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Mental Health and Public Sector Healthcare: International Case Studies

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TABLE OF CONTENTS

Among them: high work demands, low control and autonomy (especially in long-term care, and for women through routinising of work and deskilling, and reduced decision-making), long working hours, insufficient rest for recovery between shifts, high emotional demands; high work/life conflict; poor communication; lack of professional development; moral distress through conflicts between limitations on the capacity of healthcare workers to provide patient care and their professional standards; insufficient time or opportunities for management or peer support or for professional development; violence, abuse and harassment at work, and with low wages and precarity contributing significantly to financial stress and insecurity in some workforces.

Executive Summary

The mental health of the health care workforce has been deteriorating globally over many years and is primarily related to increasing work-related stress due to the deterioration of healthcare work environments. This has led to a global healthcare workforce crisis due to global shortages of healthcare workers, a crisis which has been developing over several decades and in most countries, including low-, middle- and high-income countries. The Covid-19 crisis exacerbated both the demands on national health care systems and staff shortages, with large numbers of staff sick or in quarantine. The primary cause has been decades of under-resourcing of national healthcare systems related to the dissemination and implementation of neoliberal policy frameworks that have undermined the provision of public services, including healthcare.

The emergence of high levels of work-related stress, mental health problems (including depression, anxiety, burn-out) and physical illnesses in health and care workforces compared to most other occupations has been the result of insufficient national and regional investment in:

- adequate staffing levels,
- adequate skill-mixes,
- training of new graduates and key medical specialties,
- professional development,
- management support of healthcare workers,

- adequate wages to recruit, retain and develop staff,
- addressing workplace bully, harassment, and violence,
- ensuring workplace safety and decent working conditions
- addressing precarity and job insecurity

These are associated with increased levels of psychosocial risks and poor work environments which underpin the increased work-related stress and illness in healthcare workers.

There is significant national variation in the degree of under-resourcing, the timelines over which this occurred, the structural processes and policies and their relationship with the emergence of a health and care workforce crisis. Both country specific histories and politics as well as within country or regional variations are important in understanding these issues.

The health and care workforces in all of the case-study countries in this report (Sweden, Australia, Canada, Brazil and Liberia) share some common patterns of psychosocial risks including: high work demands, low control and autonomy (especially in long term care, and for women through routinising of work and deskilling, and reduced decision-making), long working hours, insufficient rest for recovery between shifts, high emotional demands; high work/life conflict; poor communication; lack of professional development; moral distress through conflicts between limitations on the capacity of healthcare workers to provide patient care and their professional standards; insufficient time or opportunities for management or peer support or for professional development; violence, abuse and harassment at work, and with low wages and precarity contributing significantly to financial stress and insecurity in some workforces.

Psychosocial risks that are not addressed lead to adverse impacts on healthcare workers' mental and physical health. They operate as negative feedback loops in patterns of psychosocial risks. For example, insufficient nurses lead to work overload of the existing workforce, increases long working hours and overtime, limiting the release time for professional work and the mentoring of new graduates, and impacting on skill mixes. These create adverse working environments that negatively impact on recruitment, retention and training and development. Similarly, low wages further exacerbate recruitment and retention problems. These then affect the productivity of the workforce through sickness absences, turnover and healthcare workers leaving the industry. A body of evidence has substantiated the associations between staff shortages

and high workloads with burnout, harassment and violence, job dissatisfaction and the impact on the quality of patient care and on healthcare workers' mental and physical health. Psychosocial risks are created in the organisation and management of work, the design of work and the work environment which are modifiable by the key actors and are not part of the nature of healthcare systems.

High levels of psychosocial risks, poor work environments, work-related stress and mental and physical illnesses in the healthcare workforces are intimately linked to the role of gender in occupations. The healthcare workforce is predominantly female; hence the rates of psychosocial risks and work-related stress is higher in women and also in men in female-dominated occupations. This is related to the social devaluing of women's work, to structural problems such as the funding and financial models used in health and social care as well as the way that women's work is organised compared to male dominated workforces. On top of demanding jobs, women also continue to take primary responsibility for domestic work and unpaid care work, which can exacerbate work-related stress.

The differences between each of the countries examined in this report further illustrate how these issues are interrelated and the specific roles of the key actors (international organisations, governments, employers, and trade unions) and their interplay in the development of the global healthcare workforce crisis, poor work environments and high levels of work-related stress and the sequalae for healthcare workers. While in general all the cases share the impact of neoliberal policies on under-investment in healthcare, these dynamics are embedded and shaped by national histories, economics, and politics so that national healthcare workforce crises need to be understood within these contexts.

Furthermore, the international recruitment of healthcare workers to address local shortages rather than investing in national workforce development policies by governments in high income countries is discussed in relation to the negative impact on the healthcare workforces of middle and low incomes countries and the ethics of this practice during a global healthcare workforce crisis.

Briefly:

Sweden exemplifies the case of a high income, co-ordinated market economy with strong traditions of social dialogue and co-operation. It has some of the strongest Occupational Health and Safety laws and regulatory bodies in the EU and globally, which specifically addresses psychosocial risks and the work environment. Nevertheless, decades of neoliberal policies have diminished the healthcare system leading to

healthcare workforce shortages with increasing levels of work-related stress amongst healthcare workers. The case exemplifies the role of legislation and the regulatory environment and the possibilities and constraints for trade unions and governments in this arena. This case crystalises that importance of a gender critical approach to understanding the work environment and psychosocial risks.

Australia is an example of a liberal market economy with a national healthcare workforce crisis with the case providing a detailed analysis of the key psychosocial risks in the work environment for nursing and community care workforces as well as a detailed analysis of responses by the nurses' trade unions. Addressing workloads is central since this issue has negative feedback loops on the other healthcare workforce issues. Hence the importance of the nurses' union successful decades long campaign, across several Australian states, for government mandated nurse: patient ratios to address excessive workloads. Both the advantages and limitations of this approach are discussed. The case also highlights the role of coalitions of unions in successfully campaigning for significant improvements to OHS legislation and regulation as a second form of protection from work-related stress alongside that of collective bargaining and industrial action.

Canada, as a second liberal market-economy is also experiencing a healthcare workforce crisis which is decades in the making and with increasing psychosocial risk for healthcare workers. However, Canada has very limited or non-existent legislation for psychosocial risks. This case exemplifies the tensions within federal systems of healthcare with limited direction from the federal government resulting in variations between provincial health care systems. It identifies the importance of unions using evidence-based research to drive political campaigning over long time periods through coalitions between unions, advocacy organizations and patients including the role of -some professional associations such as the Canadian Nurses Association in advocacy and advice to governments and employers, and the gains that can be made through collective bargaining and industrial action.

Brazil, a middle-income country, is one of the most unequal countries in the world. Inequalities have been exacerbated over recent years by low economic growth and high unemployment. Despite having a universal healthcare system, the implementation of neoliberal policies over several decades has created a fragile public health system and very high levels of health inequalities. This case illustrates the significance of macro-level factors on the work environment of health care workers including the negative impact of the national labour reform policies from 2017 onwards on healthcare (and other) workers and trade unions. It clarifies how low wages and precarity shape

psychosocial risks including excessive work demands. The case exemplified the importance of trade union campaigning and advocacy and the possibilities, and limitations, of political change to improve the lives of workers.

Liberia is a low-income country with recent experience of civil war followed by an Ebola epidemic which decimated the health care system and its workers. The country has been rebuilding its healthcare system, including through a network of volunteer community healthcare workers. In Liberia there are few workers' or trade union rights with healthcare workers prohibited from forming trade unions and taking industrial action and lacking in OHS legislation that covers psychosocial risks. Again, it is macro-level factors that significantly shape the capacity of the healthcare system, with the case illustrating the complex relationships between governments and international organisations such as the IMF and World Bank that partly determine funding for healthcare. In Liberia, there are critical shortages of healthcare workers, precarity, low and irregular pay and a significant voluntary workforce. This case study demonstrates the barriers and the agency of trade unions in building a union that can make gains for healthcare workers in a hostile labour environment.

Part A - Mental health, work-related stress, psychosocial risk factors and the global healthcare workforce crisis

1.0 Introduction

This report emerges from rising concerns about the mental health of workers especially healthcare workers which, while apparent prior to Covid-19 pandemic, were greatly exacerbated by the pandemic.

To understand why workers and healthcare workers are experiencing worsening mental health and increased work-related stress leads to an examination of the changes to the work environment and the ways in which the organisation of work and the work environment gives rise to psychosocial risks in the work environment which in turn leads to work-related stress and to poor mental health. These psychosocial risks include excessive work demands, understaffing, long working hours, poor skills mixes, insufficient professional development, etc.

The rise in psychosocial risk for healthcare workers is linked to chronic healthcare labour shortages within countries. These problems have been developing for several decades, with the full knowledge of governments and have resulted in a current global health workforce crisis. The common policy response by high income governments is aggressive international recruitment of healthcare workers from middle- and low-income counties. This exacerbates healthcare workforce shortages within these countries which can, in many cases, ill afford further depletion of an already very limited healthcare workforce. Nor does this resolve national problems of the healthcare workforce in the medium term, as the Covid-19 pandemic has amply demonstrated.

The report begins with an examination of the global trends in mental health at work in general, and with a specific focus on healthcare workforces, followed by an explanation and discussion of psychosocial risks and the work environment and the theoretical models linking these to work-related stress and mental health problems.

The ultimate causes of these problems lies in the ways that the work environment and psychosocial risks are shaped by wider political, economic and social factors, in particular the neoliberal policy agendas pursued by governments over the past fifty years that have undermined health and care services including through various mechanisms of privatisation, marketisation, outsourcing, and the technologies of new public management. Context matters, so there is an in-depth examination of these issues in relation to high-, middle- and low-income countries including a specific focus on the psychosocial risks and work environments and mental health of healthcare workers in these countries. This analysis clarifies the key drivers related to increasing psychosocial risks in healthcare and the impact on workers, organisations as well as on the economy.

The positioning of these issues of mental health within the framework of psychosocial risks and the work environment embeds this conceptualisation within occupational health and safety. While many countries have often quite robust legislation and regulation of physical hazards at work there is much more limited coverage of psychosocial risk in legislation and regulation, so the report provides a broad international assessment of OHS legislation and regulation of psychosocial risks.

The report then uses case examples from five different countries (high, middle and low income) to deepen the analysis of how economic, political and social contexts and histories shape patterns of psychosocial risks, their governance and the responses by governments employers and trade unions. In this way the role of key actors in the development of national healthcare workforce crises, their responses to the crises and the impacts on healthcare workers and patients is revealed. This focus on key actors within specific countries and their responses establishes the ways in which psychosocial

risks and their impacts on healthcare workers and organisation are amenable to change through different polices rather than assuming that these problems are somehow endemic to the nature of healthcare systems.

1.1 Methodology and approaches to the case studies

This report is based on extensive desk-top research and on interviews with key healthcare union officials in each of the countries involved in the study. The desk-top research included a rapid literature review of the academic literature; trade union (national and international bodies) and OHS regulatory bodies reports and submissions to government inquires; reports from national governments' inquiries into mental health, healthcare and the national OHS legislative and regulatory environments; national surveys of the psychosocial risks and mental health of workers; national workers' compensation data; national surveys of healthcare worker shortages; data and analysis by international bodies (e.g. WHO, ILO, EU-OSHA) of country specific parameters regarding population mental health, psychosocial risks and the state of national healthcare workforce, etc. Academic literature, international sources and newspaper articles were especially critical for sourcing information in low- and middle-income countries where national data is sparse and language barriers limited access to material by the researchers in this project (Appendix 1).

The interviews with trade union officials addressed key issues related to the work environment, key psychosocial risks and the mental health of the healthcare workforce including the links to the national healthcare workforce crisis, as well as the various strategies adopted by trade unions to improve the working lives and mental health of healthcare workers. A list of trade union interviewees for each country is in the Appendix 2.

2.0 Global trends in mental health at work

2.1 Definitions of mental health and its relationship to work

Mental or psychological health is defined by the World Health Organization (WHO, 2018) "as a state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". A core component of this definition includes

productivity at work, as work can be a source of worker positive well-being yet can also have negative impacts on the mental health of workers.

The negative impacts of work on mental health can manifest as work-related stress. 'Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope' (WHO, 2020). The factors within the work environment that lead to work-related stress, as impacting on both mental and physical health, are referred to as psychosocial risk factors.

Work-related stress and specific psychosocial risk factors can lead to fatigue, insomnia, anxiety, depression, musculoskeletal disorders (MSDs) and cardiovascular disease, and burn-out (e.g. Leki and Jain, 2010; Johnson, *et al.*, 1996; Kivimäki, *et al.*, 2006; Melchoir, *et al.,* 2007; Rosengren, et al., 2004; Stansfeld and Candy, 2006; Tennant, 2001; Schnall, Dobson, and Landsbergis, 2016; Harvey, *et.al.*, 2017; Niedhammer, *et al.*, 2022).

In relation to burn-out, WHO (2019) has now included burn-out in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is not classified as a medical condition, rather it results from chronic workplace stress that has not been successfully managed. Work-related stress and burnout are particularly high risks in the healthcare workforce (WHO, 2023a).

2.2 Global trends in mental health

While the Covid-19 pandemic shone a spotlight on mental health and work-related stress, particularly in healthcare workforces globally, in fact, significant concerns about mental health issues and work-related stress more broadly were apparent well before the pandemic. Data from 2019 (Datani, *et al.*, 2021) indicates that 10% (range 10-19%) of the global population suffers from a mental illness, predominantly, depression or anxiety, or substance abuse issues, and WHO / ILO (2022) estimated a global average of 15% of working age adults suffering from a mental illness in 2019. This equates to a global estimate of 12 billion working days lost every year to depression and anxiety at a cost of US$ 1 trillion per year in lost productivity.

While global estimates of mental health generally do not indicate a significant increase in mental health illnesses from 1990 to 2020 (Datani *et al.,* 2021) however, work-related stress has been increasing globally, affecting 33% of workers in 1990 and rising to 44% of workers in 2021 (Gallup, 2022). The cost of the impact of work-related stress is conservatively estimated at between US$221.13 million to $187 billion, with 70-90%

related to lost productivity and the remainder for medical and healthcare costs (Hassard, *et al.,* 2018).

More fine-grained country by country estimates of work-related mental health issues indicates significant increases in many countries. For example, in the EU, work-related stress increased from 1995-2015 which was largely driven by increased psychological demands at work (Rigo, *et al.*, 2021) and by 2021 39% of workers reported daily stress with 50% of workers reporting stress as an issue in their workplace (Gallop,2021). Work-related stress was the second most reported work-related health problem in Europe (ILO, no date). Australia had the highest rate of mental illness globally in 2019 (Datani *et al.*, 2021) and in 2021, 47% of workers reported daily stress which was an 2% increase from 2020 (Gallup, 2021). The highest levels of work-related stress were reported in Canada (55%) and the US (52%) (Gallup, 2021).

The impact of the burden of mental health and related issues has been central to trade union concerns and campaigns and more recently has led key international organisations (e.g. OECD, WHO, ILO, etc.) to develop reports and policies briefs on the global challenges of mental health and mental health at work. This has been accompanied by interest from business consulting firms, especially in countries where there is increasing national government focus on work and mental health, which may include changes to occupational health and safety legislation and regulatory regimes.

2.3 Mental health, work-related stress, and psychosocial risks at work

The key approach to understanding the drivers of mental health at work has been through examining how the organisation of work affects mental and physical health at work. Work organisation includes 'how work is planned, organised and managed within companies and to choices on a range of aspects such as work processes, job design, responsibilities, task allocation, work scheduling, work pace, rules and procedures, and decision-making processes' (Eurofound, 2022).

The understanding of the interrelationships between work organisation and workers' health has been developed within the Occupational Health and Safety (OHS) literature through the concept of 'psychosocial risks or hazards'. These shape workers' experience of work and the levels of work-stress, which then affect their physical and mental health. The European Agency for Safety and Health at Work (EU-OSHA) describes this link: 'Psychosocial risks … which are linked to the way work is designed, organised and managed, as well as to the economic and social context of work, result in increased

levels of stress and can lead to serious deterioration of mental and physical health' (EU-OSHA, 2007, p. 1).

Examples of psychosocial risks factors include high job demands such as excessive workloads, fast pace of working, long working hours, high cognitive or emotional demands, etc.; job insecurity and lack of career prospects; low job autonomy or lack of control; role conflict or lack of role clarity; lack of managerial or peer support; poor communication; poor work/life balance; poorly implemented organisational change; workplace bullying and violence.

High levels or prolonged periods of exposure to psychosocial risks increase the likelihood that workers will experience work-related stress, which then leads to physical and mental health problems, absence from work, reduced quality of outputs, increased welfare and medical spending and reduced productivity (Eurofound, 2010).

OHS plays a central role in identifying, assessing, monitoring, and controlling risk and hazards that impact on the physical health of workers. However, it is only in very recent decades that the OHS literature has considered the impact of work and working conditions on workers' mental health. This concern is often driven primarily by economic rather than moral or social justice concerns, with key rationales for addressing workers health based on estimates of productivity losses to businesses or the economy at a macro-level.

Rising concerns about psychosocial risks have developed in parallel with increasing empirical research and a developing theoretical conceptualisation of the relationships between key aspects of work and work processes and their impact on workers mental health; on the relationships between work-related stress and physical health; and a more recent extension of this research to focus on the organisational, managerial, and economic/social worlds within which work and mental health is embedded.

2.4 Models of psychosocial hazards and psychological health

There are a several proposed models for assessing psychosocial hazards at work, with Karasek's Demand-Control-Support model one of the most widely used (Rick *et al.*, 2002). This model proposes that when psychological and physical demands are high and/or decision latitude/skills discretion (control) and social support (peer and supervisor) are low then this will lead to high levels of job strain/ work-related stress. While common models, including Karasek's, have been critiqued for lacking the theoretical, reliability and validity robustness (Rick *et al.*, 2002), there is evidence to

support the link between high job demands, low job control, and low social support with psychological distress in workers (Madsen *et al.,* 2017).

The model is commonly used in research on work stress and employee mental health and is frequently the basis for government Health and Safety Bodies' development of indicators of employee work-related stress. For example, the UK Health and Safety Executive Indicator tool incorporates 'job demands', 'control over work', 'support and feedback' with the addition of 'roles' (e.g. role clarity) and 'change' (e.g. worker participation in processes of organisational change) (Edwards *et al.,* 2008) while in the EU there are a variety of tools often drawing to varying degrees on Cox's (1993) list of psychosocial hazards (job content; workload and work pace; work schedule; control; environment and equipment; organisational culture; communication; interpersonal relationships at work; role in the organisation; career development; job insecurity; work-home interface).

More recently, researchers have extended the model's focus from job-level factors to propose a multi-level assessment of work-related stress based on the concept of Psychosocial Safety Climate (PSC). This adds to Karasek's model by including an assessment of the role of managerial support and commitment to psychosocial workplace safety (Dollard and Karasek, 2010).

Other influential models in the OHS literature on psychosocial risks include Siegrist's (1996) effort-reward imbalance model (distress is caused when the rewards are perceived as insufficient relative to an individual's efforts) and Moorman's (1991) organisational justice model, where workers' health is impacted when a set of socially constructed and shared norms about what is fair and unfair in an organisation are violated.

In the Latin American context, the model developed by the Spanish Trade Union Institute of Work, Environment, and Health (in Spanish, *Instituto Sindical de Trabajo, Ambiente y Salud de España*) based on the above models is influential (Moncada, *et al.,* 2014). In this model there are six key psychosocial risk factors that contribute to worker distress: 'psychological demands' (e.g. a sustained cognitive or emotional effort, including the volume and intensity of workload); 'double presence' or work/family conflict; 'job insecurity', 'work control' i.e. autonomy; 'social support' (peer and supervisor support) and 'esteem' which is the extent to which workers feel the compensation received is equitable in relation to their effort.

2.5 Social and economic factors including precarious work: interactions with psychosocial risk factors and mental health

Over the past 50 years neoliberal economic, social, political and managerial agendas have transformed work and social life, increasing precarity at work and diminishing the role of unions. The provisions of previous welfare state models have been reduced, accompanied by the marketisation of public services, privatisation of previous state assets and weakening of regulatory regimes. Economic crises, including financial crises, have intensified these processes, especially through the discourses and practices of austerity and the transfer risk to workers and citizens in ways that are gendered, racialised and classed and that lead to a trend of increasing insecurity more generally. Technological changes have dramatically altered the way that people work and have enabled the rise of new forms of the employment relationship typified by gig economy workers, teleworking in some domains of work and telehealth in the health sector.

There is a significant body of research that argues for a more expanded understanding of the interaction between social and economic factors and psychosocial risks factors and workers health, drawing attention to how social class, gender, migration, age may interact with psycho-social risk factors and mental health (e.g. Benach *et al.,* 2014; Campos-Serna, *et al.,* 2013; Kvart *et al.,* 2021; Rivero *et al.*, 2021). There is a strong body of empirical research demonstrating links between job insecurity and precarious work and workers health and mental well-being (Benach *et al.,* 2014; Quilan, 2009; Kvart *et al.,* 2021) with emerging evidence that job insecurity and precarity play a significant role of maintaining OHS disparities based on class, ethnicity, and migrant status (Landsbergis*, et al.,* 2014).

There is a developing research agenda aiming to identify and theorise the actual pathways that link precarious employment to negative health outcomes, which include through (1) direct psychological effects (e.g. uncertainty, unfairness, poor working conditions; (2) higher exposure to workplace hazards including psychosocial risks with weaker OHS functions in the workplace; (3) poverty and limited protection regarding disabilities (Julià *et al.*, 2017).

More macro-level approaches demonstrate the impact on psychosocial risk factors and mental health of: globalisation (Schnall *et al.,* 2016), the collapse of welfare state regimes (Dragano, *et al.*, , 2011; Kim, Muntaner, Vahid Shahidi, Vives, Vanroelen, and Benach, 2012; Cortès-Franch, Puig- Barrachina, Vargas-Leguás, Arcas, and Artazcoz, 2019), austerity and economic recession (Eurofound, 2013; Mucci,*et al.*, 2016; Volkos

and Symvoulakis, 2021); national labour and social policies (Lunau, Rigó, and Dragano, 2020) and the Covid-19 pandemic on health care workers (Franklin and Gkiouleka, 2021; Martínez, *et al.,* 2022).

In commenting on the increase in psychosocial risk factors in the EU, a Eurofound/ EU-OSHA report (p.10, 2014), attributes the increase in the incidence of psychosocial risks to the re-restructuring of the economy with a decrease in manufacturing and significant increase in the service sector where psychosocial risks are more prevalent. Economic crisis, new technology and the stress associated with organisational restructuring also contribute to psychosocial risks. Impact of the economic crisis following the 2008 global financial crisis on working conditions in Europe (Eurofound, 2013a) show evidence of an increase in some psychosocial risks such as job insecurity, work intensity, and violence and harassment linked to changes that took place during the economic crisis (such as higher unemployment, flexibilisation of labour regulations and restructuring processes).

2.6 Psychosocial risks, work-related stress and mental health in the high-income countries

Some of the best evidence about psychosocial risks, work-related stress and health and performance outcomes comes from research connected to the various EU organisations and trade union bodies which have a shared commitment to improving the working conditions and health of workers. These organisations have collected longitudinal data on population level mental health, psychosocial risk, health outcomes and impacts on organisation and costs to the economy. Particularly valuable is the European Working Conditions Survey which has run every 5 years since 1991. This research has resulted in a series of reports on the trends in psychosocial risks, work-related stress, and health, along with reports on progress on legislative and regulatory reforms, guidelines on assessing, reporting and preventing psychosocial risks; the development of case studies of good practice; and have supported social dialogue between governments, employers and workers and their representatives.

2.61 Mental health of workers

The analysis of 2010 EWCS data demonstrated that there were significant differences between EU countries in reports of poor mental health amongst workers. For example, countries with lower levels of reported poor mental health included Denmark (7%), Ireland (9%) and Spain (9%) while those with and higher level included Lithuania (41%),

the Czech Republic (32%), Latvia (32%) and Croatia (31%) (Eurofound /EUOSHA, 2014).

