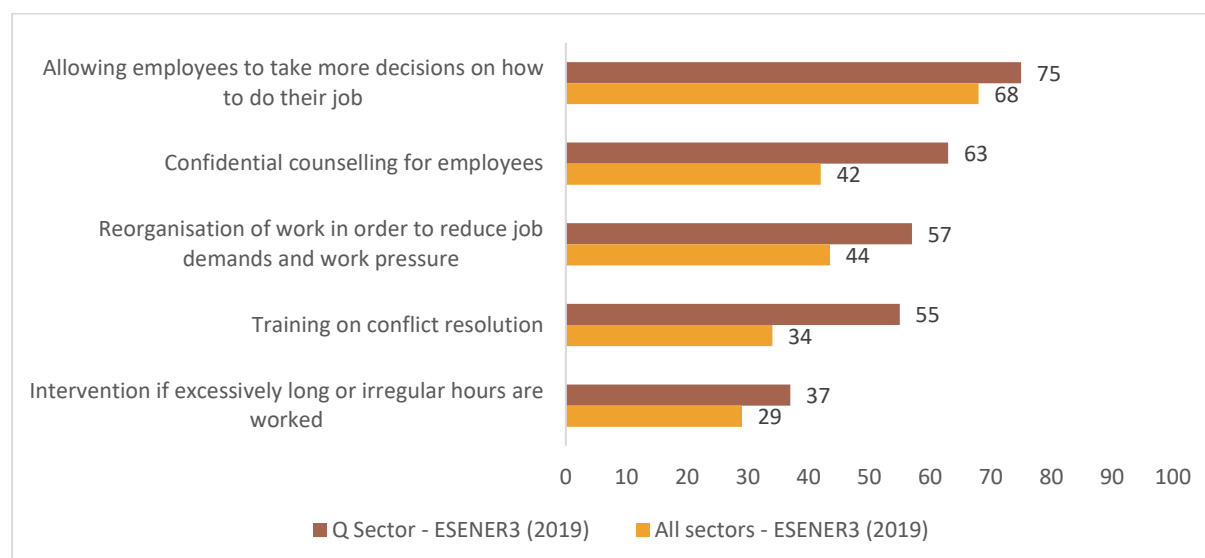
**Figure 16 : Measures taken to prevent psychosocial risks, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27 with 20 or more employees

When comparing the sector with all sectors, all measures were reported to be taken more often in the former than in the latter. This is particularly the case for training on conflict resolution (34% in all sectors, 55% in the Q sector) –also a new item in the ESENER 2019 questionnaire- and confidential counselling (42% in all sectors, 63% in the Q sector). For details, see Figure 17. In all sectors as well, the adoption of measures increased between ESENER 2 (2014) and ESENER 3 (2019).

**Figure 17 : Measures taken to prevent psychosocial risks, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27 with 20 or more employees

Experts interviewed for this study noted that the most effective measures to tackle psychosocial risks include legislation at EU level that allows for the reorganisation of working time. Training on how to handle stress and anxiety is another measure that can be effective in mitigating psychosocial risks according to interviewees. The value society places on the human health and social work activities sector is also key, as this feeds into the objective and subjective wellbeing of the workforce through improved salary, benefits, and detailed policy developed with unions and staff representatives.

Interviewees also highlighted that more could be done to mitigate psychosocial risks. A key view clearly emerges in terms of the need to address staffing shortages quickly. Communicating guidance effectively and easily is another key theme. One interviewee particularly underlined the need to do more to protect the sector's workforce from violence.

#### ■ **Presence of action plans and procedures to prevent psychosocial risks**

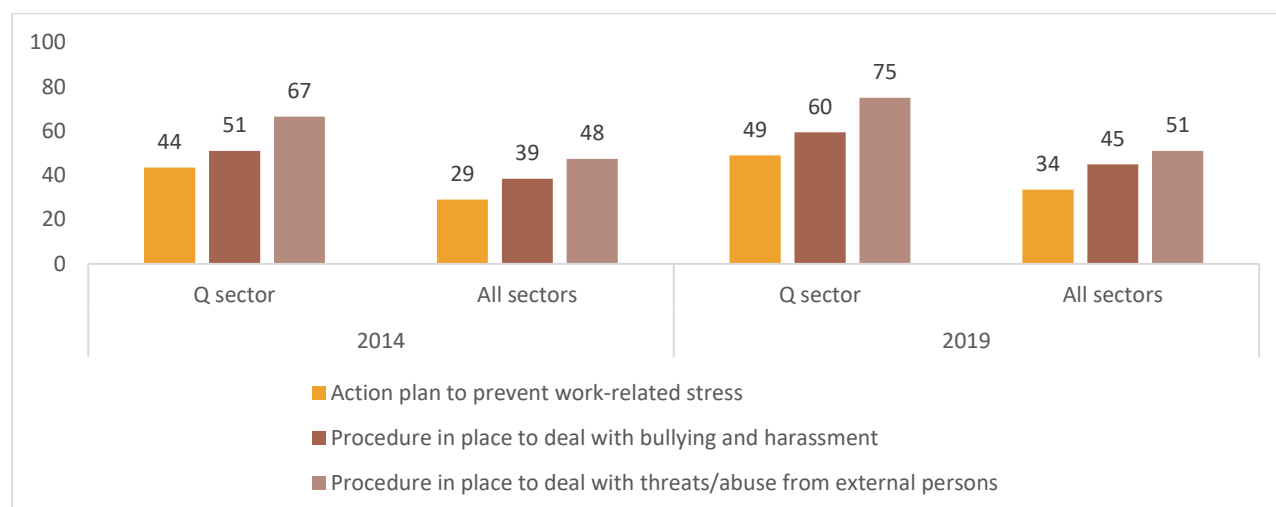
Action plans to prevent work-related stress, procedures to deal with bullying and harassment, and those aimed at dealing with threats or abuse from people outside the organisation are additional measures to mitigate psychosocial risks. Overall, more establishments in the sector than in all sectors reported that they adopted these types of measures. The widest gap between the sector and all sectors is in terms of procedures to deal with external threats/abuse, at 24 percentage points (75% human health and social work activities sector, 51% all sectors). This is consistent with interviewee views that having to deal with difficult patients and their relatives, and even more so in the context of COVID-19, is a key challenge for the sector.

Based on 2019 data for the sector, almost one in two (49%) establishments had an action plan in place to prevent work-related stress, more than one in two (60%) had procedures to deal with bullying and harassment, and three in four (75%) had procedures to deal with external threats/abuse. Across the three measures, there was an increase between 2014 and 2019, of 5.5, 9, and 8.5 percentage points respectively for action plans to prevent stress, bullying and harassment procedures, and external threats/abuse procedures. For all action plans and procedures considered, larger establishments have a higher reported rate of using them.

It is also interesting to note that in 2019, employees in the sector were reported to be much more often involved in identifying possible causes for work-related stress than in all sectors (reported by 73% of companies in the sector compared with 46.5% of companies in all sectors). There is no data available for previous years.



**Figure 18 : Percentage of establishments with action plans/procedures in place, Q sector and all sectors 2014 and 2019 (%)**



Base: all establishments in the EU-27 with 20 or more employees

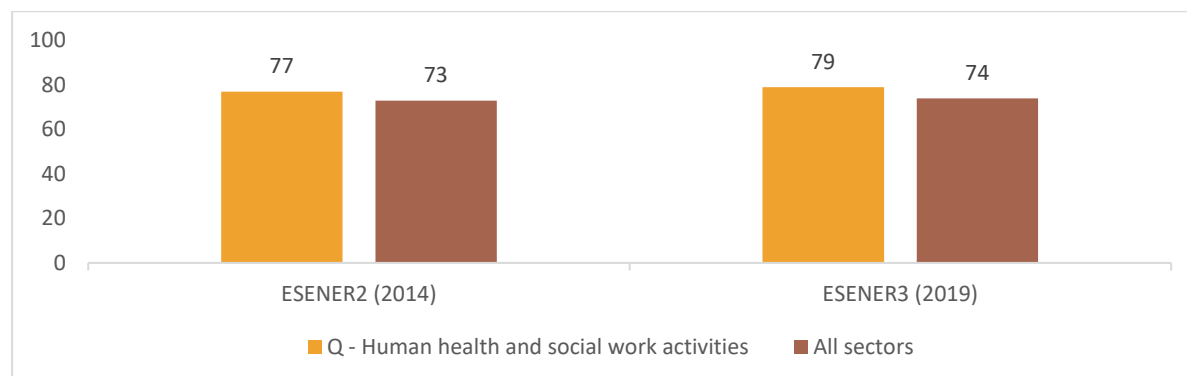
### 5.3 Regular medical examinations

The proportion of companies reporting that they arranged regular medical examinations in 2009 was the same in the human health and social work activities sector as in all other sectors (76%). However, since then the proportion slightly increased (by three percentage points) over time in the sector, while it decreased slightly, by two percentage points in the case of all sectors. Therefore, in 2019, there was a five percentage-point difference between the sector (79%) and all other sectors (74%), as shown in Figure 19.

Experts interviewed for this study understand this to be an important area of concern. This is particularly so in the case of doctors, as the question is ‘who is the doctor of the doctor?’ Further, COVID-19 has introduced biological risk factors and a combination of different risks such as stress, workload and burnout that impact the immune system, thus compounding the challenges faced in the sector.

Interviewees also generally felt that there was an increase in the regularity of medical examinations, even though they felt that there were some problems and gaps. However, the interviewees also stated that sometimes there is still not enough attention to this type of prevention, as medical examinations often tend to be carried out when needed, rather than routinely or automatically.

**Figure 19 : Regular medical examinations, Q sector and all sectors 2014 and 2019 (%)**

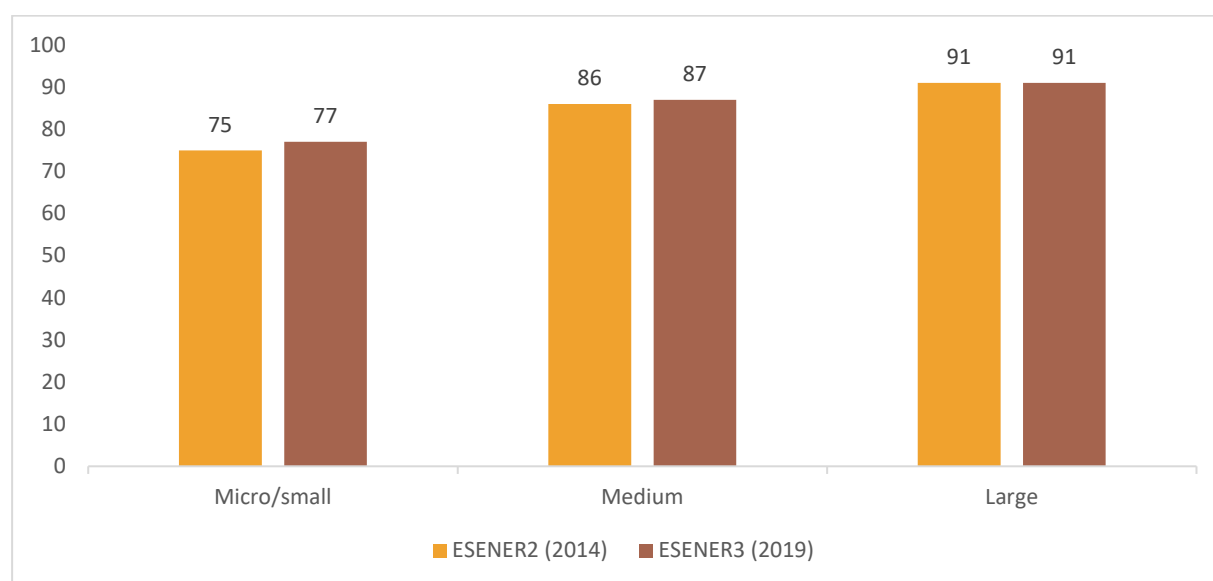


Base: all establishments in the EU-27

In terms of company size, over time there is an increase in the reporting of regular medical examinations for all company sizes in the sector. The most notable increase is that recorded by medium-sized companies, of 9 percentage points: 78% in 2014 and 87% in 2019. This is followed by that reported by large companies, of 6 percentage points: 85% in 2014 and 91% in 2019. In the case of micro/small companies (which were covered in the ESENER 2014 and 2019 surveys only), there is a 3 percentage-point increase, from 74% in 2014 to 77% in 2019.

Overall, as can be seen from the 2019 data, company size appears to have a positive association with the reported occurrence of regular medical examinations. Medical examinations are reported to take place more often in larger companies – 91%, compared with 87% for medium companies, and 77% for micro/small ones.

**Figure 20 : Regular medical examinations by company size, Q sector 2014 and 2019 (%)**



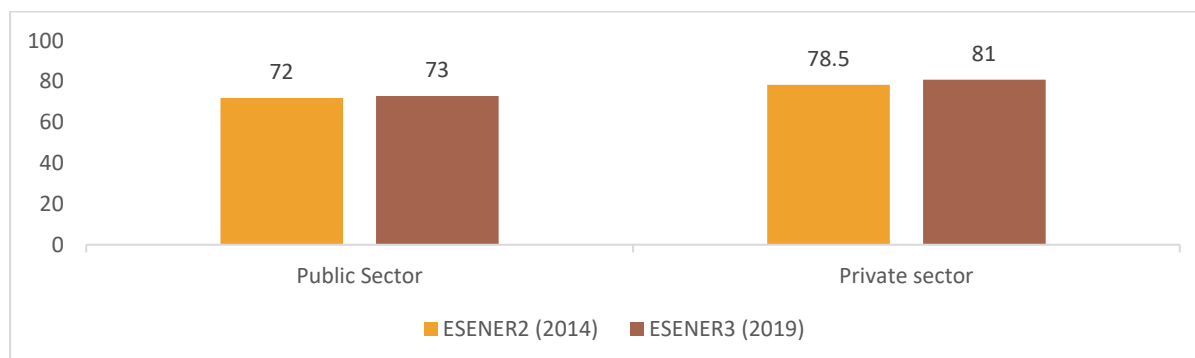
Base: all establishments in the Q sector in the EU-27

This finding is confirmed by the expert interviewees who stated that as the size of the company decreases, less attention is placed on medical examinations. On the one hand, this is because guidance is difficult to obtain and access, and on the other due to the absence or scarcity of more specialised personnel that are able to increase awareness in simple terms.

In terms of differences between public and private sector establishments, over time there has been an increase in the reported incidence of medical examinations in the public sector, by 7 percentage points between 2009 (65%) and 2014 (72%), and by one percentage point between 2014 and 2019 (73%). By contrast, the reported incidence of medical examinations fell slightly over time in the private sector. However, it should further be noted that the private sector's performance in terms of reported medical examinations dipped between 2009 (82%) and 2014 (78.5%), but increased again between 2014 and 2019 (81%), eventually making up for most of its earlier deterioration in the first half of the decade.

Despite these divergent trends, the private sector overall is still reported to perform better than the public sector in terms of medical examinations and would have done so even at its lower 2014 levels (78.5%). According to ESENER data, there was an 8 percentage-point difference in 2019 between the private sector (81%) and the public one (73%).

**Figure 21 : Regular medical examinations by public/private sector, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

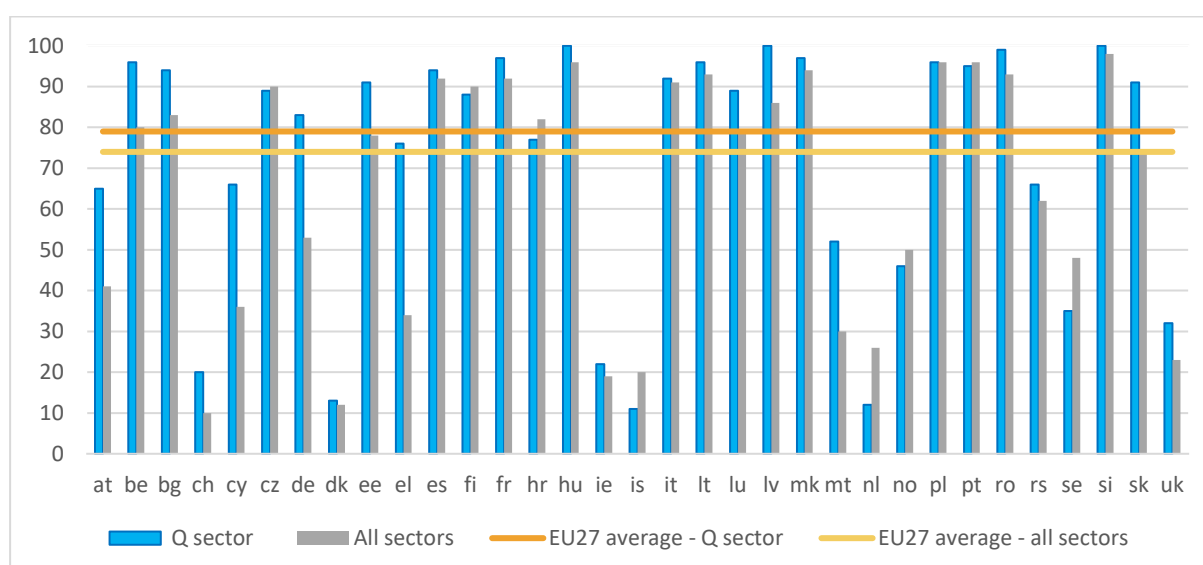
### Differences between countries

The EU-27 average regarding the percentage of organisations reporting regular medical examinations is 79% in the sector, which is 5 percentage points higher than the figure for all sectors. However, there is significant variation by country. There are 19 countries that have a national average for the sector that is higher than the EU-27 average and 14 countries where the national average is below the EU-27 average. Of these 14 countries, six have an average that is above 50%, while 8 have an average below this threshold, and significantly so with the exception of Norway (46%).

This finding is in line with interviewees' views regarding the fact that legal obligations and national policies have an influence on this dimension of OSH management. This is because in some countries enterprises do not have to take responsibility for these medical check-ups, which helps to explain the low average in certain countries, such as Denmark, among others.

Figure 22 also compares the national average in the sector with the national average across all sectors to see if and how the sector differs. It is quite revealing how the sector outperforms all sectors in several countries, whereas in others it is just slightly higher, and only in few countries it is clearly lower, namely: Netherlands, Sweden and Iceland.

**Figure 22: Regular medical examinations by country, Q sector and all sectors 2019 (%)**



Base: all establishments

## 5.4 Use of health and safety services

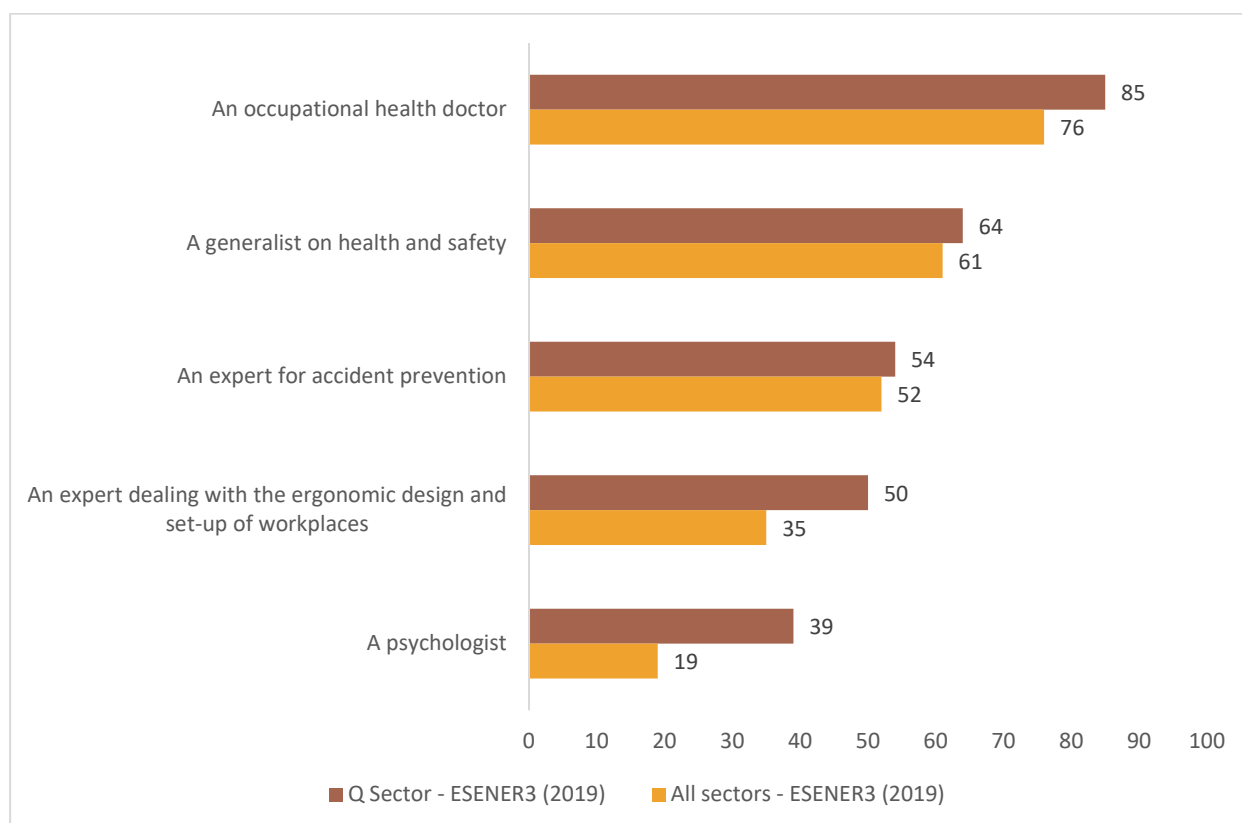
Overall, there is a reported higher use of health and safety services in the human health and social work activities sector than in other sectors across ESENER waves for almost all services. Occupational health doctors were the most used service in both the sector and all sectors. The use of expert services, such as psychologists and ergonomists, is clearly higher in the sector than in other sectors: 39% in the sector and 19% in all sectors (psychologists), and 50% in the sector and 35% in all sectors (ergonomists).

