PSYCHOSOCIALLY PROMOTED OCCUPATIONAL HEALTH – A WORLD-WIDE CHALLENGE

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THE CHALLENGE:
• More than **2 million** people die every year from work-related diseases;
• **160 million** annual non-fatal cases cause immense human suffering;
• This also causes major **economic losses** – 4% of the world’s gross domestic product;
• 205 million people are **unemployed**;
• **Young** people are nearly three times as likely to be unemployed;
• An estimated 1.5 billion are in **vulnerable employment**;
• 900 million are **working poor**;
• **470 million new jobs** will be needed 2016-2030;
• ”A pressing demand for **more and better jobs**” (Guy Ryder).  
  (ILO, 2013)
GLOBAL EMPLOYMENT TRENDS (ILO, 2013)

• 73.8 million young people are unemployed globally;
• 12.7 million young Europeans are Neither Employed nor in Education or Training (NEETs).
• There is, often, an incoherence between monetary and fiscal policies, piece-meal approaches, and uncertainty about future conditions;
• Skill and occupational mismatches;
• Austerity measures may increase the risk of a spiral of lower wages, weaker consumption and faltering global demands.
FIFTH EUROPEAN WORKING CONDITIONS SURVEY (EU27)

- Psychosocial dimensions are a decisive factor, and not only in cases of anxiety or depression.

- High ‘psychological demand’ increases musculoskeletal diseases among white-collar workers; high ‘skill discretion’ decreases them among all workers, while ‘decision authority’ increases them for both blue-collar and white-collar workers.
ILO APPROACH TO MENTAL HEALTH AND WELLBEING AT WORK

• Broaden enterprise policy on OSH to include psychosocial hazards in risk assessment measures;
• Evaluate workplace psychosocial risks through risk assessment;
• Identify specific needs, and measures to be taken;
• Implement workplace action through preventive/promotive measures.

(Forastieri, SafeWork, 2011)
ILO’S APPROACH TO PREVENTION OF PSYCHOSOCIAL HAZARDS IN THE WORKPLACE:

• Implementing collective risks assessment and management measures as it will be done with other workplace hazards;
• Adopting collective and individual preventive and control measures;
• Increasing the coping ability of workers, by increasing their control over their tasks;
• Improving organizational communication;
• Allowing workers’ participation in decision making;
• Building up social support systems for workers within the workplace;
• Taking into account the interaction between working and living conditions;
• Enhancing the value placed on safety and health within the organization.

(Santos-O’Connor, 2013)
WORKPLACE HEALTH PROMOTION AND WELLBEING:

• Promotion of health among all workers and their families through preventive and assistance programmes in the area of drug and alcohol abuse, HIV/AIDS, workplace stress and the promotion of tobacco-free workplaces;

• SOLVE focuses on the prevention of psychosocial risks and the promotion of health and well-being at work through policy design and action.

(ILO, 2013)
SHIFT OF INDUSTRY AND SERVICES TO DEVELOPING COUNTRIES:

- Absence of (or presence of weak) regulatory systems;
- Many jobs are hazardous to workers’ health;
- 80% of the world’s GDP is produced in industrialized countries; only 20% in developing countries -- where 80% of the world’s workforce resides;
- It follows that wealth and prosperity are extremely unequally shared.

(Kortum et al., 2010)
WORK-RELATED STRESS IN DEVELOPING COUNTRIES

The health impact from psychosocial risks and work-related stress is considerable in developing countries and should be regarded as a threat to public health. (Kortum et al., 2010)

It could be expected that the incidence of workplace stress is higher in developing countries. (Chopra, 2009)
THEORETICAL MODELS FOR OCCUPATIONAL MENTAL HEALTH ACTION:

- Person-Environment Fit;
- Life changes;
- Demand-control-support (iso-strain);
- Effort-reward imbalance;
- Person-Environment Fit;
- Recovery;
- Justice (equality/inequality).
QUESTIONS TO BE CONSIDERED:

• Are the occupational exposures necessary for causing disease?;
• Are they sufficient for causing disease?;
• Are they contributory?;
• Are they unrelated?
MANY WORK-RELATED DISEASES HAVE MULTIFACTORIAL AETIOLOGY:

• Occupational diseases have a specific or strong relation to occupation;
• Work-related diseases have multiple causal agents, where factors in the work environment play a role;
• Diseases affecting working populations – without direct causal relationship with work but which may be aggravated by occupational hazards to health. (cf. Lesage, 2011)
REATIONS CAUSED BY PSYCHO-SOCIAL OCCUPATIONAL FACTORS:

• **Emotional** reactions (anxiety, depression, hopelessness, helplessness, pathogenic interpretation of extrinsic and intrinsic perceptions);