2.62 Mental health and the Covid-19 pandemic

Many high-income countries reported worsening mental health during and after the Covid-19 pandemic, with healthcare systems developing significant backlogs in unmet care. For example, an EU survey (Eurofound, 2022) at the later end of the pandemic in 2022 found a doubling of the number of people reporting 'bad' or 'very bad' health between 2020 and 2022, with numbers continuing to increase after lockdowns were lifted. Those people reporting bad or very bad health, were at an increased risk of depression. Similarly, those reporting difficulties in making ends meet were at greater risk of depression. With the pandemic leaving healthcare systems struggling to cope, there was a significant increase to 18% of people overall reporting unmet healthcare needs and rising to 48% for those aged 45-64 years. The backlog in care is highest for hospital and specialist care with unmet mental healthcare.

The effects of the Covid-19 pandemic underline the significance of the broader economic, political, and social environment on mental health and in particular the impact of insufficient resourcing of healthcare systems over time in reducing the resilience of these systems to be able to cope with multiple crises (pandemic and economic consequences).

2.63 Psychosocial risks and work-related stress – macro-level factors

There are significant variations between countries, sectors, and occupations in the profiles of key psychosocial risk factors and their intensity, i.e., different psychosocial risks affect different groups of workers.

Longitudinal data from the EWCS demonstrates a significant increase in work stress in the 15 EU countries examined from 1995 to 2015 (a period associated with economic restructuring and the global financial crisis) which was largely related to increases in psychological demands. The degree of job strain varied with gender, age, skill levels, and contract type, with women experiencing significantly lower control (skill discretion and decision authority). While all occupations increased in jobs strain, those in lower skilled jobs or fixed term contracts had higher levels of job strain compared to high skilled occupations on indefinite contracts (Rigo, *et al.*, 2021). This has implications for women workers who are frequently employed in these low skilled jobs on fixed term or temporary jobs.

Despite the intensified globalisation, economic crisis and technological change that occurred in all EU countries over this period, Rigo *et al.*, (2022) found significant differences between countries in relation to spending on labour market programmes, with workers in countries with higher spending on active labour market programmes over this period (e.g Denmark, Sweden) faring better in relation to work stress compared to those in lower spending countries (e.g. Spain and UK).

Subsequent research indicates that this relationship may be mediated by the positive effect that active labour market policies have on the reward component of reward/effort balance (as reward/effort imbalance contributes to work-related stress).

In relation to specific psychosocial risks, from 2005 to 2010 there were increases in work-related stress with similar levels in women (27%) and men (26%) having that problem always or most of the time, and similar numbers reporting that work negatively affected their health, with sleeping disorders reported by 20% of women and 16% of men. There were also increases in work intensity in some countries over this period with overall 62% reporting working to tight deadlines and 59% reporting working at fast speed. There were increases in some countries in violence and harassment and overall, nearly 15% of workers reported experiences of adverse social behaviour (e.g., verbal abuse, harassment, violence) but this varies significantly by country, sector, and gender. Some risk factors such as working long hours and lack of social support had decreased with 10% of workers reporting lack of social support from colleagues and 19% lack of social support from managers. (Eurofound and EU-OSHA, 2014).

2.64 Psychosocial risks and the Covid-19 pandemic (2020-2022)

The Covid-19 pandemic and associated rapid and profound changes to the work environment seem to have resulted in a dramatic deterioration of working conditions globally. More recent analysis of the changes in psychosocial risks in the EU from 2020-2022 is provided by the current ETUI report Benchmarking Working Europe (2023), which reported that ' … exposure to psychosocial risks at work in the European Union rose sharply between 2020 and 2022, with some risk factors jumping significantly'. Time pressure or overload of work jumped from 19.5% to 46%, lack of communication or cooperation within the organisation from 3.9% to 26%; lack of autonomy, or lack of influence over work pace or work processes moved from 1.4% to 18%, while harassment or bullying rose from 0.8% to 7% (Franklin, *et al.*, 2023).

This combination of increases in work-related stress and work demands, lack of communication and reduced autonomy (control) are particularly worrying in the light of

the demand control support model that predicts this combination as having quite adverse effects on work-related stress and on mental and physical health.

The authors of the report argue that this deterioration in working conditions is linked to the pandemic and to increased use of digital technologies, since 44.6% of workers report exposure to at least one risk factor in 2022 compared to 19.5% before the pandemic and 44% of the respondents agree or strongly agree that they experience more work-related stress as a result of the Covid-19 pandemic (EU-OSHA 2022). Furthermore, workers with the highest exposure to psychosocial risks were in occupations involving human health and social work activities (58.5%) and in education (50.4%), both of which have a high proportion of women; hence these effects are likely to be more deleterious for women (Franklin *et al.,* 2023).

2.65 Emerging psychosocial risks and new digital technologies

The Covid-19 pandemic intensified the use of digital technology at work, including enabling remote working for many workers, which had benefits for some workers, such as enabling more flexible work regimes. Nevertheless, even before the pandemic, increasingly sophisticated digital technologies have been changing the organisation of work with impacts upon workers.

Franklin *et al.*, (2023) draw attention to the growing use of digital technology, the re-organisation of work and deteriorating working conditions in many job roles, which are leading to increased work-related stress, digital stress with negative impacts on mental health. They identify evidence amongst workers in the EU that digital technologies are used to determine the speed or pace of their work (53%); have increased their workload (33%); and increased surveillance (37%); and reduce autonomy at work (19%). The use of digital systems to monitor workers performance or to determine the content and algorithmic management of the pace of work increases time pressure, the pace of work and contributes to longer working hours.

This demonstrates the importance of research and education about how new and emerging technologies can reshape the organisation of work and the attendant psychosocial risks.

2.66 Psychosocial risks in health and long-term care

Health and social care employees report some of the highest levels of work-related stress in the EU and are amongst the highest at-risk occupations in many other countries where data is available.

These occupations are predominantly women (e.g., women make up 86% of the total healthcare workforce in the EU) so increased psychosocial risks that are not addressed serves to deepen gender-inequality.

For workers in the EU the key psychosocial risks in health and long term care that have been identified (Llorens Serrano *et al*. 2022) are: high job insecurity and working conditions insecurity e.g. reassignments and short notice of changes to shift scheduling; high workloads; high emotional demands; high work-life conflict; low autonomy and control through routinising tasks and deskilling; limiting decision-making; insufficient time to deliver care expected by professional standards; low recognition and rewards e.g. inadequate income; lack of professional development opportunities; low social support e.g. lack of time for peer or management support and poor communication; psychological and sexual harassment, intimidation, bullying or work-place violence.

Exposure to psychosocial risks increased with the dramatic increase in demands made upon health and long-term care staff during the Covid-19 crisis because of staff shortages, insufficient resources, and high patient demand. Increased workloads and time pressure related to staff shortages resulted in workers having to do additional shifts at short notice without sufficient rest days and which compromise work-life balance. This occurred in a context of low wages and for those in the long term and elder care sector, job insecurity, hence likely leading to an effort reward imbalance (Franklin & Gkiouleka, 2021). There is emerging evidence that a work environment that is dealing with communicable diseases exacerbates psychosocial risks and work-related stress (Barello, *et al.*, 2020).

These increased risks were associated with a range of adverse outcomes for healthcare workers during Covid-19 pandemic, including, higher prevalence rates of anxiety, stress, and depression; post- traumatic stress symptoms (with some studies reporting rates of 56.5%); sleep disturbances and insomnia; burnout, fatigue, physical and emotional exhaustion. Women and nurses had a higher prevalence of psychological symptoms than their male colleagues (Franklin and Gkiouleka, 2021).

There is emerging evidence that healthcare workers also suffer from moral injury or distress, which is associated with psychological distress. During Covid-19 this resulted from the shift from patient-centred care to public health-centred care and with insufficient resources relative to demand. This creates a conflict between professional identities and expectations and an inability to fulfil their duty to care for each patient (Hossain and Clatty, 2020). However, the phenomenon of moral injury preceded the Covid-19 pandemic with nurses reporting this due to increased work intensity and short

staffing linked to under-resourcing of healthcare systems where they are unable to deliver the care to patients that they have been trained to provide (Čartolovni, *et al.,* 2021).

Psychosocial risks are substantially affected by the global healthcare workforce crisis with healthcare worker shortages reported in most countries, for example, there is an estimated shortage in the EU of 1 million healthcare workers, with internal and external migration exacerbating these issues, especially for remote and rural areas. This crisis long preceded the Covid-19 pandemic, which rather revealed the pre-existing lack of resilience within healthcare systems that have been under-resourced for decades through economic crises and austerity, New Public Management and privatisation.

2.7 Psychosocial risks, work-related stress and mental health in low and middle-income countries (LMICs)

Globalisation, the development of global value networks, de-regulation and new technology have deepened global economic and political inequalities. There are large disparities in wealth and resources between high income countries and low- and middle-income countries, with LMICs having 80% of the global workforce but only 20% of the world GDP. This means that they have limited resources to be able to fully develop education, welfare, and health systems. While globalisation led to the transfer of production facilities to some LMIC's along with direct foreign investment, this was underpinned by the competitive advantages offered these countries in relation to more limited regulatory regimes, a large informal workforce, and often relatively weak unions, where they exist, so that workers are subject to poor regulation of work and few employee rights. Key issues underpinning psychosocial risks and mental health include job insecurity, low job quality, poverty, illiteracy, limited transport infrastructure, life stress, more limited access to education, health, and welfare services all of which exacerbate the vulnerability of workers (Kortum*, et al.*, 2010).

Furthermore, some LMICs are subject to economic, political, and social crises related to conflict, climate change, and natural disasters and epidemics which strain or disrupt established systems of support and affect internal and external migration.

While some approaches to understanding psychosocial risks and mental health at work focus on job design or the organisational level, for LMICs the impact of the broader economic, political, social, and cultural systems needs to be addressed in understanding causality and developing appropriate interventions using a multi-level approach (Kortum and Leka, 2014). This may include understanding the complex relationships between

national governments, the international agencies with which they interact and are partially dependent upon, such as the IMF and World Bank, as well as relations with external and internal non-government agencies, such as donors and programme providers and multi-national companies. These relationships impact on the quality and security of work, worker representation and advocacy via unions, psychosocial risk factors and the mental and physical health of workers.

The current evidence concerning psychosocial risk factors, work-related stress, and mental health in LMICs is limited, particularly for sub-Saharan Africa. Over the past two decades there is an emerging but still limited body of research on these issues in South America, particularly for Brazil. The research can be limited by poor data, including lack of longitudinal and national level data, and is marred by the lack of involvement of local perspectives and understanding of the unique circumstances of each country (Mutambudzi and Vanajan, 2020).

A comprehensive review of the literature on one psychosocial construct, 'work intensity', in selected LMICs in Africa, Southeast Asia and the Western Pacific countries (Mutambudzi and Vanajan, 2020) found the research in Africa concentrated mainly on Nigeria, South Africa and Ethiopia and was focussed on healthcare workers.

This review found that there were high levels of work intensity amongst various healthcare workers, including high workloads, emotional demands, and for South African nurses the addition of high administrative burdens, that were related to job strain. In one study, Ethiopian nurses' high workloads was correlated with low job satisfaction. Workload was the main source of stress for nurses in another study, which found that females were twice as likely to experience work-related stress compared to their male counterparts. Widowed and divorced females were ten time more likely to report work stress. As Mutambudzi and Vanajan, (2020) explain, this is particularly relevant given that during the HIV pandemic young and mid-aged males had a mortality of 50-70%, leading to high numbers of female headed households which exacerbated their work-life conflict.

These issues need to be contextualised in an understanding of the healthcare systems in most of sub-Saharan Africa which are generally under-funded with stretched resources and problems retaining healthcare workers. Hence there is a healthcare workforce crisis, where staff shortages lead to work overload for the remaining healthcare workers. Mutambudzi and Vanajan's (2020) review identifies the healthcare workforce crisis as underpinned by low wages, unsafe working environments, poor opportunities for training and development, regional and international migration. This literature review includes an analysis of the consequences of the psychosocial risks of

high workloads and job demands as low motivation, burn-out, absences, low productivity, and early retirement, which creates a negative feedback loop that reinforces the problems. This further undermines the physical and mental health of healthcare workers.

Much of the donor aid to LMICs is directed towards the control and treatment of infectious diseases, with little attention to occupational health and safety or to physical and mental health or to building local research infrastructure capable of investigating these issues. Key recommendations from Mutambudzi and Vanajan's (2020) review include resourcing to develop and implement labour laws and policies to protect the precarious and informal workers, and a more multifactor focus in aid development work to address the upstream causes of poverty that make workers vulnerable.

For Latin America, a recent comprehensive review of psychosocial risks, health, and performance in Latin America by Pujol-Colsa and Lazzaro-Salazar (2022) found most of the studies were done in Brazil and were concerned with musculoskeletal impacts of psychosocial risk factors and were focussed on healthcare, educational settings, and manufacturing. Those studies addressing psychological impacts included a range of psychological disorders including burnout, depersonalisation, common mental disorders, psychiatric illnesses, and depression. Some studies considered the impact on performance including productivity, individual performance, absences, turnover, accidents.

The research found that increasing exposure to psychosocial risks, such as psychological demands, job control, social support, effort-reward imbalance, workplace violence, and work-family conflict were significant predictors of individuals' health status and organisational performance across a large body of studies, and were associated with mental health outcomes including anxiety, decreased vitality, depressive thoughts, fatigue, and insomnia. In the case of Brazil, despite having universal health care, there are very high levels of health inequality that mirror Brazil as one of the most unequal countries in the world. Lack of investment in the public health system has produced a very fragile system that exacerbates health inequalities. The Labour Law reforms from 2017 onwards have led to a growth in the informal labour market, precarity and a further deterioration in wages and working conditions for workers. For healthcare workers these changes have exacerbated poor work environments and psychosocial risks.

2.8 OHS legislation and psychosocial risks in high-, middle-, and low-income countries

2.81 High-income countries: The EU case

With evidence of high, and for many workers, increasing levels of work-related stress in high-income countries such as the EU, it becomes relevant to consider the protections in place for workers concerning psychosocial risk factors which are largely caused by work organisation and the work environment and so are modifiable. Eurofound/EUOSH (2021) note that only 25% to 30% of EU establishments have procedures in place to deal with psychosocial risks, with more formalised procedures being widespread in only a few countries. This is supported by the recent evidence that only 43% of EU respondents say they are consulted about the stressful aspects of their work, with only eight Member States exceeding the 50% mark (EU-OSHA, 2022).

Since the EU has a strong tradition of tripartite consultation, an ethos affirming social dialogue and some of the strongest protections for workers globally, it is useful to briefly consider the role of OHS legislation and regulation in relation to psychosocial risks in the EU.

The overarching frame is the EU Framework Directive on Occupational Safety and Health (Directive 89/391/EEC), which requires employers to protect workers' health and safety in all aspects of work including both physical and mental well-being. While the Working Time Directive mentions mental strain there are no specific references to any psychosocial risk factors. Work-related stress and bullying and violence at work are covered in two framework agreements but these are not legally binding, and implementation varies amongst the EU member states. Overall, there is a marked difference between EU member states in whether psychosocial risks are specifically included in OHS legislation, and where they are and the degree to which psychosocial risks are specifically recognised and addressed. Only 44% of countries have any legal requirement to prevent and control psychosocial risk factors, only 52% have legal provisions to prevent work-related stress and 60% have legal provisions to prevent workplace bullying (Franklin *et al.,* 2022).

Franklin *et al* (2022) reports that 'interviews with trade union representatives show that even where there is legislation, implementation is hampered by a lack of resources, such as labour inspectors, and by lack of political will, accountability or punitive measures to push reluctant employers to address psychosocial risks: 'Ultimately, it depends on the priority politicians make in terms of money for healthcare and how the employer distributes it in healthcare' (Vårdförbundet, Sweden).

Trade unions recognise the importance of OHS legislation and in Europe the ETUC (2018) is advocating for a new EU directive specifically on psychosocial risks. Together

with *Eurocadres*, it has a campaign 'EndStress.EU' advocating for a new directive. This directive needs to include the specificities of psychosocial risks, provide common definitions and practices, and bring awareness of new emerging risks. EPSU, as one of the European Social Partners for Central Government, adopted a new guide on psychosocial risks (PSR) in 2017, which offers several solutions for dealing with psychosocial risks in the workplace including involving staff and their representatives, assessing all risks and prioritising them. It recommends employing external experts and organising appropriate bottom-up training for staff to enable them to deal with psychosocial issues as they arise.

There is also work to be done on the implementation of regulations, including the education and resourcing of labour inspectorates and education and training for managers and trade unionists.

Trade union action can also be effective in focusing research and education on psychosocial risks, taking collective action, and organising effective OHS campaigns on working conditions, workers' well-being, and resourcing in public sector organisations as well as by representing workers in class actions related to work-related stress and mental well-being.

2.82 Middle- and low-income countries

Psychosocial risks legislation occurs in less than 30% of developing countries. Workplace violence is regulated in three out of four developed countries, but only in one out of three developing countries.

In relation to OHS legislation in Africa, psychosocial risk prevention is mandatory in 14 countries, while workplace violence is included in legislation in 16 African countries (34.78%), of which 6 exclusively deal with sexual harassment, however only ten African countries have OHS regulations for both psychosocial risks and workplace violence. These differences in Africa needs to be considered in the light of the fact that most countries around the world have not included mandatory regulation for psychosocial risks and workplace violence prevention in their OHS legislation, including some middle income (e.g., Russia, China, Brazil) and high-income countries (Singapore, Qatar) and including several EU members. Some countries, such as USA, Switzerland, and Canada, only legislate for workplace violence not psychosocial risks (Chirico*, et al.,* 2019).

These differences both within and between developed and developing countries lead Chiroco, *et al* (2019) to argue that it is not simply an issue of economic capacity but rather of different cultural and economic models for social development. They consider

that the inclusion of psychosocial risks and workplace violence in OHS legislation found in some of the EU is related to the principles underlying co-ordinated market economies common in the EU (Hall and Soskice, 2001), which place a value on tripartite social dialogue and where some countries have supported a Scandinavian model of workplace health and safety culture which emerged from the 1970s onward. On the other hand, countries based upon liberal market economies are more likely to rely on market forces for the regulation of OHS legislation.

However, a more nuanced approach to understanding differences between countries needs to account more directly for the role of unions and collective bargaining. As the case of Australia (below) demonstrates, strong and persistent advocacy co-ordinated across trade unions can lead to stronger legislation and regulation of psychosocial risks within OHS legislation even in liberal market economies such as Australia (see case study below).

2.9 The Global healthcare workforce crisis and migration

Decades of underfunding of the healthcare systems across most nations has led to significant levels of healthcare worker shortages in many countries and is a major driver of the increase in psychosocial risks, deteriorating work environments and increasing work-related stress and consequent mental health issues reported for healthcare workers. This global healthcare workforce crisis has been widely acknowledged for several decades as worsening. A key approach by governments to address shortfalls of healthcare workers has been through international migration schemes. This has been particularly the case of high-income countries aggressively recruiting in middle- and low-income countries, although recently there has been increased regional migration between middle- and low- income countries as workers re-locate to better paying jobs. While healthcare workers often move overseas for a variety of reasons, including opportunities for professional development, the aggressive recruitment tactics of high-income countries can severely deplete the source countries healthcare workforce and its ability to sustain the national healthcare system and healthcare training systems. This practice constitutes outsourcing the training of a significant number of healthcare professionals to middle- and low-income countries. WHO (2023b) recognises this with their code of practice concerning international recruitment that emphasise the need for equivalent reciprocal benefits for the source country. WHO has developed a safeguarding list identifying 55 countries in which aggressive recruitment for overseas work should not occur. It is significant that the number of countries on this list has been increasing over time. On the other hand, some countries such as The Philippines have

had the capacity to actively support the training of large number of healthcare workers on the understanding that some will migrate overseas and send remittances back home to families and communities. However, since Covid-19 there are increasing healthcare shortages within The Philippines healthcare system. A second problem with overseas recruitment is the often limited support provided to migrant healthcare workers in making the transition to a new role and healthcare system, which adds to the psychosocial risks they encounter in working overseas healthcare systems.

3.0 Conclusions

Mental ill health is a significant problem globally, affecting 1 in 10 people. Work-related stress can lead to depression, anxiety, insomnia, fatigue, burn-out, musculoskeletal disorders (MSDs) and cardiovascular disease. Work-related stress has been increasing globally from 33% of workers in 1990 and rising to 44% of workers in 2021 with the health and social care sectors one of the most severely affected. There are significant variations in work-related stress between countries, sectors, occupations and skill levels, gender, age, etc., with low skilled workers, those on temporary contracts or with precarious work, and women particularly vulnerable to exposure to work-related stress and psychosocial risks.

Work-related stress is associated with how work is organised including work processes, job design, decision-making, etc, which give rise to specific psychosocial risk factors which are commonly related to the demands of work, the degree of control that workers have, and the level social support provided, as well as the effort/reward balance. Key psychosocial risks in health and social care include work pressure, work overload and bullying, harassment and workplace violence, low wages as well as job insecurity. Psychosocial risks are dynamic. New and emerging risks have been identified, which are associated with the more widespread use of digital technologies, especially where these are used to regulate the pace of work and to monitor work performance.

While psychosocial risks are commonly framed in terms of the organisation of work, they are significantly shaped by the broader economic, political, and social factors including differences in economic systems, welfare regimes and levels of resourcing of public services, economic crises, austerity, labour market policies, precarity and the Covid-19 pandemic. For healthcare workers, the global health care workforce crisis i.e., staff shortages and poor skill mixes, etc, underpins to a significant degree the increase in psychosocial risk exposure, work related stress and the adverse mental and physical health outcomes being experienced by these workers. The global healthcare workforce crisis developed long before the Covid-19 pandemic which served to expose the lack of

resilience of healthcare systems globally, while also intensifying work-related stress and psychosocial risk exposure. Decades of underfunding of healthcare systems driven largely by neoliberal ideas and polices, including new public management, at national and international levels has resulted in overstretched and fragile healthcare systems.

The global healthcare workforce crisis and related psychosocial risks affects low-, middle- and high-income countries. However, the dynamics underpinning these need to be contextualised in relation to the economic, social, and political circumstances of these countries, including the relative positions of unions, their recognition and resourcing as well as national relationships with international bodies such as the IMF, World Bank and NGO doners.

National OHS legislation and regulation specific to psychosocial risk is not common even in the EU which advocates for improving working conditions and social dialogue. Efforts to achieve legislation and regulation of psychosocial risk is one key platform for unions. However, even in the relatively few countries where these are in place, such as Sweden, key barriers remain in relation to country and sector specific research and monitoring on psychosocial risks and the actual implementation of existing regulations which requires the education and commitment of managers and regulators and adequate resourcing to address significant psychosocial risks within a sector. Unions can play a key role here.

Part B - Healthcare Sector Case Studies – High-, middle- and low-income countries

The previous background discussion and literature review on psychosocial risks, work-related stress and mental health sets the scene for a more detailed integration of these issues in the context of workers in the healthcare sector, using detailed case studies from specific countries. These cases demonstrate the ways in which specific national histories, economics, politics, social norms and politics shape changes in healthcare systems and the psychosocial risks and work-related stress of healthcare workers as well as the possibilities and constraints on trade unions as key actors.

The first case is from Sweden, a country with a co-ordinated market economy and strong social democratic traditions that recognises the role of social dialogue. Sweden has some of the strongest OHS legislation and regulation in Europe which specifically identifies psychosocial risk factors and the wider work environment as associated with work-related stress. Nevertheless, there is a national healthcare workforce crisis with high levels of work-related stress in healthcare workers. This case exemplifies how the

development of neoliberal polices in a country with a previous strongly social democratic orientation has undermined the work environment of healthcare workers. It illustrates the efforts of trade unions to identify the key issues and to campaign politically and through collective bargaining to improve the work environment of healthcare workers. It highlights the possibilities and limitations of legislative and regulatory approaches to improving the work environment. It also identifies the role of gender in the psychosocial work environment of healthcare, as a female dominated industry.

The second case study from Australia is considered in detail because it exemplifies the development of a healthcare workforce crisis in the context of a liberal market economy. The current healthcare workforce crisis is underpinned by an increase in psychosocial risk factors, work-related stress, and negative impacts on healthcare staff that in turn exacerbates the workforce crisis. This case also exemplifies the trade union strategies that are making real gains for workers and for the sustainability of the healthcare system over time through collective bargaining and industrial action, especially with the achievement of mandated nurse: patient ratios as a mechanism to reduce workloads, includes a discussion of the possibilities and limitations of these mechanisms. The case demonstrates the importance of key achievements by unions in gaining significant changes to legislation and regulation of occupational health and safety, including of psychosocial risks.