There is no clear change between 2014 and 2019 in the sector in relation to any of the health and safety services used. Occupational health doctors were still reported to be the most frequently used health and safety service in 2019 (85%).

However, since 2009, there has been a 12 percentage-point increase in the use of generalists on health and safety (52% in 2009, 66% in 2014 and 64% in 2019) and an 18 percentage-point increase in the use of ergonomists (32% in 2009, 48% in 2014, and 50% in 2019). This is a particularly relevant finding, given the high levels of reported MSDs.

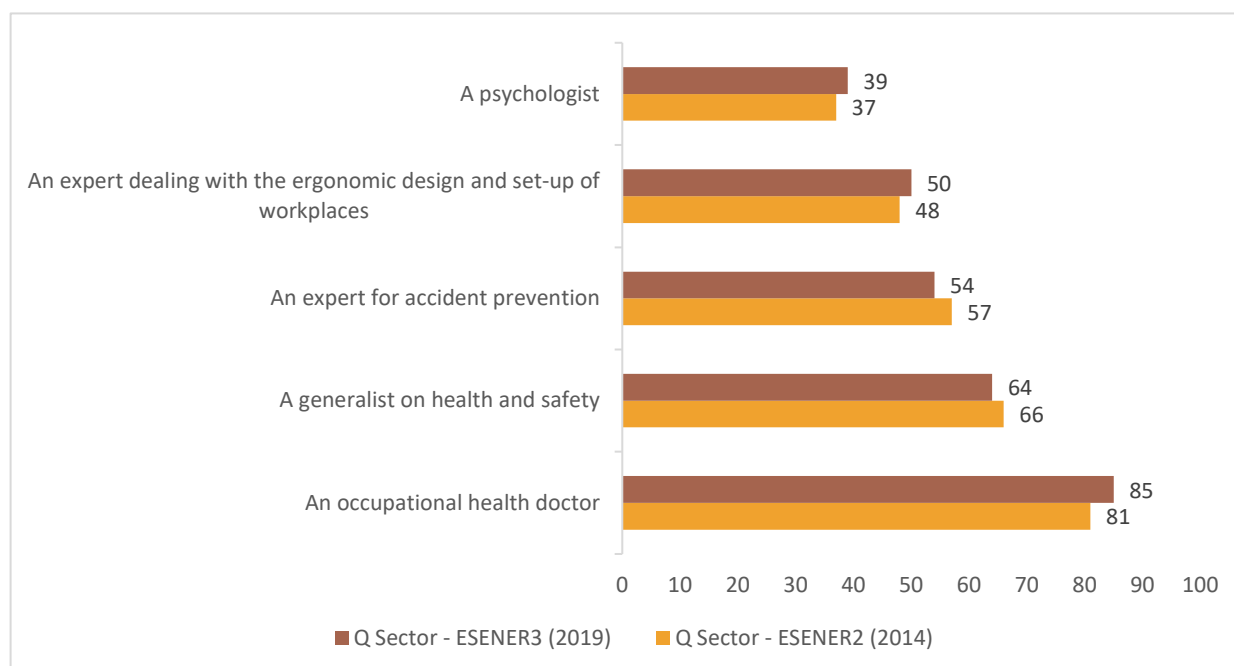
For details, see Figure 23 and Figure 24.

**Figure 23 : Health and safety services used, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27

Figure 24: Health and safety services used, Q sector 2014 and 2019 (%)



Base: all establishments in the Q sector in the EU-27

## 5.5 Use of health promotion measures

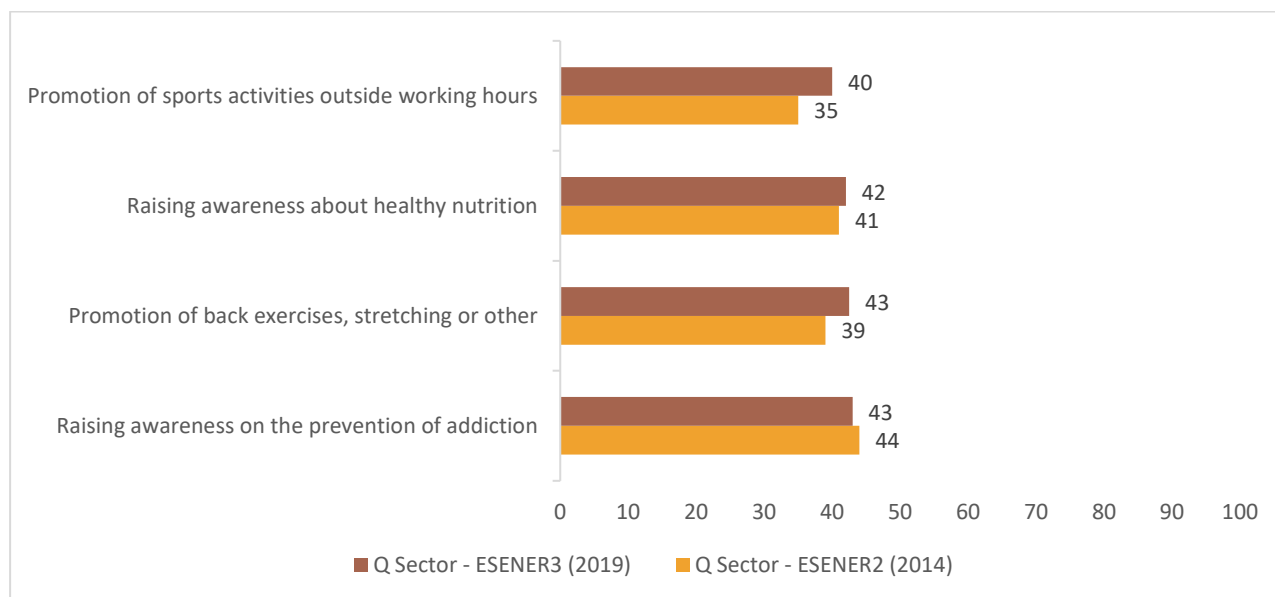
Overall, there is higher use of health promotion measures in the human health and social work activities sector than in other sectors for almost all types of measures and in all ESENER waves. There has been an increase in the use of measures between 2014 and 2019 for the sector as well as in all sectors.

Based on interview findings in the sector, aspects related to healthy nutrition and to physical exercise have been of renewed importance in the context of the pandemic. For example, obesity was one of the key risk factors for those who died of COVID-19.

The only measure that decreased slightly was raising awareness on the prevention of addiction, by one percentage point (from 44% to 43%) in the sector. While this is still higher than the 36% in all sectors, interviews clarified that this is an area of concern, for example in terms of prevention of overmedicalisation and drug abuse among healthcare staff<sup>23</sup>. This type of challenge, according to interviewees, is relevant for the workplace, but also linked to broader trends in society in both Europe and the United States.

<sup>23</sup> [https://www.researchgate.net/publication/232141594\\_Substance\\_misuse\\_by\\_doctors\\_nurses\\_and\\_other\\_healthcare\\_workers](https://www.researchgate.net/publication/232141594_Substance_misuse_by_doctors_nurses_and_other_healthcare_workers)

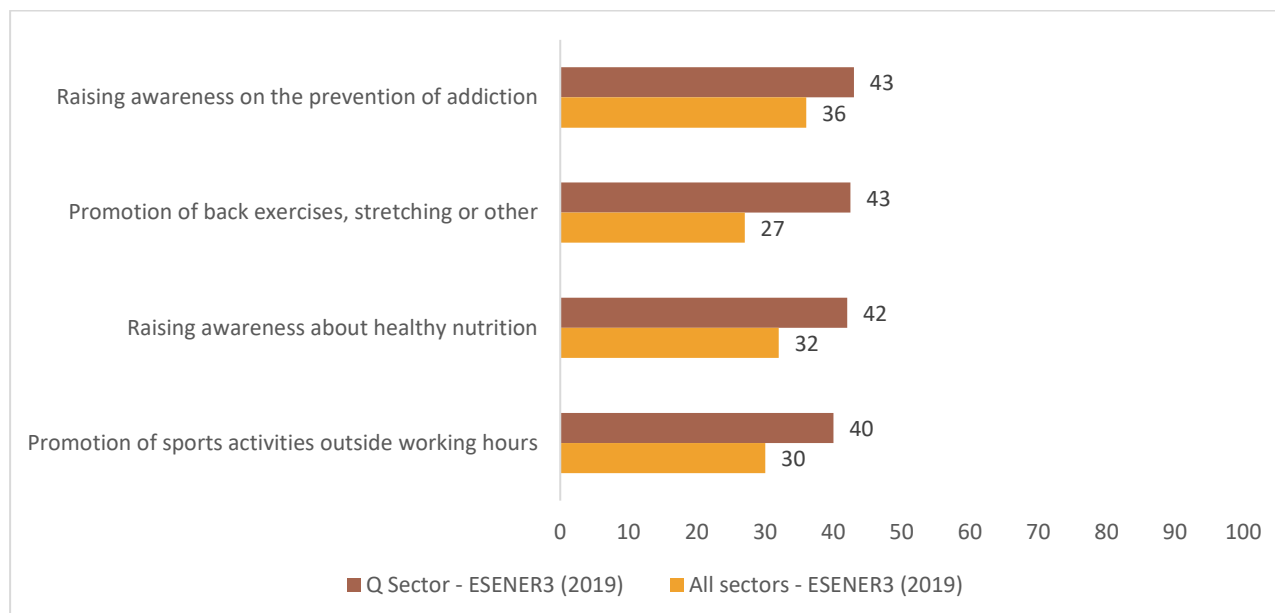
**Figure 25 : Health promotion measures used, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

In terms of health promotion measures used in the sector in comparison with all sectors, Figure 26 shows that all measures are used more often in this sector than the average of all sectors.

**Figure 26 : Health promotion measures used, Q sector and all sectors 2019 (%)**

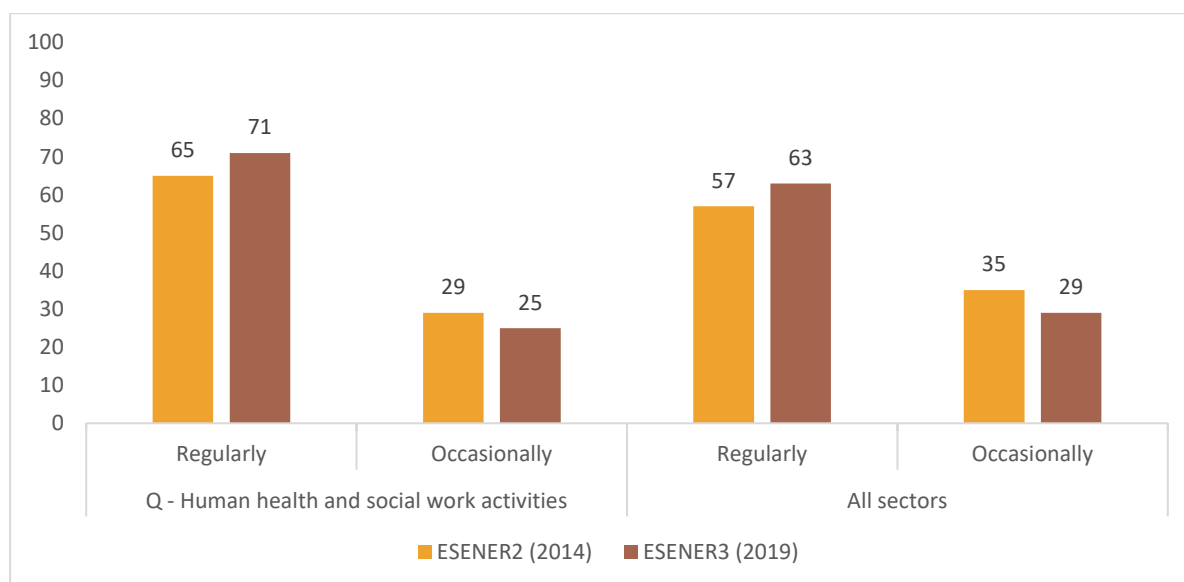


Base: all establishments in the EU-27

## 5.6 Discussion of health and safety issues

Health and safety issues are discussed more regularly in the health and social work activities sector than in other sectors. Over time, both this sector specifically and all sectors in general experienced an increase of discussing issues regularly. For details, see Figure 27.

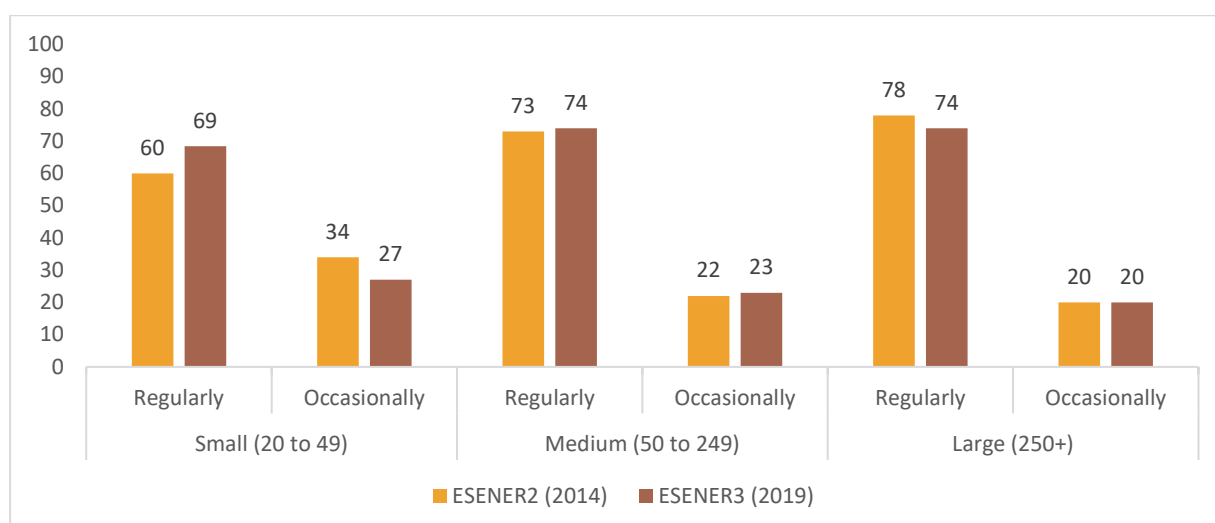
**Figure 27 : Health and safety issues discussed at top management level, Q sector and all sectors 2014 and 2019 (%)**



Base: all establishments in the EU-27 with 20 or more employees

In relation to company size in the sector, the trend is towards an increase in the discussion of issues for both small and medium companies. For large companies, an increase can be seen from 2009 to 2014, followed by a slight decrease between 2014 and 2019. Despite these trends, issues are still discussed less regularly in small companies (68.5%) than in medium (74%) and large (74%) companies.

**Figure 28 : Health and safety issues discussed at top management level by company size, Q sector 2014 and 2019 (%)**

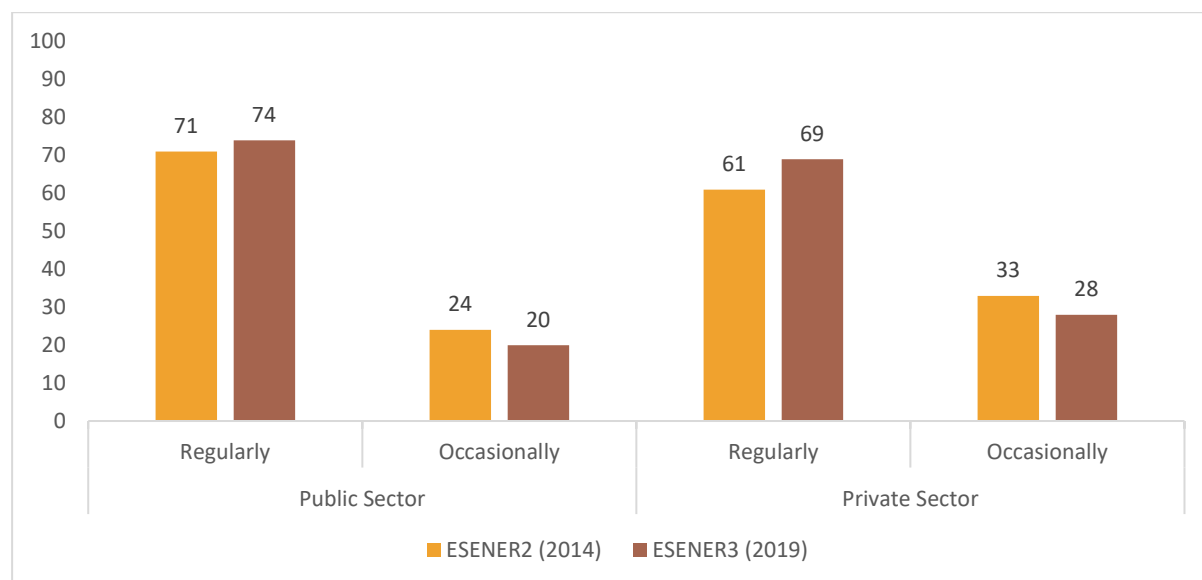


Base: all establishments in the Q sector in the EU-27 with 20 or more employees



Over time, there is a trend towards more regular discussion of health and safety issues in companies in the sector, both in the public and private sectors. However, overall they are discussed more regularly in the public sector.

**Figure 29 : Health and safety issues discussed at top management level by public/private sector, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27 with 20 or more employees

### ***Differences between countries***

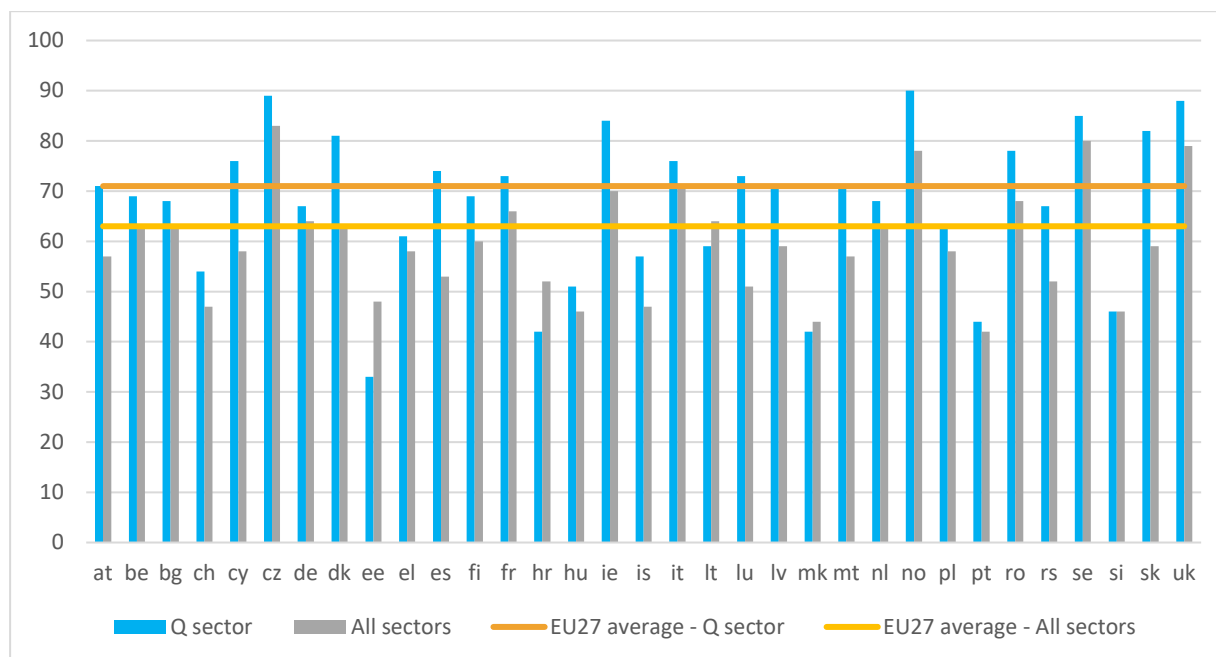
The EU-27 average for health and safety issues being regularly discussed at top management level was 8 percentage points higher in the human health and social work activities sector (71%) than in all sectors (63%) in 2019.

There are 13 countries that have a sector national average higher than the EU-27 average, particularly Norway, Czechia, and the United Kingdom (90%, 89% and 88% respectively); three countries (Austria, Latvia and Malta) that match exactly the EU average of 71%; and 17 countries where the national average is below the EU average – particularly Estonia, with a 38 percentage-point difference (33%).