• **Cognitive** reactions (problems with recollection, concentration, creativity, learning, decision making);

• **Behavioral** reactions (smoking, alcohol, overeating, drugs, aggressiveness, suicidal behaviour);

• **Physiological** reactions (cardio-vascular, genito-urinary, skeletto-muscular, gastro-intestinal: dysfunction potentially leading to structural damage);

• Can to some degree influence virtually **every** disease, its course, treatment and rehabilitation.
WORK-RELATED STRESS AND ILL HEALTH MAY LEAD TO:

• **Mental health** problems (depression, anxiety);

• **Musculo-skelettal** problems (neck, shoulders, back pain);

• **Cardio-vascular** problems (IHD, hypertension, metabolic syndrome);

• **General** deterioration of virtually all types of diseases.
WORKERS’ HEALTH - WHO’s GLOBAL PLAN OF ACTION

1. Devise and implement policy instruments on workers’ health;
2. Protect and promote health at the workplace;
3. Improve the performance of and access to occupational health services;
4. Provide and communicate evidence for action and practice;
5. Incorporate workers’ health into other policies.
WORK CAN BE BOTH PATHOGENIC AND SALUTOGENIC:

• Work provides (1) goal and meaning in life; (2) structure and content of the working day, week, year and life; (3) identity and self-respect; (4) social networks and support; and (5) material rewards.

• But dangerous exposures and loads are often several times greater in the workplace than in any other environment, with adverse consequences on health.
DECENT WORK IS PROMOTED THROUGH DECENT WORK COUNTRY PROGRAMMES:

- Mean vehicle for delivering ILO support to countries;
- Distinct ILO contribution to UN country programmes;
- More than 70 DWCPs world wide.

(Pascual-Teresa, 2011)
STRESS PREVENTION AT WORK CHECKPOINTs (ILO, 2012):

• Leadership and justice at work;
• Job demands and workload;
• Job control;
• Social support;
• Physical environment;
• Work-life balance and working time;
• Recognition at work;
• Protection from offensive behavior;
• Job security;
• Information and communication.
DECENT WORK FOR ALL - IN ACTION:

- Better Factories (Cambodia);
- Employment-Intensive Rebuilding (Liberia);
- Eradicating Child Labour from Mining Industry (Peru).

(Pascual-Teresa, 2011)
EUROPEAN PACT FOR MENTAL HEALTH AND WELL-BEING:

• Mental health is a human right;
• It enables people to enjoy wellbeing, quality of life and health;
• It promotes learning, working and participation in society;
• It is a key resource for the success of the EU as a knowledge-based society and economy;
• There is a need for decisive political steps to make mental health and well-being a key priority.

(WHO and EU, 2008)
GLOBAL COMMISSION ON "SOCIAL DETERMINANTS OF HEALTH":

Social determinants are the conditions in which people live and work. They are "the causes behind the causes" of ill health. They include poverty, social exclusion, inappropriate housing, shortcomings in safeguarding early childhood development, unsafe employment conditions, and lack of quality health systems."
TOTAL RETURNS ON INVESTMENTS: PAY-OFFS PER GB£ 1 EXPENDITURE:

• Workplace health promotion: 9.7;
• Screening of alcohol misuse: 11.8;
• Suicide prevention training to all GPs: 44.0

(Knapp, McDaid and Parsonage, 2011)
GLOBAL NEED FOR A HOLISTIC APPROACH

• A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities (Treaty of Lisbon, Article 168);

• Health in All Policies takes into account the health and health-systems implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity (Finnish EU Presidency, 2006).
PSYCHOSOCIAL FACTORS AT WORK – RECOGNITION AND CONTROL (1984):

- Psychosocial factors at work contribute to a wide range of workers´ health disorders.
- Positive psychosocial factors can act as health-maintaining and health-enhancing agents.
- Somatic ill health resulting from infectious diseases, poverty, malnutrition, overcrowding, lack of education, sanitation and health care probably *render individuals more susceptible* to environmental psychosocial hazards at the workplace.
WORKERS’ HEALTH: GLOBAL PLAN OF ACTION (WHO, 2008-17):

• Workers represent half the world’s population and are the major contributors to economic and social development;
• The growing informal economy is often associated with hazardous working conditions;
• It involves vulnerable group as children, pregnant women, older, disabled, and migrant workers;
• All workers should be able to enjoy the highest attainable standard of physical and mental health and favourable working conditions. The workplace should not be detrimental to health and well-being;
• The workplace can also serve as a setting for health promotion.
FRAGMENTED APPROACH, OR A HOLISTIC ONE?
PERSON-ENVIRONMENT FIT?

How can they imagine that this foot...

...will fit into this shoe?

Do they believe the foot looks like this?