The third case is from Canada which is also experiencing a healthcare workforce crisis and increased psychosocial risk for healthcare workers, but Canada has very limited legislation for psychosocial risks. This exemplifies the tensions within federal systems of healthcare with limited direction from the federal government resulting in variations between provincial health care systems. It identifies the importance of unions using evidence-based research to drive political campaigning over long time periods through coalitions between unions, advocacy organizations and patients including the role of some professional associations such as the Canadian Nurses Association in advocacy and advice to governments and employers, and the gains that can be made through collective bargaining and industrial action.

The fourth case is that of a middle-income country, Brazil, which is one of the most unequal countries in the world, with low economic growth over recent years and high unemployment. While Brazil has a universal healthcare system, neoliberal policies have created a fragile public health system with high levels of health inequalities. This case demonstrates the negative impact of the national labour reform policies from 2017 onwards on healthcare (and other) workers and on trade unions. It demonstrates the interrelationships between low wages and precarity and how these shape psychosocial

risks, including excessive work demands. The case exemplifies the importance of trade union campaigning and advocacy for change to improve the lives of workers and both the possibilities created by the election of a more social democratic coalition government under Lula da Silva as well as the potential limitations of political parties as a sole means of change for workers lives.

The fifth and final case is Liberia, a low-income country with recent experience of civil war and then the Ebola epidemic which decimated the health care system and its workers, but which has been rebuilding its healthcare system, using innovative models of healthcare. The context is one where there are few workers' rights or OHS legislation concerning psychosocial risks, and where there are complex relationships between governments, international organisations such as the IMF/World Bank and trade unions. In Liberia there are critical shortages of healthcare workers, precarity, low and irregular pay and a significant voluntary workforce. The case demonstrates the capacity of trade unions to build a union and make gains for healthcare workers in a hostile labour environment.

3.0 Psychosocial risks, work stress and mental health in healthcare workers: Sweden

3.1 Summary:

- The increasing work-related stress and mental illness in the healthcare workforce is related to the healthcare workforce crisis in Sweden. This is underpinned by decades of reductions in government resourcing of healthcare, the privatisation of public services, and the use of New Public Management to drive efficiency gains.

- Deteriorating work environments and working conditions for healthcare workers are a result of understaffing, poor skill mixes including lack of wage premium incentives for professional specialisation in nursing, with low wages and precarity in long term care exacerbating recruitment and retention issues.

- Poor work environments are related to specific psychosocial risks of excessive workloads, insufficient time off to recover; low autonomy and control, insufficient support and with poor supervisor/staff ratios and job precarity in long term care.

Workplace violence and harassment is also significant in healthcare work environments.

- These underpin the high and increasing levels of work-related stress and related mental and physical illnesses amongst healthcare workers, leading to high rates of sickness absence. Women (and men in healthcare) have higher levels of work-related stress and mental health issues than men in other occupations making gender a central analytic.

- The OHS regulator, SWEA, has had a significant focus over the past decade on the work environment of healthcare, with its work demonstrating the gendered nature of this issue and how financial models at national and municipal levels as well as the organisation of work shapes these outcomes.

- Despite relatively strong OHS legislation and regulations that specifically address the work environment and psychosocial risks, there remain key issues in the implementation of regulations which are recognised by regulators, employers and trade unions.

- Trade unions have been active in educating, campaigning and taking action to address poor work environments and psychosocial risks that give rise to work-related stress, however the general undermining of the power of unions by governments over recent decades has curbed their capacity to address these issues of the work environment in healthcare more directly through collective bargaining.

3.2 The context of Sweden:

Nordic and Scandinavian countries are known for their well-structured work organisation, collaborative union-management relations, and advanced welfare systems. This progressive work model has been under increasing pressure for several decades with union and worker rights eroding along with union membership falling from 77% in 2006 to 62% in 2021 (Bender, 2023). This is associated with the increasing influence of neoliberal political ideology and policies, with negative consequences for wages, job quality and security (Spector, 2023). Although this shift was slowed down by strong and effective unions, the policies of conservative governments have caused significant damage to the old model through drastic funding cuts, public sector privatisations and new public management (Adler, 2013).

Inequalities have been growing in recent years in Scandinavian countries that used to be the most equal countries in the world (Health–Europe, 2023). In Sweden, privatisations of public assets have increased during the last decade along with demands for increased efficiency in the public sector accompanied by cuts in resources. The combination of cuts in taxes and allowances for education and health care, is leading to deterioration in service quality and equality in hospitals. There is a critique that the previous Swedish social democratic model is being replaced by liberal capitalism characterised by short-term profit seeking, increased job insecurity, growing gaps in wages and wealth and uncontrolled privatisation of the public sector including education and health sector (Sandberg and Movitz, 2013). Active labour market policies have been important for the welfare state in Sweden however, the expenditure on these policies has been cut almost by half in the early 2000s (Nelson, 2020).

3.3 Mental health and work-related stress in Sweden

Mental health issues are a growing problem in Sweden especially amongst young people. Between 2011 and 2021 self-reports of nervousness or anxiety increased in the Swedish population (16–84 years old), from 31 percent to 42 percent, and was particularly significant amongst young women (Public Health Agency of Sweden, no date). The Covid-19 pandemic worsened the mental health of Swedes, with 43% reporting clinically significant symptoms of depression, anxiety, and PTSD (Lovik, *et al.,* 2023). These changes need to be understood in the context of the changing economic and social conditions in Sweden over the past three decades, including their impact on work and work environments, as indicated above.

A consequence of these macro-economic and social changes was the deterioration of working conditions from the 1990s onwards, which has a direct impact on workers mental health, including healthcare workers. The greatest deteriorations were found in psychosocial working conditions, with increases in work intensification and job demands, later followed by decreases in job control and with those in the public sector most affected. Between 1991-1999 the proportion of healthcare workers reporting that their 'jobs had too high job demands' increased by 25%, while job control decreased by 10%. These trends were more marked in female dominated occupations (Corin, 2021).

Stress and mental stress related to work were the most common issues reported in a SWEA 2016 national survey of Swedish worker and from 2010-2016 the number of ill health and occupational diseases caused by psychosocial factors increased with a SWEA report indicating that by 2019 these had increased by 70% over 2010 levels, with psychosocial issues dominating (49%) in females and high (22%) in males. The highest

incidences of organisational and social factors were in healthcare, social services and education, all of which are female dominated occupations, and between 2013 and 2017 the highest rated factors contributing to ill-health and occupational diseases for women were: 'very high work rates' and 'stress', then 'too much work' and 'a heavy workload' (in Nilsson, 2019). The situation in Sweden is reflective of a broader trend across Europe with 25% of workers reporting that they experience work-related stress for all or most of their working time, and a similar proportion reporting that work affects their health negatively (Eurofound and EU-OSHA, 2014).

More recent data indicates that burnout and stress in Sweden continues to be a common problem, despite having flexible work schedules, shorter workdays and decent work-life balance compared to other countries (Egerstrom, 2022). The Flash Eurobarometer survey in Sweden (European Agency for Health and Safety at Work, 2022) found that 32% of Swedish workers reported stress, depression, or anxiety in the previous 12 months with 40% reporting overall fatigue, however only 38% reported that workers are consulted about the stressful aspects of work. This is supported by sick leave data (Swedish Social Insurance Agency, 2022) with more than 40 % of those taking sick leave in Sweden in 2020 having an underlying psychological condition including mental health issues due to work-related stress, with women constituting 80% of workers on sick leave because of stress between July 2019 and July 2022. The number of workers on sick leave due to stress has been increasing dramatically since 2010 (Swedish Social Insurance Agency, no date) with a rise of 13% between 2019 and 2020, and with the highest increases amongst women workers. The top occupations for highest levels of women's sick leave continue to be in health and social care, social services, transport and storage and education), which reflects the gender disparities between occupations and their work environments.

These increasing rates of work-related stress are underpinned by key psychosocial risks. The Swedish Work Environment Survey (SWEA, 2019) found high levels of work-related stress with 64% of the respondents reporting that they have 'too much work' and 'too much to do'; 23% feel they have jobs under pressure, with high demands and little autonomy in their work; 13% report having been exposed to violence or threats of violence at work at least once in the past year; 11% of women and 2% of men report having been victims of sexual harassment at work in the past year with 25% of young women affected. Overall, 20% of occupational ill health cases reported in 2019 were caused by organisational and social factors such as high workload, limited opportunities to influence work, or problems with managers and colleagues (Swedish Work Environment Authority, 2020 in Asplund, 2022). This has been an ongoing and

worsening issue before the Covid-19 pandemic, with the OECD (2013) reporting that 60% of disability claims in Sweden relate to mental health issues.

Overall, mental health issues, work-related stress and associated psychosocial risks have been increasing for over a decade in Sweden, especially amongst women and those in tradition female occupations particularly in health, social care, and education. This was exacerbated by the Covid-19 pandemic. These changes are linked to the deterioration in working conditions associated with the shift away from the traditional social democratic model towards more a liberal market economy.

3.4 Psychosocial risks and the legislative and regulatory context of Sweden

The quality of working life, the nature of psychosocial risks and impact of the work environment were significant concerns amongst key stakeholders, including the government and unions, in Sweden from the 1970s onwards. Significant legislation was developed, and regulatory authorities established with a strong commitment to research and evidence-based policy. Sweden's central discourse positions work-related stress in the context of the work environment and on collective action to address problems, rather than a discourse of psychosocial risks that tends to focus on the level of the job and tasks.

The key legislative acts are the 1977 the Work Environment Act which requires that 'technology, work organisation, and job content shall be designed in such a way that the employee is not subjected to physical or mental strains which can lead to ill-health or accidents' (Cefaliello, 20 January, 2022). Legislation specifically includes considering the impact of forms of renumeration and the organisation of working time (Nilsson, 2019). Subsequent legislation required that employers investigate and address workplace violence and victimisation with the Violence and Threats in the Work Environment Regulation (AFS 1993: 2) and the Victimisation at Work Regulation (AFS 1993:17) (Cefaliello, 20 January, 2022).

As the key regulatory body, the Swedish Work Environment Authority (SWEA) is independent of government, and responsible for supervising compliance with the laws and regulations governing the work environment and working hours. It is responsible for undertaking inspections and works to bring employers and worker health and safety representatives together to address issues. They can impose sanctions in cases of significant breaches to laws and regulations.

From the early 2010's SWEA has given increased attention to gender and the work environment, based on data demonstrating the high levels of psychosocial risks and mental health issues in the healthcare, social work and education sectors where women predominate. This includes developing a multi-level understanding of the interaction between psychosocial risks, the work environment and the broader management and financial mechanisms underpinning service provision. For example, SWEA (2014) conducted a comparative research study of municipal work inspections in male (technical) and female (home care) dominated workplaces. They found that compared to the male dominated technical sector, that in the home care sector managers had fewer resources; significantly more staff to supervise with less admin support. For both managers and employees, the work was more pressured with low control over the work environment. This was accompanied by much higher levels of sleep problems, stomach ailments, palpitations, high blood pressure, dizziness, depression, and physical pain compared to workers in male occupations, and with those in home care more likely to retire early. These differences were driven primarily by lack of manpower and resources in home care. Significantly SWEA identified that the way work is differently structured has a significant impact i.e., home care work is designed as a series of time limited tasks while for male technical work it is designed as an assignment e.g., cleaning a road, without a specific time allocated for each task so that a worker has more control over how the work is accomplished. In turn these arrangements were found to be underpinned by different financial models in operation in these settings. Thus, the social and economic devaluing of women's caring work significantly shapes the psychosocial risks they encounter in their work environment.

Trade unions, SWEA OHS inspectors and employers identified significant problems in implementing the regulations for psychosocial risks, including a lack in specific guidance for making improvements to the work environment. In response, in 2015 the Swedish government introduced new regulations for the work environment (AFS 2015:4) leading SWEA to develop the 'Regulations and Guidelines on the Organisation and Work Environment'. Both the guidelines and the name of the regulatory authority represent a shift in focus from psychosocial risks related to work tasks to a more holistic focus on the organisation and work environment. This positions occupational health and safety and its effects on workers' physical and mental health as embedded in the organisation and social context within which work occurs. This focuses on how the work is arranged, controlled, communicated, how decisions are made and influenced by both employees and managers. The regulations specifically address key factors of workloads, working hours and victimisation (Nilsson, 2019).

From 2015 SWEA conducted a major drive to implement the new regulations, including training of SWEA inspectors, lawyers, manager and developing knowledge and practice sharing networks. This was followed by a major external communication and media campaign including meetings and conferences across the regions to inform employers, managers and workers about the new initiatives, the development of a website with education materials and guidance, including an evaluation of the effectiveness of the campaign. This cost 1 million Euros. Subsequently SWEA carried out a series of national supervisory projects focused on the organisational and social work environment, including in:

- elderly care;
- managers in healthcare and care working in support for children and young people with early signs of mental illness;
- social desk officers;
- construction sector;
- e-commerce;
- victimisation;
- Working Hours Act; and
- threats and violence.

Key issues identified and addressed were taking measures against unhealthy workloads; clarity around tasks and priorities; measures to prevent the organisation of working hours leading to ill health; measures to counteract work tasks and situations that are severely mentally stressful leading to ill health; measures against victimisation. A key challenge is supporting employers to work with workers on identifying the problem and devising and implementing suitable risk reduction strategies that are relevant for the specific work environment encountered. One problem is for employers to have the motivation and resources to implement strategies. For example, the employers' associations commissioned a report questioning the attribution of sick leave to work versus individual personal circumstances (Nilsson, 2019).

Despite what is now a relatively strong legislative environment, the implementation of the regulations and guidance in healthcare continues to be problematic, and the

provisions for addressing work-related stress are still not well developed (Serrano *et al.*, 2022). Furthermore, there are resourcing issues with worker representative health and safety offices:

We have quite good legislative rights but union organisation capability is under pressure. The working environment is affecting the effective collective movement. The turnover is so high. In that case our organisation starts over and over (Interview with Senior policy advisor, Vardforbundet, - trade union representing nurses and some allied health professions)

Vision (trade union representing white-collar workers in municipalities etc) health and safety representatives also highlight that despite the legislative requirement for employers to provide training in psychosocial issues and how to address them, the quality is low and that given their high workloads, they do not necessarily have the time needed to investigate psychosocial risks properly (Serrano, *et.al.,* 2022).

In other situations, employers ignore the regulations, and while there is a system of sanctions available, and with action to develop this further being considered by the Swedish Government, trade union representatives raise concerns that employers would rather pay the sanctions than comply with the regulations, as already occurs in other industries.

In relation to collective bargaining, there is no direct provision regarding psychosocial risks, however working time and general working conditions are regulated. While some aspects of psychosocial risks may be included in the annexes of collective agreement, these do not have the status of collective agreements (Vardforbundet representative in Serrano, *et al.,* 2022).

Despite this well-developed legislative and regulatory environment, the problem of work-related stress especially in health and social care continued to increase, underpinned by poor work environments giving rise to psychosocial risks. Unions in long-term care have been fighting for improved working conditions for care workers arguing the need for more staff to reduce high workloads, worker participation in decision making to reduce low control and improved ratios between workers and supervisors to increase management support (Serrano, *et al.,* 2022).

These issues will be taken up in detail in the next section.

3.5 Healthcare workforce shortages: Psychosocial risks, work organisation and health in healthcare and long-

term care in Sweden:

As in other European countries there are shortages of healthcare workers. By 2025, there will be a shortage of roughly 11,000 specialist nurses, 1,300 midwives and 2,400 biomedical analysts in Sweden (Statistics Sweden, 2022). In 2022 nine of ten employers reported experiencing nursing shortages of both experienced and recent graduates in anaesthesia, intensive care, surgery, and psychiatric care. This is related to the minimal wage premium for these specialties. Eight of ten employers report a shortage of newly graduated district nurses (Statistics Sweden, 2022). There are also significant shortages of long-term care nurses and care assistants (Huupponen, 2021), which are related to work environment and psychosocial risks, including low pay and job insecurity in long term care. For example, the Corona Commission report on the elder care during the Covid-19 pandemic identified underlying structural problems that limited pandemic preparedness, including under-staffing and poor working conditions, and recommended higher staffing, increased skills and improved skill mix, and reasonable working conditions, including great job security to enable staff continuity (Ministry of Health and Social Affairs, 2020). SWEA's investigation into elder care in 2021 identified that 89% of care home working condition were poor and contributing to psychosocial risks with a lack of systematic preventive measures, organisation, resourcing and high levels of work stress. A 2017 survey of Kommunal members found that 70% of practice nurses reported experiencing inadequate staffing, with employers also using short staffing to cut costs. Consequently, 50% of practice nurses are considering quitting due to poor working conditions (Huupponen, 2021). Where nurses leave long term care for better opportunities in other EU countries, the gaps are often filled by untrained or inexperienced staff on insecure contracts. The problem arising from insufficient well-trained staff in long term care is then exacerbated by the low levels of supervisory support with Vision union representatives reporting that in eldercare a supervisor can have up to 60 employees to supervise, so it is difficult to identify issues and to support workers (Serrano, *et al.*, 2022).

In hospital-based care trade unions have been active in collecting data on the changing work conditions, psychosocial risks and health of healthcare workers. Vardforbundet, the Swedish Association of Health professionals, is the trade union and professional organisation representing nurses, midwives, biomedical scientists and radiologists in Sweden, representing 80% of the healthcare workforce. Their 2022 report on the healthcare workforce found that even prior to the Covid-19 pandemic there were significant problems with staff shortages, lack of staff with the right skills sets and experience, high workloads with tight scheduling with insufficient time off between shifts for adequate recovery. This was leading to diminished quality of patient care

resources in care, increases in work-related stress and increases absence leave, which in turn further exacerbates staff shortages. Recent figures show that the healthcare sector has the highest number of sick leave requests (Huupponen, 2022). A recent Vardforbundet (2019) survey of members shows that nearly 50% have thought about changing professions and leaving healthcare, with 61% of these aged 30-49 years, which has the potential to contribute to serious long term workforce shortages when younger nurses leave. Respondents identified poor working environments and poor pay as the main reasons.

People are leaving their profession because of their working conditions. And there is a lack of newcomers to the professions. Demographic change is also important, this is an aging population and profession. It is also about how to deal with the issue. We have an escalating discussion about working times, how long you spend during work and out of work. They are on sick leave. This has been on the agenda for the last years so if you are out due to the sick leave it affects your full working time. (Interview with Senior policy advisor, Vardforbundet)

As a predominantly female workforce they have the additional challenge of combining a demanding professional life with personal life that includes domestic work and family responsibilities. This often leads these workers to reduce their working hours to cope which then further reduces their wages, pensions, and career opportunities (Vardforbundt, senior policy advisor).

One of the significant sources of psychosocial risks in the healthcare workplace is moral distress or injury, which occurs when healthcare professionals are unable to follow their ethical codes by providing the level and kind of care that they were trained to provide as professionals, due to lack of resources and poor working conditions (ETUI, 2022).

Health care workers have ethical codes to follow. There is also the feeling that they are forced not to follow the ethical code to be able to do the work properly. There is a conflict between the codes and the actual working conditions which causes the stress. The actual working conditions don't allow them to follow the rules as they have so much to do, you can't always follow so this causes stress. The workload is so heavy, there is little time to do reflection (Interview with Senior policy advisor, Vardforbundet)

3.51 Impact of Covid-19 pandemic

The Covid-19 pandemic put enormous strain on the Swedish Health system which became seriously overwhelmed in the winter 2020 surge. The Covid-19 pandemic exacerbated the poor working conditions of healthcare workers. Rücker *et al*. s' (2021)

study of Swedish healthcare workers found workers feeling stressed and insecure in chaotic and hazardous working conditions. Those who were caring for Covid-19 patients had an increased risk of stress and burnout, as well as mental health issues including depression, anxiety, insomnia and post-traumatic stress disorder. In a survey by Vardforbundet (2022) 75% of their members indicated that these conditions worsened, and their workloads increased with the pandemic. Nearly 60% of members believe that stress affects their professional and private life and that they think about changing jobs. Nurses worked almost 2.2 million hours of overtime during the first eight months of 2020, with 81% of their members who participated in their surveys signified that they need longer recovery between their work shifts (Vardforbundet, 2022).

The sources of psychosocial risks and mental health issues in Sweden are similar to those in other liberalised economies. Successive cuts in healthcare funding and political deprioritisation has resulted in inadequate staffing, high workloads, poor skill mixes, along with limited involvement in decision-making leading to low control, insufficient supervisor support, unsustainable working conditions, precarious contracts, low pay and financial insecurity and a fragmented care sector. This leads to high levels of work-related stress and other mental health issues among healthcare workers, reducing the productivity of the workforce and potentially impact on the quality of care that patients receive.

3.6 What the Swedish Government and regulators are doing:

In 2017, SWEA published a White Paper on women's work environments (SWEA, 2017) which highlighted the importance of gender in understanding the structures that drive health/ill-health, since the work environment in female dominated occupations has a greater risk for ill health, dissatisfaction with the work environment and risk of leaving, than in male dominated occupations. These risks are the same for males in these female-dominated occupations. SWEA identified that to address these problems:

- There needs to be a shift from the more common focus within many organisations on individuals towards a collective approach that includes all levels of the organisation,
- That changing the work environment for female-dominated occupations requires central action from within the municipalities,

- The Swedish Work Environment Authority identified that its' supervision currently does not reach this central municipal level to a sufficient extent, so there needs to be a review of how this can be developed.

To further support the work of SWEA the Swedish government established the Swedish Agency for Work Environment Expertise (SAWEE) in 2018 as a government agency to support the collection, development, and dissemination of knowledge about work and the work environment both nationally and internationally, and to evaluate and analyse effects of implemented reforms and government initiatives. In 2021 they commenced a research project to assess the work environment risks and health factors among health and medical employees which is due for completion in 2023 (SAWEE, no date).

In 2021 the Swedish Government developed a new Government Work Environment Strategy 2020-2025 that includes specific consideration of gender differences in work environments and impacts on workers' health. Significantly they changed a key goal from 'zero deaths at work' replacing this with 'zero deaths related to work' which consequently includes the work-related impacts on stress and chronic illness that is higher in female dominated occupations, especially in health and social care. The strategy notes that this is underpinned by the short-comings in the work and social environment of female-dominated occupations. The government is considering a review of the rules relating to organisational and social work environments in female-dominated occupations, particularly in relation to high workloads and victimisation. This includes whether sanctions should be expanded to new areas of the work environment (Löfven and Nordmark, 2021).

To support this aspect of the strategy the Government has requested that the Gender Equality Agency review the research on the connection between unpaid work, family life and sick leave, as well as to conduct a pilot study on inequality at work and women's mental health (Löfven and Nordmark, 2021).

The fate of these initiatives may change with the election of a new centre-right coalition Government taking over from the previous social democratic parties in 2022.

3.7 What the Trade Unions are doing:

In Sweden, the Trade Union Confederation (LO) started to work with 290 municipalities (before the Covid-19 pandemic) to help them address staff shortages directly linked to psychosocial risks by bringing in a team of experts to investigate those places where the highest rates of sick leave were reported. This is an example of how trade unions can

take investigative initiatives in identifying and resolving problematic work environments at a municipal level.

Trade unions have also been active in developing occupational specific strategies and guidelines. For example, the Swedish_Municipal Workers' Union (Kommunal) has created its own work environment strategy that covers issues such as the organisation of work, staffing, working time, threats/violence, and victimisation/sexual harassment. They also have guidelines that take account of the specificity of the sectoral work environment and feature a toolbox for specific situations or problems at work (Serrano, *et al.*, 2022).

Trade unions are also active in educating and campaigning for increased resourcing that underpins much of the problems in work environments in healthcare. In identifying excessive and unsustainable workloads and the associated work-related stress as key psychosocial risk factors, Vardforbundet is advocating and campaigning for major re-investment in increased staffing and professional development to ensure the supply of the required specialist skills and which underpin sustainable workplaces, and more worker participation in decision-making to improve working conditions. This requires both politicians and employers to work together with unions to address the healthcare workforce crisis (interview with senior policy analyst, Vardforbundet).