What is most interesting when comparing national averages in the sector with the national average across all sectors is that Estonia has a 15 percentage-point gap between the two, in favour of all sectors (33% for the sector and 48% all sectors). This means that Estonia compares poorly with other countries across both all sectors and the human health and social work activities sector, but particularly so for the latter.

Another interesting finding is that countries that do particularly well in the sector as compared with all sectors include: Spain, Luxembourg, and Slovakia (21, 22 and 23 percentage-point gap respectively). In the case of Spain and Luxembourg, this is mainly driven by a comparatively poorer performance in all sectors – with the sector average being largely in line with the EU average (74% and 73% respectively), whereas in Slovakia it is the high average in the sector (82%) that makes the difference.

**Figure 30 : Health and safety issues regularly discussed at top management level by country, Q sector and all sectors 2019 (%)**



Base: all establishments with 20 or more employees

## Management training on health and safety

There is no real difference over time between the human health and social work activities sector and other sectors in terms of the training that managers were reported to receive. Overall, around 70% of all companies provide their team leaders/managers with training.

There is a dearth of quantitative findings regarding management training. There is a (weak) positive association between company size and team leaders/managers receiving training, no clear difference between companies in the private and public sectors, and no clear trend over time. Chi-square tests were conducted on some of the data emerging from the descriptive analysis, where the results appeared particularly interesting or significant: in this case, the data presents a positive association, confirmed by chi-squared test, between discussion of issues at top management and management receiving training. This could mean that one of these factors influences the other – either where OSH issues are discussed at top management level that leads to management receiving training, or where managers receive training that leads to more discussion of OSH at top management level.

## 5.7 Types/typologies of establishments for OSH management

The latent class analysis results revealed that there are three types of establishments in terms of OSH management. Namely,

- (i) Establishments with good/high level of OSH management and the tendency to rely on external support that constitute 36% of all establishments in ESENER 2019;
- (ii) Establishments with good/high level of OSH management and the tendency to rely on internal support that constitute, equally, 36% of all establishments in ESENER 2019;
- (iii) Establishments that are slightly lagging behind with regards to OSH management that constitute 29% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments have the OSH management aspects described by the indicators. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that answered 'yes' to the corresponding question in the ESENER 2019 survey.

As can be seen in the table, over 70% of the establishments have a high level of OSH management and half of those rely on external support, while the other half relies on internal support. Overall, for both groups the vast majority of establishments carry out regular workplace risk assessments as well as regular medical examinations. They also often make use of services of external providers to support health and safety tasks.

The remaining establishments, which appear to be slightly lagging behind with regards to OSH management, mainly rely on internal support for risk assessments. They also often use some health and safety services and half of the establishments in this group carry out regular workplace risk assessments. All other measures are used by (significantly) less than half of the establishments.

**Table 3: Establishment typology on OSH Management**

	Class 1 - High level of OSH management and tendency to rely on external support	Class 2 - High level of OSH management and tendency to rely on internal support	Class 3 - Slightly lagging behind with regards to OSH management
Regular medical examinations	89%	78%	31%
Use of some health and safety services	100%	100%	66%
Regular workplace risk assessments	86%	99%	50%
Measures for sustainable working lives*	100%	100%	100%
Services of external providers to support health and safety tasks	88%	72%	31%
Visit from labour inspectorate in last 3 years	49%	63%	35%
Risks assessments were conducted by: - external staff (class 1) - internal staff (class 2 & 3)	92%	76%	83%
Class size	36%	36%	29%

Notes: \* The measures include provision of equipment to help with physically heavy work, task rotation, the encouragement of regular breaks, provision of ergonomic equipment, and the possibility of reducing working hours.  
The 100% probabilities were in reality slightly below 100% but were rounded up in this table. Please note also that the percentages in the table relate to probabilities based on ESENER 2019 answers, rather than on actual percentages.

In terms of the predictors of class membership, the results indicate that establishments in the healthcare sector, compared with all other sectors, are most likely to be in class 2 followed by class 3 and least likely to be in class 1. **Thus, in relative terms, human health and social work activities care sector establishments, compared with establishments in all other sectors, are most likely to have good OSH management and rely on internal support, followed by lagging behind, and they are least likely to have good OSH management and rely on external support. These effects are relatively strong.**

Furthermore, the LCA results also revealed that establishments in the public sector are more likely than those in the private sector to be in class 3 and in class 2 than class 1. **Thus, in relative terms, public sector establishments, compared with private sector establishments, are more likely to have**

**good OSH management and rely on internal support or to be lagging behind than to have good OSH management and to rely on external support. These effects are moderate.**

As for company size, large and medium-sized companies are less likely to be in class 3 (compared with classes 1 and 2), and thus they are less likely to lag behind with regards to OSH management than small companies. Large and medium companies are overall most likely to be in class 2 and small companies are most likely to be in class 3. **These effects are (relatively) strong. This implies that establishment size is positively associated with having good OSH management.**

Finally, the results also indicated that overall **companies that reported any risks hazards are less likely to lag behind with regards to OSH management (that is, to be in class 3) and more likely to have good OSH management (that is, to be in class 1 or 2).**

### ***First OSH management sub-typology: use of health and safety services***

The results of the second latent class analysis revealed that there are three distinct classes of establishment in terms of the **health and safety services used** by the establishment. Namely,

- (i) Establishments with high reliance on specific services, such as an occupational health doctor, a health and safety (H&S) generalist and an accident prevention expert, that constitute 32% of all establishments in ESENER 2019;
- (ii) Establishments with high reliance on health and safety services that constitute 35% of all establishments in ESENER 2019;
- (iii) Establishments with relatively low reliance on health and safety services that constitute 33% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments use each of the health and safety services considered. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that use the health and safety measures mentioned in the ESENER 2019 survey.

**Table 4: Establishment typology on use of health and safety services.**

	<b>Class 1 - High reliance on occupational health doctor, H&amp;S generalist, and accident prevention expert</b>	<b>Class 2 - High reliance on all five health and safety services</b>	<b>Class 3 - Relatively low reliance on H&amp;S services</b>
Establishment in this class uses an occupational health doctor	71%	92%	50%
Establishment in this class uses a psychologist	1%	72%	8%
Establishment in this class uses an expert dealing with the ergonomic design and setup of workplaces	33%	70%	12%
Establishment in this class uses an H&S generalist	93%	87%	21%
Establishment in this class uses an expert for accident prevention	77%	76%	9%
Class size	32%	35%	33%

The analysis results also indicate that, in relative terms, human health and social work activities sector establishments, compared with establishments in all other sectors, are more likely to have high reliance on health and safety services, followed by low reliance; they are least likely to only heavily rely on a specific set of services. These effects are strong.

Furthermore, the results also revealed that, in relative terms, public sector establishments, compared with private sector establishments, are more likely to have high reliance on health and safety services than have low reliance and particularly than have high reliance on only specific services. These effects are moderate.

Finally, as regards company size, the results imply that establishment size is positively associated with the reliance on health and safety services. These effects are strong for large companies and moderate for medium-sized companies.

## Second OSH management sub-typology: use of preventive measures

The results of the second latent class analysis results revealed that there are three types of establishments regarding the **use of preventive measures**, which include provision of equipment to help with physically heavy work, task rotation, encouragement of regular breaks, provision of ergonomic equipment, and the possibility of reducing working hours. Namely,

- (i) Establishments with high use of measures that constitute 58% of all ESENER 2019 establishments;
- (ii) Establishments with medium/average use of preventive measures that constitute 12% of all ESENER 2019 establishments;
- (iii) Establishments with relatively low use of measures that constitute 30% of all ESENER 2019 establishments.

The table below provides, for the three classes identified, an overview of the probabilities that establishments use each of the preventive measures considered. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that use the preventive measures mentioned in the ESENER 2019 survey.

As can be seen from the table, establishments with high use of preventive measures most often provide their employees with ergonomic equipment as well as equipment that helps with physical heavy work. They also usually encourage regular breaks for people in uncomfortable or static postures. To a slightly lesser extent, they provide people with health problems with the possibility to reduce working hours, and even less often they rotate tasks to reduce repetitive movements or physical strain.

Establishments with medium/average level of preventive measures often provide equipment to help with physically heavy work, and somewhat less often encourage regular breaks for people in uncomfortable positions and provide the possibility to reduce working hours for people with health problems. They also virtually always rotate tasks to reduce repetitive movements or physical strain and very rarely provide ergonomic equipment.

Finally, establishments with relatively low use of preventive measures almost never rotate tasks to reduce repetitive movements or physical strain, while between a third and just under half of the establishments use all remaining four measures.

**Table 5: Establishment typology on preventive measures**

	Class 1 - High use of preventive measures	Class 2 - Medium use of preventive measures	Class 3 - Relatively low use of preventive measures
Establishment provides equipment to help with the lifting or moving of loads or other physically heavy work	89%	76%	47%
Establishment rotates tasks to reduce repetitive movements or physical strain	67%	100%	3%
Establishment encourages regular breaks for people in uncomfortable or static postures including prolonged sitting	85%	57%	33%

	Class 1 - High use of preventive measures	Class 2 - Medium use of preventive measures	Class 3 - Relatively low use of preventive measures
Establishment provides ergonomic equipment, such as specific chairs or desks	91%	23%	47%
Establishment provides the possibility for people with health problems to reduce working hours	77%	47%	37%
Class size	58%	12%	30%

In terms of the covariates predicting class membership, establishments in the human health and social work activities sector, compared with those in all other sectors, are most likely to be in class 1 and are less likely in both class 3 and class 2. **Thus, in relative terms, establishments in the human health and social work activities sector are more likely than those in other sectors to make use of different preventive measures. These effects are moderate.**

As regards comparison between the public and the private sector, public sector establishments are more likely to be in class 3, followed by classes 1 and 2, compared with private sector establishments. **This implies that public sector establishments are less likely than private sector ones to make use of preventive measures. These effects are moderate.**

Large and medium-sized establishments are also more likely to rely on preventive measures than small establishments, as the former are most likely to be in class 1, followed by class 2 and lastly class 3. **These effects are strong for large companies and moderate for medium-sized companies. This implies that establishment size is positively associated with the uptake of preventive measures.**

### ***Psychosocial risks management typology***

The results of the third latent class analysis results revealed that there are three types of establishments in terms of **psychosocial risks management**. Namely,

- (i) Establishments with underdeveloped psychosocial risks management that constitute 40% of all establishments in ESENER 2019;
- (ii) Establishments with somewhat developed psychosocial risks management that constitute 26% of all establishments in ESENER 2019;
- (iii) Establishments with well-developed psychosocial risks management that constitute 34% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments have the psychosocial risks management aspects described by the indicators. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that answered 'yes' to the corresponding question in the ESENER 2019 survey.

As can be seen in the table, the class of establishments with well-developed psychosocial risks management most often used procedures that involve employees in the design and setup of measures to address psychosocial risks and in the identification of possible causes for work-related stress. All other aspects of psychosocial risks management are also very often applied by establishments in this group.

In the class of establishments with somewhat developed psychosocial risks management, there is strong emphasis on involving employees in the design and setup of measures to address psychosocial risks, and to a somewhat lesser extent also on having a procedure in place to deal with possible cases of threats, abuse or assaults as well as bullying or harassment. Establishments belonging to this group less often have an action plan to prevent work-related stress and a survey that includes questions on work-related stress. Finally, those establishments with underdeveloped psychosocial risks management

rely primarily on involving employees in the design and setup of measures to address psychosocial risks.

**Table 6: Establishment typology on psychosocial risk management**

	<b>Class 1 - Underdeveloped psychosocial risks management</b>	<b>Class 2 - Somewhat developed psychosocial risks management</b>	<b>Class 3 - Well-developed psychosocial risks management</b>
Establishment has an action plan to prevent work-related stress	9%	26%	77%
Establishment has a procedure in place to deal with possible cases of bullying or harassment	10%	73%	91%
Establishment has a procedure in place to deal with possible cases of threats, abuse or assaults	4%	78%	90%
An employee survey including questions on work-related stress has been conducted in the establishment in the last 3 years	23%	30%	86%
Employees have been involved in identifying possible causes for work-related stress	11%	58%	96%
Employees have a role in the design and setup of measures to address psychosocial risks	73%	92%	99%
Establishment used any measures to prevent psychosocial risks	40%	50%	86%
Class size	40%	26%	34%

In terms of the predictors of class membership, the results show that establishments in the human health and social work activities sector, compared with all other sectors, are most likely to be in class 3, followed by class 2 and least likely to be in class 1. **Thus, in relative terms, human health and social work activities sector establishments, compared with establishments in all other sectors, are most likely to have well-developed psychosocial risks management and they are least likely to have underdeveloped psychosocial risks management. These effects are relatively strong.**

Furthermore, the results also revealed that establishments in the public sector are more likely than those in the private sector to be in class 3 and in class 2 than class 1. **Thus, in relative terms, public sector establishments, compared with private sector establishments, are more likely to have well-developed or somewhat developed psychosocial risks management than to have underdeveloped psychosocial risks management. These effects are weak.**

With regards to company size, bigger companies (that is, large and to a lesser extent medium-sized companies) are most likely to be in class 3, followed by class 2, and finally class 1. Thus, bigger companies, compared with small companies, are more likely to have well-developed and somewhat developed psychosocial risks management; they are least likely to have underdeveloped psychosocial risks management. Micro companies, on the other hand, are most likely to be in class 1 (underdeveloped psychosocial risks management), followed by class 3 (well-developed psychosocial risks management) and class 2 (somewhat developed psychosocial risks management). **These effects are particularly**



**strong for large companies and moderate or strong for the remaining company sizes. This implies that overall establishment size is positively associated with having well-developed psychosocial risks management.**

Finally, the results also indicate that establishments that reported having the following three risks: time pressure, having to deal with difficult customers, pupils, etc., and long or irregular working hours are less likely to be in class 1 than class 2 or 3. **Thus, companies that reported having specific psychosocial risks are less likely to have underdeveloped psychosocial risks management.**

With regards to **the use of specific measures to prevent psychosocial risks** (which include work reorganisation to reduce job demand and work pressure, confidential counselling for employees, training on conflict resolution, intervention if excessively long or irregular hours are worked, and allowing employees to decide more on how to do their job) **the LCA results suggested the presence of two types of establishments. Namely, establishments that make high use of the measures to prevent psychosocial risks** (53.5% of establishments in the ESENER 2019) **and those that make low use of the measures** (46.5% of establishments in the ESENER 2019). For both types of establishments, the measure that involved allowing employees to take more decisions on how to do their jobs had the highest uptake and the one that was based on an intervention if excessively long or irregular hours are worked had the lowest uptake.

The results also indicated that establishments in the human health and social work activities sector were more likely than those in other sectors to have a high uptake of measures to prevent psychosocial risks (strong effects). Establishments in the public and private sectors were equally likely to be in either level of uptake (no effect) and there was a positive relationship between company size and the level of uptake with bigger companies being more likely to have a high uptake level than smaller companies (moderate effects).

In terms of obstacles to dealing with psychosocial risks (which included the lack of awareness among staff and among management, the lack of expertise or specialist support, and reluctance to talk openly about these issues), **the LCA results suggested two types of establishments. Namely, those that report high incidence of obstacles** (48% of establishments in ESENER 2019) **and those that report low incidence** (52% of establishments in ESENER 2019). For both groups, the obstacle most commonly reported was the reluctance to talk openly about the issues and the one reported least frequently was the lack of expertise or specialist support. There were no statistically significant effects of sector (that is, human health and social work activities versus others and public versus private) or of company size.

## 6 Main drivers and barriers for OSH management

This section examines the main drivers and barriers for OSH management. It firstly looks at the reasons why workplace risk assessments are not regularly carried out, and then examines the major difficulties that companies report in relation to addressing OSH issues, including the main obstacles to dealing with psychosocial risks. It also includes a section on the main barriers to OSH by establishment type, based on latent class analysis of ESENER data. It then examines the main drivers for addressing OSH at the workplace, including visits by the labour inspectorate, which could be seen as a key incentive for OSH management and legal compliance.

### 6.1 Reasons why workplace risk assessments are not regularly carried out

The most commonly reported reason for workplace assessments not being carried out in the sector in 2019 was that no major problems were identified, while in the other sectors the main reason was that the hazards and risks are already known. Overall, both in the sector and all sectors in 2014 and in 2019 these were the two most commonly reported reasons and the differences in the rates of reporting them were minimal.

It may be seen as positive that OSH risks are already known and that there are no major problems, but this also raises concerns as it overlooks the dynamic nature of the risk assessment process, as well as

the cycle of improvement in safety management. Overall, the percentage of companies reporting that they do not carry out regular risk assessments was 20% in the sector in 2019, up from 19% in 2014. In all sectors, the percentage was 23% in 2019, down from 25% in 2014.

Over time, the share of establishments in the sector not conducting regular risk assessments because the hazards are already known decreased by 9 percentage points between 2014 and 2019. However, the incidence of companies reporting that ‘there are no major problems’ increased by 3.5 percentage points to 80% between 2014 and 2019. In all sectors, there was no substantial decreasing or increasing trend.

It should be mentioned that substantially more companies surveyed in the human health and social work activities sector in 2019 compared with 2014 reported that regular assessments are not carried out because the necessary expertise is lacking (34.5% and 25.5% respectively). An increasing trend for this factor is also present for all sectors, but only by 2 rather than 9 percentage points – from 28% to 30%. Expertise may be lacking for a variety of interconnected reasons.

As noted in the previous section on OSH management, there is a substantial split between those companies that opt for internal and external experts, and this is often associated with the level of human and financial resources. Experts interviewed for this research noted that there is a scarcity of well-trained staff linked in some cases – and especially in the care sector – to low pay and high and stressful workload. Challenges linked to brain drain may compound shortages of professionals. In addition, structural underinvestment further exacerbates the situation and differences between countries.

One in four companies in the sector – only among those not carrying out risk assessments – found the procedure too burdensome, both in 2014 and 2019. The rate was 5 percentage points lower for all sectors in 2019, at 20%, and down 3 percentage points compared with 2014, at 23%. According to those interviewed for this study, it is not only the risk assessment process that is felt to be burdensome but also the processes related to reporting incidents at work, as well as OSH monitoring and inspections. These burdens were felt across the whole range of potential challenges, from those that may only result in minor injuries to those that may be fatal.

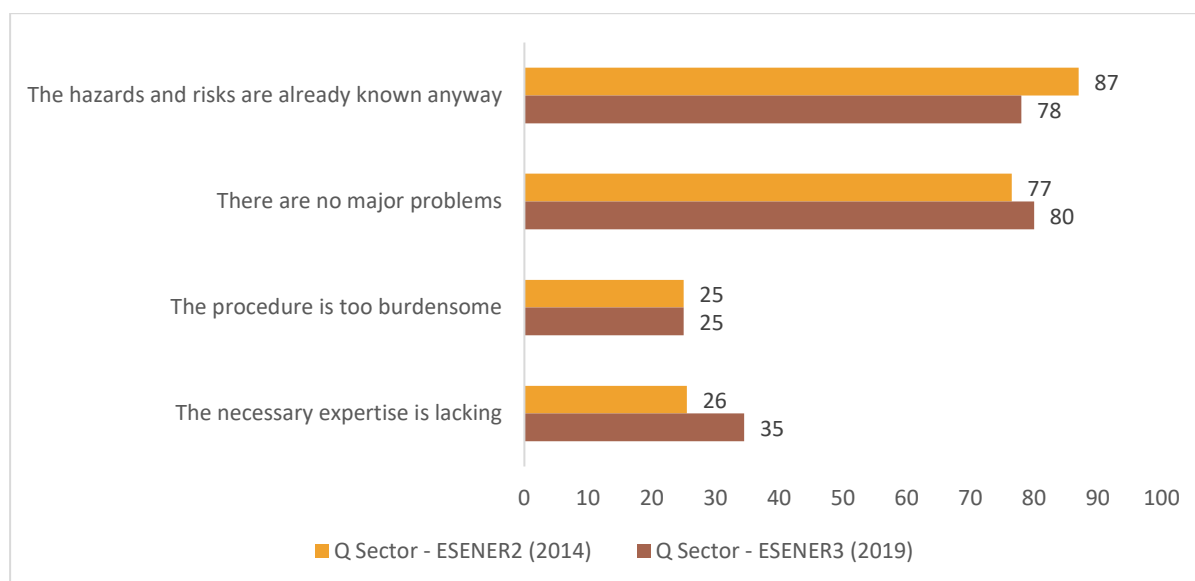
The burden is shared across levels, from management to employees. In the case of reporting accidents, this may prove burdensome not only in terms of time and administrative work, but also regarding the perceived stigma that may be attached to this. The burdens these constitute have also been recently compounded by the added pressure of COVID-19 in terms of new risks, and the substantially higher workload and lower time available. This may lead to more risks to assess, for example resulting from increased fatigue experienced by employees, and may also reduce the time available to assess risks and/or to report accidents.