At the legislative and regulatory level trade unions are active in identifying key issues and policy developments to address the work environment in health and long-term care. For example, Vardforbundet's recommendations for preventing psychosocial risks and improving mental health of healthcare workers have a range of strategies including examining how to implement existing legislation more effectively and changes to improve the capacity of unions to engage in collective bargaining on the issues related to poor working conditions. This includes further developing and updating the 'National Mental Health Strategy' which Swedish Government introduced for 2016-2020 for general conditions of employment and working conditions, as the existing policy does not address the needs of healthcare workers adequately (Interview senior policy analyst, Vardforbundet). Creating the workplace as a setting to promote good mental health is critical in protecting the mental wellbeing of the workforce. Swedish governments have been addressing these issues with an increased focus on the psychosocial risk factors, but practical implementation remains a challenge for most workplaces. Stress and mental strain derived from the work environment remain the most common causes of work-related disorders in health and long-term care which are female dominated occupations.

3.8 Conclusion:

Over recent decades Sweden has suffered significant economic neoliberal reforms with a shift away from previous social democratic traditions and a strong welfare state. This has included financialisation, the privatisation of public sector assets, the development of new public management and increased demands for efficiency in the public sector along with reduced resourcing for the public sector, including in education and healthcare.

Over the several decades this has resulted in a healthcare workforce crisis with insufficient staff, poor skill mixes and insufficient supervisory support that are compromising patient care. These underpin the increased work-related stress related to excessive workloads, insufficient time for recuperation between shifts, low autonomy, poor working conditions and particularly in long-term care the problems of low control over work, and precarity. This exacerbates difficulties in recruiting and retaining healthcare workers. The consequence is high and increasing levels of work-related stress and mental illness in healthcare workers compared to other occupations. This is strongly shaped by the gendered nature of financial models and the organisation of work within healthcare.

Despite Sweden having OHS legislation and regulations that specifically addresses psychosocial risks and the work environment in the workplace, there are barriers to implementation. This is due to the under-resourcing and limitations on the scope of the remit of the regulators and issues with the training of health and safety representatives and providing the resources for them to carry out their work. Employers also often lack either the motivation or capacity to assess and address issues in the work environment, especially in small and medium enterprises. Alternative mechanisms for addressing problems in the work environment and working conditions through collective bargaining have been eroded with the general undermining of the power and the capacity of unions in Sweden.

The trade unions representing health and long-term care workers have campaigned with some success over decades to achieve changes in legislation and regulation of the work environment and psychosocial risks, to develop their own specific occupational work environment strategies and educational and support materials, to enlarge the scope of collective bargaining agreements and most importantly continue to campaign for increased resources, staffing and training to address the core underlying problems that result in deteriorating work environments and their negative impacts on health and long term care workers' health. However, the new conservative government will not be as supportive of union campaigns to protect or extend legislation or regulation of the work environmental and psychosocial risks.

4.0 Psychosocial risks, work stress and mental health in healthcare workers: Australia

4.1 Summary

- Psychological illness is the fastest growing cause of disability and there has been a significant decline in mental health in the Australian population since 2020.
- Decades of under-investment in healthcare and the healthcare workforce both nationally and within the states has led to a national healthcare workforce crisis.
- There are high levels of work-related stress and its sequalae in nurses and long-term care workers, with the highest levels amongst younger and less experienced nurses. These are higher than for most other occupations.
- The key psychosocial risks are: high workloads, high emotional demands, insufficient organisational support and insufficient resources to perform their roles; staff conflict; harassment and bullying as well as client aggression. These were exacerbated by the Covid-19 pandemic.
- These psycho-social risks are related to chronic understaffing, poor retention of experienced nurses and graduate nurses, insufficient training places and graduate mentoring support, insufficient opportunities for professional development; poor skill mixes; increased patient acuity.
- Psychosocial risks have previously been poorly covered by legislation and the knowledge, training and experience about psychosocial risks and assessments of the regulators has been limited. Following ongoing critique by academics, and the legal profession as well as campaigning by the trade union movement in Australia, including the nurses' and midwives' union, there are currently promising changes to OHS legislation and the role of the regulators in relation to psychosocial risks. Trade unions are campaigning to be able to take up OHS prosecutions of employers independently.
- Following decades of union campaigns and collective bargaining more states are introducing nurse: patient ratios as one mechanism to monitor and leverage on the

adequacy of staffing levels. Other key demands are increased wages to retain and recruit nurses; reducing management contact with nurses and midwives who are off duty; limiting the recruitment of overseas nurses and midwives to address the workforce crisis because it is unethical and not an alternative to increased investment in the local workforce.

- Other important ways by which the nurses' and midwives' union has built strength is through providing government-funded professional development courses for healthcare workers and training and developing their own network of health and safety officers, who are well trained in psychosocial risks and assessments.

- Both effective OHS legislation and regulation of psychosocial risk and strong union power in collective bargaining are key mechanisms for unions to be able to address psychosocial risks and mental health in the healthcare workforce.

4.2 Overview of psychosocial risks and mental health in Australia workforce

Psychological illness is the fastest growing cause of disability in Australia (Safe Work Australia, 2023). A recent survey by the Australia Bureau of Statistics (2021) found that 15% of Australians experience high or very high levels of psychological distress with more women (20%) than men (12%) and more young people 18-34 years (20%) than older Australians. Workers' compensation data indicates that 90% of mental disorder claims related to mental stress (Safe Work Australia, 2015). Recent polls of workers in Australia and New Zealand indicate that 47% of respondents report daily stress (Gallop, 2022). Recent indirect measures, such as workers compensation claims data, indicates that psychological claims are increasing and represent the highest cost of worker compensation claims and the highest percentage of disease-related claims (68%) in 2018 (Safe Work Australia, 2020).

However, when the number of claims per 1000 workers is estimated, this has remained stable over time, suggesting workers' mental health has not deteriorated, however worker compensation claims data does indicate that the severity and complexity of work-related mental health conditions may have increased, with early recovery and return-to-work becoming less likely (Black Dog, 2021). The cost of these compensation claims has doubled since 2006 and were estimated in 2015 as AUD $480 million annually (Safe Work Australia, 2015).

The most recent assessment of Australian workers indicates a significant decline in mental health and affective well-being for both females and males since 2020, with more marked declines in young employees aged 15- 24 years (Black Dog, 2021). The Covid-19 pandemic and associated financial and job insecurity and other social factors exacerbated these trends with dramatic increases within working age populations, particularly young people 15 – 24 years of age, reporting high or very high levels of psychological distress in 2020 compared to 2017 (Black Dog, 2021).

Poor mental health at work is associated with psychosocial risk factors. Mental stress related compensation claims accounted for 90% of mental health related claims in 2015 (Safe Work Australia, 2015). Data on claims frequency from Work Safe Australia (2021) identify that work pressure and bullying and harassment are the most frequent basis for mental stress related compensation claims and accounted for over 40% of mental stress related claims in 2017-18, with claims by females for both causes double that of males.

The rising costs associated with poor mental health at work has resulted in psychological health becoming a key target in in the national Australian Work Health and Safety Strategy 2012–2022 and again in 2023-2033.

4.3 Work stress and mental health in healthcare workforce

Mental well-being at work varies across industries and occupations, with health and welfare support workers, nurses, midwives, and social and welfare professionals in the top ten professional groups for compensation claims for mental health issues. Hospitals, residential care, and other health care services were in the top industries for claims relating to bullying or harassment at work (WorkSafe Australia 2021).

A more direct measure of mental health and work stress is found in the Australian Workforce barometer (Dollard, *et al.,* 2010) which includes data in both psychosocial risk factors and psychological health outcomes. This shows that workers in health and community services showed significantly higher levels of known stress risk factors, including emotional demands, harassment, workplace bullying and work pressure and workload, compared to nearly every other sector. This was paralleled by significantly higher levels of psychological distress, emotional exhaustion, and depression in comparison with all other sectors (Dollard and McTernan, 2011).

A survey of the Australian Mental Health nursing workforce identified that there were high levels of ongoing stress, with younger nurses (21-30 years) and those with four years or less experience, having the highest levels. The key contributing factors were

staff conflict and bullying, high workloads, lack of organisational support and lack of adequate resources to perform their roles as well as client aggression (Foster, *et al.,* 2021). These negatively impact upon retention, with increasing annual shortfalls in the mental health workforce which is predicted to reach 18,500 nurses by 2030. This is the largest shortfall of all sectors of nursing (Health Workforce Australia, 2012).

In the aged care sector in Australia, there are 366,000 paid workers (84%) and 68,000 volunteers (16%) (2016), not including agency and self-employed workers. The workforce is older than the average, with the median age 48 years in residential and 50 years in community aged care (King *et al., 2021*). There is a high proportion of ethnically diverse workers in the sector, including migrants, compared to Australian averages. Workforce shortages continue to increase, and it is estimated that this workforce needs to be increased by 70% by 2050 to cope with the increases in the number of older people requiring care (Deloitte Access, 2021).

The Royal Commission into Aged Care Quality and Safety (2021) found key problems leading to the poor quality of care currently being provided included: inadequate staffing and poor carer-to-patient ratios; poor skills mix; inadequate training and low wages. The Commission was critical of the inadequate funding model that underpins these problems. Surveys of workers report high workloads, time pressure, low job satisfaction, non-competitive wages compared to other industries, and high intension to leave (Royal Commission, 2021). Within this workforce there are very high levels of workplace injury and compensation claims, particularly among unregistered carers.

The Aged Care Workforce Labour Market Survey (2021), published by the National Skills Commission, showed how unevenly the legislative criteria for gaining 'approved provider status' was being applied, with some programmes being covered by the criteria and others being exempt, for example, approval is not required for private aged care providers who do not receive government funding for aged care services. This research found that stakeholders identified a move towards person-centred care and the type of programme funding and price settings together motivated providers to employ workers on short-hour casual or part-time contracts. This resulted in having a 'on-demand' workforce with 'just-in-time' staffing (National Skills Commission, 2021: 285). This showed how legislative criteria, the types of programme funding and pricing can undermine working conditions and job security.

4.4 Workforce shortages, psychosocial risks and the key drivers in healthcare workforce – The ANMF view

The Australian Nursing and Midwifery Federation (ANMF) is the key trade union representing nurses, midwives, and carers in Australia. It is structured as a federation of eight branches in every Australian state and territory, with a membership of over 320,000 nurses, midwives and carers in public and private healthcare and aged care settings.

Nurses, midwives, and carers are fundamental to the provision of safe, high quality patient care and play a central role in the functioning of hospitals and other care settings. The key psychosocial risks and work stress for healthcare workers are driven primarily by workforce dynamics, particularly a shortage of nurses related to recruitment and retention issues that then give rise to a range of negative feedback loops affecting psychosocial risks. There is a growing world-wide shortage of healthcare workers including nurses and midwives, with WHO estimating the global shortage as nearly 6 million in 2020. In Australia in 2021 there were 399,455 registered nurses, midwives, and enrolled nurses (Department of Health, 2021) with modelling of the shortages of nurses indicated a shortfall of 85,000 by 2025 (Health Workforce Australia, 2012).

4.41 Workforce shortages: workloads, loss of autonomy and stress

Significant shortages of nurses and midwives lead to increased workloads for the remaining nurses and midwives. The ANMF officials interviewed reported that ward shifts are regularly severely understaffed, for example, at times a major teaching hospital in South Australia can be operating with up to 60 nurses short.

This increases the likelihood of episodes of ‘missed care’ which impacts on the safety and quality of the care that nurses and midwives can provide. Nurses and midwives are under constant pressure to work quickly, to not take breaks and are being forced to make decisions about to who and what care they can deliver, knowing that they are not providing the quality of care they have been trained to deliver. This undermines their professional identity, autonomy, and their capacity to maintain good standards. This can lead nurses and midwives to experience ‘moral harm’ or ‘moral distress’ (Musto, Rodney and Vanderheide, 2015) and other forms of work stress such as burn-out. There is a well-developed literature on the correlations of high workloads and missed care (Willis, *et al.*, 2015); stress (Lim, Bogossian and Ahern, 2010); burn-out (Leiter and Maslach, 2009); fatigue (Ghasemi, Samavat and Soleimani, 2019) and post-traumatic stress (Schuster and Dwyer, 2020).

Furthermore, the constant understaffing leads to nurses being frequently contacted at home by managers with requests to cover extra shifts, which adds to their workloads, and leads to them feeling that they are never free from work demands, even at home. This then increases the risk that nurses will either reduce their hours of work, take up

agency work where they have more control over their working hours, leave nursing altogether, or take earlier retirement. In Australia, in 2021, there were 27,285 registered nurses who are were not working in the industry (Aust. Govt. Dept of Health and Aging, 2021).

4.42 Loss of experienced nurses = loss of support roles

Recent evidence indicates that 75% of nurses in public hospitals are considering leaving nursing as a profession. Some hospitals are experiencing 30% nursing staff turnover (Waine, 2022). The loss of experienced nurses is exacerbated by the ageing nursing and midwifery workforce, with a median age of 43 years. This loss of experienced nurses with specialist qualifications, leads to shortages in these areas and impacts on the support available for new graduate and junior nurses.

4.43 Retention of graduate nurses

Retention is a significant issue for new graduate and junior nurses. The official from the ANMF NSW branch described how midwives have a university entry grade nearly equivalent to that of doctors, meaning that they can chose any career they want. They have a strong commitment to becoming midwives.

However, once they start doing placements and see what the work environment is like, they do not want to take up positions as midwives or drop out. While initial recruitment targets are achieved, it is the retention of students and new graduates that is increasingly problematic, and which exacerbate the shortages. For new graduates and junior nurses/midwives there are additional problems with insufficient numbers of clinical nurse/midwifery educators who can provide work-based training, education and support.

While universities have the capacity to increase training places, and in fact the state governments have been increasing training recruitment targets and support, the number of training placements available in hospitals is a key limiting factor which is related to shortages of nurse and midwife training facilitators.

4.44 Reduced support for professional development

Nursing and midwifery staff shortages are also having a negative impact on the professional development of experienced staff who cannot be released for training due to staff shortages. In addition, hospitals do not have the resources to pay for all professional development and training. Hence the union reports that many healthcare

workers are doing the professional development needed to maintain their registration in their own time and paying for it out of their own pockets.

4.45 Staff shortages and skill mix

ANMF branches report that the loss of experienced nurses and specialisms, insufficient clinical nurse educators, and reduced opportunities of professional development affect the quality of the nursing and midwifery workforce and its skill mix. This further exacerbates the capacity for support and adds further to the excessive demands on the remaining experienced staff.

4.46 Increased patient acuity

With the new Labour Government proposed establishment of urgent care centres to treat patients out of hospitals, this will leave the sicker patients attending hospitals which means nurses are then attending to more acute and hence more demanding cases.

4.47 Staff shortages, workloads, and bullying/harassment/violence.

While individual instances of bullying and harassment are not to be excused, these need to be considered in relation to broader problems within hospitals. Excessive workloads and staff shortages increase the pressures on managers, staff, and patients. The ANMF Officers explained that, for example, in Emergency Departments (EDs) there are increased levels of bullying, harassment and violence from patients, often related to patients waiting a very long time in pain or discomfort and who then lash out at nurses. Staff shortages means that there is not likely to be trained facilitators on-duty who could de-escalate the situation. In addition, there is a propensity for peer and managerial bullying to occur in this environment. This can lead to post-traumatic stress syndrome, and other forms of work stress. Consequently, nurses then need to take time off work which further exacerbates staff shortages.

4.48 Covid-19 and staff shortages

Staff shortages were exacerbated during Covid-19 as many overseas nurses returned to their home countries at the start of the pandemic when borders were closing, which also stopped the migration of nurses and midwives into the country. During the peak of the Covid-19 pandemic nurses and midwives were regularly doing 18-hour shifts with a 6-hour break. Along with the challenges of providing care in a novel pandemic, this has

contributed to the increase in stress and burnout amongst nurses and midwives leading to increased sick leave (Dobson, Malpas, Burrell, Gurvich, Chen, Kulkarni and Winton-Brown, 2021). At the time, public hospitals in several states including New South Wales (NSW) are still getting repeated waves of Covid-19 infections which is leading to increased staff being off work while quarantining, and which then increases the work pressure on the remaining staff. In 2022 there were 3000 nurses quarantining in NSW. This exacerbates the workload problem.

Each of these drivers exacerbates the nursing workforce shortage that is the underlying cause of increasing psychosocial risks for the healthcare workforce that leads to increasing stress burnout and poor mental health in the nursing workforce.

4.5 Psychosocial risks and the changing OHS legislative and regulatory landscape in Australia – key critiques.

Australia has a federal system of government and over recent years there has been a harmonisation of OHS legislation across the six states and two territories that constitute the federation. This brings consistency of legislation across Australia in the WHS Model Laws, which for some states represents an improvement on their previous legislation. However, the unions and ACTU have been advocating for changes to the current onus of proof in prosecutions lying with the prosecution and with the inability of trade unions to bring prosecutions. The current federal Labour Government has promised to review these provisions, which would make it easier for unions to bring cases under WHS laws.

There has been significant critique of the provisions of the model WHS laws in relation to the absence of specific provisions regarding psychosocial risks at work. The role of regulation and the regulator has also been subject to significant critique by unions and in the academic literature. Key critiques include:

- Determining how to apply the general obligations in the laws for health and safety at work more specifically to psychosocial risks, in the absence of specific regulations (Potter, O'Keeffe, Leka, Webber, and Dollard, 2019).

- Poor inclusion of risk assessment, preventive action and poor coverage of exposure factors and psychological health outcomes in regulations (Potter, O'Keeffe, Leka and Dollard, 2019)

- Lack of legislative coverage leads managers to avoid addressing comprehensive psychosocial risk mitigation strategies (Robertson, Jayne, and Oakman, 2021).

- The inspection of workplaces regarding psychosocial risks is marginal in the work of OHS inspectors due to limited training, resourcing constraints, and deficiencies in the regulation (Johnstone, Quinlan and McNamara, 2011) and inspectors were often unresponsive when these issues arise, compared to their response to non-psychosocial hazards (Popple, Way, Johnstone, Croucher, and Miller, 2023)

These concerns were re-iterated in submissions by the ACTU, other unions and the Mental Health Commission to the Productivity Commission Report (2020) which raised issues about the regulators' focus on positive motivators rather than deterrence of non-compliance; the lack of specific Regulation or Code/s of Practice specifically dealing with the management of psychosocial hazards and the specific and unique ways in which they manifest in different industries and occupations which is not addressed; the lack of any clear and comprehensive national approach; the removal of triggers that identify psychosocial risk from the Model laws.

In interviews. the representatives of the ANMF in both New South Wales (NSW) and South Australia (SA) re-iterated these issues concerning the regulator. They identified that the state regulators were under-resourced in both federal and state jurisdictions, and that in relation to nursing and midwifery there was a lack of action by the regulators including for both physical and psychosocial safety issues. Both unions reported that even in cases of nurses and midwives experiencing violence and death at work, the regulator would not investigate or intervene.

The ANMF NSW lobbied the NSW Labour opposition party who also successfully pushed the conservative government to conduct a review of the regulator. This was also partly successful due to the damning findings of Australian Government's 2021 Royal Commission into Aged Care in Australia which found very high levels of abuse, neglect, and poor staffing (Pagone and Briggs, 2021).

As a result of lobbying by unions and subsequently the Boland Review of the model WHS laws (2020) the Australian states have begun introducing amendments to the legislation now requiring employers to assess and manage psychosocial risks in the workplace. The federal regulator, WorkSafe Australia, has also amended the Model WHS regulations in June 2022 to address the lack of regulation around psychosocial risks in the workplace and clarified the role of employers in assessing and controlling psychosocial risks. This is currently flowing into most state-based regulators with changes to the regulations and new codes of practice and increased clarity for employers on their obligations (Milionis, 2023; The Lamp Editorial Team, 2022).

While these are very promising recent developments, it remains to be seen how well the regulator will be resourced for monitoring and ensuring compliance as well as how employers will respond to the new regulations and requirements.

4.6 What State Governments are doing:

4.61 Local recruitment and training

The ANMF in both SA and NSW have been lobbying governments to increase the recruitment of nurses and midwives into universities. Currently Australia trains more nurses per 100,000 population than any other OECD country, yet this is still insufficient. In NSW the recruitment was lifted to 2400 – 2700 students and again in 2022 the government lifted recruitment to 3700 students. However, the ANMF NSW argues that this needs to be substantially increased. Universities have the capacity to educate more nurses and midwives but need more facilitator resources. Training hospitals currently have very limited capacity due to lack of training facilitators and nurse/midwifery educators.

4.62 Interstate recruitment

In 2022, some state governments (Western Australia, NSW and Victoria) have offered to pay a portion of the nurses' university fees as an inducement to move interstate. The SA Government has refused to do so, so this may encourage some trainee nurses to move interstate. However, this will not solve the huge nursing shortfall across Australia.

4.63 Migration

Australia has been reliant on migration of overseas nurses and midwives to help fill shortages. In 2019, almost 20 per cent of nurses working in Australia did their qualifications elsewhere, and nearly 33 per cent were born overseas (Waine, 2022). However, with the current world-wide shortage of nurses, migration is not a viable or ethical solution to the nursing work-force crisis. It is ethically questionable for developing countries to train the nurses that they need, only to have them migrate to developed countries. For example, the largest hospital in Fiji lost 40-50 nurses to migration, which had a big impact on this major hospital, but makes negligible difference to the current staffing shortages in Australia (Interview with Officer from ANMF NSW).

4.64 Development of role of Health Care Assistants

The current (2022) NSW government is considering introducing unskilled workers as health care assistants to get more staff onto wards. The unions are concerned that this represents a deskilling of nursing care that also under-cuts wages and puts more pressure on existing nurses since the work that assistants can do will not make a significant contribution to the workload problem of nurses.

4.7 What the ANMF unions in SA and NSW are doing

4.71 Research reports and lobbying

ANMF has commissioned a series of research reports on nursing shortages, excessive workloads, the impact of Covid-19, psychosocial risks and work stress, fatigue and burn-out and uses these to lobby governments to address the nursing workforce crisis. Their research reports form the basis for submissions to key committees such as the Australian Royal Commission into Aged Care. This Commission's report resulted in their success in gaining the introduce minimum care hours for patients and a 15% wage rise for aged care workers.

Further research projects include the impact of Covid-19 and workloads and resources demonstrating the negative impact on nurses' psychosocial risks and well-being. The SA ANMF was commissioned by the SA Government to review the workforce capability framework and linked to this, a workforce renewal strategy to rebuild workforce capability. These research projects are valuable tools in identifying issues and challenges as well as providing a solution which can be influential with government and employers.

At the end of 2022, the ANMF NSW branch was able to bring together key stakeholders, including politicians, academics, leaders from professional organisations, employers from the aged care and private sector and the ANMF for a joint meeting on the nursing workforce crisis.

4.72 Developing the power of the union and key campaigns

Nurse patient ratios

One key lever for addressing inadequate staffing levels is the use of legislatively mandated minimum staffing levels through nurse-to-patient ratios e.g., 1:4 on medical and surgical wards, on a shift-by-shift basis. This method of determining staffing has the key advantage over other more complex and obscure methods in that it is transparent to all staff when staffing is inadequate and makes it easier to hold managers to account.

There is strong evidence that staffing at these ratios correlated to lower re-admission rates, low patient mortality and lower nurse burnout (Aitken *et al*, 2002; Duffield *et al*, 2010). Both the NSW and the South Australian branches of the AMNF are actively campaigning for nurse-to-patient ratios in hospitals, which will mean the number of nurses will have to be increased. In NSW, they have already recently won minimum staffing levels in aged care facilities along with minimum care hours requirements. In South Australia the ANMF has won a commitment from the recently elected Labour Government to legislate for nurse-to-patient ratios. Victoria has had these nurse-to-patient ratios since 2000. It was the first country in the world to achieve this in a collective agreement and subsequently mandated through legislation in 2015. Furthermore, mandating nurse-to-patient ratios contributes to restoring nurses and midwives' professional power, autonomy and authority to push for adequate staffing with managers. The introduction of nurse-to-patient ratios in Victoria in 2000 was a major contribution in turning around the health crisis that engulfed Victoria in the 1990s. While the current severe shortages of nurses means that these ratios are now frequently violated, OHS officers can monitor non-compliance and ensure that managers have made all reasonable steps to fill the vacant shifts.