The introduction and use of digital technologies (wearable devices, Artificial Intelligence, etc.) may be an opportunity to support such processes and procedures, as they enable the assessment and prediction of workplace risks, prevent accidents by measuring employee fatigue, render reporting accidents obsolete as they may be recorded instead, and enable employers to save time, stress, and money. Nevertheless, there are well-documented concerns about workers’ stress and privacy relating to digital monitoring<sup>24</sup>. Therefore, it is crucial to ensure that the workforce is trained and informed on aspects related to the introduction and use of digitalisation, that digital tools help workers to increase control over their work and health rather than be controlled at work, and that digitalisation ultimately reduces rather than increases stress.

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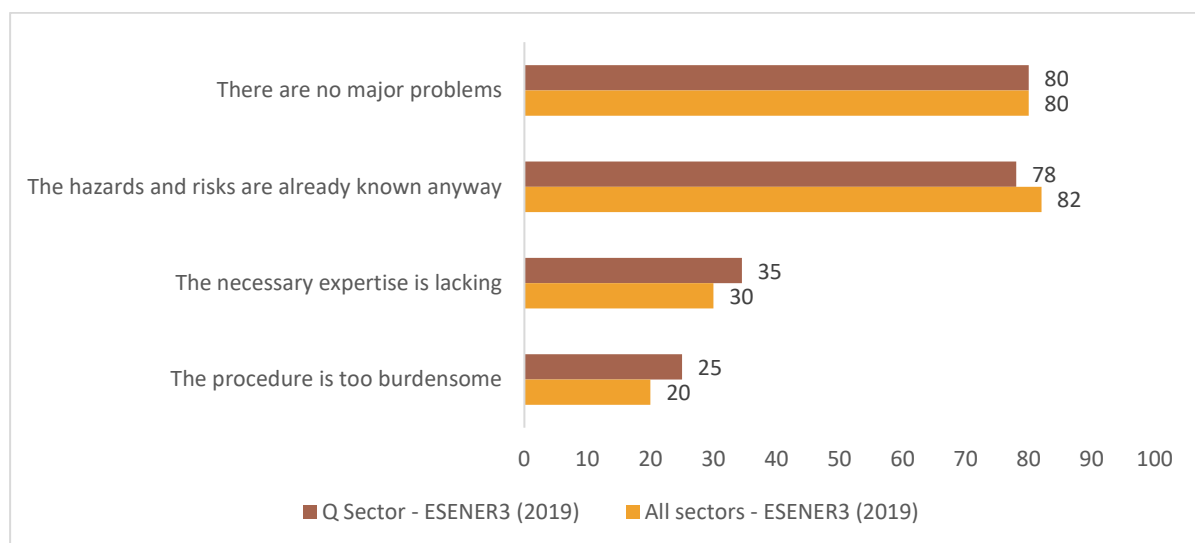
<sup>24</sup> See, for example: European Parliament (2020). Artificial Intelligence: Threats and Opportunities. Available at: <https://www.europarl.europa.eu/news/en/headlines/society/20200918STO87404/artificial-intelligence-threats-and-opportunities>; Carpenter, D., McLeod, A., Hicks, C., & Maasberg, M. (2018). Privacy and biometrics: An empirical examination of employee concerns. *Information Systems Frontiers*, 20(1), 91-110; Eurofound (2020). Employee monitoring and surveillance: The challenges of digitalisation, Publications Office of the European Union, Luxembourg, p. 7. [online]. Available at: [https://www.eurofound.europa.eu/sites/default/files/ef\\_publication/field\\_ef\\_document/ef20008en.pdf](https://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef20008en.pdf)

**Figure 31 : Reasons why workplace assessments are not regularly carried out, Q sector 2014 and 2019 (%)**



Base: establishments in the Q sector in the EU-27 reporting not carrying out regular risk assessments

**Figure 32 : Reasons why workplace assessments are not regularly carried out, Q sector and all sectors 2019 (%)**

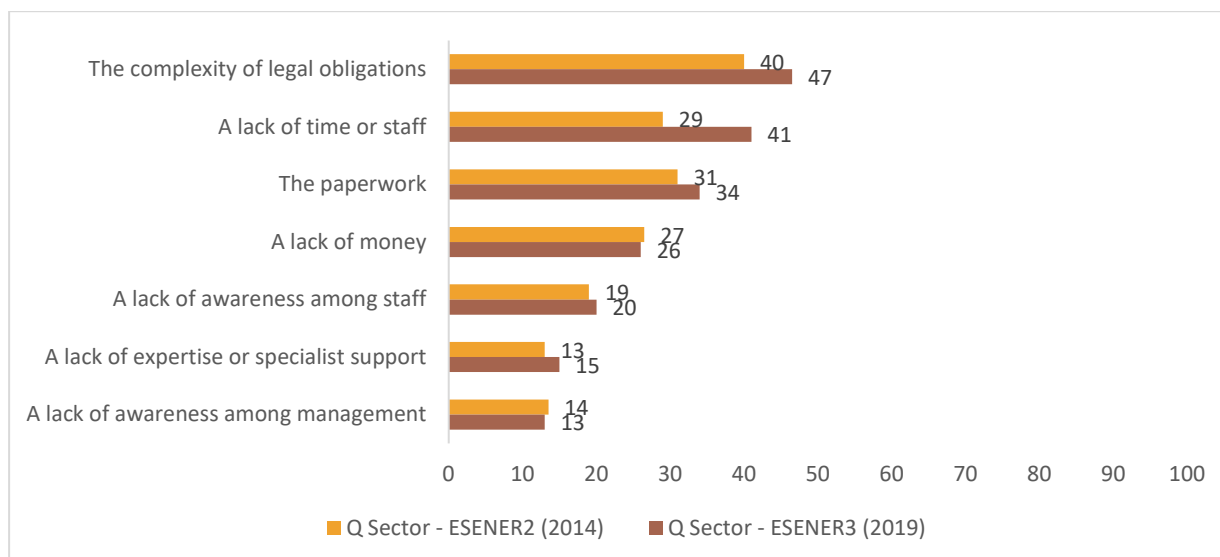


Base: establishments in the EU-27 reporting not carrying out regular risk assessments

## 6.2 Major difficulties in addressing health and safety

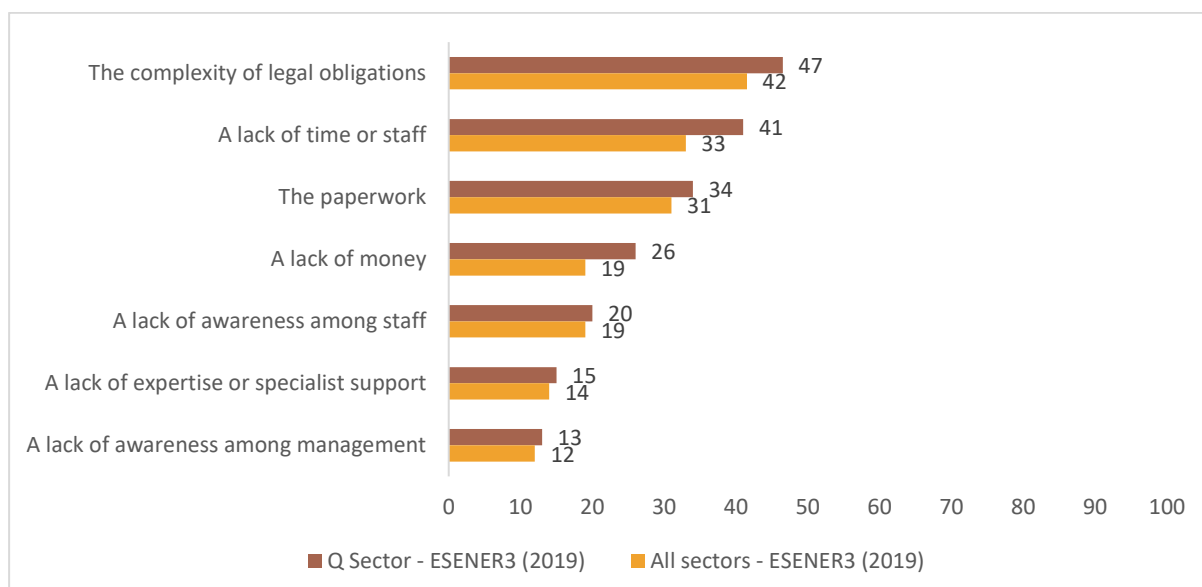
In the human health and social work activities sector, companies more often report major difficulties in addressing OSH than in all sectors. In addition, over time major problems were reported by companies in the sector more often in 2019 than in 2014. The major difficulties reported most often are the complexity of legal obligations (46.5% in 2019), a lack of time or staff (41%, with a significant 12 percentage-point increase from 2014 to 2019) and paperwork (34%).

**Figure 33 : Major difficulties in addressing health and safety in the establishment, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

**Figure 34 : Major difficulties in addressing health and safety in the establishment, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27

According to those interviewed for this study, legal obligations are perceived as complex and therefore a hindrance, especially when there is no specialist that can make sense of such complexity and explain obligations in easier terms,. However, it was held by interviewees that the perception of this varies substantially across countries. What may be a more common issue is the importance of social dialogue in mitigating this challenge. Further, interviewees felt that through social dialogue, with representatives of employees and employers working together and with clear direction through substantive internal processes, the risk of such legal obligations remaining ‘on paper’ can be mitigated, therefore increasing

their effectiveness. In essence, it was felt that legal obligations should support OSH, rather than be punitive of those establishments that encounter difficulties.

Three points made by interviewees were specific to the human health and social work activities sector in terms of legal obligations. Firstly, in Sweden, there was a view from some interviewees that the privatisation of elder care has resulted in workers having many different contracts, with different levels of protection and with substantial challenges in terms of enforcement. Secondly, some interviewees felt that the mobility of care sector professionals may be hampered by legal obstacles and a lack of awareness of rights on the part of workers. Thirdly, some interviewees expressed that informal carers may not be registered and may have little to no *de jure* or *de facto* protection.

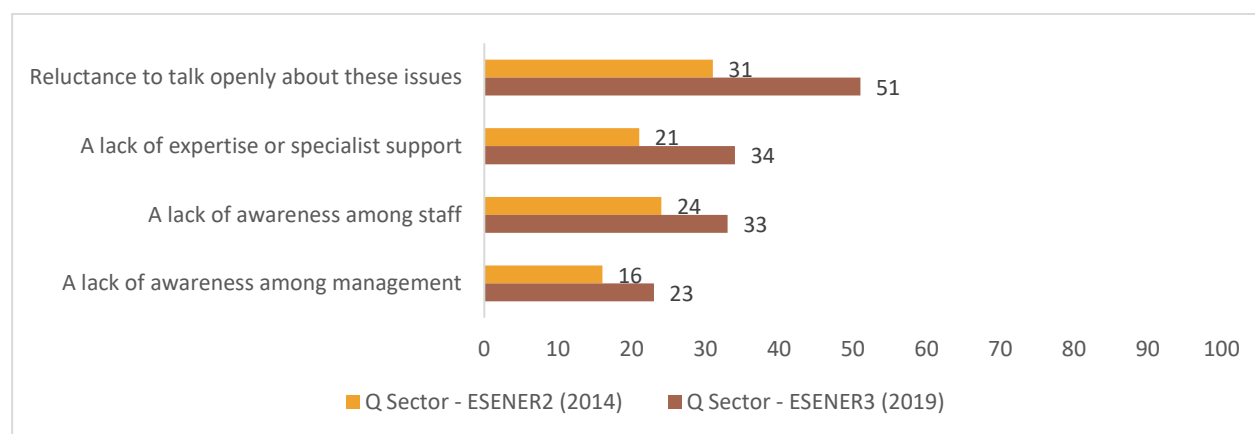
Lack of time or staff may also mean that mistakes are more likely. Further, as noted before, difficulties in staff retention and high turnover may in all likelihood affect the number of high-quality human resources. This may also affect the continuity of care, which is particularly important in the social care sector. Lean management strategies in the private sector may further contribute to staff shortages. Less affluent countries may also suffer the consequences of emigration leading to resulting staff shortages in the care sector.

Lack of awareness (among staff 20% and among management 13%) does not appear to be reported as often as a major difficulty in the survey, although interviewees emphasised that this is only because much effort has been devoted to training and awareness. They also noted that the achievements made in this area should not be lost. They further noted that COVID-19 has heightened biological risks and called for new training and new awareness-raising initiatives to demand (and supply) PPE and to institute routine hand-washing.

### 6.3 Main obstacles to dealing with psychosocial risks

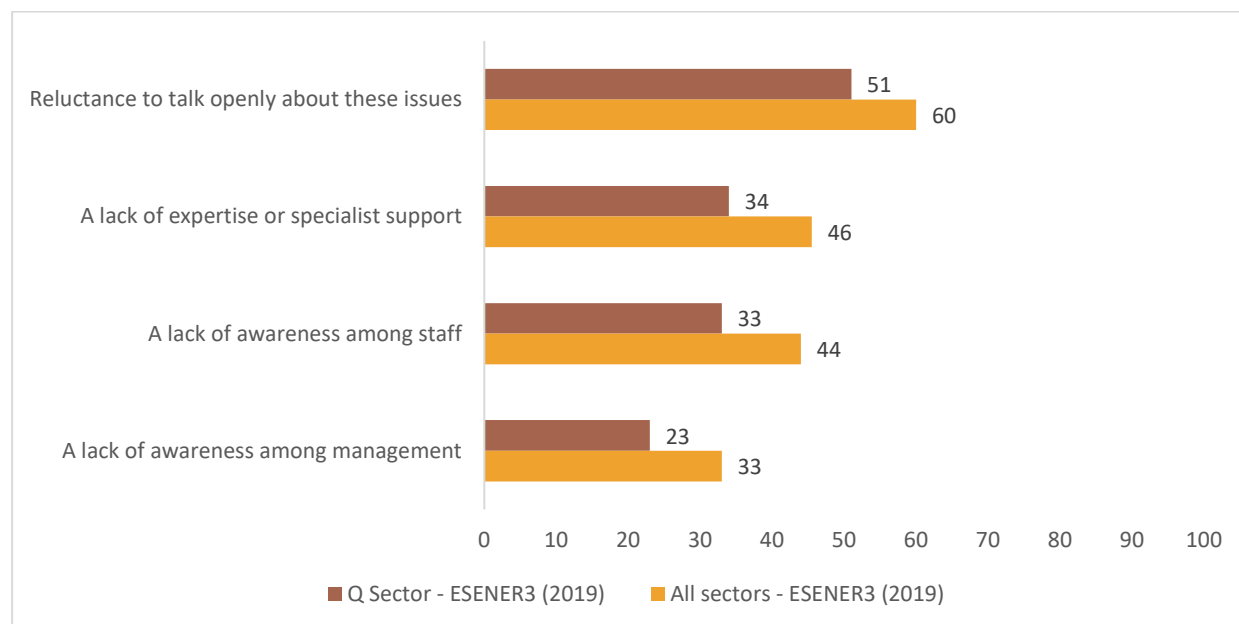
Reports of obstacles to dealing with psychosocial risks are less common overall in the sector than all sectors, according to the research for this study. It should be noted, however, that this question was only asked to those reporting that psychosocial risks were more difficult to manage than other OSH risks. On every measure, a larger number of companies in all sectors reported obstacles than in the human health and social work activities sector. For details, see Figure 35. Over time (between 2014 and 2019) the number of firms reporting obstacles increased both in the sector specifically and overall. The most commonly reported obstacle in the sector and in all sectors in 2019 was the reluctance to talk openly about these issues. The issue of stigma attached to mental health was confirmed by experts interviewed for this study, and while this is not a new finding, it is important that research contributes to its de-stigmatisation. Further, expert interviewees felt it equally important that companies' working culture be friendly and open towards mental health issues, with trained line management and specialist support who are ready and capable to discuss issues and to ensure anonymity when required.

Figure 35 : Main obstacles to dealing with psychosocial risks, Q sector 2014 and 2019 (%)



Base: establishments in the Q sector in the EU-27 that have identified one or more psychosocial risk and reporting that psychosocial risks are more difficult to address than other risks.

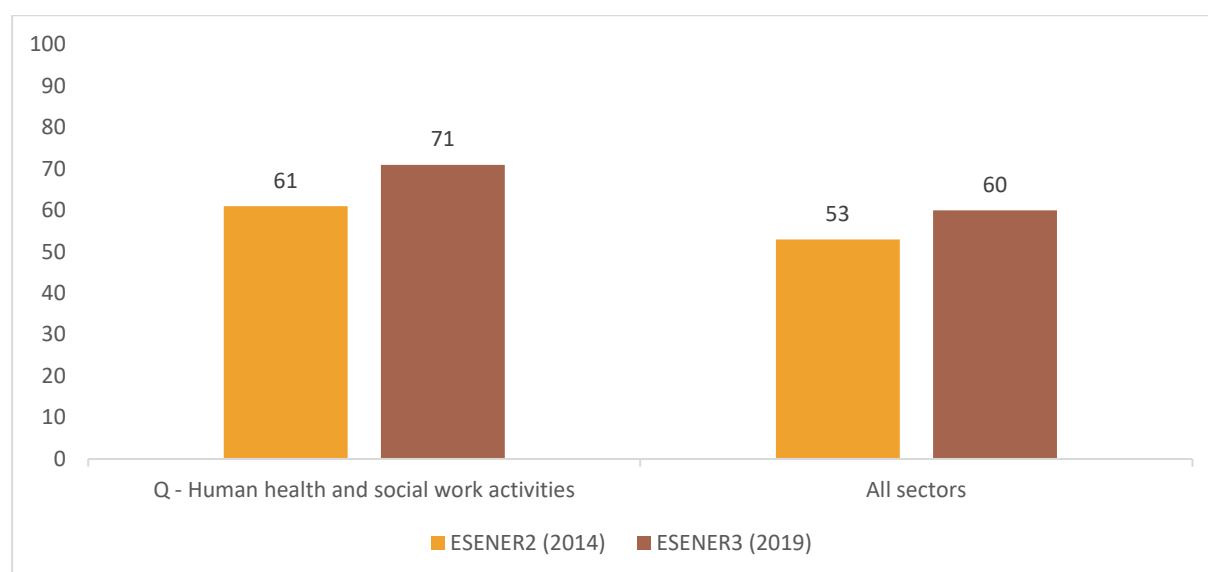
**Figure 36 : Main obstacles to dealing with psychosocial risks, Q sector and all sectors 2019 (%)**



Base: establishments in the EU-27 that have identified one or more psychosocial risk and reporting that psychosocial risks are more difficult to address than other risks.

More establishments in the sector (71%) than in all sectors (60%) reported that they have sufficient information on how to include psychosocial risks in risk assessments. Both for the sector and overall, there was an increase in the number of establishments with sufficient information between 2014 and 2019 – a 10 percentage-point increase in the sector and a 7 percentage-point increase in all sectors.

**Figure 37 : Sufficient information on how to include psychosocial risks in risk assessments, Q sector and all sectors 2014 and 2019 (%)**



Base: establishments in the EU-27 reporting carrying out regular risk assessments

## 6.4 Main barriers to OSH management by establishment type

The latent class analysis results revealed that there are three types of establishments in terms of the main barriers/difficulties in addressing health and safety. Namely,

- (i) Establishments with low incidence of difficulties or barriers to OSH management that constitute 32% of all establishments in ESENER 2019;
- (ii) Establishments with medium incidence of difficulties or barriers to OSH management that constitute 30% of all establishments in ESENER 2019;
- (iii) Establishments with high incidence of difficulties or barriers to OSH management that constitute 38% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments face the difficulties or barriers to OSH management described by the indicators. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that answered 'yes' to the corresponding question in the ESENER 2019 survey.

As can be seen from the table, the surveyed establishments are approximately equally distributed across the three types identified (that is, each of the groups contains about a third of the establishments). In the class of establishments that reported a high incidence of difficulties, lack of awareness among staff and management as well as the complexity of legal obligations appear to be the most pressing issues. They are followed by lack of time or staff, the paperwork, lack of money, and lack of expertise or specialist support. Not carrying out workplace risk assessments due to burdensome procedure or lack of necessary expertise do not seem to be major barriers.

For the group that reported medium incidence of difficulties, the most important barriers were complexity of legal obligations, the paperwork, and the lack of time or staff. The remaining reasons, in particular the lack of awareness among management, do not appear to be major contributing factors. Finally, for the group that reported low incidence, the most important factors (albeit still relatively minor) were lack of time or staff and lack of awareness among staff.