OHS representatives

The ANMF is a large enough union to have professional OHS officers, with four in the NSW branch. Along with Organisers, they are developing a network of OHS officers in every workplace, with trained and elected OHS officers who have the power to issue improvement notices and stop work orders if they believe the work is unsafe. OHS officers are now trained within the union, especially on issues relevant to healthcare settings. This has resulted in wins on safety issues such as the fit testing of PPE masks in NSW. Where nurse-to-patient ratios are mandated, OHS officers can play a key role in holding workplaces to account. In South Australia, the ANMF OHS Officer has used right of entry under the legislation to do psychosocial risk assessments, to examine rosters, policies, and procedures to try to protect staff. They are looking at prosecuting employers who don't give employees a minimum of a 10-hour break between shifts, or other breaches since the OHS regulator has been very weak. Following a recent Government commissioned review this is hopefully likely to change in the near future.

Wage increases

Nurses' and midwives' wages were frozen during the Covid-19 pandemic and real wages have been falling for the past 18 months, with 7% inflation in Australia. Decent wages have been central to attracting and retaining nurses and midwives in the healthcare system. The ANMF is currently campaigning for wage increases.

Reduce management contact outside of work

With acute nurse and midwifery shortages, managers are trying to fill gaps in shift converage by constantly contacting nurses when they are off-duty asking them to do extra shifts. This means nurses and midwives are unable to relax properly when they are at home. The SA ANMF has won an agreement that nurses will have 2 days per fortnight when they cannot be contacted by managers with requests to do extra shifts, unless they specifically agree to be contacted.

Industrial action

The NSW ANMF has a current industrial campaign including strike action over pay, nursing and midwifery shortages and nurse-to-patient ratios that has been building momentum, with the numbers of nurses and midwives attending rallies on the steps of the NSW Parliament, far exceeding the expectation of the organisers. An ANMF official present identified how important taking collective action is in giving nurses and midwives a sense of their own collective power:

(Nurses and midwives in the first strike) 'they were jubilant, … they were doing something, they were acting, … that moment of power gave them a sense of euphoria. At the second strike they were just angry (about what the Premier was doing in Parliament). The third strike, I would frame as determination, beyond which is giving members a feeling that their voice has been heard'. (Interview with union official ANMF NSW)

Professional Training programs

The ANMF runs a variety of professional training programs for nurses and midwives. For example, the SA ANMF develops and conducts training for nurses to upgrade their qualifications or gain entry to specialisms in short supply, such as ICU or mental health, which is paid for by the SA Government. This strengthens the connection between nurses and their union.

Advocacy for support for mental health of nurses and midwives

There was significant ambivalence about the introduction of resilience training for nurses within both the NSW and SA Australian branches of the ANMF. They were mindful that a focus on individual nurses coping capacity failed to address the key structural issues related to staff shortages that underpinned psychosocial risks and hence nurses' well-being. One of their key slogans is 'Stop telling us to cope!' They are critical of some employers who provide tokenistic support, for example, offering cakes, etc to 'say

thanks' to nurses, when they often have no time for a lunch or toilet break. This leads to further cynicism amongst nurses.

However, in recognising the increased risks of burnout and post-traumatic stress with rises in harassment, bullying and violence in healthcare settings, the ANMF is supporting the development of psychosocial support by trained staff to provide debriefing sessions at ward level to deal with traumatic incidents. They have also won an improved funding for employee assistance programs with more access to counsellors and referrals to professional help. Nevertheless, getting funding and resourcing by employers remains difficult, and the staffing shortage itself makes it difficult for nurses to leave the ward for support sessions.

4.8 Conclusion:

Poor mental health among Australian workers has been increasing over the past decade, with healthcare workers at highest risk. The stress, burnout, fatigue, moral distress, and post-traumatic stress increasingly reported by healthcare workers is related to high levels of psychosocial risk factors. These risk factors include high workloads, loss of professional autonomy, bullying and harassment and violence at work. In turn, these are underpinned by a long term and worsening healthcare workforce crisis in combination with, until recently, poor support for identifying and addressing psychosocial risk factors at legislative, regulative and employer levels.

The healthcare workforce crisis, while driven by severe workforce shortages, is exacerbated by a series of negative feedback loops in workforce dynamics. Staff shortages and poor skill mixes increase workloads and work stress for workers, leading to increased staff turnover, problems in supporting new graduates due to lack of nurse educators and insufficient capacity for training placements as well as related problems in retaining new graduates. Staff shortages also impact on experienced nurses by limiting their opportunities for professional and skill development, which negatively affects morale, professional autonomy, and the number in support roles for more junior staff.

Staff shortages, high workloads and time pressure exacerbate workplace bullying and harassment. Long waits for treatment in Emergency Departments contributes to patient violence towards healthcare staff. This in turn exacerbates staff shortages as workers go on sick leave.

Under pressure from trade unions and other stakeholders, very recent changes in the Work Health and Safety legislative and regulatory environment provide much clearer recognition of the specific nature of psychosocial risk factors and are now requiring

regulators and employers to monitor and address these issues, across all Australian States and Territories. It remains to be seen how well this will be resourced and what the regulators' approaches to enforcement will be. Furthermore, the current Australian Government is considering allowing trade unions to bring their own prosecutions of employers who fail to abide by Health and Safety regulations rather than solely relying on the regulators, who have been quite remiss in the past.

Various State Governments are making some attempt to address the healthcare workforce crisis through increased training places in universities, although the ANMF is arguing for a significantly greater intake. In one state, the NSW government is considering recruiting lower skills health care assistant despite the ANMF arguing that this will do little to reduce the workload of nurses. In general, state governments have relied on the recruitment of overseas nurses to address staff shortages. The worldwide shortage of nurses is set to worsen and creates intense competition for nurses from middle- and low-income countries. However, during the Covid-19 pandemic due to the closure of borders this source was cut off. Many migrant nurses returned to their home countries, worsening the workforce crisis in Australia at the time of a critical increase in demand. Furthermore, it is ethically fraught to continue to recruit nurses from middle and low-income countries which need them for their own healthcare systems.

The ANMF is taking a multi-pronged approach to addressing the healthcare workforce crisis and the associated psychosocial risks. This centres on working with key stakeholders (governments, Health Departments, employers, etc) to share information and develop solutions. Key approaches are advocating for nurse-to-patient ratios, where they don't already exist to provide transparency and accountability in staffing numbers which enable nurses to hold employers to account; increasing the pay of healthcare workers and nurses to help retain and attract staff; developing further the professional training programs for nurses so they can increase their skills and develop specialisms funded by governments; exploring the development of ward-based psychosocial support programs for nurses addressing the mental health of nurses including burn-out and PTSD; strengthening the network and training of OHS Officers who play a key role in monitoring staffing adequacy and psychosocial risk factors.

Workloads, nurse-to-patient ratios and pay are currently core issues that are mobilising nurses in some states e.g. NSW, to take industrial action and to build the union. It is primarily through union action (research, advocacy and engagement, training and education, and industrial action) that key gains to address the Australia healthcare workforce crisis and related psychosocial risk factors are being achieved.

5.0 Psychosocial risks, work stress and mental health in healthcare workers: Canada

5.1 Summary:

- Mental illness is the leading cause of disability in Canada with high levels of burnout being reported by the working population (35%), especially young women, and the highest levels reported by healthcare workers (55%), especially nurses (66%).

- Healthcare workers report the highest levels of psychosocial risk compared to other occupations, these include low levels of: clear communication; support from superiors; effective responses to difficult situations and handling of conflict; psychological and social support and protection; workload management; psychological competencies and demands; recognition and reward; work-life balance. They also feel unprotected in cases of physical safety concerns, experience few experience opportunities for growth and development.

- There is a serious and chronic shortage of healthcare workers in both hospital-based and long-term care in Canada, resulting from insufficient investment in recruitment, training, retention and professional development and high workloads resulting from understaffing. The links between understaffing, psychosocial risk, and the impact on the mental and physical health of healthcare workers and the care provided to patients as well the link to increased patient morbidity and mortality has been well established in the nursing academic literature, in research and report by nurses' professional organisations and trade unions. This body of research and knowledge has been built up over decades and supported by research from government agencies. Governments have acknowledged the emergence and worsening of the healthcare workforce crisis since the mid-1990s. The Covid-19 pandemic exacerbated these issues.

- Mandatory overtime is a key problem creating a negative feedback loop on other psychosocial risks including high work demands and poor work/life balance and is one of the key planks in campaigns by health care unions.

- Unlike Australia which has standardised OHS legislation across the states, in Canada there is no standardisation and wide variation across the provinces. There is little or

no recognition of psychosocial risks and varied and limited recognition of work-related stress in compensation regimes. Psychosocial risks at work have been addressed by a voluntary national standard on psychosocial risks at work. Many are pessimistic of the effectiveness of voluntary approaches to psychosocial risks.

- Nurses and other healthcare unions and professional associations have been somewhat successful in industrial campaigns, in lobbying governments and in driving research on the healthcare workforce crisis. They were successful in influencing the key recommendations in the government's 2023 Standing Committee on Health report 'Addressing Canada's Health Workforce Crisis' and in lobbying the national government for real increases in the 2023 budget to enable these recommendations to be honoured, including new money to the provinces over the next 10 years to support key initiatives. For example, nurses in British Columbia recently won the introduction of nurse: patient ratios to address understaffing and the HEU gained a reversal of privatisation by bringing previously outsourced housekeeping and food service workers back in-house (HEU, 2022). In Ontario, unions achieved a major staffing commitment in long-term care homes in Ontario after a long campaign. This will involve hiring and retaining more than 27,000 registered nurses, registered practical nurses and personal support workers to provide an average of 4-hours of direct care per resident per day by 2025. However, this same government in Ontario has been attempting to freeze the wages of the public healthcare workforce, which was successfully opposed by a coalition of trade unions. This illustrates the difficulties associated with the fragmentation of responses that can arise in in a federal political system.

5.2 The context of Canada

Canada is a liberal market economy with a federal system of government and healthcare provision and with the crisis in the healthcare workforce recognised by various governments since the 1990s. While worsening over decades there has been no sustained efforts by governments to address the developing crisis.

5.3 Mental health in Canada

Mental illness is the leading cause of disability in Canada with 1 in 5 Canadians experiencing a mental health issue and by the time people reach 40 years of age, 1 in 2 people will have had or have a mental illness. Young people and those in the prime of their working lives are hardest hit (MHCC, 2012).

The cost to the economy was predicted to rise from $50 billion in 2011 to $79.9 billion by 2021. In 2011, mental health issues among working adults cost employers more than $6 billion in lost productivity from absenteeism, presenteeism and turnover. Mental health issues account for 30 to 40 percent of short-term disability (STD) claims and 30% of long-term disability (LTD) claims and are rated one of the top three drivers of such claims by more than 80% of Canadian employers. Mood and anxiety disorders are the most prevalent at 11.75% of the population in 2011 and with the prevalence of these more than double for women compared to men (MHCC, 2012)

The Covid-19 pandemic and the more recent inflation cost of living crisis has contributed to a deterioration in the mental health of the general population. The prevalence of major depressive disorder doubled from 7% in 2015-2018 to 16% in 2020 (Shields *et al.,* 2021). Similarly, about 10% of Canadians self-reported as having moderate to severe symptoms of anxiety, which is a dramatic increase from 4% in 2019 prior to Covid-19; and with 20% self-reporting as having symptoms of severe to moderate depression, up from 5% in 2019 (Dozoi, 2021). There was a decrease in the number of people report very good or excellent mental health from 68% in 2018 to 54% in 2020 (Findlay and Arim, 2020).

Although the Covid-19 pandemic has contributed to the increase in mental illness in the population, the increase in mental illness that was evident before 2020 and corresponds to the impact of neo-liberalism policy agendas and the imposition of austerity measures during the period 2011-2021. These contributed to an increase in work precarity and wider economic insecurity.

5.4 Mental health in the workplace, including healthcare workers:

The MHRC (2023) survey of mental health in the workplace (with responses collected in 2021) reported that 35% of participants reported feelings of burnout, with the highest rates for young women. Those in healthcare reported the highest levels of burnout (53%), especially nurses (66%). Only 35% of respondents overall reported that their employer had programs in place to address burn-out, dropping to 27% for those in healthcare. Only a minority of employees considered that their employer had prepared them for the psychological demands of their job (39%). These figures are substantially lower for those working in health and patient care (31%), first responders (34%) and education (31%). Those in healthcare (42%) have the highest reports of work having a negative impact on their mental health and 40% report being exposed to events they found to be traumatic, with 13% reporting experiences of bullying or harassment.

Approximately 10% of the Canadian workforce are employed in healthcare (Standing Committee on Health, 2023). Healthcare workers currently report significant levels of psychosocial risks at work. Compared to the other occupations, healthcare workers experience the lowest levels of: clear communication (33%), support from their superiors (46%) and effective response to difficult situations (31%), and together with those in transport experience the least psychological and social support (41%), psychological protection (44%), workload management (46%), psychological competencies and demands (48%), recognition and reward (48%); work-life balance (41%). They also feel unprotected in cases of physical safety concerns (46%), and few experience opportunities for growth and development (45%) and few report that the workplace handles conflict well (36% (MHRC, 2023).

Despite these significant work-related psychosocial risks negatively impacting on healthcare workers they continue to report high levels of engagement in their work (72%) (MHRC,2023).

The stigma attached to mental health issues means that workers are reticent to report mental health issues at work, with 75% of working Canadians would either be reluctant to admit or would not admit to a boss or co-worker that they have a mental illness (Ipsos, 2019), and over 67% of those with a mental illness report having been refused jobs, promotions or other disadvantages in the workplace (Ipsos, 2019). Moreover, this lack of support for mental health at work is reflected in the fact that most workplaces in Canada (70%) do not have a workplace mental health strategy in place (Deloitte 2019).

Prior to the Covid-19 pandemic mental health issues were the leading cause of disability in Canada with a substantial impact on those in the prime of their working lives. The Covid-19 pandemic has led to further deterioration, including increasing rates of work-related burn-out, with those working in the healthcare sector particularly affected. This is associated with high rates of a range of psychosocial risks factors in the working environments of healthcare workers which are preventable or controllable.

5.5 Psychosocial risks and the healthcare workforce crisis in Canada

There are an estimated 120,000 health and social care vacancies across Canada with rural and remote area suffering the most. For nurses, the major component of the healthcare workforce, there were 34,315 vacant nursing jobs in Canada at the end of 2021, which was an 133% increase from 2019. It is estimated that Canada will be short of 117,600 nurses by 2030 (Standing Committee on Health, 2023). A third of the current

nursing workforce is close to retirement and a 2020 national survey found that nearly 60% of early-career nurses say they are considering leaving their current job, and 25% reporting they will leave the profession (McGillis Hall and Visekruna, 2020)

While the Covid-19 pandemic drew broad attention to the workforce shortages and under-resourcing of healthcare workers in Canada, the healthcare workforce crisis emerged well before this, with governments in the 1990s recognising the problem but only making intermittent attempts to respond to the problem that were not sustained. From the 1990's onwards, various organisations representing nurses (e.g. Canadian Nurses Association (CNA) and the Canada Federation of Nursing Unions (CFNU)) and registered practice nurses (RPNs) and other healthcare workers (e.g. Hospital Employees Union (HEU) in British Columbia, Ontario Council of Hospital Unions (OCHU) and unions in other provinces) as well as independent researchers (e.g. Aitkin *et al.,* 2001, etc), have all provided a wealth of data on staff shortages, healthcare workers working conditions, and the impact of these on the quality of patient care and on nurses mental and physical health and their job satisfaction. These surveys have been accompanied by national level surveys through Canadian Institute for Health Information and Statistics (CIHI) and Statistics Canada. This evidence indicates that since the 1990s the staffing shortages and working conditions for health care workers have been deteriorating with increasingly negative impacts on workers' health and the quality of care they are able to deliver. These have all been further exacerbated by the Covid-19 pandemic.

The impact of privatisation on the quality of long-term care and the staffing and working conditions of long-term care workers was set out in a report by NUPGE (2021). It found that only 20% of for-profit long-term care homes met legal staffing guidelines. Privatisation introduced lower pay and poorer working conditions because the pursuit of profit in a labour-intensive sector can only be met by reducing pay and conditions. With lower wages comes poorer quality of care. Even attempts by one company to address shortages of care workers led to the introduction of new category of lower paid care worker (NUPGE, 2021).

The relationship between pay, working conditions and privatisation in long-term care homes has been documented by Armstrong and Armstrong (2022) in a long--term study of facilities in Canada. They argued that privatisation needed to be removed from the long-term care sector. Government regulations and the enforcement of minimum staffing levels, the provision of full-time jobs paying living wages, organising work to promote continuity of care as well as physical spaces to promote health were all necessary to create high quality care home environments that support both residents and workers.

5.51 Psychosocial risks and mental health in the nursing workforce.

There have been a series of studies of the nursing workforce over several decades which demonstrate serious issue with workloads, staffing shortages, burnout, harassment and violence, which precede the Covid-19 crisis. In particular an international comparison of nursing workforces, the RN4Cast study (Sermeus, *et al.,* 2011) has produced a series of papers substantiating the associations between staff shortages and high workloads with burnout, harassment and violence, job dissatisfaction and the impact on the quality of patient care and on nurses' mental and physical health. This was followed by a range of reports from governments and nurses' representatives including those from the CAN, CFNU, CIHI, etc.

McGillis Hall and Visekruna, (2020) provide a concise history of nursing driven research on the deterioration in nurses work environment and the impact of work-related stress. For example, in 2001 the CFNU identified problems with excessive nurse: patient ratios (i.e., high workloads for nurses); nursing shortages; high levels of overtime and absenteeism, leading to recruitment and retention issues. This was followed by a large national survey of nurses in 2005 by CIHI which found high workloads; extended working hours and missing of work breaks; high physical demands with back problems (25%) and pain preventing normal daily activities (37%) due to work-related activities (75%); and depression in 9% of nurses. High levels of absenteeism (61% had taken time off for health reasons in the previous year with an average of 23.9 days absent). Multivariate analysis demonstrated that work-related stress, including high job strain, work overload, low support from their supervisor or co-workers, high job insecurity; low autonomy, poor nurse-physician working relations, low respect from superiors and high physical demands were all associated with fair to poor physical and mental health.

Working conditions for those in long term care and home care were also becoming increasingly difficult, with concerns about the quality of care even before the Covid-19 pandemic. A CFNU report (Vector, 2017) on nurses in long-term care and care homes found that client acuity had increased significantly across the survey yet 75% of nurses in nursing homes reported that staffing numbers and skill mixes were not sufficient to meet the clients' needs. Workloads had increased considerably (64% in long-term care). Despite significant overtime being worked (with 63% of nurses saying they worked overtime when they preferred not to at least once a week or almost every week), 55% of long-term care nurses reported that usually did not have enough time at work to do their job well with nurses reporting that in the previous month residents frequently or sometimes weren't helped with walking or exercise (62%), didn't receive foot care

(51%) and toileting (49%), turning residents so they don't get bed sores (44%), bathing (35%), and feeding residents (24%).In home care and long-term care, six in 10 nurses report feeling tired regularly after a typical shift, with 50% reporting they were mentally exhausted and 27% of long-term care nurses report experiencing pain regularly after shifts (compared to 18% of home care nurses).

It is noteworthy that the CIHI (2005) report led the Canadian Nursing Advisory Committee (CNAC) in 2009-2011 to support a series of pilot projects to address the workforce crisis which subsequently advised that these be scaled up across the provinces and territories. Government failed to act on this evidence and advice, rather CNAC was disbanded, and governments made political decisions to further reduce resourcing which increased the pressure on of nurses (McGillis Hall and Visekruna, 2020).

5.52 Mental health of nurses

Subsequently, a CFNU commissioned survey of the mental health of nurses across Canada in 2019 (Stelnicki, *et al.*, 2021) found disturbing levels of: Major Depressive Disorder (36.4%); Panic Disorder (20.3%) and suicide ideation over lifetime (33%); critical incident stress (i.e., symptoms of burnout or compassion fatigue following overwork or prolonged stress) at least once during their careers (81.7%), with 29.3% reporting clinically significant symptoms of burnout (29.3%), and most (63.2%) reporting at least some symptoms of burnout. There were also high numbers of nurses (23.0%) who screened positive for current symptoms consistent with PTSD. For nurses working in long-term care many of these mental health problems were significantly worse. These statistics for nurses are worse than the general population. The key recommendation then was for additional mental health support for nurses.

This research highlights the high levels of mental distress occurring in nurses in both hospitals and long-term and home care. Given the relationship between psychosocial risks at work and mental health, the root cause of these high levels of mental distress in nurses, i.e., staff shortages, work overload and exposure to violence in work environments, needs to be addressed.

5.53 Nurses' work environment

The CFNU subsequently commissioned a further survey (McGillis Hall and Visekruna, 2020) on the pre-Covid-19 Canadian nursing workforce and their working environment that included nurses in hospitals, long-term care settings, home care and other health care workplaces. While nurses work hard to provide quality care to patients they were

concerned about safety and quality issues related to problems in nurse-to-nurse communication during care transfers and shift changes and poor communication between managers and nurses resulting in punitive work cultures. At least half (50.2%) of the nurses participating in this study do not feel free to question decisions or actions made by those in positions of authority, while 45.1% feel their mistakes are held against them. A large minority (39%) disagreed with the statement that 'management actions in their workplace reflect that patient safety is a priority'. In relation to their career and development nurses reported significant levels of dissatisfaction with: pay (42.7%), educational opportunities (57.7%), vacations (46.9%), sick leave (39.3%), education leave (58.7%). Nurses reported poor work environments (66.2%) and significant levels of workplace violence from patients and families, with (41.8%) reporting verbal abuse and physical abuse (19.9%) daily or several times per week. This was accompanied high levels of burnout with 65.3% reporting high levels of emotional exhaustion and 50.2% reporting high level of depersonalisation. Not surprisingly 59.7% of nurses reported planning to leave their current job in the next year due to high levels of job dissatisfaction (52%), with 27.1% of these planning to leave the nursing profession, which is a significant loss of experienced nurses during a crisis of staffing. Job satisfaction (over 50%) had deteriorated significantly compared to the 2005 NSWHN survey which found 10% of nurses being dissatisfied with their work (McGillis Hall and Visekruna, 2020).

5.54 Psychosocial risks and mental health in RPNs and other healthcare workers

The Canadian Union of Public Employee (CUPE) is the largest union in Canada with over 700,000 members and represents public sector employees in both federal and provincial jurisdictions. CUPE represents over 200,000 workers in a range of occupations the healthcare sector including registered practice nurses (RPNs) and auxiliary nurses, personal support workers, cleaners, food service workers and cooks, with the largest numbers in Ontario (Ontario Council of Hospital Unions members), British Columbia (Hospital Employees' Union members), Quebec (through the *Conseil Provincial des Affaires Sociales*), as well as Manitoba, Saskatchewan, and New Brunswick. Many of these workers are lower-paid compared to registered nurses and are particularly vulnerable to inflation and cost-of living increases. Like nurses they were at working at the forefront of the Covid-19 pandemic. Unions representing RPNs and other healthcare workers have been active in collecting data and advocating on behalf of healthcare workers.

During the peak of the pandemic the Statistics Canada (2022a) Survey on Healthcare Workers' Experiences During the Pandemic (SHCWEP) showed that 9 in 10 nurses (92.0%) reported feeling more stressed at work than before the pandemic. Increased stress was also reported by other health professionals including physicians (83.7%), personal support workers (PSWs) or health care aides (83.0%), and other healthcare workers (83.0%) (Statistics Canada 2022a). As a result of the deteriorating working conditions, an increased number of workers intended to leave or change their jobs. In 2021, there was the largest increase in the job vacancies in the fourth quarter (Canadian Institute for Health Information, 2022; Statistics Canada, 2022b). The SHCWEP results show that job stress or burnout as a key reason for intending to leave their job or change jobs for the majority and was more prevalent among women (63.9%) than men (59.5%) and among nurses (70.9%) (Statistics Canada, 2022a)

Brophy *et al's.,* (2020) research of the experiences of RPNs, PSWs, clerical staff and cleaners in Ontario during the peak of the pandemic found significant concerns about insufficient PPE and risk of catching COVID-19 and infecting family members which created increased anxiety and stress in conjunction with understaffing, violence against workers and increased workload which has resulted in burnout and exhaustion. The inadequacy of protection for healthcare workers was mainly caused by the under-expenditure for social services and inconsistencies in policy. Furthermore, healthcare workers were fearful of reprisals if they raise concerns about working conditions etc. with managers in their workplace, which left them feeling anxious, sad, abandoned, and vulnerable.