**Table 7: Establishment typology on barriers to OSH management**

	<b>Class 1 - Low incidence of difficulties</b>	<b>Class 2 - Medium incidence of difficulties</b>	<b>Class 3 - High incidence of difficulties</b>
Workplace risk assessments are not carried out as the procedure is too burdensome	7%	21%	29%
Workplace risk assessments are not carried out as the necessary expertise is lacking	10%	26%	46%
A main difficulty in addressing health and safety in the establishment is a lack of time or staff	28%	66%	89%
A main difficulty in addressing health and safety in the establishment is a lack of money	18%	48%	81%
A main difficulty in addressing health and safety in the establishment is a lack of awareness among staff	22%	38%	96%



	Class 1 - Low incidence of difficulties	Class 2 - Medium incidence of difficulties	Class 3 - High incidence of difficulties
A main difficulty in addressing health and safety in the establishment is a lack of awareness among management	7%	7%	90%
A main difficulty in addressing health and safety in the establishment is a lack of expertise or specialist support	6%	30%	80%
A main difficulty in addressing health and safety in the establishment is the paperwork	7%	74%	84%
A main difficulty in addressing health and safety in the establishment is the complexity of legal obligations	17%	86%	90%
Class size	32%	30%	38%

In terms of the predictors of class membership, the results show that establishments in the human health and social work activities sector, compared with all other sectors, are more likely to be in class 3 and (to a somewhat lesser extent) in class 2 than in class 1. **Thus, in relative terms, human health and social work activities sector establishments, compared with establishments in all other sectors, are more likely to report a higher incidence of difficulties or barriers to OSH management. These effects are moderate.**

Furthermore, the results also revealed that establishments in the public sector are more likely than those in the private sector to be in class 3 and in class 2 than class 1. **Thus, in relative terms, public sector establishments, compared with private sector establishments, are also more likely to report more difficulties or barriers to addressing occupational health and safety in their establishment. These effects are moderate.**

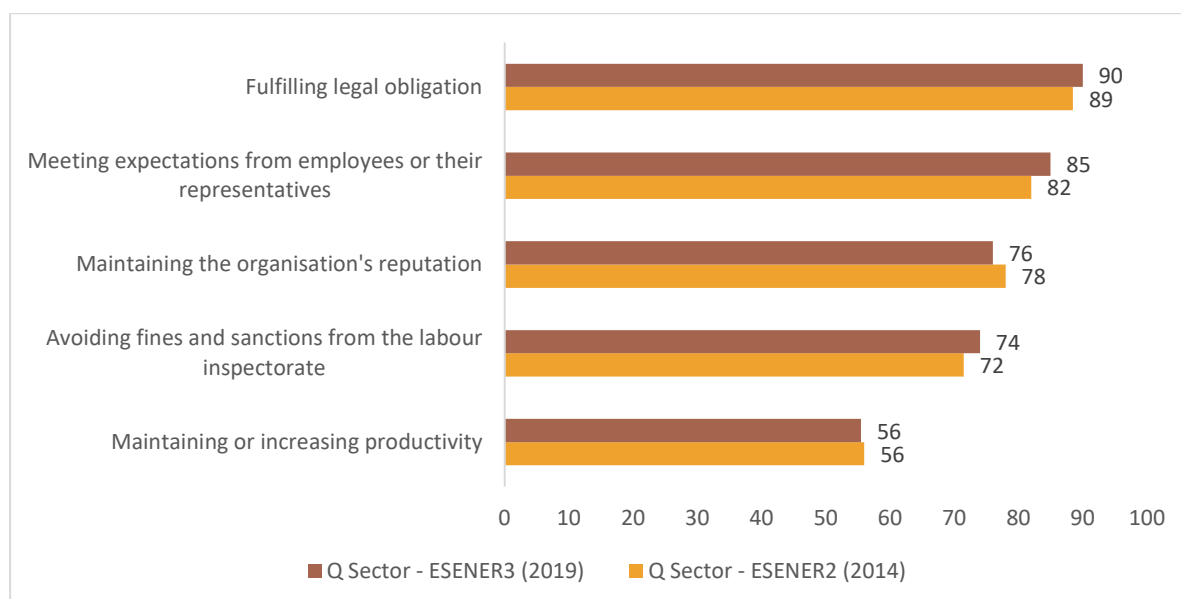
With regards to company size, bigger companies (that is, large and to a lesser extent medium-sized companies) are most likely to be in class 3, followed by class 1 and 2 (wherein large companies are least likely to be in class 2 and medium-sized companies are equally likely to be in class 1 and 2). Thus, bigger companies, compared with small companies, are more likely to report facing more difficulties or barriers to OSH management. Micro companies, on the other hand, are most likely to be in class 1 (low incidence of reported difficulties), followed by class 2 (medium incidence) and class 3 (high incidence). **These effects are moderate for bigger companies and moderate to weak for micro companies. This implies that bigger companies are more likely to report higher incidence of difficulties in managing OSH.**

## 6.5 Main drivers for OSH management

In terms of the main drivers for addressing health and safety in establishments, the ESENER analysis indicates that in the human health and social work activities sector, the main driver is fulfilling legal obligations (90% in 2019 and up from 88.5% in 2014). This is followed by meeting expectations from employees or their representatives (85% in 2019) and maintaining the organisations' reputation (76% in 2019). For details, see Figure 38.



**Figure 38 : Main reasons for addressing health and safety in the establishment, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

In comparison with the average of all sectors, as can be seen in Figure 39, the main drivers in the human health and social work activities sector are more often reported to be fulfilling legal obligations and meeting expectations from employees or their representatives. Less frequently reported in the sector are maintaining reputation, avoiding fines and sanctions from the labour inspectorate, and maintaining or increasing productivity.

**Figure 39 : Main reasons for addressing health and safety in the establishment, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27

In addition to this, there is one key aspect that is considered to drive OSH management in the human health and social work sector. As seen many times across this report, the sector tends to fare better than all sectors. A specificity of the human health and social work activities sector is that management does not only think about productivity, as there is **an ingrained culture of caring and of human relations**. This means that there is goodwill on the part of the staff, according to one of the experts interviewed for this study. However, this expert also stressed that employers also need to carry on providing PPE, sufficient resources and good quality work organisation to enable workers to perform their job adequately and without unnecessary risks.

As mentioned above, another driver is **reputation** – on one hand, the willingness to avoid scandals and stigma, and on the other, the motivation to do well and be recognised. These findings confirm an increasing amount of literature that highlights how rewards and sanctions may not need to be monetary, based on choice and competition, for example, but rather based on reputational effects.<sup>25</sup>

Another important driver is **legislation**. There is ample opportunity to fully take advantage of legislative frameworks and this is particularly the case when there is well-functioning social dialogue. Legislation, according to interviewees, may be important in terms of the rights and entitlements of workers, with regards to enforcement of OSH with the aim of improving rather than sanctioning, as well as in relation to the qualification of professionals, which not only benefits patients but also the overall quality of OSH management.

**COVID-19** is considered by experts interviewed for this study to be another significant driver, in that it has renewed attention and awareness of the link between public health and the human health and social work activities sector. There has been increasing publicity of the incredibly professional work of health and social care workers in difficult circumstances. This may lead to the establishment of health and social care onto the political agenda, as a consequence of societal support. In addition, as professionals and citizens have all experienced a long, difficult and stressful period of time, it is also possible that mental health will be given more consideration overall. COVID-19 has also emphasised the link between health care and social care, and the need to continue in the direction of their integration, which is fundamental for the health, dignity and autonomy of patients and professionals, particularly with an ageing population.<sup>26</sup>

## 6.6 Visits by the labour inspectorate

The labour inspectorate in itself is not an OSH management factor. However, visits by the labour inspectorate have significant influence on the management of OSH in that they drive compliance with OSH legislation and avoidance of fines from the labour inspectorate, which are identified as key drivers of OSH compliance as set out in Figure 39.

The proportion of establishments visited by the labour inspectorate in the three years prior to the survey was reported to have decreased over time both for all sectors and the human health and social work activities sector specifically, and particularly in 2019 for the latter. Overall, establishments in the sector are reported to be visited by the labour inspectorate less often than those in other sectors.

Expert interviewees add rich insights to this area of investigation. Firstly, there is a recurrent theme that labour inspectorates are under significant pressure in terms of number of personnel, and specialisation and training on specific risks. This calls for a renewed emphasis on prioritising efforts, given the scarce resources available, which are not considered to be sufficient. This situation has been compounded by the economic crisis. This finding is in line with the views of Anyfantis, Papagiannis, and Rachiotis (2021)<sup>27</sup>, who underline the importance of the role of the labour inspectorates, coupled with increased job demands in the context of austerity measures. Lack of flexibility may also have significant

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<sup>25</sup> Bevan, G., Evans, A. and Nuti, S., 2019. Reputations count: why benchmarking performance is improving health care across the world. *Health Economics, Policy and Law*, 14(2), pp. 141-161.

<sup>26</sup> [https://ec.europa.eu/health/sites/default/files/systems\\_performance\\_assessment/docs/2017\\_blocks\\_en\\_0.pdf](https://ec.europa.eu/health/sites/default/files/systems_performance_assessment/docs/2017_blocks_en_0.pdf)

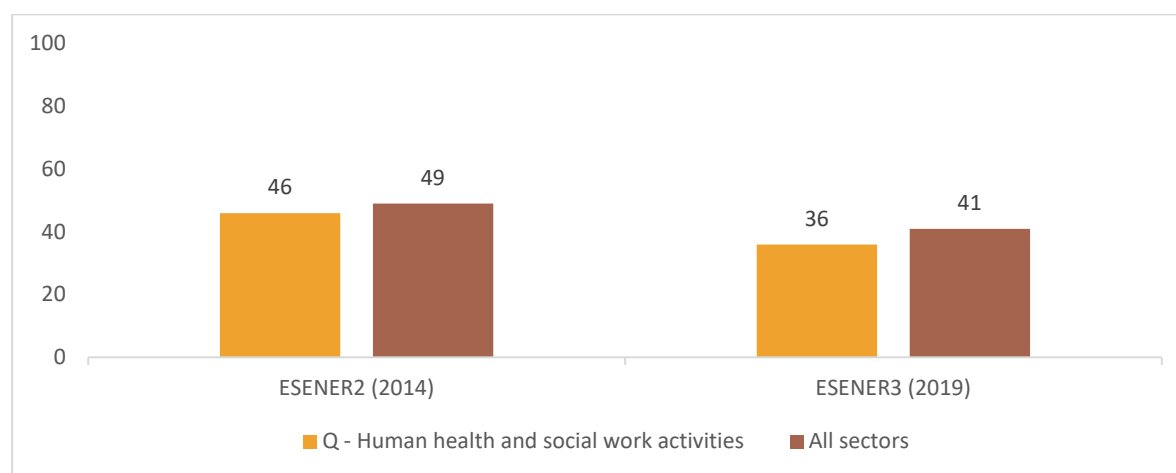
<sup>27</sup> Anyfantis, I.D., Papagiannis, D. and Rachiotis, G., 2021. Burnout among labour inspectors in Greece: A nationwide cross-sectional study. *Safety Science*, 135(3): 105134. Available at: [https://www.researchgate.net/publication/348136077\\_Burnout\\_among\\_labour\\_inspectors\\_in\\_Greece\\_A\\_nationwide\\_cross-sectional\\_study](https://www.researchgate.net/publication/348136077_Burnout_among_labour_inspectors_in_Greece_A_nationwide_cross-sectional_study)

physiological and psychological effects on labour inspectors, further depressing available resources. Relatedly, according to one interviewee, labour inspectors face additional challenges such as having to pay for their own fuel when driving to inspect workplaces.

Secondly, interviewees shared the understanding that despite these challenges, labour inspectorates pay proper attention to OSH in the workplace and are very good at doing this, and even more so in light of the COVID-19 pandemic. Inspections are considered useful because they are a reassurance that an organisation is doing well, and they also provide indications and advice on how to improve.

Thirdly, the COVID-19 pandemic has also meant that labour inspectorates have on occasion not been allowed to enter workplaces due to biological risk factors.

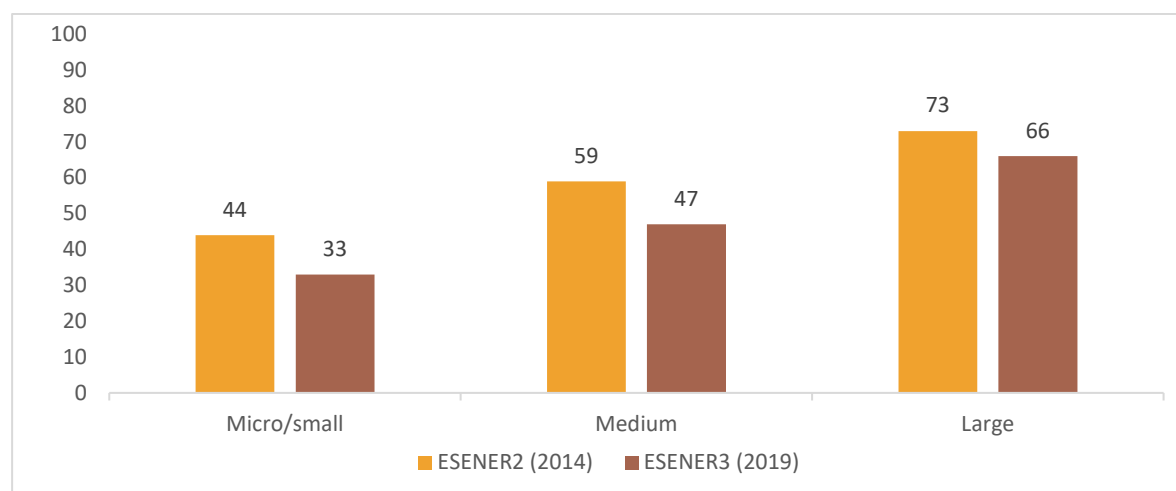
**Figure 40 : Establishment visited by the labour inspectorate in the three years prior to the survey, Q sector and all sectors 2014 and 2019 (%)**



Base: all establishments in the EU-27

In terms of company size in the sector, there appears to be a positive association between size and the occurrence of visits, with larger companies more often reporting these visits, as expected. For details, see Figure 41 .

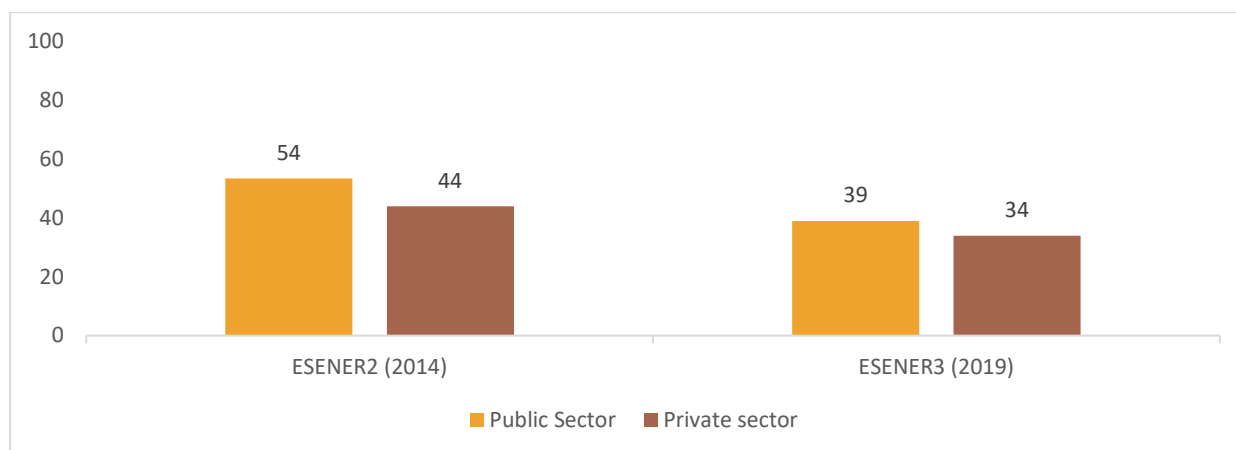
**Figure 41 : Establishment visited by the labour inspectorate by company size, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

In terms of type of company, there has been a decrease in reported visits to companies in both the private and public sectors over time and in particular between 2014 and 2019. Overall, more visits are reported to take place in the public than the private sector.

**Figure 42 : Establishment visited by the labour inspectorate in the three years prior to the survey, by public/private sector, Q sector 2014 and 2019 (%)**



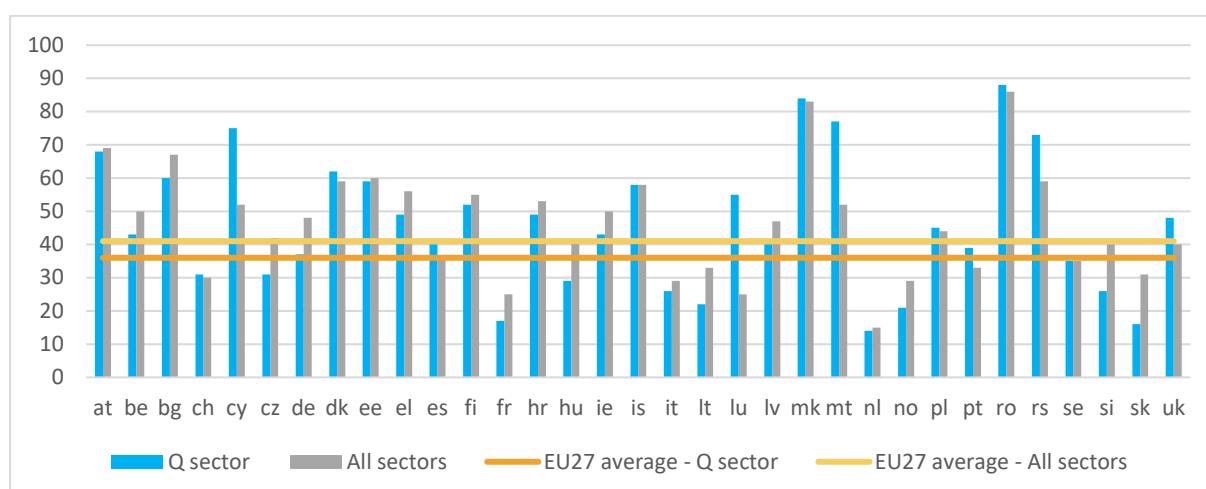
Base: all establishments in the Q sector in the EU-27

### Differences between countries

The EU-27 average in terms of reported visits by the labour inspectorate in the three years prior to the survey is 36% in the Q sector, which, as mentioned above, is 5 percentage points lower than in all sectors (41%). However, there is significant variation by country: 11 countries have a national average for the sector that is lower than the EU-27 average and 22 countries have a national average that is higher than the EU-27 average.

There are 13 countries in which the sector average is lower than the average for all sectors. There are also five countries where the opposite applies: this is particularly the case for Luxembourg, with a 30 percentage points gap, 55% in the sector and 25% in all sectors. Large differences are also reported in Malta and Cyprus.

**Figure 43: Establishments visited by the labour inspectorate in the three years prior to the survey by country, Q sector and all sectors 2019 (%)**



Base: all establishments

## Role of digitalisation

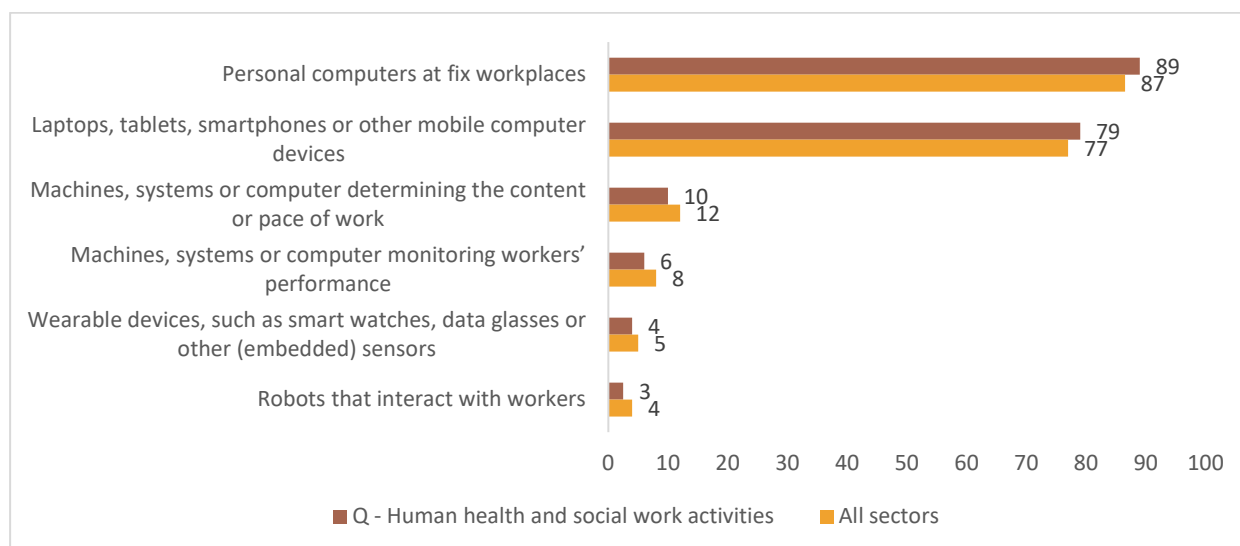
Digitalisation is playing an increasingly important role in the organisation of work and this can have significant impacts on OSH, both in a positive and more challenging sense. It is likely that AI-based systems will increasingly be used in this sector in the future to automate tasks that are both cognitively and physically-based, due to factors such as an increase in demand for staff.

On the positive side, digitalisation is a key driver of high-quality, effective and efficient OSH management. For example, automation may directly reduce OSH risks, and this is particularly relevant in the context of an ageing workforce. More specifically, AI-based systems can perform strenuous tasks such as patient lifting, and also some routine tasks, such as reporting of scans or needle insertion. This will help to prevent MSDs and can also reduce psychosocial risks by removing some of the burden of routine work. Digitalisation also has the potential to support OSH management in terms of the processes involved in carrying out risk assessments, inspections, OSH monitoring, prevention of accidents and reporting. Experts interviewed for this study felt that a digitally native workforce will be in a good position to seize these opportunities.

However, AI-based systems may also create new and emerging risks linked to fear of job loss, deskilling and lack of appropriate skills. These themes have been discussed widely in the literature<sup>28</sup>. It is therefore important to ensure that workers are fully informed about all potential implications of the introduction of AI and digital tools. The experts interviewed for this study agreed, stating that it is important to focus on the risks of digitalisation as well as the benefits, and ensure that workers are informed, trained, and have a voice in their design and the goals for which these new tools are used.

As for the digital tools used at work both in the sector and all sectors, personal computers at fixed workplaces and laptops, tablets, smartphones or other mobile devices are the most often used technologies; these are slightly more often used in the sector than all sectors. Other technologies, such as various machines to determine pace of work, worker performance, wearable devices, and robots that interact with workers, are generally rarely used but they are somewhat more often used in all sectors than the sector. For details, see Figure 44 .

Figure 44 : Digital technologies used for work, Q sector and all sectors 2019 (%)



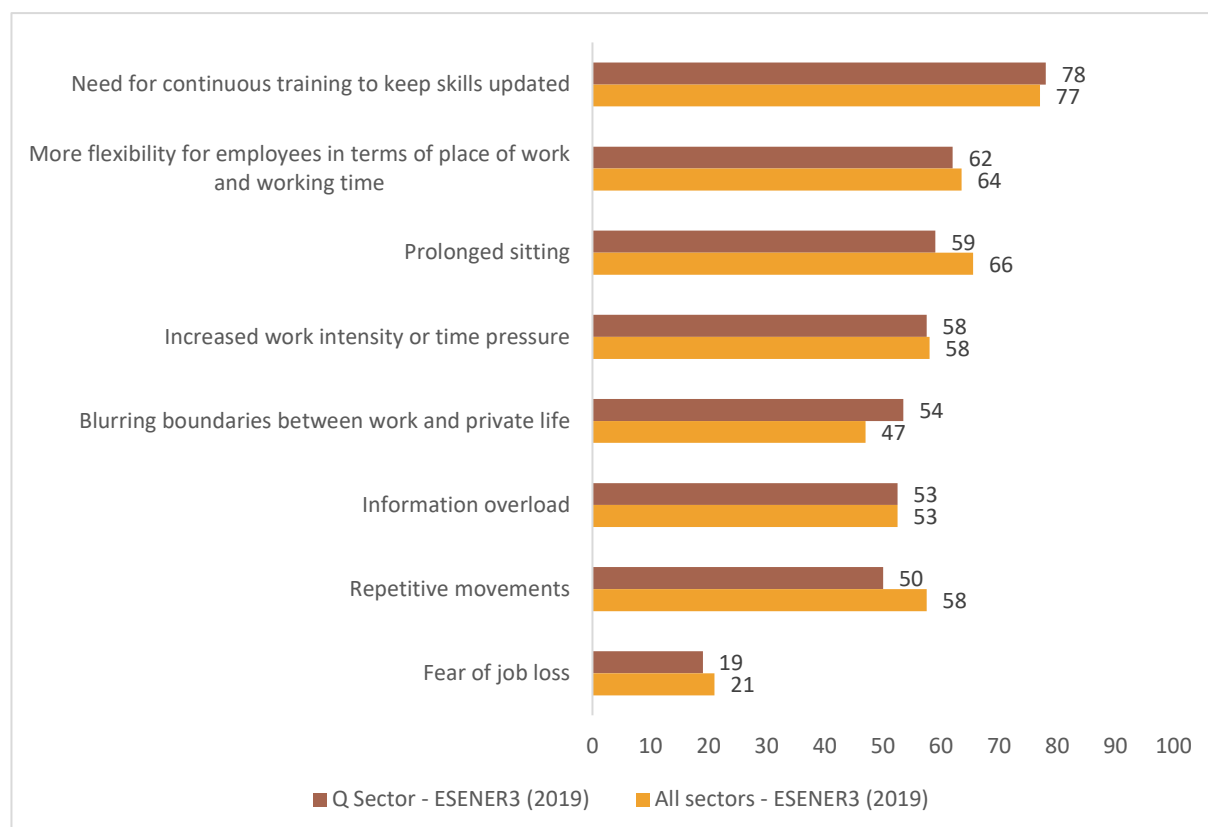
Base: all establishments in the EU-27

<sup>28</sup> See, for example, European Commission (2019), AI, the future of work? Work of the future!: on how artificial intelligence, robotics and automation are transforming jobs and the economy in Europe: <https://op.europa.eu/en/publication-detail/-/publication/096526d7-17d8-11ea-8c1f-01aa75ed71a1>; and European Parliament (2021), Improving working conditions using Artificial Intelligence: [https://www.europarl.europa.eu/RegData/etudes/STUD/2021/662911/IPOL\\_STU\(2021\)662911\\_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2021/662911/IPOL_STU(2021)662911_EN.pdf)

When establishments were asked whether or not the potential impacts of various digital technologies on OSH were discussed, in 2019 this was the case more often in the sector than in all sectors (28% versus 24%), although these figures are generally relatively low.

As for the types of impacts discussed, most impacts are discussed more often in all sectors than in the sector specifically. Impacts that are more often discussed in the sector are the need for continuous training to keep skills updated, more flexibility for employees in terms of working place and time, prolonged sitting, and increased work intensity and time pressure.

**Figure 45 : Impacts discussed in the context of use of technologies, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27 reporting use of digital technologies at work

## 6.7 Main drivers for OSH management by establishment type

The latent class analysis results revealed that there are three types of establishments in terms of the main drivers in addressing health and safety. Namely,

- (i) Establishments with medium incidence of reported drivers for OSH management that constitute 7% of all establishments in ESENER 2019;
- (ii) Establishments with relatively high incidence of reported drivers for OSH management that constitute 23% of all establishments in ESENER 2019;
- (iii) Establishments with very high incidence of reported drivers for OSH management that constitute 70% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments report drivers for OSH management described by the indicators. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that answered 'yes' to the corresponding question in the ESENER 2019 survey.

Overall, as can be seen from the table, over two-thirds of the establishments surveyed (those with a very high incidence of reported drivers) indicated that fulfilling legal obligation, meeting expectations from employees, maintaining the organisation's reputation, and avoiding fines and sanctions are major drivers for OSH management. Maintaining or increasing productivity, on the other hand, does not appear to be a very important driver.

Furthermore, almost a quarter of the establishments surveyed (those with a relatively high incidence of reported drivers) indicated that fulfilling legal obligation and meeting expectations from employees are important drivers, while the remaining three (and in particular maintaining or increasing productivity) are less important. The group of establishments that had a medium incidence of reported drivers was very small (and only consisted of 7%). They indicated that all drivers, with the exception of maintaining or increasing productivity, are somewhat important drivers for OSH management.

**Table 8: Establishment typology on drivers for OSH management**

	Class 1 - Medium incidence of reported drivers for OSH management	Class 2 - Relatively high incidence of reported drivers for OSH management	Class 3 - Very high incidence of reported drivers for OSH management
Fulfilling legal obligation is a main reason for addressing health and safety	49%	77%	97%
Meeting expectations from employees or their representatives is a main reason for addressing health and safety	41%	67%	92%
Maintaining or increasing productivity is a main reason for addressing health and safety	20%	37%	28%
Maintaining the organisation's reputation is a main reason for addressing health and safety	40%	50%	95%
Avoiding fines and sanctions from the labour inspectorate is a main reason for addressing health and safety	41%	53%	92%
<b>Class size</b>	<b>7%</b>	<b>23%</b>	<b>70%</b>

In terms of the predictors of class membership, the results show that establishments in the human health and social work activities sector, compared with all other sectors, are more likely to be in class 2 and class 3 than in class 1. **Thus, in relative terms, human health and social work activities sector establishments, compared with establishments in all other sectors, are more likely to report a high incidence of drivers to OSH management. These effects are moderate.**

Furthermore, the results also revealed that establishments in the public sector more likely than those in the private sector to be in class 1 and in class 2 than class 3. **Thus, in relative terms, public sector establishments, compared with private sector establishments, are less likely to report very high incidence of drivers. These effects are also moderate.**

With regards to company size, bigger companies (that is, large and to a lesser extent medium-sized companies) are more likely to be in class 2 and 3 than in class 1. Thus, bigger companies, compared with small companies, are more likely to report more drivers for OSH management. Micro companies, on the other hand, are most likely to be in class 1. **These effects are strong for large companies and moderate for medium-sized and micro companies. This implies that the incidence of reporting drivers for OSH management is positively associated with company size.**

## 7 Worker participation in OSH

This section examines the main results of the study related to worker participation in OSH. There are many studies that indicate the benefits of involving workers in OSH to reduce a range of work-related risks. Workers and their representatives have detailed knowledge and experience of how the job is done and how it affects them. For this reason, workplaces in which workers actively contribute to health and safety often have a lower occupational risk level and accident rates<sup>29</sup>. More specifically, worker participation helps to develop effective ways of protecting workers. By getting involved in an issue at the planning stage, workers are more likely to identify the reasons for taking a particular action, help find practical solutions, and comply with the end result. Further, if workers are given the opportunity to participate in shaping safe work systems, then they can advise, suggest and request improvements, helping to develop measures to prevent occupational accidents and ill-health in a timely and cost-effective manner.

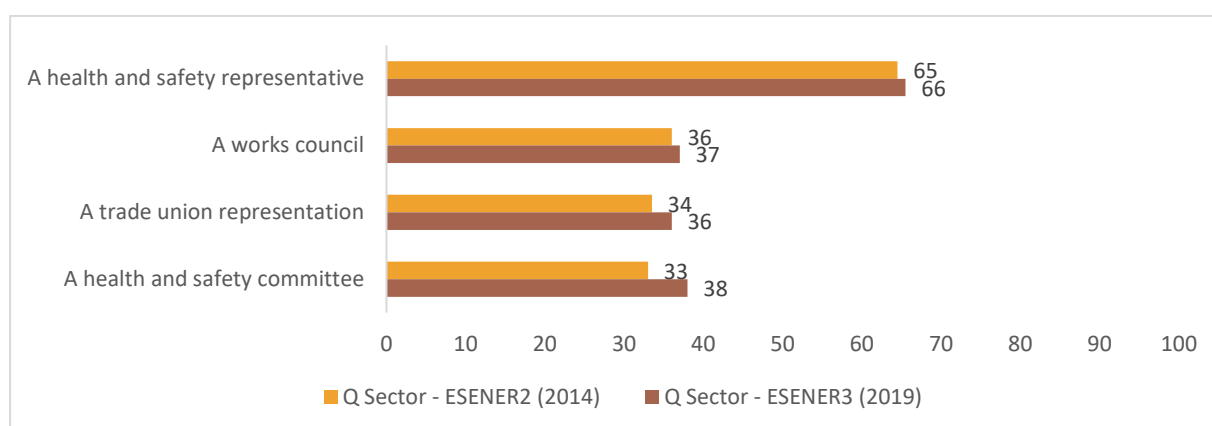
### 7.1 Forms of worker participation in OSH

From the descriptive analysis of ESENER, it is clear that all forms of worker participation were more common in the human health and social work activities sector than in all sectors, both in 2014 and in 2019; overall a health and safety representative is the most common form of worker participation (in 64.5% of establishments in 2014 and 65.5% in 2019 in the human health and social work activities sector and in 56% of establishments in 2014 and 56.5% in 2019 in all sectors). It should be noted that the way in which health and safety representatives are appointed differs between countries. In about half of EU-27 countries, they are elected directly by the workforce, while in others, they are either selected by the employer or they are partly directly elected and partly selected by the employer. There are also variations in the thresholds for choosing representatives and setting up committees as well as variations in their powers.

In terms of trends, there was an increase in all forms of worker participation between 2014 and 2019 in the human health and social work activities sector (most notably in the case of health and safety committees, which rose from 33% to 38%). In all sectors, there was a slight decrease in the forms of works council (from 25% to 24%) and trade union representation (from 20% to 18.5%), and a slight increase in health and safety committees (from 20% to 22.5%) as well as health and safety representatives (from 56% to 56.5%).

For details of the human health and social work activities sector, see Figure 46 .

**Figure 46 : Forms of employee representation in the establishment, Q sector 2014 and 2019 (%)**



Base: all establishments in the Q sector in the EU-27

<sup>29</sup> EU-OSHA (2012). Worker Participation in Occupational Safety and Health. A practical guide.  
<https://osha.europa.eu/en/publications/worker-participation-occupational-safety-and-health-practical-guide>



## 7.2 Discussion of OSH

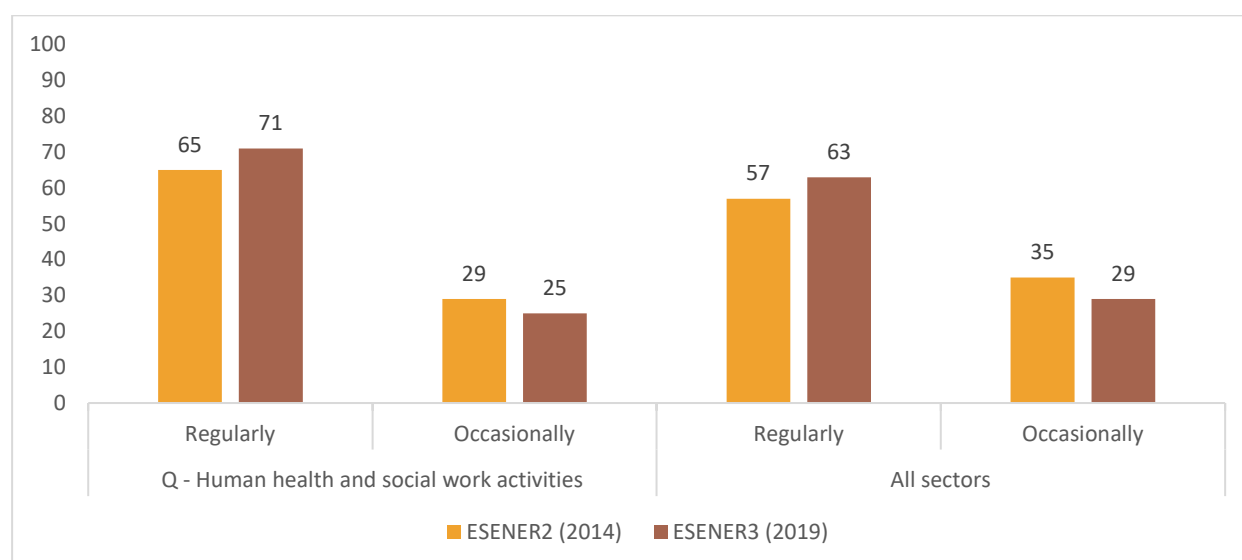
Health and safety was discussed more regularly between employee representatives and the management in establishments in the human health and social work activities sector in 2019 than in all sectors – 62% compared with 51%. Conversely, fewer establishments in the sector discussed health and safety only when particular issues arise than was the case in all sectors – 30% compared with 37%. A total of 7% of companies in the sector said that these issues were never discussed at all, compared with 10% in all sectors.

Between 2014 and 2019, the proportion of establishments in the human health and social work activities sector that said they regularly discussed OSH was stable, at 61.5% in 2014 and 62% in 2019, as was the proportion that said that they discussed OSH when particular issues arise.

The proportion of establishments in all sectors stating that OSH issues are discussed regularly fell from 54% in 2014 to 51% in 2019 and those saying that these issues were never discussed rose from 4% to 10%.

For details, see Figure 47.

**Figure 47 : How often health and safety is discussed between employee representatives and management, Q sector and all sectors 2014 and 2019 (%)**

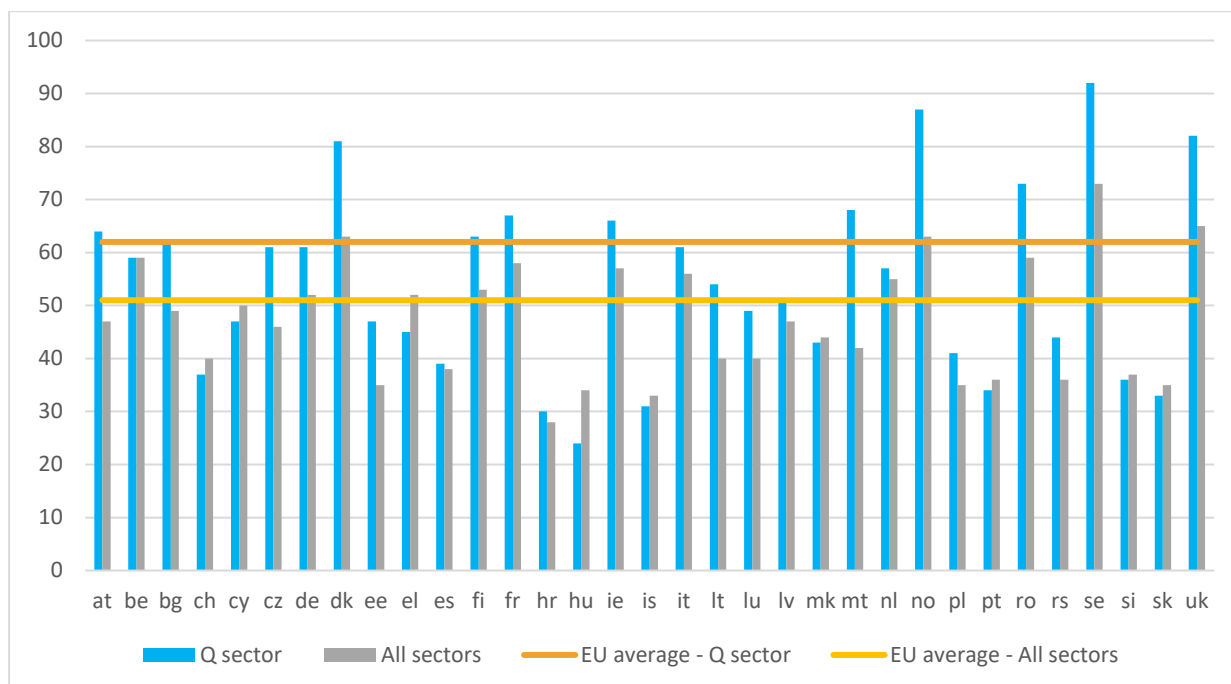


Base: all establishments in the EU-27 reporting that they have a form of employee representation in place.

There is a **positive association between company size and the frequency of discussing health and safety issues** between employee representatives and management in the sector, ranging from 78.5% of large companies, 73% of medium-sized companies and 58.5% of micro/small companies discussing this regularly. Between 2014 and 2019 the rate of large companies where these issues are regularly discussed dropped slightly, from 82% to 78.5%.

There are some country differences also in this regard. Figure 48 shows that health and safety issues are discussed much more regularly with employee representatives in Sweden (92% of establishments reported this), Norway (87%), the UK (82%) and Denmark (81%). These countries also show the largest difference in the performance of the human health and social work activities sector and all sectors. It may be that the incidence and culture of employee representation in the sector in these countries contributes to this. Conversely, the sector underperforms in relation to all sectors in countries such as Hungary and Greece, and to a lesser extent also in Cyprus, Iceland, Portugal, Slovakia, Slovenia and Czechia.