The situation continues to be dire, despite the passing of the immediate Covid-19 crisis. For example, a 2023 poll in Ontario of RPNs in a range of settings including hospitals and long-term care in Ontario found that more than 60% surveyed are considering quitting, driven out of healthcare by short staffing, physically and mentally draining workloads and suppressed wages as the main causes of the RPN exodus. A majority of RPNs (53%) report they work short-staffed almost every day and 74% saying they work short 3 or 4 times a week. The result of high workload is that 82 % of them experience high stress, 64% have trouble sleeping, 64% dread going to work, 42% suffer from depression (SEIU, 2023).

In British Columbia a 2022 survey of the Health Employees Union (HEU) members found that an astounding 75.2% experienced pandemic-related burnout, 32.9% do not believe there are adequate mental health supports in the workplace, 64.1% say their workloads have gotten worse over the last two years, 24.9 % report that their employer rarely or never backfills positions left vacant by illness or vacation, and 33% report thinking they

will leave healthcare within the next two years. Economic vulnerability adds further to their work-related stress with 35.8% saying they are less financially secure than two years ago and 26.1% are concerned that their housing is currently at risk (HEU, 2022a).

5.55 Mandatory overtime

A notable concern for healthcare workers is the large amounts of overtime worked and often unpaid. In most provinces it is mandatory for nurses and RPNs to work overtime, despite any preference not to do so. This often results in them working 24-hour shifts with impacts on the quality of care they can deliver and on their mental and physical health (Silas, 2023, submission to Report by Standing Commission on Health). Since the beginning of the pandemic, there has been an increase in the number of healthcare employees working overtime. According to Statistics Canada Labour Force Survey, more than 1 in 5 employees in health occupations (236,000) worked overtime in 2021, with averages of 8.2 hours per week of paid overtime hours and 5.8 hours per week of unpaid overtime. Paramedical occupations, followed by salaried family physicians/general practitioners and respiratory therapists, had some of the greatest proportions of their workforces working overtime in 2021. (Statistics Canada, 2022; quoted in Canadian Institute for Health Information).

These interrelationships between staff shortages, workloads, healthcare workers health and the quality of care is clearly articulated in an interview with a HEU representative from British Columbia and included insight into some of the collective measures that are needed to address the issues.

> **‘Working conditions were already contributing to mental health issues but COVID-19 made them worse. There were understaffing and workload issues pre-COVID-19, all of these got worse. Stress, burnout, working short and fast working have become the norm. Patients become sicker, staffing levels haven’t increased. They don’t have enough staff to cover extra hours. We have also a lot of staff left the sector. Literally you cannot hire to fill the job vacancies. Overtime rates have skyrocketed, mental health issues associated with them’ (Interview with senior research officer, CUPE-HEU)**

Long-term care workers also experienced ‘moral injury’ due to their inability to provide quality care to LTC home residents in the context of low staffing levels and high workload demands. The heavy workload and lack of mental health support has resulted in a larger number of staff sick due to stress and mental health reasons (interview with senior research officer, CUPE-HEU).

'Workers need to be paid better. Precarious work and mental health link is so clear. Also privatisation is a major problem. When these jobs are contracted out, they become more precarious. You need to support these workers with good benefit systems, counselling services. What we have now is an e-response like ‘here is an app, that’s going to solve all your problems’. I am sorry, that is not enough!' (Interview with senior research officer, CUPE)

Like nurses, lower paid healthcare workers are experiencing the long-term impact of insufficient staffing, increased patient acuity, excessive workloads, work-related stress and burnout, leading to increased turnover of workers leaving the industry, which further exacerbates the problems. These workers have additional issues related to precarity, outsourcing and privatisation that further diminishes their working conditions and creates a highly fragmented long-term and home care sector. CUPE highlights the need for a collective approach to resolving these workforce issues rather than one limited to individual resilience training.

5.6 Policy, regulatory and legislative context:

In Canada, the 10 provinces and 3 territories have jurisdiction for OHS legislation, regulation, and policies. In general, OHS legislation recognises workplace violence and, in most jurisdictions, harassment. Following changes to provincial level Workers Compensation legislation there is now recognition of PTSD as being workplace-induced for those in first responder occupations, after a strong campaign by CUPE (CUPE, 2017). This was subsequently followed by vigorous campaigning by the Ontario Nurses Association (ONA, 2016), with these provisions now to be extended to nurses providing direct patient care (Canadian Occupational Safety, 2023) and to five other occupations. This limitation of compensation to a small number of occupations fails to recognise that traumatic stress is possible in any occupation.

The provisions in the legislation vary across the different jurisdictions, with little standardisation (Samra, 2017). Other sources of legislation relevant to work-related mental health and psychosocial risks are the Canada Labour Code and provincial level employment law and standards as well as human rights provision which may include issues related to mental health, worker compensation and tort law (Shain, 2010).

In relation to work-related stress, there is a separation between acute/traumatic and chronic work-related stress, with some provinces not recognising chronic stress as compensable, while others that do allow this, place significant restrictions on its applicability. This is likely to reduce employer incentives to address psychosocial risks that can lead to more chronic and cumulative work-related stress (Hall, *et al*., 2018).

Unlike the EU or more recently Australia, no Canadian jurisdiction has specific legislation recognising psychosocial risk factors and their impact on mental health. Rather, psychosocial risks are included under the general provisions requiring employers to provide safe working conditions for employees (Lippel, 2011). Canada has taken a voluntarist approach to address emerging concerns about the increasing legal, social and economic costs of mental health issues at work. In 2013, the Mental Health Commission of Canada (MHCC) launched the National Standard for Psychological Health and Safety in the Workplace, which is important as it establishes causal links between workplace and organisational environment and psychological health, including chronic stress. This Standard is based on voluntary compliance with an educational orientation, so it is supported by guidance notes, case studies and a range of resources on work and mental health. The Standard identifies 13 organisational factors that impact mental health, including organizational culture, psychological job fit, workload management, engagement, balance and psychological protection and it provides guidelines for implementing a program to educate, train, assess, lead and manage workplace mental health (MHCC, 2013).

Apart from the MHCC's own review of the implementation of the Standard using 40 case study organisations, there does not appear to be any systematic evaluation of the impact of the Standard in organisations and work-related mental health. Hall *et al* (2018) are rather pessimistic about the likely impact of a voluntarist approach when combined with restrictive workers compensation legislation concerning chronic work-related stress and HR policies that tend to be overly focussed on supporting individual workers affected by work-related stress rather than addressing the root causes in the workplace, especially where these might involve costs to change.

Healthcare workers themselves are increasingly cynical of the over-emphasis by employers on individual resilience of healthcare workers. For example, a report on

healthcare workers experiences during the Covid-19 pandemic comments on nurses' perceptions of work-related stress, patient care and individual resilience:

> **'Calling nurses resilient is patching up the problem. If nurses are resilient, they can manage working short, they can return to work after a death in the waiting room, they can stay longer than 12 hours when there is no replacement coming. We don't want to be resilient. We want safe staffing levels, safe patient care and safe work environments. The environment in the ER has taken away our ability to care for patients and families the way we want to, and the way they deserve to be cared for' — Emergency department nurse, Vancouver (Source: Canadian Institute for Health Information, 2022)**

The demand here is for staffing levels and a working environment that is safe for workers and patients. This focus on individuals has been called out by unions including CUPE, which while appreciating the need for increased mental health support by employers for healthcare workers is critical of this becoming the primary response to psychosocial risks in healthcare. CUPE has firmly embedded an OHS approach to identifying, monitoring and addressing psychosocial risks in healthcare setting which employers need to prevent, remove or control to ensure the physical and psychological health of workers. This includes the need for collective bargaining to address these issues (CUPE, 2021).

5.7 What governments are doing:

National and provincial governments have been aware of the emerging crisis in the healthcare workforce and its underlying causes since the 1990s. At times there have been significant work done to understand and address the problem, however these have proved to be intermittent and were not sustained. McGillis-Law and Visekruna (2020) provide a good account of key moments in their historical account of government action and inaction on the emerging healthcare workforce crisis.

Highlights include: in 1999 the national government established and directed the Advisory Committee on Health Human Resources (ACHHR) to develop a plan to address

the future of the nursing workforce and established the Office of Nursing Policy in Health Canada to represent nurses and ensure their perspectives informed the development of health policy. In 2000, the national government created the Canadian Nursing Advisory Committee (CNAC) to develop policy to improve the working lives of nurses. In 2002, a nursing database was established and had begun collecting and reporting data on the supply, distribution and practice characteristics of Canada's regulated nursing health professionals. Then in 2005 the Quality Work Life – Quality Healthcare Collaborative (QWQHC) was established and recommended that all health care organisations in Canada adopt and monitor a set of quality work-life indicators tied to performance agreements and accountability reporting and released is own version. This led to the first national survey of nurses in 2005- the National Survey of the Work and Health of Nurses which documented the extent of staff shortages, increased workloads, deteriorating working conditions and the impact on patient care and nurses' health and highlighted the problems of staff turnover and aging workforce and nurses leaving the profession. This was followed in 2009-2011 of a series of pilot projects were developed to address the nurse shortages and related issues which was led by the CFNU and Health Canada who subsequently recommended their rollout across the provinces. However, this work was abandoned by provincial governments which instead increased healthcare budget restraints. The following decade of governments' inaction exacerbated the crisis in the healthcare workforce, which was the Covid-19 pandemic has dramatically foregrounded.

In response to the accumulated research and data on the dire state of the healthcare workforce in 2022 the national government instituted some decisive changes to address the crisis. The national government appointed a Chief Nursing Officer to providing strategic advice to Health Canada on priority policy and program areas. This has been followed by the Chief Nursing Officer and the Government of Canada intending to hold a Nursing Retention Forum with representatives of a range of organisations to address health workforce challenges in June 2023. At the same time the national government established a Coalition for Action for Health Workers to provides advice to inform immediate and longer-term solutions to address significant health workforce challenges.

In March 2023 the Standing Committee on Health delivered its report 'Addressing Canada's Health Workforce Crisis' to the House of Commons, Canada (Standing Committee on Health, 2023). Key representatives of the various organisations covering the healthcare workforce provided submission to the Committee. The Committees key recommendations included: streamlining the recruitment and professional accreditation of overseas healthcare workers; financial relief to retain healthcare workers especially those in rural and remote areas; the establishment of a Pan-Canadian Mental Health Strategy for healthcare workers; the establishment of an independent body to collected

data and develop strategies to address issue in the healthcare workforce; increased spending on healthcare.

The Government of Canada's Budget 2023 included a plan to invest close to $200 billion over 10 years, including $46.2 billion in new spending, to improve health care for Canadians. It includes $25 billion through tailored bilateral agreements with provinces and territories to advance shared health priorities, one of which is supporting Canada's health workers. While key representatives of healthcare workers welcome the Standing Committee's report and the promise of significant new money, they remain concerned about the lack of focus on increasing domestic education and training, and measures to improve domestic recruitment and retention of healthcare workers (CAN, 2023; CFNU, 2023). CUPE is calling for -improvements to the wages and conditions of personal support workers (improved wages, 18 paid sick days, more full-time positions, and access to a pension for personal support workers in healthcare) they raise concerns about the lack of specific funding for long-term care and for new federal funding for public health care rather than privatisation (CUPE, 2023).

5.71 Provincial Governments:

Provincial government receive federal funding for healthcare, as well as providing additional funding, and retain responsibility for the administration of healthcare within the province. The crisis in healthcare workforce involves all provinces, however, there is variation amongst them in funding and responses to the crisis. For example, in a recent report by the Financial Accountability Office of Ontario (FAO, 2023) found that the current budget for healthcare of the Ford administration will not suffice to meet is commitments with a deficit of $21.3 billion in health spending predicted by 2027-2028, despite predicted overall budget surpluses. While the new 2023 budget allocates some money towards additional training places there will still be a predicted shortfall of 33,000 nurses and personal services workers. Instead, the Ford government has attempted to slash the wages of healthcare workers with a cap of 1% increase over 3 years (Bill 124). While this was recently successfully challenged by unions and overturned in the courts, the government is appealing. There are also moves to extend privatisation of key health care services. If successful, these moves are likely to exacerbate the healthcare workforce crisis in Ontario.

This can be contrasted with the government of British Columbia. The HEU's secretary-business manager Meena Brisard considers 'that the $6.4 billion in additional health care spending in today's three-year budget plan will support initiatives designed to ease workloads and improve safety in health care settings by expanding training places for the

health workforce, providing an additional 9.25 million hours in extra staffing under our main provincial collective agreement and with a significant wage increases for health care workers'. However, the HEU remains concerned about the lack of specific commitment to senior care, in particular how the government will address the fragmented long-term care sector resulting in significant disparities in wages and working conditions across the sector (HEU, Feb 28 2023).

5.8 What unions and professional associations are doing

Health care unions and the representatives such as CFNU and CUPE, along with CNA have been conducting ongoing research on the emerging healthcare workforce crisis since the 1990s, preparing numerous submissions on the extent of the crisis and advice to government on how to address the crisis; organising campaigns to pressure government to respond to the workforce crisis; lobbying politicians; disseminating federal election platforms and preparing pre-budget submissions to advise government on spending priorities to address the healthcare workforce crisis (e.g. CNA, 2022; Silas, 2022; CUPE, 2022; HEU, 2023) .

For example, the Ontario Council of Healthcare Unions/CUPE worked with a coalition of labour unions including teachers' unions, the Ontario Nurses' Association and OPSEU to successfully appeal the Ford Governments' Bill 143 as unconstitutional. This bill aimed to limit public sector pay increases to 1% for 3 years. They are currently campaigning with other healthcare unions in Ontario for the Ford Government to boost frontline staffing; - provide responsive incentives to the current workforce and return to work for those who have left; relieve administrative pressure by hiring new hospital support staff; restrict the use of private health care staffing agencies; reject privatisation and commit to invest all new funding in public hospitals.

Unions continue to fight hard through collective bargaining to improve wages and conditions for healthcare workers. For example, following a decades long campaign supported by CFNU, nurses in British Columbia are the first province to achieve government mandated nurse patient ratios which will require the hiring of more nurses and can be used by unions to drive changes to nurse workloads. This is supported by an additional $750 million in new money for healthcare.

5.9 Conclusion:

Mental health issues are the leading cause of disability in Canada with high levels of burnout, especially amongst women and healthcare workers. These have been exacerbated by the Covid-19 pandemic. This is associated with healthcare workers reporting the highest levels of psychosocial risk compared to other occupations, with high workloads and long working hours key issues. These high levels of psychosocial risks have negative impacts nurses mental and psychological health and on the quality of patient care.

These problems are underpinned by a national shortage of healthcare workers that has developed since the 1990s, but without any sustained attempts by governments to address the issues. Nurses' and other healthcare workers' unions and professional associations have driven the research and data collection identifying the key issues affecting the healthcare workers crisis and used this to devise solutions and to lobby politicians and governments. Mandatory overtime is a key problem creating a negative feedback loop on other psychosocial risk including high work demands and work/life balance and is one of the key planks in campaigns and collective bargaining by nurses' union', along with nurse: patient ratios to address excessive workloads.

Canada's OHS legislation, regulation and compensation schemes are fragmented across the different provinces and with limited or no recognition of psychosocial risks and work-related stress. At a national level a National Standard for psychosocial risk exists as a voluntary standard, with some pessimistic as to its effectiveness.

The healthcare unions have been notably effective in their lobbying through influencing the key recommendations to the government's 2023 Standing Committee on Health report 'Addressing Canada's Health Workforce Crisis' and then lobbying the national government for real increases in the 2023 budget to enable these recommendations to be honoured, including new money to the provinces over the next 10 years to support key initiatives.

6.0 Psychosocial risks and mental health in the healthcare workforce: Brazil

6.1 Summary:

- Mental health, especially anxiety and depression, has become a society wide concern in Brazil. Yet the psychological health care is severely underfunded.

- Mental health is shaped by racial and economic inequalities, with poorer people and Afro-Brazilians being more affected.

- The 2017 Labour Reform resulted in a severe deterioration in workers' and trade union rights and led to increases in precarious work, lower wages, over-work and unpaid overtime, a decrease of collective bargaining and the financial collapse of the trade union movement, with unemployment and informal work increasing. Nurses' work became precarious with large amounts of overtime or working two jobs to survive financially and exacerbating psychosocial risks to which workers were exposes.

- Bolsonaro's austerity regime damaged Brazil's universal health care system. The funding cuts and labour law reforms cut healthcare workers' wages and created precarious and poor working conditions in hospitals which were exacerbated Covid-19 pandemic and led to increased mental health issues among healthcare workers.

- The negligent Covid-19 response of the Brazilian Bolsonaro government increased the psychosocial risks and poor mental health, especially, for health-care workers, with nurses and nurse assistants badly affected with burnout.

- The psychosocial risks and mental health of female healthcare workers is shaped by gender norms where women in healthcare face a triple burden: working at two jobs as well as unpaid domestic and care-work at home.

- Brazilian nurses have been mobilising for over 30 years for higher wages and a shorter working week. Last year the newly-elected Brazilian government approved a National Nurses Minimum Wage (NNMW) which is significantly higher than the National Minimum Wage. However, the NNMW has not been fully implemented as employers have used the Federal Supreme Court to limit its scope. Currently healthcare trade unions are mobilising to overturn this decision.

- With the newly-elected Lula government at least a partial reversal of the 2017 labour law is expected, however there are limitations to what can be achieved through political change, which requires the rebuilding of trade unions to ensure change is carried through despite employer opposition.

6.2 Overview of psychosocial risks and mental health in Brazil

Mental health problems, account for more than a third of total disability in Latin America and the Caribbean, with depression and anxiety disorders are the most common mental health problems (Pan American Health Organization (PAHO), 2018). In Brazil mental disorders constitute 1/3 of all work incapacity with depression the major cause and constituting over 30% of payment of sickness benefits unrelated to work accidents, followed by anxiety disorders with 17.9%. Yet, the psychological health care is severely underfunded with only 2% of these country's health budgets allocated for treating mental health (Rossi, 2020).

Research on psychosocial risks, mental health and work-related stress in Brazil is generally constrained by two aspects: a) there is a significant lack of data available as the government is not collecting basic statistics (Interview 1) and b) most of the academic research to date is shaped by the prevalence of Western theories, models, and instruments and thereby disregards the specific economic, social, and cultural conditions in Brazil (Ferreira *et al.*, 2021). Nevertheless, small scale studies of healthcare professionals suggest for example that burn-out symptoms have been present before Covid-19 and for nurses this is related to low pay and high workloads from excessive overtime including double shifts (e.g., Alves *et al*, 2016) and workplace violence (Fernandes, *et al.*, 2018)

As in many countries, the labour market in Brazil has been shaped by an increase in the degree of precarisation of work with a proliferation of its various forms which impact on mental health. What needs to be considered in this context is that Brazil is one of the most unequal countries of the world (Oriá, 21 December 2020), with a GINI co-efficient of 48.9 in 2020 (World Bank, 2020). These inequalities mean that socio-economic factors shape the prevalence and distribution of mental health within the population and access to mental health care. A recent study showed that lower educational standards increase susceptibility to symptoms of depression, anxiety, and stress, particularly during the pandemic (Goularte *et al.*, 2021). This is in line with a previous study across Latin America that found that mental health problems were less severe in highly educated neighbourhoods (Sampson *et al.*, 2019).

Furthermore, a review of the links between race/skin colour and mental health found evidence that mental health problems are more frequent among Afro–Brazilians than Whites, with indications for several underlying causes including links between stress and depression, and links between discrimination and negative mental health issues. Overall, there is very limited research on health inequalities in relation to race/skin colour, and in most studies the race is not included in survey questions, and where it is, it is rarely analysed as a variable of interest (Smolen and Araújo, 2017).

Finally, access to good quality healthcare is an increasing problem in Brazil at least for those in lower socio-economic groups or in poorer regions of Brazil (OECD 1, no date; Rocha *et al.*, 2021; Masuda *et al.*, 2018). Despite having universal health care through a public system, reductions in financing for public healthcare over the past two decades has compromised its capacity to deliver good care and access to services, with concerns being raised that the public system is fragile and will be further compromised unless there are increases in resourcing and a better distribution across the regions (Castro *et al.*, 2019). This, along with the growth of private insurance and private healthcare, with 25% of people having private health insurance, has exacerbated health inequalities in Brazil (OECD 1, no date).

6.21 Covid-19 and mental health in Brazil

Brazil was severely affected by the pandemic. By April 2021 Brazil recorded the highest number of fatalities from Covid-19 globally, with government policies directly contributing to the high numbers of excess deaths. The previous Brazilian Bolsonaro government and some state governments were negligent in their pandemic response (Saad-Filho and Feil, 27 April 2021).

Healthcare workers, in particular nurses, nurse assistants and nurse technicians were specifically affected. The situation for health care workers was exacerbated as the Bolsonaro government ignored the science, failed to develop a coordinated and planned crisis response. This was in a context where the health care system was already struggling due to a lack of financial resources and budget cuts (Cotrin *et al.*, 2020; Castro *et al.*, 2019). Brazil's universal health system has been degraded in recent years under Bolsonaro's austerity regime (Saad-Filho and Feil, 2021; Castro *et al.*, 2019).

In some more remote towns, there is often just one single nurse responsible for an entire hospital (Interview 1). This has created precarious working conditions in hospitals, which not only made the Covid-19 pandemic more severe than it had to be but also led to a mental health crisis among health care workers. Being unable to attend to several emergencies simultaneously and therefore being unable to help creates a desperate situation and a sense of "failure" that fosters mental health problems and occasionally suicide (Interview 1). The chronic problem of over-work and the resulting mental health problems were already the case before the pandemic, but it became extreme during the pandemic (Interview 1).

Many health care workers were forced to change their work routines, often moving from other unrelated jobs to treating Covid-19. Also, holidays and days off were cancelled for health care workers and even people who were sick were called back into work, leading

to exhaustion and burn out (Interview 1). In addition, they had to work in a high-risk environment where their personal health was put at risk. Personal protective equipment (PPE) was lacking or insufficient – for example, nurses received surgery masks but not N95 masks. Many healthcare workers died during the pandemic (as there is no obligation to report those death to the authorities it is unclear how many health care workers died) (Interview 1).

These changes, in combination with a lack of personal protective equipment, insufficient training and poor working conditions contributed to an increase of poor mental health of health care workers during the COVID-19 pandemic. Common problems were anxiety, depression, insomnia, problematic alcohol use, and psychosomatic symptoms (Cotrin *et al*. 2020) and a high prevalence of burn-out symptoms in frontline healthcare workers (Medeiros *et al.*, 2022).

Covid-19 exposed the deterioration in the healthcare system and exacerbated pre-existing psychosocial risks and mental health problems in the healthcare workforce.

6.3 The Brazilian Labour Reform of 2017

The 2008 Global Financial Crisis impacted upon Brazil from 2011 onwards. GDP was negative by 2015 (-3.5%) and 2016 (-3.6%) before reaching a fairly anaemic 1.1% by 2017, 1.89% in 2018, then followed by another decline in 2019 with 1.22% (Macrotrends, no date). The Brazilian government's response was to adopt legislation to reduce workers' rights and to freeze the budget on social protection. Between 2014 and 2016, the gross national income per capita fell sharply from US$12 202 to US$8840; those living in poverty increased from 20.4% to 23.5% of the population and more than 100 000 people became homeless. In 2017 (3rd quarter) unemployment was 12.4% (in Masuda *et al.*, 2018).