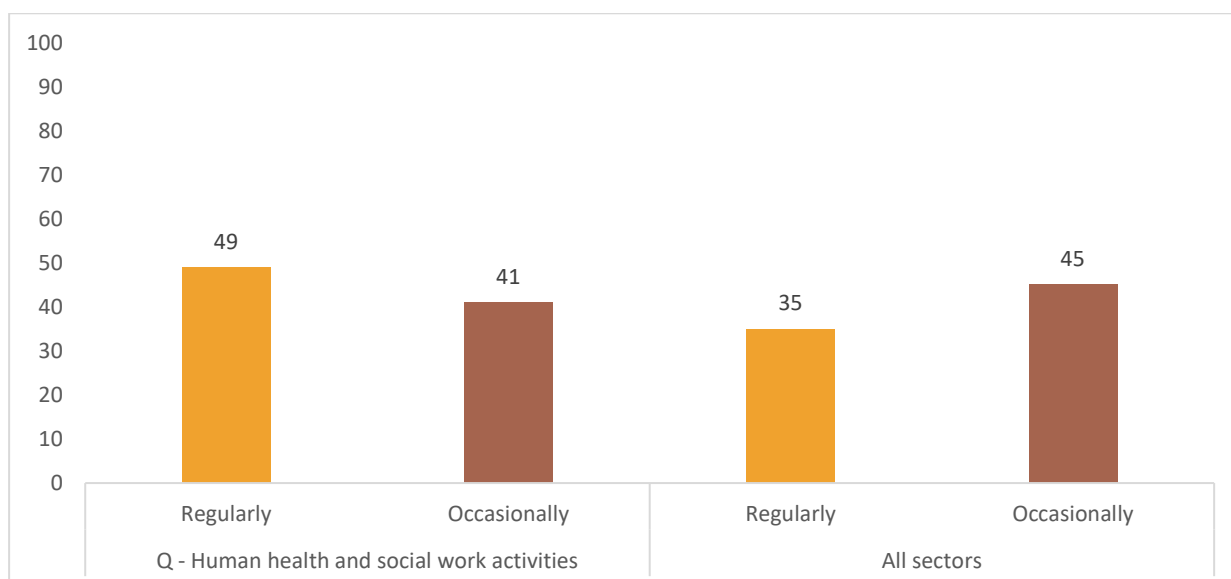
**Figure 48 : How often health and safety is discussed between employee representatives and management by country, Q sector and all sectors 2019 (%)**



Base: all establishments reporting that they have a form of employee representation in place

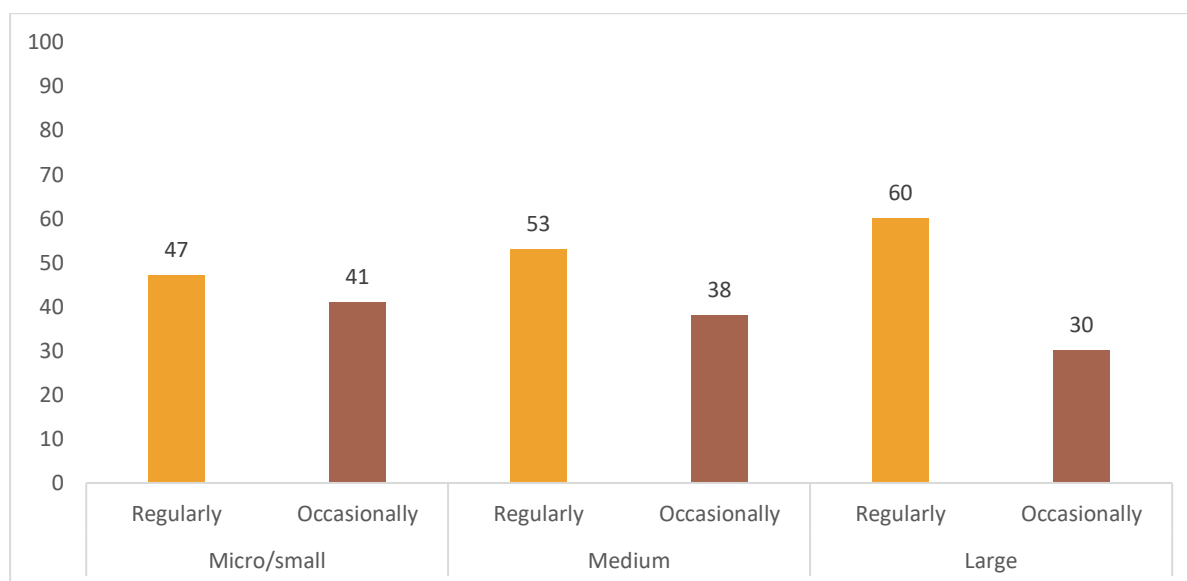
Health and safety is discussed more regularly in meetings in establishments in the human health and social work activities sector, than in all sectors. There is also a positive association between company size and the frequency of discussing health and safety issues during meetings. For details, see Figure 49 and Figure 50.

**Figure 49 : How often health and safety is discussed in staff or team meetings, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27

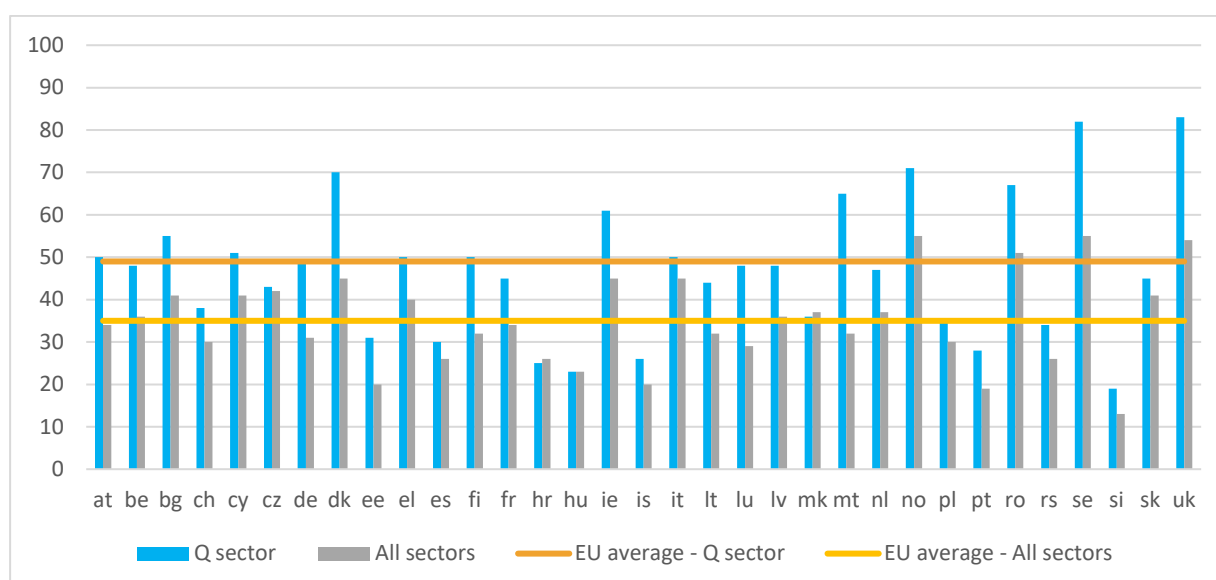
**Figure 50 : How often health and safety is discussed in staff or team meetings by company size, Q sector 2019 (%)**



Base: all establishments in the Q sector in the EU-27

There are also differences between individual countries in terms of how often health and safety is discussed in staff or team meetings in the sector, ranging from 83% in the United Kingdom and 82% in Sweden to 19% in Slovenia and 23% in Hungary. In almost all countries, OSH is discussed more often in the sector than in other sectors, and the EU-27 average for the sector is higher than for other sectors. For details, see Figure 51.

**Figure 51: How often health and safety is regularly discussed in staff or team meetings by country, Q sector and all sectors 2019 (%)**



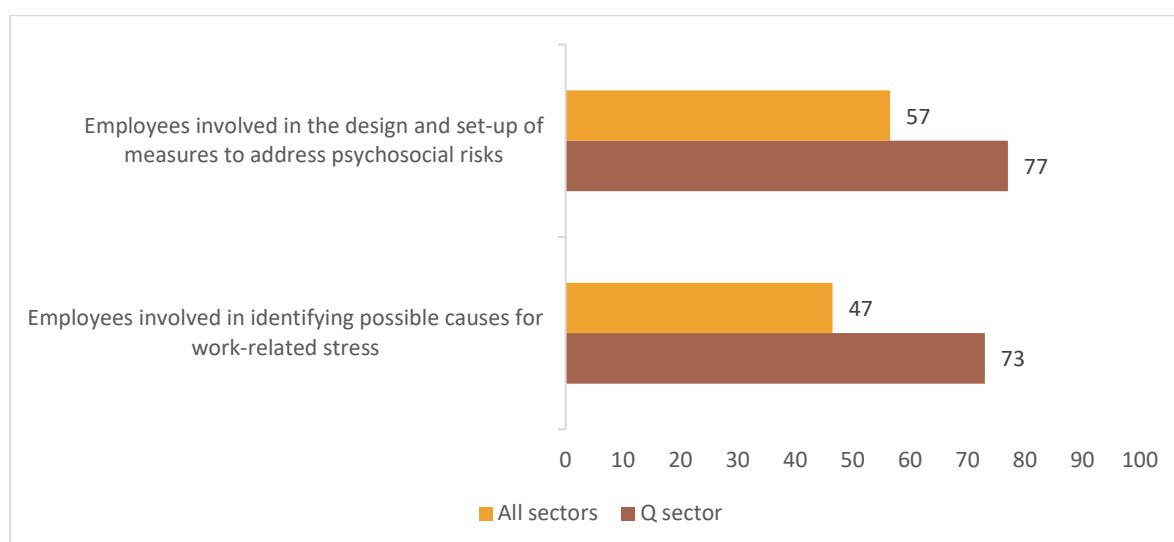
Base: all establishments

### 7.3 Involvement of worker representatives in identifying risks and formulating measures

For both the human health and social work activities sector and all other sectors, the vast majority of companies that have regular risk assessments involve their employees in the design of the measures if measures need to be taken following the assessment; this proportion is slightly higher for the human health and social work activities sector than all sectors.

Employees in the sector are also much more often involved in identifying possible causes for work-related stress than in all sectors (reported in 73% of establishments, compared with 46.5% in all sectors). They are also involved in the design and setup of measures to address psychosocial risks more often in the sector than all sectors. In addition, for the human health and social work activities sector the involvement of employees increased while for all sectors it decreased in the period 2014 to 2019. For details, see Figure 52.

**Figure 52: Employee involvement in psychosocial risk management, Q sector and all sectors 2019 (%)**



Base: all establishments in the EU-27 with 20 or more employees

In addition, establishments in which workers are involved in identifying possible causes for work-related stress are also more likely to involve employees in the design and setup of measures to address psychosocial risks.

In the human health and social work activities sector, health and safety representatives are provided with training during working time slightly more often compared with all sectors; in both cases the rate of companies in which these representatives receive training dropped slightly between 2014 and 2019, from 85% to 83% in the sector and from 80% to 79% in all sectors.

### 7.4 Worker involvement in OSH by establishment type

The LCA results revealed that there are three types of establishments in terms of worker involvement in OSH. Namely,

- (i) Establishments with relatively low level of worker involvement that constitute 47% of all establishments in ESENER 2019;
- (ii) Establishments with medium level of worker involvement that constitute 8% of all establishments in ESENER 2019;
- (iii) Establishments with high level of worker involvement that constitute 46% of all establishments in ESENER 2019.

The table below provides, for the three classes identified, an overview of the probabilities that establishments involve workers in various OSH management aspects as described by the indicators included in this typology. These probabilities can be loosely interpreted as the percentage of establishments in each of the classes that answered 'yes' to the corresponding question in the ESENER 2019 survey.

As can be seen from the table, most establishments either have a high level (46%) of worker involvement or a low level of worker involvement (47%) and only 8% have a medium level. Those with high involvement levels primarily rely on the provision of health and safety representatives with training, on regularly discussing health and safety between employee representatives and management, and on involving employees in the design and implementation of measures following a risk assessment. All remaining measures are also implemented in the establishments often.

For the medium level class, the uptake of measures is overall high with the two exceptions of involving employees in identifying possible causes for work-related stress and in the design and setup of measures to address psychosocial risks (for which the uptake is somewhat lower).

In the class with relatively low levels of involvement, establishments predominantly involve employees in the design and implementation of measures following a risk assessment and provide health and safety representatives with training. They most rarely have a health and safety representative.

**Table 9: Establishment typology on worker involvement in OSH**

	Class 1 - Relatively low level of worker involvement	Class 2 - Medium level of worker involvement	Class 3 - High level of worker involvement
If measures have to be taken following a risk assessment, employees are involved in their design and implementation	72%	79%	88%
Establishment has a health and safety representative (as a form of employee representation)	29%	88%	82%
Health and safety is discussed between employee representatives and the management - occasionally (class 1 & 2) - regularly (class 3)	37%	95%	88%
Health and safety representatives are provided with any training during work time to help them perform their health and safety duties	63%	84%	92%
Health and safety issues are discussed in staff or team meetings - occasionally (class 1 & 2) - regularly (class 3)	54%	96%	75%
Employees have been involved in identifying possible causes for work-related stress/ employee survey including questions on work-related stress has been conducted in your establishment in the last 3 years	35%	61%	66%
Employees have a role in the design and setup of measures to address psychosocial risks	45%	60%	75%
Class size	47%	8%	46%

In terms of the predictors of class membership, the results show that establishments in the human health and social work activities sector, compared with all other sectors, are most likely to be in class 3 followed by class 2 and least likely to be in class 1. **Thus, in relative terms, human health and social work activities sector establishments, compared with establishments in all other sectors, are most**

**likely to have a high level of worker involvement in OSH management, followed by a medium level, and they are least likely to have a low level of worker involvement. These effects are strong.**

Furthermore, the LCA results also revealed that establishments in the public sector are more likely than those in private sector to be in class 3 and in class 2 than class 1. **Thus, in relative terms, public sector establishments, compared with private sector establishments, are more likely to have a medium level of worker involvement than to have a low level of worker involvement. These effects are moderate.**

With regards to company size, large and medium-sized companies are most likely to be in class 3 and thus they are more likely to have a high level of worker involvement than small companies. Micro companies are most likely to be in class 1, and thus are more likely than small companies to have a low level of worker involvement. **These effects are (relatively) strong, in particular for large companies. This implies that establishment size is positively associated with having a high level of worker involvement.**

## 8 Conclusions

This project has analysed the main OSH risks for the human health and social work activities sector, triangulating data from the ESENER surveys in 2014 and 2019 with data gathered from interviews with key OSH experts and stakeholders from the sector. Extra insights were gained from advanced statistical analysis of the ESENER data, which was able to group companies into key typologies in terms of OSH management. The key conclusions from this analysis are that there is a higher than average awareness of OSH in the sector, when compared with the average of all sectors. The sector also performs well in terms of OSH management and worker participation in OSH, compared with all sectors. COVID-19 has had a severe impact on this sector, both in terms of impacts on workload and increasing psychosocial risks for those working in the sector. A range of further key conclusions are set out below.

This research has confirmed that the **main reported ergonomic risks** for those working in the human health and social work activities sector are repetitive hand and arm movements, prolonged sitting, and lifting or moving people or heavy loads. These risks can cause MSDs in general and back pains in particular. These factors are identified as risks for all sectors, but lifting or moving heavy loads is reported to be more of a risk for this sector than for other sectors. Risks from chemical or biological substances were also confirmed as higher for this sector than for other sectors.

In terms of **psychosocial risks**, having to deal with difficult customers, patients or pupils is confirmed as the most significant reported risk for this sector. Time pressure is also identified as a significant risk for the sector. Over time, all risks have increased in the sector, with the exception of fear of loss of job.

The **impact of COVID-19** has been significant for the sector in many different ways, a result that came out strongly from the interviews conducted for this research. Interviewees pointed to a huge rise in stress for those working in the sector, caused by factors such as overwork due to increases in the number of patients and staff shortages, lack of PPE in the first wave of the pandemic, and general anxiety about their own health as a result of potential exposure to COVID-19 at work, and the health of their families during the pandemic. The pandemic has also had an impact on workplace inspections, leading to reduced numbers of inspections taking place due to factors such as shortages of labour and restrictions on entering workplaces due to biological risks.

In terms of OSH management, the study found that human health and social work activities sector establishments, compared with establishments in all other sectors, are **most likely to have good OSH management and rely on internal support for OSH management**. Further, in relative terms public sector establishments, compared with private sector establishments in the sector, are more likely to have good OSH management and rely on internal support. This analysis also found that establishment size is positively associated with having good OSH management.

Establishments have a range of **mitigation measures** in place to try to minimise both ergonomic and psychosocial risks in this sector. The sector performs better than the average of all sectors in terms of companies reporting that they have **action plans** in place to deal with workplace stress, and

**procedures** in place to deal with bullying and harassment and threats and abuse from external parties. This is in response to increased risks, compared with other sectors, in the case of abuse and threats from external parties.

The analysis found that establishments in the human health and social work activities sector are more likely than those in other sectors to make use of different preventive measures in the case of MSDs, with public sector establishments less likely than those in the private sector to make use of these measures. Further, establishment size is likely to be positively associated with the uptake of preventive measures. This is reflected in the descriptive analysis, which found that all measures to prevent ergonomic risks are reported more often in the sector than all sectors combined. **The provision of specific ergonomic equipment, such as chairs or desks, was the most popular measure**, followed by the provision of equipment to help with the lifting or moving of loads or other physically heavy work, and the possibility for people with health problems to reduce working hours. Overall, all measures to mitigate risk, with the exception of the provision of equipment to help with the lifting or moving of loads or other physically heavy work, are more common in this sector than in all sectors, though the provision of these measures generally decreased between 2014 and 2019.

In terms of measures taken to mitigate psychosocial risks, the most common measure in the sector in 2014 was **confidential counselling for employees**, but in 2019, a new ESENER question, on **allowing employees to take more decisions on how to do their job**, was the most popular. This is an interesting finding, reflecting the value of autonomy and permitting employees more control over their work as a way of reducing stress.

Overall, establishments in this sector, compared with establishments in all other sectors, are **most likely to have well-developed psychosocial risk management**. Public sector establishments, compared with private sector establishments, are more likely to have well-developed or somewhat developed psychosocial risks management. Additionally, establishment size is positively associated with having well-developed psychosocial risk management. The results of this analysis also indicated that establishments in the sector were more likely than those in other sectors to have a high uptake of measures to prevent psychosocial risks.

In terms of specific measures to mitigate risk, the incidence of **regular medical examinations** was reported to be around the same in the sector as in all sectors, with a positive correlation according to company size. There is significant variation by country, but this is also influenced by the fact that in some countries enterprises do not have to take responsibility for these medical check-ups, which helps to explain the low share in countries such as Denmark.

There is reported **higher use of health and safety services** in the sector than in other sectors across ESENER waves for almost all services. They are least likely to heavily rely on a specific set of services only. **Occupational health doctors** were the most used service in both the sector and all sectors.

The proportion of establishments **visited by the labour inspectorate** in the past three years was reported to have decreased over time for all sectors and particularly for this sector. There are a number of reasons for this, such as the fact that labour inspectorates are under significant pressure in terms of number of personnel, and specialisation and training on specific risks. This has been exacerbated in recent years due to economic pressure. The COVID-19 pandemic has also meant that labour inspectorates have on occasion not been allowed to enter workplaces due to biological risk factors.

The proportion of companies that reported carrying out **risk assessments** was higher in the sector than in all sectors, both in 2014 and 2019, though the trend is decreasing. There is **an increase over time in risk assessments being conducted internally** for the sector, in particular for micro/small and medium companies. Overall, large companies more often have internal staff conducting risk assessments than micro/small or medium-sized companies. There is also a substantial split between those companies that opt for internal and external experts, and this is often associated with the level of human and financial resources. Experts interviewed for this research noted that there is a scarcity of well-trained staff in some cases – especially in the care sector – due to low pay and high and stressful workload.

Overall, there is **higher use of health promotion measures** in the human health and social work activities sector than in other sectors for almost all measures and ESENER waves. In particular, aspects



related to healthy nutrition and to physical exercise have been of renewed importance in the context of the pandemic.

**Health and safety issues are discussed more regularly** in the health and social work activities sector than in other sectors. There is also a positive association between discussion of issues at top management and management receiving training on OSH.

The most commonly reported reasons for workplace risk assessments not being carried out in the sector in 2019 were that **no major problems were identified, or that the hazards and risks are already known**. However, this overlooks the dynamic nature of the risk assessment process, as well as the cycle of improvement in safety management. Further, substantially more companies surveyed in the sector in 2019 compared with 2014 reported that regular assessments are not carried out because the necessary expertise is lacking.

The major difficulties reported most often in terms of addressing OSH risks are the **complexity of legal obligations, a lack of time or staff, and paperwork**. In the case of psychosocial risks, the most commonly reported obstacle in the sector in 2019 was the reluctance to talk openly about issues. Further, the issue of stigma attached to mental health was confirmed by experts interviewed for this study.

The main drivers for addressing OSH risks include **fulfilling legal obligations, meeting expectations from employees or their representatives, maintaining or increasing productivity, organisational reputation and avoiding fines and sanctions**. The analysis found that human health and social work activities sector establishments, compared with establishments in all other sectors, are more likely to report a high incidence of these drivers for OSH management, with this effect stronger in the private sector and with a positive correlation according to company size. From the interviews, key identified drivers included **reputation and legal compliance**. Further, interviewees consider that **COVID-19** has resulted in higher levels of awareness of the importance of the human health and social work activities sector and the link between the quality of this sector and the quality of public health. Finally, **digitalisation** can also be seen as a key driver of OSH in that it can contribute to high-quality, effective and efficient OSH management, particularly in the area of automation. The risks cannot be overlooked though, and it is important that workers are informed, trained, and have a voice in the design and the goals for which these new tools are used.

In terms of worker participation in OSH, **health and safety representatives** are the most common form of employee representation, both in this sector and in all sectors. Overall, health and safety was discussed more regularly between employee representatives and the management in establishments in the human health and social work activities sector in 2019 than in all sectors, although the trend was slightly downwards between 2014 and 2019. There is a positive association between company size and the frequency of discussing health and safety issues. Some country differences can be explained by differences in national employee participation systems.

Health and safety representatives are provided with **training during working time** slightly more often in the sector compared with all sectors, though the trend has been slightly downward since 2014.

For both the human health and social work activities sector and all other sectors, the vast majority of the companies that have regular risk assessments involve their employees in the design of the measures; this proportion is slightly higher for this sector than all sectors. Employees in the human health and social work activities sector are also much more often involved in **identifying possible causes for work-related stress and designing measures to deal with them** than in all sectors. These findings are confirmed by the latent class analysis, which found that human health and social work activities sector establishments, compared with establishments in all other sectors, are most likely to have a high level of worker involvement in OSH management, and that the effects of this were more positive in the public sector and for larger companies.