The Brazilian Labour Reform, carried out in 2017 under the then President Michel Temer (2016-2018), was supported and subsequently extended by the next president, Jair Bolsonaro (2018-2022). Silva (2019) and Nakaharada *et al.*, (2022) give comprehensive overviews of the main changes which included : approving the unrestrained outsourcing law (Lei No. 13.429, 2017) allowing all the activities of the companies, including the core-activities, to be outsourced and shifting employment to Civil Law rather than Labour Law; reducing the rights associated with Labour Law; challenging the rights of workers to improve their social conditions established by the Constitution; establishing the prevalence of the agreement negotiated between employers and employees over what is provided for by the law; attempts to restrict the jurisdiction of the Labor Court; extending the duration of the temporary work contract from 90 to 120 days, renewable

for the same period; allowing workers to sell their labour directly to the employer, without the need for intermediation by a company specialized in temporary work. By various means the legislation also legitimized the non-payment of overtime.

Health and safety provisions were also amended. For example, the law making it illegal to reduce the rights that are a part of the norms of health hygiene and safety at work was amended to exclude working hours and intervals, which were not to be considered as related to health, hygiene, and safety standards at work. In addition to legislative changes the effectiveness of regulatory bodies was undermined, for example by the temporary elimination of the Ministry of Labor and Social Security and budget cuts to labour inspectorates. This was accompanied by impunity for violations of labour rights which then leaves little incentive for employers to abide by labour and social protection regulations.

The International Labor Organization has condemned some aspects of the reforms as detrimental to workers. These provisions introduced extreme precariousness, including exhausting, intense, intermittent working hours, with a clear reduction of the payment levels for workers. The removal of legislative rights and protections worsened working conditions, increased workers' exposure to risks in the workplace, increased the risk of mental and physical illness and lower wages (Santana *et al.*, 2020). Wages have fallen from 2.74 *reais* in 2017 to 2.65 *reais* in 2022 (despite an inflation of nearly 10%) along with a dramatic rise in the informal economy. 39% of Brazilian workers (about 40 million) are informal workers (Konchinski, 4 November 2022), rising to 60% in some states in the Northeast Region (Dorcadie, 26 October 2022). These workers are largely in insecure work, with no employment contract, few rights and little social protection. They constitute a larger number than those working formally in the private sector (Konchinski, 4 November 2022)

While the economic recession and the Covid-19 pandemic have contributed to a further rise in unemployment and an increase in informal economy work, the 2017 labour reform and subsequent policies of the former President Bolsonaro made matters considerably worse (Dorcadie, 26 October 2022). Unemployment is high – still over 10% in 2022 - even though it improved slightly as the country recovered from the Covid-19 pandemic.

In 2022 the International Trade Union Confederation declared Brazil as one of the ten worst countries in the world for working people. The adoption of the 2017 labour law has enabled employers to regularly violate basic employment rights. Collective bargaining systems have collapsed, since the reforms allowed employers to tear up the standards agreed in collective bargaining agreements. There has been a 45% decline in the number of collective agreements. The Organisation for Economic Co-operation and

Development (OECD) Watch points to Brazil's "failures to protect the human rights of workers" (Nakaharada *et al.*, 2022).

While trade union membership had been in decline for years, the drastic changes by the 2017 labour law significantly diminished the ability of unions to advocate for workers – at the very moment workers needed their unions the most (Dorcadie, 26 October 2022). With the collapse of collective bargaining the number of strikes also decreased considerably from around 4,000 annually to less than 600 in the same timeframe (Fletcher and Gallegos, 15 May 2023). The reforms also limited the ways that trade unions collect resources, in particular union dues, and thereby they suddenly lost 99% of their income. Trade unions had to build new organisational structures with the capacity to identify workers and gain their consent to pay dues. They are largely relying on volunteers to do this (Dorcadie, 26 October 2022; Nakaharada *et al.*, 2022). This led to a drastic reduction of their funding, the de-structuring of unions, and significant loss of union bargaining power (Najaharada *et al.,* 2022) At the end of the dictatorship at the end of the 1980s, trade union membership was around 33 percent, but by 2023 it is only 10%, with the most dramatic decline taking place during the Bolsonaro government.

6.4 Work stress, psychosocial risks and mental health in nurses in Brazil:

The Michel Temer and Jair Bolsonaro governments introduced a series of economic and social reforms that exposed workers to psychosocial risks. The loss of social security and workers' rights, high unemployment with the dramatic increase in precarious work with no employment contract, and loss of bargaining power for trade unions and the impunity of employers to change working conditions and wages all contributed to lower wages and worse working conditions for all workers, including healthcare workers. This leads to increased exposure to occupational risks and to physical and psychological overload (Santana *et al.*, 2020).

The majority of healthcare workers in Brazil are nurses. Nurses' employment conditions are typified by short and temporary contracts with multi-employment and lack of institutional bonds, creating precariousness and insecurity in the work environment. A 2021 study that looked at data from the Regional Labor Courts in Brazil found that the new labour law 'brought harm and had negative repercussions for nursing work' (Farias *et al.*, 2021; Farias *et al.*, 2023). Precarious work in nursing has resulted 'in insecurity and work overload, limitations on breaks, excessive physical and mental effort, and doing double working shifts. Employers have the power to dismiss workers without

repercussions, reduce, change, or increase hours, lower wages and change the work schedules without prior notice.

Faris *et al* (2023) link this to increased physical and mental illnesses, work-related stress, job dissatisfaction and intention to leave the profession amongst nurses. They point out that precarity in nursing creates a professional dilemma. While there is a need for increased sophistication in their skills and knowledge, including new technology, required by nurses, the work demands and lack of resources limit nurses' capacity to extend their knowledge and skills to be able to effectively deliver the care they were trained for. Oliveira *et al.*,'s (2023) study of psychosocial risks and mental health indicates that these were key drivers of the large number of nurses (22.1%) reporting they intended to leave the profession.

Pousa and Lucca's (2020) review of psychosocial risk in nursing in Brazil identified the key psychosocial risks as: nursing work demands, work organisation, social relationships and leadership, work-home interface, workplace health and well-being and offensive behaviours. They identified that the daily work of nurses involved high cognitive and emotional work demands, high work pace and the hiding of emotions as a coping mechanism. In comparing nursing work in Spain and Brazil, Baldonedo-Mosteiro, *et al.*, (2019) concluded that nursing assistants suffer from higher levels of emotional exhaustion in both Brazil and Spain, compared to nurses.

High work demands for nurses in Brazil is particularly related to long working hours. For nurses the shift work is intense – 24-hour shifts are common in Brazil. While the work is hard, the pay is low. To make ends meet nurses often work two jobs and that means double shifts. Nurses are required to work at least 36 to 40 hours but often they work many more hours (especially during the pandemic), so when working two jobs their total hours can come up to 70-80 hours per week. Often this can take place in double shifts of working 24-hours shift in one job and then going straight to the next job to take on another 12 hours or even 24-hour shift (Trade Union Officers - Interview 1 and 2).

In addition to paid work many nurses have care responsibilities at home (Interview 1 and 2). In Brazil, 78.9% of the workforce in the primary healthcare is female. A recent study of primary healthcare workers examined the link between workload and mental health, in particular anxiety and depression. Female healthcare workers had higher workload scores in primary care roles than males, including in levels of mental demand, physical demand, frustration, and total workload. This study also included the unpaid domestic work of women in their workloads. The result showed that the higher workloads in both domestic and paid work experienced by women were associated with high levels of

depression and anxiety compared to men (Cezar-Vaz *et al.,* 2022). As such, many nurses face a triple burden: working two jobs and care-work at home.

The low wages and the long hours also mean that nurses and nurse assistants and nurse technicians do not have money and time for recreational activities and health care. It is a paradox that the very people that provide health care do not have access to it (Interview 1 and 2).

6.5 Worker shortages and the global recruitment of nurses

The ratio of the Brazil nursing workforce in 2019 of 8 per 1000 of population has been getting closer to the OECD average of 9.1 per 1000 of population and is much higher than for most Latin American countries (OECD 1, no date). Nevertheless, a key problem within Brazil is the unequal distribution of nurses across the different regions with a concentration of nurses in the economically richer southeast of the country, leaving other regions significantly under supplied (OECD 1, no date; OECD 2, no date).

Despite training a significant number of nurses, many skilled nurses are leaving Brazil once they are trained as there is a global shortage of healthcare workers and they can earn more money in global North countries. In recent years countries like Germany, Portugal and Canada have set up recruitment agencies in Brazil to recruit Brazilian nurses to fill the acute staff shortages in their respective countries since Brazil's nurses are well-trained. Simultaneously, Brazil is attracting nurses from other Latin American countries where their working conditions and the pay is even worse (Interview 1).

Recruiting international healthcare workers to cover domestic shortages avoids the responsibility of countries to train sufficient healthcare workers and to ensure working conditions and wages are sufficient to retain them. This is unethical as it leaves lower income countries with a deficit of healthcare workers that they can't afford.

6.6 What governments and trade unions are doing

Being very aware about the mental health issues caused by psychosocial risks including excessive workloads, long working hours (overtime) and poor pay, the unions representing nurses have fought for three decades for a dignified living wage through campaigning for a sectorial minimum wage for nurses and for a shorter working week. While doctors in Brazil work on average 20 hours a week, nurses are required to work at least 36 to 40 hours but often they work many more hours. As explained above, many nurses work two jobs as they cannot survive on one (Interview 1).

Currently, many nurses and especially nursing technicians and nursing assistants earn the national minimum wage or below (Interview 1). In August 2022 a significant victory was achieved with the new Brazilian government approving a National Nursing Minimum Wage (NNMW) which is about a 30% increase. The NNNW sets the minimum wage of R$4,750 (US$ 992) for nurses, R$3,325 (US$ 694) for nursing technicians and R$2,375 (US$ 496) for nursing assistants and midwives (Uni Global 17.02.2023). Hence, the NNMW is significantly higher than the current minimum wage of R$1307 (US$273). This was a significant victory for the unions; however, the problem is in implementing the law which the unions have been campaigning for across Brazil since early 2023.

To support implementation, President Lula da Silva will release 7.3 billion Brazilian *reals* to enable the minimum wage for nurses, midwives, and associated staff to be paid. While this will apply directly to hospitals under federal jurisdiction with the Supreme Court lifting its previous injunction, the Brazilian Supreme Court has now ruled that for nurses paid by the states and municipalities, they will only need to pay wages to the extent that these are covered by extra funding from the federal budget. Private hospitals have been exempted from the new law. The judges have also placed limits to its application to a proportion of wages where nurses work less than 44 hours per week and require collective bargaining for the payment of CLT professionals. These restrictions undermine the intent of the legislation.

At the time of writing (June 2023) large mobilisations of healthcare workers are planned and strike actions will commence from the 29th of June onwards to fight for the removal of restrictions and all nurses to receive the national minimum wage for nurses (Araújo 20. June 2023: Interview 1 and 2).

6.61 The current Lula government and its impact on workers mental health

The newly re-elected President-elect Luiz Inácio Lula da Silva promised in the election to build new labour legislation that "*guarantees minimum rights – such as labour and social security rights – and salaries for a dignified life*". This was re-iterated in his inauguration speech on January 1, 2023, where he specifically identified new labour legislation, implying at least a partial overhaul of the 2017 labour law (Gacek, 10.03.2023).

However, these promises need to be seen in context. The new President was elected by the democratic group Frente Ampla (Broad Front), a broad coalition of diverse political forces. So, it is very different from the Lula government of 2002, which was built on the strength of the Workers' Party together with trade unions, associations, and social

movements (Marques and Nakatani, 01 May 2023). In this new context it might be difficult to achieve fast changes to the 2017 labour law reforms and the subsequent radical neoliberal policies instituted by the previous Bolsonaro government.

The current focus of the Lula government in relation to the 2017 labour reform is: a) to reform the intermittent work rules, through which employees can be made to work without specific hours and be paid less than the minimum wage; b) the creation of a sustainable system of trade union financing with unions being able to decide on their funding mechanisms; and c) the creation of specific labour laws for the gig economy (Audi, 25 April 2022).

National collective bargain has been re-established under the current Lula government. The national negotiation group for healthcare workers that discusses policies and regulations on working conditions, working hours, wages and health and safety has been re-instituted, and similarly, a national negotiation group for all public sector workers has been re-created (Interview 1).

6.7 Conclusion

Poor mental health, especially anxiety and depression, are a major cause of ill health in Brazil, yet mental healthcare provision is severely under-funded. Mental health, like healthcare in general, is shaped by racial and economic inequalities with poorer people and Afro-Brazilians most disadvantaged.

In the context of poor economic growth and high unemployment, Bolsonaro's austerity regime damaged Brazil's universal health care system, exacerbating inequalities especially in the economically poorer regions of Brazil. The 2017 Labour Law Reform greatly circumscribed workers' rights, leading to a large increase in informal and precarious work, lower wages, over-work and unpaid overtime, poor working conditions and disregard for workers health and safety and undermining the rights of unions leading to further decreases of collective bargaining and the financial collapse of the trade union movement.

These reforms, together with funding cuts to healthcare, created precarious working conditions for healthcare workers and increased psychosocial risks especially increased workloads, with nurses working double shifts or two jobs leading to excessive working hours and low wages. This has negatively impacted on the mental health of healthcare workers, including depression, anxiety disorders and symptoms of burn-out.

The negligence of the Bolsonaro government's response to the Covid-19 pandemic increased the psychosocial risks for healthcare workers and exacerbated burn-out, post-traumatic stress, anxiety and depression, with nurses and nurse assistants particularly affected.

The mental health of healthcare workers also has a gender and racial dimension. The majority of nurses are women and face a triple burden: two jobs and care-work at home which exacerbates work-related stress. Afro-Brazilian health care workers are impacted by discrimination as well as higher levels of mental ill health in the Afro-Brazilian population.

The nurses have been mobilising for over 30 years for higher wages and a shorter working week. Last year the new Brazilian government approved a National Nurses Minimum Wage (NNMW) which is significantly higher than the National Minimum Wage. While the Lula Government has invested significant money to cover the additional payroll, the Brazilian Supreme Court is attempting to limit coverage and undermine the new law. With the newly elected Lula government at least a partial reversal of the 2017 labour law is expected.

7.0 Psychosocial risks, work stress and mental health in healthcare workers: Liberia

7.1 Summary:

- The psychosocial risks, the work stress and the mental health of health care workers in Liberia need to be seen in the context of 14 years of civil war and the Ebola epidemic which had devastating effects on the health care system overall, as a large proportion of the healthcare workforce died or migrated.

- A key government strategy for the health care system recovery was to develop a large system of volunteer healthcare workers, including extending their reach to rural and remote areas. As such, large sections of the Liberian Health Care system were built on unpaid labour.

- Liberia has invested in the training of nurses, midwives and doctors and since 2010 the numbers of health care workers have increased. Yet there is still a systematic

lack of staff in the health care sector. Insufficient staffing and the irregular or non-existent payment of wages have led to fatigue, burn-out, depression and other mental health problems.

- A key barrier to fixing the problem of understaffing is the IMF imposed freeze on government employment as a part of structural adjustment programmes.
- In recent years health care workers have organised to fight back against unpaid volunteering and poor wages, staff shortages and poor working conditions. In 2010 they created a new union, the National Health Workers Union of Liberia (NAHWUL), despite legislation banning healthcare workers from forming unions, engaging in collective bargaining, or taking strike action. The union now covers up to 80% of the healthcare workforce, despite harsh victimisation of union organisers, including being forced into exile. In 2019 they had 6,000 healthcare workers on strike.

7.2 The context of Liberia:

Liberia's healthcare system has been severely affected by the many years of a civil war that destroyed the fabric of the public sector. The war started in 1989 and lasted 14 years with a short period of peace between 1997 and 1999. Around a quarter of a million people were killed during the war and about 1 million people fled the country – among them many health professionals. Before the war, in 1988 Liberia recorded 3526 healthcare workers, by 1998 this number had shrunk to 1396, with only 89 doctors and 329 nurses and 242 out of 292 health facilities destroyed (Varpilah, 2011).

While the country, and specifically the healthcare system, was still recovering from the devastating effects of the war, the next crisis hit: The Ebola outbreak from 2013-2016 killed more than 4,800 people, including more than 150 healthcare workers. Almost 10% of Liberia's doctors and 8% of its nurses and midwives died in the Ebola outbreak (Fall, 2019). Barely having recovered from that, in mid-March 2020, the first cases of Covid-19 were recorded in Liberia. Unlike many Western countries, Libera reacted very quickly, drawing on their experience of the Ebola epidemic. The government implemented infection control measures, including lockdown, contact-tracing, social distancing, screening of travellers and educational awareness raising to address fear and stigma (Alhassan *et al*. 2023).

Liberia's response was so fast because it drew on a decentralised community-based strategy with healthcare workers doing a door-to-door response to tackle COVID-19 misinformation, including myths about vaccination. This was very successful: Liberia had

a vaccination rate of 81% by the end of 2022 (WHO, 2023c). However, the redeployment of healthcare workers to focus on the response to the COVID-19 outbreak created further gaps in the already over-stretched healthcare service (Babalola, 2022). Like many low-income countries, Liberia is facing another chronic threat to its health care system: the IMF's loan conditionality that demands cuts in public spending. This systematically undermines Liberia's development of an effective healthcare system.

7.21 IMF imposed spending cuts

A study from 2017 that analysed IMF programmes from 1995 to 2014 to identify the pathways and the impact of conditionality on government health spending in 16 West African countries, including Liberia, found that "*IMF policy reforms reduce fiscal space for investment in health, limit staff expansion of doctors and nurses, and lead to budget execution challenges in health systems*" (Stubbs *et al.*, 2017). A study from 2020 by Public Services International and Action Aid revealed that in Liberia the IMF recommended the country cut its public sector employment funding by 17%, which had severe impacts on the healthcare sector (PSI and Action Aid 2022).

This is a striking finding as previous research suggests that the IMF imposed spending cuts might have weakened the health care system and thereby contributed to the circumstances that have enabled the Ebola outbreak (Kentikelenis *et al.*, 2014).

7.3 Mental Health in Liberia

As the consequence of the long civil war, as well as poverty and the Ebola crisis, many people in the country suffer from post-traumatic stress disorder (PTSD). The brutality of the war, the use of rape, including gang rape as a structural weapon, and the use of child soldiers has left a deep imprint on the mental health of society. It is estimated that around 40% of the girls and women have been subject to rape in the war. The UN had estimated that in the Liberian civil war up to 20,000 children, some as young as six years old, became child soldiers. Among previous child soldiers, mental health problems are particularly high with it being estimated that up 20% of them have committed suicide, with up to 36% of girl child soldiers having committed suicide (Child Soldiers International, 2021).

Yet, the issue of mental health is not so well understood in Liberia and there is still huge stigma around it. Consequently, it is difficult to estimate how many people are affected. However, according to Libera's 2017 strategic mental health plan around 400,000 people in Liberia suffer from mental health, epilepsy, or addiction problems, which is more than 10% of the population (Ministry of Health and Social Welfare, 2016).

7.4 Liberia's Healthcare System and financing

Liberia's healthcare system has been highly dependent on humanitarian healthcare delivery systems. After the war, the Liberian government had no transition plan. Liberia had received nearly continuous aid through 16 years of conflict and post-conflict reconstruction. When the humanitarian aid organisations withdrew their services, this caused a public health emergency. The Liberian government depended on the humanitarian response for staffing, materials, pharmaceuticals, logistics, resources as the state-administered clinics and hospitals remained unable to provide effective healthcare delivery (Abramowitz, 2016). Even years after the war international funds still supported 80% of all healthcare jobs (Ibid.).

7.41 Healthcare workers shortages in Liberia

In 2016, the WHO published a study that showed a shortage of 9 million nurses and midwives worldwide. Poor countries are particularly affected with 70% of this shortage in lower middle- and low- income countries (Peters, *et al.*, 2020). This is a growing problem because globally, the demand for health workers is predicted to double to 80 million by 2030. So, by then the gap will have increased to 18 million, again most of them missing in low- and middle-income countries (WHO Regional Office for Africa, 2023). While in Africa the shortages of nurses are particularly severe, the numbers of nurses is currently rising on the continent. Adjusting for population density, the growth rate for nursing in the African region was 17.78 % between 2015 and 2020 (WHO Regional Office for Africa, 2023).

Nurses and midwives are pivotal to running a healthcare system and with many African countries having comparatively low investment in healthcare, the demand for nurses can be estimated either in relation to actual healthcare spending or, alternatively, be based on population needs. Ironically, while there is a shortage of nurses and midwives based on need, in some African countries nurses and midwives can experience unemployment because there are insufficient funding to create positions, meaning there is limited absorption capacity. Based on capacity to pay, the demand for nurses and midwives in the African region was approximately 4.2 million. With recent economic instability and uncertainty, the capacity to pay may reduce demand by 15% to 2025, before it picks up again in 2030. In 2020 there were at least 18,473 to 31,000 unemployed nurses in the African region (WHO, 2022).

Using a needs-based approach that included the disease burden and population demographics of specific countries, the need for nurses in 2020 was 4 million, rising by

20% in 2025. The supply of nurses in 2020 was 39% of the need in the African region overall (WHO, 2022). This distinction between capacity demand and population needs regarding the healthcare workforce is relevant to the case of Liberia where resourcing of healthcare, especially in the context of repeated challenges, is limited and precarious and where frequently, healthcare workers are not paid and so are working voluntarily, although often with a hope for paid work.

Like many Sub-Saharan African countries, in Liberia the brain drain of health care workers is significant with many health care professionals leaving to country to take on jobs abroad when they finish their training. In 2013, a study found that more than half of the newly trained health care staff left Liberia in the same year (in Peters, 2020).

In 2018 there were 246 doctors and 9415 nurses and midwives in Liberia, which together have a ratio of 2.013/1,000 population. While this has significantly increased from 2010 (0.449 nurses per 1,000 population), it remains significantly below the WHO recommendation of the 4.45 /1,000 population needed for Universal Health Coverage in the African region and which is part of the WHO Sustainable Development Goal (SDG) 3 (PSI, 2022).

7.42 Development of community health networks

Much of the health services in the communities, especially in rural and remote areas, is delivered by community health workers (CHWs) often supervised by nurses and mid-wives. CHWs are key in screening, monitoring and intervening in the control and treatment of infectious diseases such as malaria and HIV, maternal and child health and preventative medicine, for communities more than five kilometres from a health facility (Chen *et al.*, no date)

A key problem in the nursing workforce in Liberia is that it is highly dependent on unpaid volunteer labour. In 2008, the Liberian government launched the National Policy and Strategy on Community Health Services, since at that time there were only 51 doctors to serve a population of 3.7 million. The community health service strategy introduced a network of unpaid community health worker volunteers to quickly improve access to basic health care. By 2013 Liberia had 8,052 health worker volunteers (Chen *et al.*, no date).

This system of community-based healthcare suffered from fragmentation and inconsistency of the organisation and service provision so in 2016 the Liberian Government introduced a revised National Community Health Services Strategic Plan with the introduction of a new group of paid community health workers, called

Community Health Assistants (CHAs), which are intended to upgrade quality of the community-level workforce. In 2019 there were 3,761 CHAs and their supervisors and the policy aims to have one CHA for every 40-60 households or 350 people, which will require 4,000 CHAs and 400 supervisors (Chen, *et al.*, no date; Simen-Kapeu, *et al.*, 2021). Despite considerable donor pressure (IMF/World Bank) on the Liberian government for this workforce to be voluntary, as a compromise the government provided CHA's with an 'incentive payment' of $70/month (Rogers, et.al., 2020). Liberia is dependent to some extent on the support from NGO donors for these payments. At this time, the government also improved wages and incentive payments for nurses and doctors in to increase recruitment and retention, resulting in an increase in numbers from 2010 levels.

This Illustrates the ongoing contradiction between donors such as the IMF and the World Bank and the restrictions they impose on public sector employment and wages (in return for loans) and the need for a qualified and skilled healthcare workforce to reach SDG3 - Universal Health Coverage. There is additional need for healthcare workers with the emergence of chronic disease and associated risk factors, with non-communicable diseases estimated at 37.9% of Liberia's total disease burden and constituting 43.4% of all deaths in 2016 (Beddoe *et al.,* 2022).

7.5 Psychosocial risks in the healthcare workforce

7.51 Insufficient healthcare professions and reliance on volunteers

The healthcare workforce has a significant shortage of doctors and nurses and relies upon volunteer community-based healthcare workers with limited training and insufficient support. A representative from the National Health Workers Union of Liberia estimates that 7 out of 10 health care workers are volunteers and work unpaid. Workers take on unpaid volunteer positions in the hope of gaining a paid job. Yet, these hopes often did not become reality (Interview with a trade union representative).

"People started to volunteer, hoping that one day that they would get employed…. And some people worked for years … some worked for ten years plus, working for nothing" (Interview with a trade union representative)

7.52 Excessive workloads and moral distress

With chronic understaffing healthcare workers experience excessive workloads and long working hours.

Usually, nurses are divided between 2 shifts – of twelve hours each. Yet often, due to understaffing, there is only one shift from 8am-4pm and then there is a person on call. This means that there is an emergency then you need to stay on (Interview with a trade union representative).

Excessive workloads means that healthcare workers are unable to give patients the care that they have been trained to provide. As the trade union officer explained, if one health care worker has to take on too many patients, they are unable to help all of them in the same time. In addition, if the right supplies are not there to support the patients' needs, then if their health deteriorates or if patients die because they could not be helped in time, the healthcare workers feel moral distress.

And then people tend to blame themselves, you hold guilt and these really plays on the mental health of workers in the country (Interview with a trade union representative)

7.53 Impacts healthcare workers mental health

The excessive workload leads to exhaustion, burn-out, depression and other mental illnesses amongst healthcare workers (Interview with a trade union representative).

7.6 Healthcare and labour laws: building a new trade union

The National Health Workers Union of Liberia (NAHWUL) was founded in the 2010 and it started to represent all types of workers in the healthcare sector, both paid and unpaid workers. In Liberia it is illegal for public sector workers to organise into unions and to collectively bargain (PSI, 2016). Liberia's 2015 Decent Work Act bars workers in essential services from striking (Republic of Liberia, (2015). Despite this, the healthcare workers organised and fought for their right to set up a union. The initial campaign was initially focussed on the large numbers of healthcare workers being volunteers and not being paid and so they fought for more paid positions for healthcare workers. Large numbers of healthcare workers joined the union with up to 80% of workers becoming a part of the union, including joining the subsequent strike actions which had large turnouts and with large numbers of workers attending union meetings. (Interview with a trade union representative).

The NAHWUL first lobbied the ministry of health and the civil service agency. After 6 months of strike action over unpaid labour in the health sector, in July 2013 they succeeded in forcing the government to promise to employ 2000 more health workers annually from 2014 onwards. However, the recruitment system was not transparent with

no clear criteria and with personal networks being prioritised rather than volunteers being offered paid positions.

The 2014 Ebola epidemic further exposed the failings of Liberia's health care system including the issue of unpaid labour. Despite attempts by the union to dialogue with the government about the dire working conditions for healthcare workers during the Ebola epidemic, including the deaths of 10% of healthcare worker population, and following a national strike of healthcare workers, the government fired 22 union leaders without any hearing. Following an intervention by a range of stakeholders and alongside an international campaign, twenty union leaders were reinstated, except for the President and General Secretary of NAHWAL. After further international pressure they were eventually re-instated. However, during a 2020 national strike by NAHWUL, its key leader was forced into exile from where he continued to campaign. These tactics of trade union victimisation continue to be common in Liberia.

In 2018 some health workers were wrongly removed from the government payroll system and a government wage-harmonisation exercise saw the reduction of salaries of health workers in 2019. Consequently, 6,000 health workers walked out and went on strike in September 2019 (Crisis24, 24 September 2019).With the increasing influence of the NAHWUL on the government, employment conditions for health care workers have begun to improve with more healthcare workers on the payroll and receiving more stable employment conditions.

A key win in the campaign for union recognition was NAHWUL's success in gaining agreement to have union representatives on the Boards of some referral hospitals and on some regional health boards. The health boards with union representatives potentially provide opportunities to hear the workers' views on policy issues and for them to take part in some decision-making. This is a landmark victory since inclusion of union representatives on boards gives legitimacy to the union`s quest for recognition by the government and inclusion in social dialogue.

However, many health boards remain hostile to unions and refuse to have workers' representatives on their boards. Even where they are present on boards, often the boards do not listen to the concerns of workers. (Interview with a trade union representative). Despite this functional acceptance of the NAHWUL, there is currently no legal recognition of NAHWUL by the government of Liberia in employment relations.

7.7 Conclusion:

The Liberian healthcare system was almost decimated by civil war, followed by the Ebola epidemic, with a large proportion of the healthcare workforce dead or migrating. A key government strategy for recovery was to develop an extensive system of volunteer Health Care Workers, including extending their reach to rural and remote areas. This was subsequently supplemented by the incorporation of trained Health Care Assistants, who received small incentive payments and who were supervised by trained health professions, mainly nurses and midwives. Healthcare workers are focused on monitoring and assessing infectious diseases and maternal and child health. While Liberia has worked hard to train nurses, midwives and doctors and has been increasing their numbers since 2010 there is still a severe shortage.

A key problem for recruiting more healthcare workers is the IMF-imposed freeze on government employment as a part of structural adjustment funds. While there is a shortage of doctors and nurses there is simultaneously a problem of unemployment and job insecurity for healthcare workers. This is made worse by irregular or non-existent payment of wages. Staff shortages leads to chronic overwork by the existing staff and associated issues of fatigue, burn-out, depression and other mental health problems.

Healthcare workers have responded to these workforce shortages, poor wages and poor working conditions by forming a new trade union (NAHWUL), despite legislation banning healthcare workers from forming unions, engaging in collective bargaining, or taking strike action. The union now covers up to 80% of the healthcare workforce and despite harsh victimisation of union organisers, including being forced into exile, they have successfully campaigned for the payment of unpaid wages, for increases in the numbers of healthcare professionals and for trade union representation on the national health board. More recently they have had 6,000 healthcare workers going on strike for increased wages.

This case demonstrates the interplay between a low-income countries and international funding bodies, such as the IMF, in restricting the capacity of governments to develop their healthcare systems as well as the capabilities of government and unions in overcoming these constraints to rebuild the Liberian healthcare system. It demonstrates the power of trade unions to organise and achieve significant changes in working conditions for healthcare workers, in the face of significant anti-union laws and persecution by the government.

8.0 Discussion and Conclusion

Globally, work-related stress has been increasing for several decades and affects both mental and physical health. These issues are most severe in healthcare, social care and education occupations, all public sector dominated industries in which most workers are female. These high levels of work-related stress and mental health issues affect both men and women in these industries. Increased burnout, anxiety, depression, and post-traumatic stress was apparent in healthcare workforces prior to the Covid-19 pandemic but which exacerbated these issues in all the countries examined in this report.

There is a relationship between the increases in mental health problems and work-related stress in the healthcare workforce globally and the imposition of neo-liberal policies, as seen through public sector reforms, privatisation, cuts in public spending and the under-investment in public services. These reforms lead to reductions in real pay and deteriorating working conditions, problems of recruitment and retention of public sector workers, which then affect the quality of public services.

The rise in work-related stress is associated with increasing levels of psychosocial risks. These links between psychosocial risk have been demonstrated empirically as well as theoretically. Common psychosocial risks in healthcare include: high work demands, low control and autonomy (especially in long term care, and for women through routinising of work and deskilling, and reduced decision-making), long working hours, insufficient rest for recovery between shifts, high emotional demands; high work/life conflict; poor communication; lack of professional development; moral distress through conflicts between limitations on capacity to provide care and professional standards; lack of time or opportunities for management or peer support; violence and harassment at work, low wages and precarity which contributes significantly to financial stress in some workforces. These risks are common across all the countries investigated, although the specific dynamics and patterns of interaction are shaped by the country-specific economic, political, and social contexts.

A gender-sensitive framework is required to understand the dynamics that lead to workplace psychosocial risks and poor work environments, one which incorporates the multiple levels that shape workplace psychosocial risks and work environments. This includes gender differences in funding and financial models, the way that work is organised and monitored as well as the social valuing attending women's' work, including how pay reflects these values. These issues are highlighted, particularly in the case of Sweden, which has developed a relatively sophisticated understanding of these interrelationships particularly through the research programs and investigations of the Swedish Work Environment Agency.

Pay has a central role in the patterns of psychosocial risks in healthcare, although it is not usually included in risk assessments, with Sweden being a notable exception. Most healthcare workers, largely women, are on relatively low and often declining wages. This may require working extensive overtime or two jobs to survive, with women also taking primary responsibility for unpaid childcare and domestic work, resulting in a triple workload burden for women. This links pay to long working hours and excessive work demands. These issues are particularly salient for health care assistants and those working in long term care as well as healthcare workers in middle- and low-income countries where precarity and job insecurity compound the psychosocial risks within workplaces. In high income countries, such as Sweden, poor wage premiums for specialist nurses has led to nurse shortages in key specialties.

Over the past forty years a substantial body of empirical evidence and theory-based research has developed demonstrating the links between psychosocial risks and poor mental and physical health in healthcare workers as well as with poorer patient outcomes including increased morbidity and mortality. These constitute a significant financial burden both to the healthcare system and to workers compensation regimes. Much of this research has been driven by nurses and other healthcare workers, the nursing professions and by trade unions within countries and through international collaborations. This research then informs evidence -based policy development and is effectively used in the development of white papers and in submissions to various government commissions on healthcare, mental health of workers and OHS matters. Notably the healthcare unions have used this knowledge to effectively influence the key policy recommendations within governments, for example the Canadian government's 2023 report on 'Addressing Canada's Health Workforce Crisis' and to apply leverage on the national government to provide the new money to implement the recommendations.

However, there are significant gaps in the research on the dynamic of psychosocial risk in healthcare and their links to broader organisational and political processes, and in applying gender-sensitive frameworks. The very high levels of health inequalities in Brazil are linked to socio-economic conditions and to race, which suggests that these may also be highly salient to understanding the dynamics of psychosocial risks, with patterns and outcomes likely to be context-dependant.

Psychosocial risks and poor work environments are caused by the way work is organised so are modifiable by key agents. They are not inherent to the nature of health care systems. Like other occupational hazards, psychosocial risks are amenable to intervention. The development of occupational health and safety research and subsequent legislation has largely focused on physical risks which are relatively easy to

identify, measure and prevent or ameliorate. However, with rising rates of work-related stress and mental illness linked to psychosocial risks, many countries have begun to acknowledge and address these issues, including in some countries through legislation and regulation. Internationally there is a high degree of variability as to whether psychosocial risks are considered under OHS legislation and regulation and where it is present, the ways this is addressed. The extent of legislation for psychosocial risks is independent of the income status of countries with both high and low incomes countries, including some in the EU, failing to have any legislation regarding psychosocial risk, while some middle- and low-income countries do. While many countries have legislation to prevent workplace violence, and to address bullying and harassment, there is much more limited coverage of psychosocial risks, as well as often non-existent or very limited coverage of chronic work-related stress in workers compensations schemes.

Sweden has invested in strong OHS legislation, including for psychosocial risks and the work environment since the 1970s. Over the decades since then the legislation has progressively been strengthened, sanctions have been developed as well as research programs on the work environment and work-related stress. The regulatory body, SWEA, invested in specific training for inspectors on psychosocial risk assessment and intervention and was funded to conduct an extensive national education program for employers, trade unions and workers on psychosocial risks and invention strategies based upon their model of social dialogue as a change mechanism. SWEA was also directed to carry out industry-level programs of psychosocial risk assessment and intervention.

Despite, these developments in OHS legislative and regulation, Sweden has a healthcare workforce crisis with understaffing leading to high levels of work-related stress and associated psychosocial risks. This crisis has exposed failing in the legislative and regulatory regime, including issues concerning the use of sanctions and fines for recalcitrant employers, insufficient resources for workplace inspections, employer strategies to undermine address psychosocial risk assessment and intervention, poor training provision and insufficient resourcing by employers in psychosocial risk management for workplace health and safety representatives.

Nevertheless, OHS legislation and regulation remains an important platform through which trade unions can gain leverage to address poor work environments and work-related stress. The Australian case demonstrates the power of trade unions to improve OHS legislation to specifically address psychosocial risks in the workplace, to achieve standardisation across the various state jurisdictions, and to address the failings of

regulatory bodies and inspectorates. The nurse' union (ANMF) in Australia has taken over the training of its health and safety representees ensuring they get both adequate training in psychosocial risk assessment and intervention specific to the setting in which they work, and the resources they need to do inspections. This has enabled the union to build networks of OHS inspectors which also helps to build the strength of the union. In a coalition with other trade unions, they are advocating for further legislative changes including their right to prosecute recalcitrant employers themselves, rather than rely upon the regulators.

It is, however, through collective bargaining and building the strength of trade unions that offers the most fundamental mechanism for trade unions to address the healthcare workforce shortages and understaffing that underlies the rise in psychosocial risk and work-related stress. The Australian case demonstrates one way through which evidence-based research, political advocacy, building community support and collective bargaining with industrial action together can be effective in instituting change. In this case, through winning nurse: patient ratios to address understaffing in hospitals.

Following over a decade of campaigning, the nurses' union in the State of Victoria won government mandated nurse: patient ratios of one nurse to four patients in general wards to address the chronic shortages and overwork of nurses. The legislation passed in 2015. This was the first jurisdiction in the world to achieve this (Gordon, et al., 2008). Since then, amendments to the Act in 2020 have further improved ratios and extended their application. The Act itself politically establishes the link between staffing levels and patient safety as central [Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act]. Nurse: patient ratios are subsequently spreading to other states in Australia as a key mechanism for nurses on wards to easily identify short staffing and to hold management to account in their efforts to address the problem as it occurs in real time. Key to their successful industrial campaign was linking staff shortages to the quality of patient care and building community support for their industrial action.

Despite these ratios, understaffing is often still an ongoing problem with employers trying to find loopholes in the legislation to circumvent the legislation. This is occurring even in major teaching hospitals in Victoria (Rollason, 2023). However, the advantage for the union is that nurse: patient ratios provide much more clarity than there was previously, making it easier to hold recalcitrant employers to account, as well as governments to ensure funding is adequate to enable hospitals to fulfil the requirements of the legislation.

In both these cases, OHS and nurse: patient ratio legislation, while good legislation and regulation is fundamental, their effectiveness depends upon collective bargaining and

union organising power. Collective bargaining over pay and other working conditions remains fundamental to trade unions ability to respond to national healthcare workforce crises.

Governments use of neoliberal policies to reduce investment in the public sector, including in healthcare, has simultaneously been accompanied by the undermining of trade unions through anti-union legislation to make it more difficult for trade unions to organise and finance their activities. This has been happening globally, with falling rates of union membership and reductions in the number of workers covered by collective agreements. While public sector unions in high income countries, especially in healthcare, have been somewhat more resilient in maintaining membership and with nurses having large member bases, resourcing, and organising has been undermined to some extent. The case of Brazil exemplifies the extreme damage done by labour law reforms that roll back the protections and right of workers and of trade unions. Healthcare workers' wages fell, they were exposed to increased precarious and insecure work and very long working hours, with increased levels of psychosocial risk and work-related stress. However, with the recent change in government and a more progressive President, the nurses' union has won mandated National Nursing Minimum Wage following over a decade of campaigning. Nurses' wages will increase by up to 30%. Subsequently, employers have attempted to use the Supreme Court to circumvent the legislation by placing limits the applicability of the national nurse minimum wage. In response trade unions are currently coordinating a massive campaign for fight these limitations.

Similarly in Liberia, which has legislation banning trade unions, collective bargaining and strikes for public sector workers, including those in healthcare. Healthcare workers endure low wages, infrequent payment, often working voluntarily in the hope of being paid or gaining employment. Even under these very difficult circumstances, trade union leaders have demonstrated the power of trade unions to organise and achieve significant changes in working conditions for healthcare workers, despite anti-union laws and direct persecution of union leaders by the government.

A part of neoliberal policy agendas has been attempts by governments to undermine the power of trade unions and to roll back the wages and working conditions of workers, with negative impacts on workers' health. Healthcare unions, while significantly impacted by anti-union legislation, have proven resilient and adaptable in making use of progressive changes in government, while recognising the limitations of relying solely upon political change. The implementation and effectiveness of any progressive legislative or policy changes in relation to national healthcare workforce shortages and

psychosocial risks ultimately relies upon the power of unions and their capacity for collective bargaining.

The global healthcare workforce crisis has been acknowledged by governments and international organisations since the mid-1990's and is associated with the dissemination and influence of neoliberal economic and politics which have undermined public healthcare systems. Lack of investment in national healthcare systems and workers has led to global shortages of healthcare workers. A key policy approach by high income countries in attempting to fill gaps has been aggressive international recruitment of migrant healthcare workers. This further depletes the health care workforces in middle- and low-income countries which can least afford the loss of workers they have invested in training. Some middle-income countries, for example, the Philippines, have traditionally trained large number of nurses knowing that some will go overseas and that overseas remittances contribute to the support of local communities. However, since the Covid-19 pandemic demonstrated the risks of understaffing, even The Philippines, a long-standing source of overseas nurse for high income countries, is suffering a shortfall of 350,000 nurses with governments now expressing deep concerns about the impact on their own healthcare systems (Pauls, 2023). WHO has identified international recruitment of the healthcare workforce as an ethical issue and developed a list of 55 vulnerable countries from which high-income countries should not recruit, and in countries where recruitment does happen that the source countries should receive comparable benefits from the host countries (Walton-Roberts & Bourgeault, (July 11 2023).

The alternative to the unethical practices of aggressive recruitment through exploiting middle- and low-income counties production of healthcare workers, is for high income countries to invest in rebuilding their own national healthcare workforces by drawing upon the knowledge, skills and experience of healthcare workers and their trade unions.

9.0 Key recommendations

9.1 International Level

9.1.1 Challenging the global neoliberal 'consensus' and its drivers

9.1.1.1 Campaigns to increase government pro-public spending policies and the wider financial well-being of governments, with unions working with civil society organisations (CSOs).

9.1.1.2 Strengthen campaigns against Central Bank policies that target inflation rates and set ceilings on wages/ employment and international organisations such as the WTO, World Bank and IMF that limit spending on public services in low and middle incomes limiting their capacity to develop effective healthcare systems.

9.1.1.3 Continue to campaign to reduce the influence of International Financial Institutions (IFIs) on health and social care services.

9.1.1.4 Strengthen campaigns against the privatisation of public services, reductions in government spending and outsourcing of public services to the private sector.

9.1.1.5 Support campaigns for international tax justice and the reduction of corporate tax evasion.

9.1.2 Migration of health workers

9.1.2.1 Aggressive recruitment of migrant health workers can lead to healthcare workforce labour shortages that can compromise health care delivery in the source countries. WHO and ILO recommendations regarding the recruitment of migrant workers should be the minimum standards, including not actively recruiting from the 55 countries identified by WHO as having vulnerable healthcare systems and ensuring that there are equitable benefits for the source countries compared to those for the receiving countries.

9.1.2.2 PSI should build on the work of the PSI Migration and Refugees project to raise awareness of the links between migration, labour shortages and psychosocial risks through workshops and commissioned research.

9.2 National Level

9.2.1 Action on wages and job insecurity

Low pay and job insecurity are core issues that contribute to increased psychosocial risks. Actions to reduce psychosocial risks must start with campaigns for improved pay and job security.

9.2.2 Health worker safe staffing levels

Mechanisms that establish safe staffing levels, such as mandated patient ratios, provide transparency and accountability in staffing numbers which enable unions to hold employers to account. Campaigning for these mechanisms is an essential part of

addressing workloads and stress that underpin a range of psychosocial issues. The established links between excessive workloads and the quality of patient care is a key rationale for this campaign and for creating trade union coalitions with patient advocacy and community groups locally.

9.2.3 Increased training places and support for trainees

Training places need to be increased sufficient to the needs to replenishing the healthcare workforce and reducing dependance on migrant labour. Collaboration between governments, training institutions and trade unions on key ways to increase recruitment and retention of healthcare worker students and trainees including in-work support for new graduates

9.2.4 OHS Legislation, regulation and training for psycho-social risks

Joint trade union campaigns that aim to ensure that psycho-social risks are included in health and safety legislation and that work-related stress is recognized in worker compensation schemes provides leverage for trade union in relation to employers. This needs to be accompanied by the training and resourcing of labour and health and safety inspectorates. Occupation-specific training of trade union Health and Safety Officers in psychosocial risk assessment, interventions and campaigns at the workplace level should be resourced preferably by government to enable trade unions to lead on training and building support networks of health and safety officers (as happened for example in Australia).

Legislation can be enhanced by allowing trade unions to issue stop work notices in relation to psychosocial risks and to be able to take prosecution against recalcitrant employers. This would help counter governments practices of under-resourcing labour inspectorates.

9.2.5 Harmonisation of OHS legislation

In countries with federal systems of government the devolution of OHS legislation can lead to highly inconsistent approaches. The case of Australia shows how national harmonization of OHS legislation across states can lead to improvements in states with poorer legislation. Trade unions can start by taking the best case and develop a relationship with key stakeholders to support harmonisation of legislation.

9.3 Data collection and research

Nurses and healthcare worker trade unions have been at the forefront of establishing the links between psycho-social risks, work-related stress, mental and physical health of healthcare workers and the links to the quality of patient. This research has been effectively used to educate healthcare workers about the issues they face collectively, assist in formulating trade union strategies, to influence policy makers and politicians and to galvanise healthcare workers and the public to take action. Further research should focus on understanding specific patterns of psychosocial risk and their interrelationship within specific healthcare occupations and contexts at a country specific level and their intersections with gender, class, age, precarity and pay. To understand the underlying causes of these issues requires examining how macro-level factors such as privatisation and funding and financial models impact on the work environment and psychosocial risks.

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Appendix 1: Research Questions and Methodology

This report was commissioned by Public Services International (PSI) in April 2022 to address the following research questions:

1. What are the main global trends in mental health? What are the structural causes of the mental health crisis with particular regards to employment?
2. What policy changes are required globally as well as nationally in selected countries that promote health and care workers mental health?
3. What are good practices of trade unions responses to the mental health crisis, specifically in what way have unions affectively shown that universal quality public services alleviate mental health problems and/or that collects evidence on the employment related structural causes that is driving the mental health crisis?
4. What are the positive benefits of universal quality public services to mental health and wellbeing and build alliances with allies in the sector

A key-factor-based literature review was conducted to establish the key factors in the link between psychosocial risks, work environment, pay and precarity with work-related stress and mental health. The ways in which gender, class and race, and macros-level factors such as funding regimes, financial models, labour market programs and economic, social and political factors impact on the links between work-environment,

psychosocial risk and their adverse outcome including on the mental health for healthcare works. In particular, the research considered four areas: I) psycho-social risks and the work environment II) pay/precarious work, III) quality of work and IV) industrial democracy/ social dialogue.

A series of meetings between PSIRU and specific PSI affiliates was conducted to identify the evidence from their own research/ campaigns that links mental health, working conditions and public services. From these discussions the five case studies were identified, with case selection guided by sampling form high- middle- and low-income countries in different regions. Expert interviews with PSI affiliates and other stakeholders in the field were used to develop the case studies.

Appendix 2: List of Interviewees by country

Sweden:

Interview 1: Trade union official from Vardforbundet, interviewed by Safak Tartanoglu Bennett

Australia:

Interview 1: Senior trade union official from Australian Nurses and Midwives Federation, New South Wales branch, interviewed by Ruth Ballardie

Interview 2: Senior trade union official from Australian Nurses and Midwives Federation, South Australian branch, interviewed by Ruth Ballardie

Canada:

Interview 1: Senior Research Fellow for the Canadian Union of Public Employees (CUPE), interviewed by Safak Tartanoglu Bennett

Brazil:

Interview 1: Nurse and trade union official of the National Nurses Federation on the 20th June 2023, Interviewed by Vera Weghmann, translated by Euan Gibb

Interview 2:Nurse technician and trade union official of the Confederation of Workers in the Federal Public Service (CONDSEF) on the 21th June 2023, Interviewed by Vera

Weghmann, translated by Euan Gibb

Interview 3: Nurse and trade union official of the National Nurses Federation on the 20th June 2023, interviewed by Vera Weghmann, translated by Euan Gibb

Interview 4: Nurse technician and trade union official of the Confederation of Workers in the Federal Public Service (CONDSEF) on the 21th June 2023, interviewed by Vera Weghmann, translated by Euan Gibb

Liberia:

Interview 1: Nurse and trade union representative of the National Health Workers Union of Liberia (NAHWUL) on the 9th November 2022, interview by Vera Weghmann