## 9 Main learning points

There are a range of learning points to be gained from the conclusions of this research, which may contribute to improving OSH in the human health and social work activities sector. These are as follows:

- It is crucial to acknowledge psychosocial risks in the workplace, especially following the COVID-19 pandemic, which has caused many of those working in the human health and social work activities sector, and particularly in acute care facilities such as hospitals, to suffer from post-traumatic stress due to the high levels of illness and death in the workplace. If psychosocial issues are discussed openly and enterprises cultivate a culture of acceptance, the stigma around mental health issues will be significantly reduced.
- Mechanisation and digitalisation can play an important role in mitigating ergonomic risks in the sector, and this role will doubtlessly increase in the future. This can include, for example, automation of disinfection in hospitals, and the mechanisation of lifting patients in a range of care settings. Medicines can also potentially be dispensed online. Further, automation of procedures related to risk assessments can significantly reduce risks, though there needs to be awareness of any potential negative impacts of these new technologies.
- Most specifically, the introduction and use of digital technologies such as wearable and AI devices is an opportunity to support OSH processes and procedures, as they enable the assessment and prediction of workplace risks, prevent accidents by measuring employee fatigue, make reporting of accidents much easier, and enable employers to save time, stress and money. However, it is crucial to ensure that the workforce is trained and informed on aspects related to the introduction and use of digitalisation, that digital tools help workers to increase control over their work and health rather than be controlled at work, and that digitalisation ultimately reduces rather than increases stress.
- This research has shown that this sector performs well in terms of having a range of OSH risk mitigation strategies in place, particularly in the case of stress, bullying and harassment and abuse and threats from external parties. This is important, as issues such as abuse and threats from external parties have been identified as a cause of stress for the sector's workforce in hospitals and also in residential and non-residential care. This is a solid basis on which to encourage establishments to focus further on ensuring that their action plans and procedures respond to the evolving ergonomic and psychosocial risks, particularly those that have resulted from the pandemic.
- Training and awareness-raising is also a vital tool in reducing OSH risks in the workplace across the sector, both for employees and for managers, and the sector performs relatively well in this regard. It is therefore important to carry on building on this as training and awareness-raising is relevant both for the prevention of MSDs and the reduction of psychosocial risks. This is particularly important in non-residential care and social care settings, where the work environment is less controlled. This can also be used to address specific issues, such as noise or needlestick injuries in hospital settings.
- The sector also performs relatively well in terms of discussion of OSH issues, both among top management and with employee representatives. Given the paramount importance of communication, this should continue to be a focus for the sector.
- Exchange of best practice can also play a role in improving risk assessment and OSH awareness. It is crucial that good practice examples that address the issues in the sector and within the different sub-sectors of the sector are available to all, which means that translation of good practice into more EU languages would be advisable.
- The involvement of employee representatives and employees in OSH management and risk assessment is an acknowledged advantage in terms of risk mitigation. Involving employee representatives in the formulation of policy, risk assessments and mitigation measures is therefore key. Employee representatives can also be helpful in building cooperative

relationships with labour inspectorates. The sector performs well in this area and should therefore continue to build on this.

- The human health and social work activities sector has undoubtedly suffered greatly from the COVID-19 pandemic in many respects, not least the increase in workload and stress caused by the massive demand for care. This has been particularly the case in the hospital sector, where the number of seriously ill patients increased dramatically as a result of the pandemic, leading to a massive increase in workload for those working in a hospital environment. Nevertheless, this could be used as a catalyst to improve OSH in the sector, based on the increased profile of the sector in the public eye and the strengthened links between this sector and public health policy. Future areas for focus include resolving staffing shortages, possibly linked to improvements in pay and conditions, and protecting the workforce from factors such as violence and harassment.

Finally, and in view of the ongoing significant changes affecting the sector, further research would be recommended in order to analyse many of these issues. Research based on trend analysis using ESENER data would be very valuable as this would enable the study of developments over time. Other methods would also be of value, including EU-OSHA's forthcoming OSH Overview in the healthcare sector, scheduled to run between 2022 and 2024.

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## Annex I – Interview guide for expert interviews

**Interviewer to explain the outline of the project:** The project aims to provide EU-OSHA with information to properly capture the factors that influence the management of health and safety in European workplaces in the human health and social work activities sector, looking at indicators such as management commitment, worker involvement, existence of procedures, availability of expertise and support, among others. The study will examine differences by business size and country to identify different types of enterprises in their approach to managing OSH in the sector.

*The study will also examine how recent trends in the sector – and in particular COVID-19 – may have influenced the management of OSH in the human health and social work activities. These include the privatisation of health services, the shortage of health professionals in some countries and the degree of unionisation, among others.*

### ▪ General questions

Just to give me an overview of your own particular experience and priorities, can you tell me about your role and your involvement with OSH and/or the human health and social work activities sector?

#### 1. Main OSH risks

According to the ESENER 2019 survey, respondents identified a range of physical risks. What are, in your view, the main **physical** risks in the sector?

- a) Vibration
- b) Noise (In the ESENER 2019 survey, 22.5% of workplaces surveyed in the health and social care identified noise as a risk, compared with 30% of workplaces overall.)
- c) Radiation
- d) Slips, trips and falls (In the ESENER 2019 survey, 30.5% of workplaces surveyed in the health and care sector identified slips, trips and falls as a risk, compared with 34% of workplaces overall.)
- e) Other physical risks such as collisions, crushing, cuts, or risks relating to the safety of equipment used (In the ESENER 2019 survey, 30% of workplaces surveyed in the health and care sector identified accidents with machines or hand tools as a risk, compared with 48% of workplaces overall.)

For each of these risks:

- a. What is being done to mitigate these risks, in your view?
- b. Could anything be improved in terms of mitigating these risks?

In the ESENER 2019 survey, 47% of workplaces surveyed in the health and care sector identified both biological and chemical substances as a risk, compared with 36% of all workplaces surveyed. What are, in your view, the main biological risks in the sector? (prompt for issues around infections caused by needle stick injuries and exposure to other communicable diseases, including COVID-19)

- c. What is being done to mitigate these risks, in your view?
- d. Could anything be improved in terms of mitigating these risks?

What are, in your view, the main **chemical** risks in the sector? (Prompt for issues around risk from drugs used in the treatment of cancer and from disinfectants, or unintended consequences from drugs or other medications used to treat patients.)

- a. What is being done to mitigate these risks, in your view?

b. Could anything be improved in terms of mitigating these risks?

What are, in your view, the main **psychosocial** risks in the sector? (Prompt for violence and harassment, high workload (possibly related to COVID-19), need to multitask, shiftwork, lone working and lack of control over work.)

For information, in the ESENER 2019 survey:

- 27.5% of workplaces surveyed in the health and care sector identified **poor communication or cooperation within the organisation** as a risk, compared with 18% of workplaces overall.
- 31% of workplaces surveyed in the health and care sector identified **long or irregular working hours** as a risk, compared with 21.5% of workplaces overall.
- 58% of workplaces surveyed in the health and care sector identified **time pressure** as a risk, compared with 45% of workplaces overall.
- 13% of workplaces surveyed in the health and care sector identified **fear of job loss** as a risk, compared with 11% of workplaces overall.
- 83.5% of workplaces surveyed in the health and care sector identified **having to deal with difficult customers, patients, pupils, etc.** as a risk, compared with 59.5% of workplaces overall.

e. What is being done to mitigate these risks, in your view?

f. Could anything be improved in terms of mitigating these risks?

What are, in your view, the main ergonomic risks in the sector? (Prompt for lifting patients, pushing heavy equipment and other objects, working in tiring or painful positions, performing repetitive movements, and work involving prolonged standing and sitting.)

For information, in the ESENER 2019 survey:

- 57% of workplaces surveyed in the health and care sector identified **lifting or moving people or heavy loads** as a risk, compared with 52% of workplaces overall.
- 66% of workplaces surveyed in the health and care sector identified **repetitive hand or arm movements** as a risk, compared with 65% of workplaces overall.
- 58% of workplaces surveyed in the health and care sector identified **prolonged sitting** as a risk, compared with 57% of workplaces overall.
- 38% of workplaces surveyed in the health and care sector identified **working in tiring or painful positions** as a risk, compared with 31.5% of workplaces overall.

a. What is being done to mitigate these risks, in your view?

b. Could anything be improved in terms of mitigating these risks?

## 2. Day-to-day OSH management

1. In your view, to what extent do you think that companies in the sector arrange regular medical examinations to monitor the health of employees?
  - a. Is this an area of particular concern, in your view?
2. In your view, to what extent do you think that companies in the sector have in place safety procedures such as internal audits and reporting systems?

3. Do you have any information about the extent to which companies tend to use in-house or external experts for their health and safety services?
  - a. What are the advantages and disadvantages of using in-house and external experts?
4. Do you have any views on the extent to which the labour inspectorate undertakes visits to check health and safety conditions in the sector? (In the ESENER survey, there has been a reduction in the proportion of workplaces that report having had a visit from the labour inspectorate in the 3 years prior to the survey: 41% in 2019, down from 49% in 2014.)
  - a. Do you think that there should be more or fewer regular visits, or do you think the level of visits is currently appropriate?
  - b. What, in your view, are the main challenges around enforcement and inspection of OSH in the sector?
5. To what extent do you think that management engages with psychosocial risks at workplaces?

For information, in the ESENER 2019 survey:

- Over 70% of workplaces surveyed in the human health and social work activities sector reported having procedures in place to **prevent violence**.
- Almost 60% of workplaces surveyed in the human health and social work activities sector reported having procedures in place to **prevent bullying or harassment**.
- Almost 50% of workplaces surveyed in the human health and social work activities sector reported having procedures in place to **prevent stress**.

6. Do you have any views on whether companies have documents in place to explain OSH procedures and responsibilities?

If you think that they do not, why not, and what could be done to help them to do this? (Prompt, for example, worker representative involvement.)

7. Do you think that there are challenges around sickness absence (possibly related to COVID-19) and accidents at work in the sector?
  - a. What is your reason for saying this?
  - b. Does this vary by company size and type of job or by country?
  - c. What, in your view, would help to improve the situation?
8. Are there any challenges related to the availability and use of personal protective equipment (PPE), particularly in the context of COVID-19? For example, using masks when caring for patients, including in their own homes.
9. Do you think that there are any challenges around OSH training in companies in the sector?
  - a. For example, is it adequate? Is there a need for more or more specialised training?

What would help to improve training levels in companies in the sector? (Prompt, for example, more trade union or worker representative involvement, commitment of senior management or use of external training providers.)

10. Do companies promote healthy lifestyle actions, involving exercise, nutrition, and awareness of the risks of smoking and alcohol?
  - a. Do you think that there is a need to do more in this area?
  - b. What would help companies to encourage healthy lifestyles among their workforces?
11. Do you think that there are challenges around management commitment to OSH in the sector?

- a. If so, what do you think could help to increase management commitment to OSH among companies in the sector?

### 3. Employee representation in OSH

What sort of employee representative structures are in place in the sector? (Prompt for health and safety committees, health and safety representatives, works council, or trade union representatives.)

For information, in the ESENER survey,

- A health and safety representative is clearly the most frequently reported form of employee representation in the sector, reported by 57% of workplaces surveyed in 2019, slightly higher than in 2014.
- 36% of workplace surveyed in the sector had no form of employee representation.

How do you think that the role of employee representatives in the sector has changed over time? (Prompt, for example, more structures in place, fewer structures in place, or changes in degree of influence.)

What sort of actions, initiatives and agreements are in place in the sector? (Prompt, for example, actions taken at company, sector and/or national level.)

### 4. Drivers and barriers

1. Which factors are currently influencing or will influence OSH in the sector in the near future?
  - a. Ageing population (that is, more care needed for older people and the need for individual home care, which is a new type of workplace with specific OSH challenges)
  - b. Lifestyle issues that impact on the health of the population
  - c. Levels of migration among health sector workers
  - d. Economic issues regarding investment as a result of the crisis over the past decade
  - e. Privatisation of health services
  - f. Shortage of health professionals
  - g. Levels of trade union representation in the sector
  - h. COVID-19
  - i. Other (please specify)
2. What, in your view, could be done to mitigate these risks?
3. What are the main barriers to successful mitigation of these risks?
4. What could be done to reduce or remove these barriers?
5. Which opportunities might arise from new trends such as digitalisation or automation of some cognitive tasks, and using AI systems?

### 5. Final questions

1. What, in your view, is the greatest OSH risk in the sector at present?
2. What are the main actions that could be taken, overall, to mitigate OSH risks in the sector?
3. What sort of OSH trends do you expect in the future? For example, do you expect OSH to improve or to deteriorate in the coming years? What is the reason for your answer?
4. Are there any other relevant issues that we have not discussed?

Thank you for your time!



## Annex II – LCA analysis methodology and results

The LCA analysis was run on the 2019 ESENER data that included all companies (both those in the human health and social activities sector and those in all other sectors) and all countries. The analysis considered nine different typologies that focused on OSH management, worker involvement in OSH, psychosocial risks as well as barriers and drivers to OSH management.

Each of the nine typologies included three predictors of class membership: (i) a sector dummy variable (1- human health and social work activities sector; 0- all other sector), (ii) a dummy variable indicating whether an establishment is in the public or private sector, (iii) and establishment size dummy variables indicating whether a company is small, medium or large.

For each typology, several models were considered with the number of classes varying from 2 to 8. The final model selection was based on the Bayesian Information Criterion (BIC) (which measures model fit), as well as on the interpretative value of the obtained classes and class sizes:

The first typology focused on **OSH management**, and included the following variables as indicators:

- **Q150:** Does your establishment arrange regular medical examinations to monitor the health of employees?
- **Q151:** What health and safety services do you use, be it in-house or contracted externally? (A dummy variable, which takes up the value of 1 if any services are used and 0 if none)
- **Q152:** In the last 3 years: Has your establishment used the services of any external provider to support you in your health and safety tasks?
- **Q154:** Has your establishment been visited by the labour inspectorate in the last 3 years in order to check health and safety conditions?
- **Q202:** Has your establishment [in the last 3 years] taken any of the following measures? (A dummy variable, which takes up the value of 1 if any measures were taken and 0 if none)
- **Q250:** Does your establishment regularly carry out workplace risk assessments?
- **Q251:** Are workplace risk assessments mainly conducted by internal staff or are they contracted to external service providers?

Additionally, the model for the first typology also included the presence of different risk factors in the establishment (Q200\_1 to Q200\_10) as a covariate/predictor of class membership.

The second typology was an **OSH management sub-typology** that focused on **health and safety services** used by the establishment and included the following variables as indicators:

- **Q151:** What health and safety services do you use, be it in-house or contracted externally?
  - **Q151\_1:** An occupational health doctor (dummy variable – 1 if yes, 0 if no)
  - **Q151\_2:** A psychologist (dummy variable – 1 if yes, 0 if no)
  - **Q151\_3:** An expert dealing with the ergonomic design and setup of workplaces (dummy variable – 1 if yes, 0 if no)
  - **Q151\_4:** A generalist on health and safety (dummy variable – 1 if yes, 0 if no)
  - **Q151\_5:** An expert for accident prevention (dummy variable – 1 if yes, 0 if no)

The third typology was an **OSH management sub-typology** that focused on **preventive measures** taken by the establishment and included the following variables as indicators:

- **Q202:** Has your establishment [in the last 3 years] taken any of the following measures?
  - **Q202\_1:** Provision of equipment to help with the lifting or moving of loads or other physically heavy work
  - **Q202\_2:** Rotation of tasks to reduce repetitive movements or physical strain

- **Q202\_3:** Encouraging regular breaks for people in uncomfortable or static postures, including prolonged sitting
- **Q202\_4:** Provision of ergonomic equipment, such as specific chairs or desks
- **Q202\_5:** The possibility for people with health problems to reduce working hours

The fourth typology focused on **worker involvement** in OSH and its management and included the following variables as indicators:

- **Q258:** If measures have to be taken following a risk assessment, are employees usually involved in their design and implementation?
- **Q350:** Which of the following forms of employee representation do you have in this establishment?
  - **Q350\_4:** A health and safety representative (dummy variable – 1 if yes, 0 if no)
- **Q352:** How often is health and safety discussed between employee representatives and the management? Do such discussions take place regularly, occasionally or practically never?
- **Q354:** Are the health and safety representatives provided with any training during work time to help them perform their health and safety duties?
- **Q303b:** Have employees been involved in identifying possible causes for work-related stress, such as, for example, time pressure or difficult clients?
- **Q306:** Did the employees have a role in the design and setup of measures to address psychosocial risks?

The fifth typology focused on **psychosocial risks and their management** and included the following variables as indicators:

- **Q300:** Does your establishment have an action plan to prevent work-related stress?
- **Q301:** Is there a procedure in place to deal with possible cases of bullying or harassment? Bullying or harassment occurs when employees or managers are abused, humiliated or assaulted by colleagues or superiors.
- **Q302:** And is there a procedure to deal with possible cases of threats, abuse or assaults by clients, patients, pupils or other external persons?
- **Q303a:** Has an employee survey including questions on work-related stress been conducted in your establishment in the last 3 years?
- **Q303b:** Have employees been involved in identifying possible causes for work-related stress, such as, for example, time pressure or difficult clients?
- **Q304:** In the last 3 years, has your establishment used any of the following measures to prevent psychosocial risks? (dummy variable – 1 if yes, 0 if no)
- **Q306:** Did the employees have a role in the design and setup of measures to address psychosocial risks?

Additionally, the model for the fifth typology also included the presence of different risks resulting from the way work is organized, from social relations at work or from the economic situation in the establishment (Q201\_1 to Q201\_5) as a covariate/predictor of class membership.

The sixth typology was a **psychosocial risks sub-typology** that focused on **preventive measures** taken by the establishment and included the following variables as indicators:

- **Q304:** In the last 3 years, has your establishment used any of the following measures to prevent psychosocial risks?
  - **Q304\_1:** Reorganisation of work in order to reduce job demands and work pressure (dummy variable – 1 if yes, 0 if no)

- **Q304\_2:** Confidential counselling for employees (dummy variable – 1 if yes, 0 if no)
- **Q304\_3:** Training on conflict resolution (dummy variable – 1 if yes, 0 if no)
- **Q304\_4:** Intervention if excessively long or irregular hours are worked (dummy variable – 1 if yes, 0 if no)
- **Q304\_5:** Allowing employees to take more decisions on how to do their job (dummy variable – 1 if yes, 0 if no)

The seventh typology focused on **barriers for OSH management** and included the following variables as indicators:

- **Q260:** Are there any particular reasons why workplace risk assessments are not regularly carried out? Please tell me for each of the following whether it applies to your establishment or not?
  - **Q260\_3:** The procedure is too burdensome (dummy variable – 1 if yes, 0 if no)
  - **Q260\_4:** The necessary expertise is lacking (dummy variable – 1 if yes, 0 if no)
- **Q263:** What are the main difficulties in addressing health and safety in your establishment? Please tell me for each of the following options whether it is a major difficulty, a minor difficulty, or not a difficulty at all.
  - **Q263\_1:** A lack of time or staff (dummy variable – 1 if yes, 0 if no)
  - **Q263\_2:** A lack of money (dummy variable – 1 if yes, 0 if no)
  - **Q263\_3:** A lack of awareness among staff (dummy variable – 1 if yes, 0 if no)
  - **Q263\_4:** A lack of awareness among management (dummy variable – 1 if yes, 0 if no)
  - **Q263\_5:** A lack of expertise or specialist support (dummy variable – 1 if yes, 0 if no)
  - **Q263\_6:** The paperwork (dummy variable – 1 if yes, 0 if no)
  - **Q263\_7:** The complexity of legal obligations (dummy variable – 1 if yes, 0 if no)

The eighth typology focused on **drivers of OSH management** and included the following variables as indicators:

- **Q262:** In your establishment, how important are the following reasons for addressing health and safety? For each reason, please tell me whether it is a major reason, a minor reason or not a reason at all.
  - **Q262\_1:** Fulfilling legal obligation (dummy variable – 1 if yes, 0 if no)
  - **Q262\_2:** Meeting expectations from employees or their representatives (dummy variable – 1 if yes, 0 if no)
  - **Q262\_3:** Maintaining or increasing productivity (dummy variable – 1 if yes, 0 if no)
  - **Q262\_4:** Maintaining the organisation's reputation (dummy variable – 1 if yes, 0 if no)
  - **Q262\_5:** Avoiding fines and sanctions from the labour inspectorate (dummy variable – 1 if yes, 0 if no)

The ninth typology focused on **obstacles for the management of psychosocial risks** and included the following variables as indicators:

- **Q308:** What are the main obstacles to dealing with psychosocial risks in your establishment?
  - **Q308\_1:** A lack of awareness among staff (dummy variable – 1 if yes, 0 if no)
  - **Q308\_2:** A lack of awareness among management (dummy variable – 1 if yes, 0 if no)
  - **Q308\_3:** A lack of expertise or specialist support (dummy variable – 1 if yes, 0 if no)
  - **Q308\_4:** Reluctance to talk openly about these issues (dummy variable – 1 if yes, 0 if no)

**The European Agency for Safety and Health at Work (EU-OSHA)** contributes to making Europe a safer, healthier and more productive place to work. The Agency researches, develops, and distributes reliable, balanced, and impartial safety and health information and organises pan-European awareness raising campaigns. Set up by the European Union in 1994 and based in Bilbao, Spain, the Agency brings together representatives from the European Commission, Member State governments, employers' and workers' organisations, as well as leading experts in each of the EU Member States and beyond.

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